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/sebb or call 1 (800) 628-3481 (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 (800) 628-3481 (TRS: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual (single coverage) / $3,000 family per calendar year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,200 individual (single coverage) / $8,400 family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed $7,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, member coinsurance paid to out-of-network providers and non-network pharmacies, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Find a doctor at ump.regence.com/go/sebb-high-deductible or call 1- 800-628-3481 (TRS: 711) for a list of network providers (preferred providers). For a list of network pharmacies, visit the pharmacy-locater webpage at ump.regence.com/go/2023/pharmacy-locator or call 1-888-361-1611 (TRS: 711).	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
		In-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	None
	Specialist visit	15% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	Certain tests aren't covered and other tests require preauthorization. Please refer to your plan document. *See section Radiology.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at ump.regence.com/sebb/benefits/prescriptions	Value Tier	15% coinsurance for all other prescription drugs Covered insulins: 5% coinsurance up to $10 maximum	15% coinsurance for all other prescription drugs Covered insulins: 5% coinsurance	Deductible does not apply to covered insulin and certain drugs indicated on the UMP Preferred Drug List. Preauthorization may be required. Please refer to your plan document. *See section Your prescription drug benefit. Up to a 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / mail order prescription Postal Prescription Services (PPS) and Costco Mail Order Pharmacy are the plan's only network mail-order pharmacies. Specialty drugs must be filled from the specialty pharmacy, Ardon Health, except when a drug can only be dispensed by a certain pharmacy. Covers up to a 30-day supply for most specialty prescription drugs.
	Tier 1	15% coinsurance for all other prescription drugs Covered insulins: 10% coinsurance up to $25 maximum	15% coinsurance for all other prescription drugs Covered insulins: 10% coinsurance	
	Tier 2	15% coinsurance for all other prescription drugs Covered insulins: 30% coinsurance up to $35 maximum	15% coinsurance for all other prescription drugs Covered insulins: 30% coinsurance	
	Specialty drugs	15% coinsurance	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Preauthorization may be required. *See section Surgery.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	In-network deductible applies to in-network and out-of-network services.
	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	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
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. *See section Surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	40% coinsurance	Preauthorization may be required. *See section Behavioral health.
	Inpatient services	15% coinsurance	40% coinsurance	Preauthorization required for inpatient admissions. Provider must notify the plan for detoxification, intensive outpatient program, and partial hospitalization. *See section Behavioral health.
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	None
	Rehabilitation services	15% coinsurance	40% coinsurance	80 inpatient days / year 80 outpatient visits / year (combined with habilitation services) Includes physical therapy, occupational therapy and speech therapy. Inpatient admissions for rehabilitation services must be preauthorized. *See section Therapy: Habilitative and rehabilitative.
	Habilitation services	15% coinsurance	40% coinsurance	80 professional neurodevelopmental visits / year (combined with outpatient rehabilitation services) Includes physical therapy, occupational therapy and speech therapy. Preauthorization is required. *See section Therapy: Habilitative and rehabilitative.
	Skilled nursing care	15% coinsurance	40% coinsurance	150 inpatient days / year Preauthorization is required. *See section Skilled nursing facility.
	Durable medical equipment	15% coinsurance	40% coinsurance	None
	Hospice services	No charge	40% coinsurance	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	0% coinsurance	40% coinsurance	Eye exams for medical conditions are subject to deductible and coinsurance.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

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.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (24-visit limitation)
- Bariatric surgery
- Chiropractic care (24-visit limitation)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or 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 (800) 628-3481 (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 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 the plan at 1 (800) 628-3481 (TRS: 711) or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.gov.

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 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	**$1,500**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
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 *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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