

 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/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?	\$250/per person, \$750/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 \$250 and the maximum the family pays for medical deductibles is \$750. Once a particular person pays their \$250 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 designated as preventive on the UMP Preferred Drug List	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?	Yes, for prescription drugs : \$100/per person, \$300/family for Tier 2 drugs and specialty drugs. 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?	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	Even though you pay these costs, they don't count toward the out-of-pocket limit .

	<p>services that exceed plan limits or maximums.</p> <p>Prescription drugs: Medical services, premiums, noncovered drugs, balance billing charges, amounts paid by the plan, amounts exceeding the allowed amount for drugs, and costs paid for other enrolled family members' drugs and products.</p>	
<p>Will you pay less if you use a network provider (preferred provider) or network pharmacy?</p>	<p>Yes. See regence.com/ump/sebb or call 1-800-628-3481 (TRS: 711) for a list of network providers (preferred providers). For a list of network pharmacies, visit regence.com/ump/sebb/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>

 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	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

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

				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	40% coinsurance	Not applicable
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% 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 .

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<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at regence.com/ump/sebb/benefits/prescriptions.</p>	<p>Preventive Value Tier</p> <p>Tier 1 drugs</p>	<p>Preventive: 0%</p> <p>Value Tier: <u>0-30 day supply:</u> 5% coinsurance or \$10, whichever is less</p> <p><u>31-60 day supply:</u> 5% coinsurance or \$20, whichever is less</p> <p><u>61-90 day supply:</u> 5% coinsurance or \$30, whichever is less</p> <p>Tier 1: <u>0-30 day supply:</u> 10% coinsurance or \$25, whichever is less</p> <p><u>31-60 day supply:</u> 10% coinsurance or \$50, whichever is less</p> <p><u>61-90 day supply:</u> 10% coinsurance or \$75, whichever is less</p>	<p>Preventive: 0%</p> <p>Value Tier: 5% coinsurance</p> <p>Tier 1: 10% coinsurance</p>	<p>No coverage for prescription drugs with an over-the-counter alternative. Not subject to prescription drug deductible. 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.</p>
	<p>Tier 2 drugs</p>	<p><u>0-30 day supply:</u> 30% coinsurance or \$75, whichever is less</p> <p><u>31-60 day supply:</u> 30% coinsurance or \$150, whichever is less</p>	<p>30% coinsurance</p>	<p>No coverage for prescription drugs with an over-the-counter alternative. Subject to prescription drug deductible. 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.</p>

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		61-90 day supply: 30% coinsurance or \$225, whichever is less		
	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. No prescription drug deductible for Tier 1. Prescription drug deductible applies to Tier 2. Preauthorization is required.
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 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 person per calendar year	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 person per calendar year Professional services: 15% coinsurance	40% 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	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 calendar year	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 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	40% coinsurance	Coverage is limited to 80 inpatient days per calendar year for all therapies combined and 80 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:	40% coinsurance	Coverage includes neurodevelopmental therapy. Coverage is limited to 80 inpatient days per calendar year for all therapies combined and 80 outpatient visits per calendar year for all therapies combined.

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

		15% coinsurance		Preauthorization is required.
	Skilled nursing care	Inpatient: \$200 copayment per day up to \$600 per person per calendar year Professional services: 15% coinsurance	40% coinsurance	Coverage is limited to 150 days per calendar year. Services must be preauthorized .
	Durable medical equipment	15% coinsurance	40% coinsurance	Foot orthotics are covered only for prevention of diabetes complications. 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 medical eye exam	\$0	40% coinsurance	Eye exams for medical conditions are subject to deductible and coinsurance .
	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'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](#)
- Vision (routine)
- 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 1-800-628-3481 (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 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 1-800-628-3481 (TRS: 711).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-628-3481 (TRS: 711).]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-628-3481 (TRS: 711).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-628-3481 (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	\$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
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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 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*)
[Durable medical equipment](#) (*continuous glucose monitor*)

Total Example Cost	\$7,460
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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

(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
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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