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 regence.com/ump/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?	$125/per person, $375/family	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 deductible amount before this plan begins to pay. Each person has an individual medical deductible of $125 and the maximum the family pays for medical deductibles is $375. Once a particular person pays their $125 deductible, the plan begins paying for covered services for that person. 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, covered prescription drugs on the UMP Preferred Drug List, vision hardware, and most primary care services are covered before you meet your 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?	Medical: $2,000/per person, $4,000/family Prescription: $2,000/per person, $4,000/family	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Medical: Premiums, balance billing charges, prescription drug costs, member coinsurance paid to out-of-network providers, health care this plan doesn't cover, amounts paid by the plan, and services that exceed plan limits or maximums Prescription drugs: Medical services, premiums, noncovered drugs, balance billing charges, amounts paid by the plan, amounts exceeding the	Even though you pay these costs, they don't count toward the out-of-pocket limit.

	allowed amount for drugs, and costs paid for other enrolled family members' drugs and products.	
Will you pay less if you use a network provider or network pharmacy?	Yes. See regence.com/ump/pebb or call 1-888-849-3681 (TRS: 711) for a list of network providers. For a list of network pharmacies, visit regence.com/ump/pebb/benefits/prescriptions or call 1-888-361-1611 (TRS: 711)	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 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.	UMP does not require a referral from your primary care provider to see a specialist.

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	Primary care network provider 0% coinsurance, no deductible for office visit	50% coinsurance	Must see a primary care network provider contracted with UMP Plus—Puget Sound High Value Network, or a Regence network naturopathic physician, for primary care office visits to be covered in full with no deductible.
	Specialist visit	15% coinsurance	50% coinsurance	Not applicable.
	Preventive care/screening/ immunization	$0	50% coinsurance	This plan covers some items and services even if you haven't 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 share 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/.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	50% coinsurance	Not applicable

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

	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	No coverage for routine Computed Tomographic Colonography, upright MRI, Carotid Intima Media Thickness testing, 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 regence.com/ump/pebb/benefits/prescriptions	Preventive Value Tier Tier 1 drugs	**Preventive**: 0% **Value Tier:** 0-30 day supply: 5% coinsurance or $10, whichever is less 31-60 day supply: 5% coinsurance or $20, whichever is less 61-90 day supply: 5% coinsurance or $30, whichever is less **Tier 1**: 0-30 day supply: 10% coinsurance or $25, whichever is less 31-60 day supply: 10% coinsurance or $50, whichever is less 61-90 day supply: 10% coinsurance or $75, whichever is less	**Preventive**: 0% **Value Tier**: 5% coinsurance **Tier 1**: 10% coinsurance	No coverage for prescription drugs with an over-the-counter alternative. Tier 1 does not include high-cost generic drugs. 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.

	Tier 2 drugs	0-30 day supply: 30% coinsurance or $75, whichever is less 31-60 day supply: 30% coinsurance or $150, whichever is less 61-90 day supply: 30% coinsurance or $225, whichever is less	30% coinsurance	No coverage for prescription drugs with an over-the-counter alternative. Tier 2 also includes some high-cost generic drugs. 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	**Tier 1:** 10% coinsurance Prescription cost limit: $25 up to a 30-day supply **Tier 2:** 30% coinsurance; Prescription cost limit: $75 up to a 30-day supply	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	50% coinsurance	Not applicable
	Physician/surgeon fees	15% coinsurance	50% 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 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	50% coinsurance	Not applicable

If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per day up to $600 per person per calendar year.	50% coinsurance	Provider must notify plan on admission.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	Preauthorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	50% coinsurance	Preauthorization may be required. No coverage for marriage or family counseling.
	Inpatient services	$200 copayment per day up to $600 per person per calendar year Professional services: 15% coinsurance	50% coinsurance	Preauthorization required for inpatient admissions. Provider must notify the plan for detoxification, intensive outpatient program, and partial hospitalization.
If you are pregnant	Office visits	15% coinsurance	50% 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	50% coinsurance	Elective deliveries before 39 weeks gestation only covered if medically necessary.
	Childbirth/delivery facility services	$200 copayment per day up to $600 per calendar year	50% coinsurance	Elective deliveries before 39 weeks gestation only covered if medically necessary.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	Custodial care, maintenance care, and private duty nursing, or continuous care are not covered.
	Rehabilitation services	Inpatient: $200 copayment per day up to $600 per person per calendar year. Professional services: 15% coinsurance	50% 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 person per calendar year Professional services: 15% coinsurance	50% 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 person per calendar year Professional services: 15% coinsurance	50% coinsurance	Coverage is limited to 150 days per calendar year. Services must be preauthorized.
	Durable medical equipment	15% coinsurance	50% coinsurance	Foot orthotics are covered only for prevention of diabetic complications. Lost, stolen, or damaged durable medical equipment is not covered.
	Hospice services	$0 after deductible is met	50% coinsurance	Hospice care 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 eye exam	$0	50% coinsurance	Eye exams for medical conditions are subject to deductible and coinsurance. Contact fitting fees covered up to $65 per year and member may pay charges exceeding that amount
	Children's glasses or contact lenses	$0 for one pair of lenses and standard frames per calendar year up to the allowed amount; or $0 for a one-year supply of contact lenses in lieu of glasses up to the allowed amount.	$0 for one pair of lenses and standard frames per calendar year up to the allowed amount; or $0 for a one-year supply of contact lenses in lieu of glasses up to the allowed amount. Providers may balance bill you for charges that exceed the allowed amount.	Not subject to the deductible. Coverage for children ages 0-18 years only.
	Children's dental check-up	Not covered	Not covered	Not applicable

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

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.)

- Coronary or cardiac artery calcium scoring
- Cosmetic Surgery
- Custodial care
- Dental care
- Immunizations for travel or employment
- Infertility treatment after initial diagnosis
- Lost, stolen, or damaged durable medical equipment
- Maintenance care
- Marriage or family counseling
- Medical foods or food supplements
- Medications for sexual dysfunction
- MRI, upright
- Out-of-network massage therapy
- Private duty nursing and continuous care
- Computed Tomographic Colonography for routine colorectal cancer screening
- Vitamins
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Non-emergency care if traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care for certain medical conditions

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 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, kwiijigo 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 network prenatal care and a hospital delivery)

The plan's overall deductible	$125
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:

Cost Sharing	
Deductibles	$125
Copayments	$200
Coinsurance	$1,675
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

Managing Joe's type 2 diabetes
(a year of routine network care of a well-controlled condition)

The plan's overall deductible	$125
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)*
Durable medical equipment *(continuous glucose monitor)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$125
Copayments	$0
Coinsurance	$1,679
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$2,059**

Mia's simple fracture
(network emergency room visit and follow up care)

The plan's overall deductible	$125
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:

Cost Sharing	
Deductibles	$125
Copayments	$75
Coinsurance	$282
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$482**

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