




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 (TRS: 711) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | \$250/per member, \$750/family | The medical deductible is what you pay before the plan begins to pay. Generally, you must pay all of the costs for medical services up to the medical deductible amount before this plan begins to pay. Each member has an individual medical deductible of \$250 and the maximum the family pays for medical deductibles is \$750. Once a particular member pays their \$250 deductible , the plan begins paying for covered services for that member. Once the family deductible has been met the plan begins paying for covered services for everyone in the family. |
| Are there services covered before you meet your deductible? | Yes: Covered preventive care , hearing aids, sterilization, tobacco cessation 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 medical 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | Yes, for prescription drugs : \$100/per member, \$300/family for Tier 2 drugs. There are no other specific deductibles . | There is no deductible for covered insulins or for covered prescription drugs designated as preventive, Value Tier, or Tier 1 on the UMP Preferred Drug List. You must pay all of the costs for Tier 2 drugs up to the specific prescription drug deductible amount before this plan begins to pay for Tier 2 drugs. |
| What is the out-of-pocket limit for this plan? | Medical: \$2,500/per member, \$5,000/family Prescription drugs : \$2,000/per member \$4,000/family | The medical out-of-pocket limit is the most you pay during a calendar year for covered medical services before the plan pays 100 percent of the allowed amount for preferred providers . The prescription drug out-of-pocket limit is the most you pay during a calendar year for covered prescription drugs and products before the plan pays 100 percent of the allowed amount . 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. |

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| <p>What is not included in the out-of-pocket limit?</p> | <p>Medical: Premiums, balance billing charges, prescription drug costs, member coinsurance paid to out-of-network providers and non-network pharmacies, amounts paid for services this plan doesn't cover, amounts paid by the plan, amounts paid for services over a benefit limit, and amounts that are more than the maximum dollar amount paid by the plan.</p> <p>Prescription drugs: Costs for medical services and drugs covered under the medical benefit, prescription drugs and products not covered by the plan, amounts paid by the plan, and amounts exceeding the allowed amount for prescription drugs, paid to non-network pharmacies.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket 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> |

* For more information about limitations and exceptions, see the [plan](#) or policy document at hca.wa.gov/ump-pebb-coc.

 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 https://www.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 plan document. |
| 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 | Value Tier (high value prescription drugs for chronic condition) | 5% coinsurance or \$10, whichever is less | 5% coinsurance | Not subject to prescription drug deductible . Cost based on a 30-day supply. You can receive up to a 90-day supply for some prescriptions. Cost share depends on whether you get up to 30 days, 60 days, or 90 days at a time. Tier 1 does not include high-cost generic drugs. 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. |
| | Tier 1 drugs (low cost generic prescription drugs) | 10% coinsurance or \$25, whichever is less | 10% coinsurance | |
| | Tier 2 Drugs (preferred brand drugs and high cost generic drugs) | 30% coinsurance or \$75, whichever is less | 30% coinsurance | Subject to prescription drug deductible except covered insulins. Cost based on a 30-day supply. You can receive up to a 90-day supply for some prescriptions. Cost share depends on whether you get up to 30 days, 60 days, or 90 days at a time. Tier 2 includes some high-cost generic drugs. Preauthorization may be required. Note: |

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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) | |
| | | | | Postal Prescription Services (PPS) is the plan 's only network mail-order pharmacy. |
| | Specialty drugs | Value Tier: 0-30 day supply: 5% coinsurance or \$10, whichever is less Tier 1: 0-30 day supply: 10% coinsurance or \$25 whichever is less Tier 2: 0-30 day supply: 30% coinsurance ; or \$75 whichever is less | Not covered | No prescription drug deductible for Value Tier and Tier 1. Prescription drug deductible applies to Tier 2. Costs based on a 0-30-day supply. Covers up to a 30-day supply for most specialty prescription drugs. Preauthorization may be required. Most prescriptions must be filled from the specialty pharmacy Ardon Health, except when a drug can only be dispensed by a certain pharmacy. |
| 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 a hospital or facility as inpatient from the emergency room (but you will pay an 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 member per admission | 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 | \$200 copayment per day up to \$600 per | 40% coinsurance | Preauthorization required for inpatient admissions. Provider must notify the plan for |

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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) | |
| | | member per admission Professional services: \$0 coinsurance | | 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 member per admission | 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 | Inpatient: \$200 copayment per day up to \$600 per member per admission 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 member per admission 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. Preauthorization is required. |
| | Skilled nursing care | Inpatient: \$200 copayment per day up to \$600 per member per admission Professional services: 15% coinsurance | 40% coinsurance | Coverage is limited to 150 days per calendar year. Services must be preauthorized . |

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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) | |
| | 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. |
| | 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 the 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 . There is no contact lens fitting fee. 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 document for more information and a list of any other excluded services .) | | |
|--|---|---|
| <ul style="list-style-type: none"> • Computed Tomographic Colonography for routine colorectal cancer screening • Coronary or cardiac artery calcium scoring • Cosmetic services or supplies • Custodial care • Dental care (Adult) • Immunizations for travel or employment • Infertility or fertility testing or treatment after initial diagnosis | <ul style="list-style-type: none"> • Long-term care • Maintenance care • Marriage or family counseling • Massage therapy services when the massage therapist is not a preferred provider • Medical foods or food supplements • Medications for sexual dysfunction | <ul style="list-style-type: none"> • MRI, upright • Private-duty or continuous care in the member's home • Replacement of lost, stolen, or damaged durable medical equipment • Vitamins • Weight loss programs and drugs |

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage: There is an agency that can help if you want to continue your coverage after it ends. The contact information for that agency is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the [plan](#) at 1-888-849-3681 (TRS: 711). 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](#) document 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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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 | \$200 |
| ■ 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 | \$250 |
| Copayments | \$200 |
| Coinsurance | \$1,550 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,060 |

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*)
[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 | \$250 |
| Copayments | \$0 |
| Coinsurance | \$1,707 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$255 |
| The total Joe would pay is | \$2,212 |

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 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$75 |
| Coinsurance | \$257 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$582 |

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