




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 <u>deductible</u>?	\$125 individual / \$375 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,000 individual / \$4,000 family per calendar year. <u>Prescription drugs</u> : \$2,000 individual / \$4,000 family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. <u>Prescription drugs</u> do not apply to the medical <u>out-of-pocket limit</u> and are subject to their own <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. Find a doctor at ump.regence.com/go/pebb/ump-plus-uwmacn or call 1- 888-849-3681 (TRS: 711) for a list of <u>network providers</u> (<u>preferred providers</u>). For a list of network pharmacies, visit the <u>pharmacy-locator webpage</u> at ump.regence.com/go/2023/pharmacy-locator or call 1-888-361-1611 (TRS: 711).	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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	0% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	Primary care provider must be contracted with UMP Plus-UW Medicine ACN to avoid <u>cost sharing</u> .
	Specialist visit	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No charge	50% <u>coinsurance</u>	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% <u>coinsurance</u>	50% <u>coinsurance</u>	Certain tests aren't covered and other tests require <u>preauthorization</u> . Please refer to your plan document. *See section Radiology.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at ump.regence.com/pebb/benefits/prescriptions	Value Tier (High value <u>prescription drugs</u> for chronic condition)	5% <u>coinsurance</u> or \$10 <u>copay</u> , whichever is less / prescription	5% <u>coinsurance</u>	*Coinsurance for Tier 2 covered insulins are capped at \$35 per 30-day supply. <u>Preauthorization</u> may be required. Please refer to your plan document. *See section Your prescription drug benefit. Up to a 90-day supply / retail prescription (your <u>cost share</u> 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 <u>network</u> mail-order pharmacies. <u>Specialty drugs</u> 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 <u>prescription drugs</u> .
	Tier 1 (Low cost generic <u>prescription drugs</u>)	10% <u>coinsurance</u> or \$25 <u>copay</u> , whichever is less / prescription	10% <u>coinsurance</u>	
	Tier 2 (Preferred brand drugs and high cost generic drugs)	30% <u>coinsurance</u> or \$75 <u>copay</u> , whichever is less, up to 30 day supply / prescription*	30% <u>coinsurance</u>	
	Specialty drugs	5% <u>coinsurance</u> or \$10 <u>copay</u> , whichever is less / value tier drugs 10% <u>coinsurance</u> or \$25 <u>copay</u> , whichever is less / tier 1 drugs 30% <u>coinsurance</u> or \$75 <u>copay</u> , 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)	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u> after \$75 <u>copay</u> / visit	15% <u>coinsurance</u> after \$75 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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.
	<u>Urgent care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> per day up to \$600 per individual per calendar year	50% <u>coinsurance</u>	<u>Provider</u> must notify <u>plan</u> on admission.
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Behavioral health.
	Inpatient services	\$200 <u>copay</u> per day up to \$600 per individual per calendar year; Professional services: No charge	50% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient admissions. <u>Provider</u> must notify the <u>plan</u> for detoxification, intensive outpatient program, and partial <u>hospitalization</u> . *See section Behavioral health.
If you are pregnant	Office visits	15% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$200 <u>copay</u> per day up to \$600 per individual per calendar year	50% <u>coinsurance</u>	
	<u>Home health care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None

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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	<u>Rehabilitation services</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 15% <u>coinsurance</u> Outpatient services: 15% <u>coinsurance</u>	50% <u>coinsurance</u>	60 inpatient days / year 60 outpatient visits / year (combined with <u>habilitation services</u>) Professional and outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy. Inpatient admissions for <u>rehabilitation services</u> must be <u>preauthorized</u> . *See section Therapy: Habilitative and rehabilitative.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	60 professional neurodevelopmental visits / year (combined with outpatient <u>rehabilitation services</u>) Includes physical therapy, occupational therapy and speech therapy. <u>Preauthorization</u> is required. *See section Therapy: Habilitative and rehabilitative.
	<u>Skilled nursing care</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 15% <u>coinsurance</u>	50% <u>coinsurance</u>	150 inpatient days / year <u>Preauthorization</u> is required. *See section Skilled nursing facility.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam / year Limited to individuals under age 19.
	Children's glasses	No charge	Not covered	1 pair of standard lenses and frames / year 1 year supply of contact lenses in lieu of standard lenses and frames Limited to individuals under age 19.
	Children's dental check-up	Not covered	Not covered	None

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