



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 ump.regence.com/pebb 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 healthcare.gov/sbc-glossary/ or call 1-888-849-3681 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | \$1,400/per member, \$2,800/family | Deductible is what you pay before the plan begins to pay. Generally, you must pay all of the costs for medical services and prescription drugs (combined) up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes: Covered preventive care , female sterilization, tobacco cessation, covered insulins, covered prescription drugs designated as preventive on the UMP Preferred Drug List, and vision hardware are covered before you meet your medical deductible. | 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 healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet other deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$4,200/per member, \$8,400/family. Out-of-pocket expenses for a single member under a family plan will not exceed \$7,000. | The out-of-pocket limit is the most you pay during a calendar year for covered medical services and prescription drugs before the plan pays 100 percent of the allowed amount to preferred providers and network pharmacies. If you have other family members in this plan , the family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance billing charges, noncovered drugs, coinsurance paid to participating and out-of-network providers and non-network pharmacies, amounts paid for | Even though you pay these costs, they don't count toward the out-of-pocket limit . |

*For more information about limitations and exceptions, see the [plan's](#) certificate of coverage at hca.wa.gov/ump-pebb-coc.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| | <p>services the plan does not cover, amounts paid by the plan, amounts that are more than the maximum dollar amount paid by the plan, and amounts paid for services over a benefit limit.</p> | |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. Visit the UMP website at ump.regence.com/pebb or call 1-888-849-3681 (TRS: 711) for a list of network providers (preferred providers). For a list of network pharmacies, visit the Prescription drugs webpage at ump.regence.com/pebb/benefits/prescriptions or call 1-888-361-1611 (TRS: 711).</p> | <p>This plan uses a provider network. You will pay less if you use a provider or pharmacy in the plan's network. You will pay the most if you use an out-of-network provider or out-of-network pharmacy and you might receive a bill from a provider or pharmacy for the difference between the provider's or pharmacy's charge and what your plan pays (balance billing). Be aware your network provider (preferred provider) might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>UMP does not require a referral from your primary care provider to see a specialist.</p> |

 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 | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/ . |
| 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 | Certain tests aren't covered and other tests require preauthorization. Please refer to your COC. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at ump.regence.com/pebb/benefits/prescriptions | Preventive | Preventive: \$0 | Preventive: 15% coinsurance | No coverage for prescription drugs with an over-the-counter alternative. You can receive up to a 90-day supply for some prescriptions. Preauthorization may be required. Postal Prescription Services (PPS) is the plan's only network mail-order pharmacy. Prescriptions purchased through other mail-order pharmacies will not be covered. |
| | Covered Insulins | Insulins – for a 30 day supply (deductible does not apply) Value Tier – 5% up to \$10 maximum Tier 1 – 10% up to \$25 maximum Tier 2 - 30% up to \$75 | Value Tier – 5% Tier 1 – 10% Tier 2 – 30% | Claims will apply to your deductible once they have been processed by Washington State Rx Services. You can receive up to a 90-day supply for some prescriptions. |

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| 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) | |
| | | maximum | | |
| | All other covered retail and PPS mail-order drugs | 15% coinsurance | 15% coinsurance | No coverage for prescription drugs with an over-the-counter alternative. You can receive up to a 90-day supply for some prescriptions. Preauthorization may be required. Note: Postal Prescription Services (PPS) is the plan's only network mail-order pharmacy. Prescriptions purchased through other mail-order pharmacies will not be covered. |
| | Specialty drugs | 15% coinsurance | Not covered | Coverage is limited to up to a 30-day supply per prescription or refill from the plan's specialty pharmacy, Ardon Health. 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 | 15% coinsurance | 15% coinsurance | Not applicable |
| | 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) | 15% coinsurance | 40% coinsurance | Provider must notify plan on 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 | 15% coinsurance | 40% coinsurance | Preauthorization required for inpatient admissions. Provider must notify the plan for detoxification, intensive outpatient program, |

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| 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) | |
| | | | | 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 | 15% coinsurance | 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 or continuous care in the member's home are not covered. |
| | Rehabilitation 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 | 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. Preauthorization is required. |
| | Skilled nursing care | 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. Replacement of lost, stolen, or damaged durable medical equipment is not covered. |

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| 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) | |
| | 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 routine eye exam | \$0 of the allowed amount | Not covered | Not subject to deductible . Coverage for children under the age of 19. You pay \$0 of the allowed amount when you see a VSP Choice network provider for one covered preventive eye exam with refraction or visual analysis per calendar year. |
| | Children's glasses or contact lenses | \$0 up to the allowed amount for one pair of standard lenses and frames per year; or \$0 up to the allowed amount for a one-year supply of contact lenses in lieu of standard lenses and frames. | Not covered | Not subject to the deductible . Coverage for children under the age of 19. Vision coverage is provided by UMP, in collaboration with Regence Choice Vision Plan administered by Vision Service Plan (VSP). |
| | 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's](#) certificate of coverage for more information and a list of any other [excluded services](#).)

| | | |
|--|--|---|
| <ul style="list-style-type: none"> • Cosmetic services or supplies • Custodial care • Dental care • Immunizations for travel or employment | <ul style="list-style-type: none"> • Infertility or fertility testing or treatment after initial diagnosis • Maintenance care • Marriage or family counseling • Massage therapy services when the massage therapist is not a preferred provider. | <ul style="list-style-type: none"> • Medical foods or food supplements • Medications for sexual dysfunction • Private duty or continuous care in the member's home • Weight loss programs and drugs |
|--|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan's](#) certificate of coverage.)

| | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing Aids • Non-emergency care when 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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Your Rights to Continue Coverage: 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 [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](#)'s certificate of coverage also provides 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); Washington State Rx Services at 1-888-361-1611 (prescription benefits) (TRS: 711). The Consumer Protection Division of the Office of the Insurance Commissioner (OIC) is currently designated by the U.S. Department of Health and Human Services as the official ombudsman in the State of Washington for consumers who have questions or complaints about health care appeals. Consumers may contact the OIC Consumer Hotline number at 1-800-562-6900.

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, kwijigo 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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,400 |
| Copayments | \$0 |
| Coinsurance | \$1,627 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,087 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*insulin pumps and insulin pump supplies*)

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

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,400 |
| Copayments | \$0 |
| Coinsurance | \$809 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$255 |
| The total Joe would pay is | \$2,464 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist coinsurance](#) 15%
- Hospital (facility) [copayment](#) 15%
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,400 |
| Copayments | \$0 |
| Coinsurance | \$79 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,479 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.