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?	$750 individual / $2,250 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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?	Yes. $250 individual / $750 family per calendar year for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,500 individual / $7,000 family per calendar year. Prescription drugs: $2,000 individual / $4,000 family per calendar year	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?	Premiums, balance-billing charges, and health care this plan doesn't cover. Prescription drugs do not apply to the medical out-of-pocket limit and are subject to their own out-of-pocket limit.	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/pebb/ump-select or call 1- 888-849-3681 (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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% 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)	20% 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)	20% 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/pebb/benefits/prescriptions	Value Tier (High value prescription drugs for chronic condition)	5% coinsurance or $10 copay, whichever is less / prescription	5% coinsurance	Deductible does not apply for Value Tier drugs, Tier 1 drugs and insulin. *Coinsurance for Tier 2 covered insulins are capped at $35 per 30-day supply. 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 (Low cost generic prescription drugs)	10% coinsurance or $25 copay, whichever is less / prescription	10% coinsurance	
	Tier 2 (Preferred brand drugs and high cost generic drugs)	30% coinsurance or $75 copay, whichever is less, up to 30 day supply / prescription*	30% coinsurance	
	Specialty drugs	5% coinsurance or $10 copay, whichever is less / value tier drugs 10% coinsurance or $25 copay, whichever is less / tier 1 drugs 30% coinsurance or $75 copay, whichever is less / tier 2 drugs		

*For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-pebb-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)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization may be required. *See section Surgery.
If you need immediate medical attention	Emergency room care	20% coinsurance after $75 copay / visit	20% coinsurance after $75 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	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)	$200 copay per day up to $600 per individual per calendar year	40% coinsurance	Provider must notify plan on admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization may be required. *See section Surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required. *See section Behavioral health.
	Inpatient services	$200 copay per day up to $600 per individual per calendar year; Professional services: No charge	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	20% 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$200 copay per day up to $600 per individual per	40% coinsurance	

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