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?	$250/per member, $750/family	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: Covered preventive care, hearing aids, sterilization, and tobacco cessation are covered before you meet your medical deductible.	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, for prescription drugs: $100/per member, $300/family for Tier 2 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 member, $4,000/family Prescription drugs: $2,000/per member, $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 and non-network pharmacies, amounts paid for services this plan doesn't cover, amounts paid by the plan, amounts paid for services over a benefit limit, and amounts that are more than the maximum dollar amount	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	paid by the plan. Prescription drugs: Costs for medical services and drugs covered under the medical benefit, prescription drugs and products not covered by the plan, amounts paid by the plan, and amounts exceeding the allowed amount for prescription drugs paid to non-network pharmacies.	
Will you pay less if you use a network provider?	Yes. Find a doctor at ump.regence.com/go/sebb/ump-achieve2 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-locator webpage at ump.regence.com/go/2022/sebb/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 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.
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
		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	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	Not applicable
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Certain tests aren't covered and other tests require preauthorization. Please refer to your plan document. *See section Radiology.
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 (High value prescription drugs for chronic condition)	5% coinsurance or $10 copayment, whichever is less / prescription	5% coinsurance	Not subject to prescription drug deductible. Cost based on a 30-day supply. You can receive up to a 90-day supply for some prescriptions. Cost share depends on whether you get up to 30 days, 60 days, or 90 days at a time. Tier 1 does not include high-cost generic drugs. Preauthorization may be required. *See section Your prescription drug benefit. Postal Prescription Services (PPS) is the plan's only network mail-order pharmacy.
	Tier 1 drugs (Low cost generic prescription drugs)	10% coinsurance or $25 copayment, whichever is less / prescription	10% coinsurance	
	Tier 2 drugs (Preferred brand drugs and high cost generic drugs)	**Tier 2:** 0-30 day supply: 30% coinsurance or $75 copayment,, whichever is less / prescription	**Tier 2:** 30% coinsurance	Subject to prescription drug deductible except covered insulins. Cost based on a 30-day supply. You can receive up to a 90-day supply for some prescriptions. Cost share depends on whether you get up to 30 days, 60 days, or 90 days at a time. Tier 2 includes some high-cost generic drugs. Preauthorization may be required. *See section Your prescription drug benefit. Note: Postal Prescription Services (PPS) is the plan's only network mail-order pharmacy.
	Specialty drugs	**Value Tier:** 0-30 day supply: 5% coinsurance	Not covered	No prescription drug deductible for Value Tier and Tier 1. Prescription drug deductible applies to Tier 2.

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		or $10 copayment, whichever is less / prescription **Tier 1:** 0-30 day supply: 10% coinsurance or $25 copayment, whichever is less / prescription **Tier 2:** 0-30 day supply: 30% coinsurance or $75 copayment. whichever is less / prescription		Costs based on a 0-30-day supply. Covers up to a 30-day supply for most specialty prescription drugs. Preauthorization may be required. *See section Your prescription drug benefit. Most prescriptions must be filled from the specialty pharmacy Ardon Health, except when a drug can only be dispensed by a certain pharmacy.
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. *See section Surgery.
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 a 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 member per calendar year	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	Outpatient services	15% coinsurance	40% coinsurance	Preauthorization may be required. No coverage for marriage or family counseling. *See section

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse services				Behavioral health.
	Inpatient services	$200 copayment per day up to $600 per member 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	15% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, 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	Elective deliveries before 39 weeks gestation covered only if medically necessary.
	Childbirth/delivery facility services	$200 copayment per day up to $600 per member 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 or continuous care in the member's home are not covered.
	Rehabilitation services	Inpatient: $200 copayment per day up to $600 per member per calendar year Professional services: 15% coinsurance	40% coinsurance	The total limit for therapies for inpatient habilitative and inpatient rehabilitation services is a combined limit of 80 days annually. The total limit for therapies for outpatient habilitative and outpatient rehabilitation services is a combined limit of 80 visits annually. Inpatient admissions for rehabilitation services must be preauthorized. *See section Therapy: Habilitative and rehabilitative.
	Habilitation services	Inpatient: $200 copayment per day up to $600 per member per calendar year	40% coinsurance	Coverage includes neurodevelopmental therapy. The total limit for therapies for inpatient habilitative and inpatient rehabilitation services is a combined limit of 80 days annually. The total limit for therapies for

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Professional services: 15% coinsurance		outpatient habilitative and outpatient rehabilitation services is a combined limit of 80 visits annually. Inpatient admissions for habilitation services must be preauthorized. *See section Therapy: Habilitative and rehabilitative.
	Skilled nursing care	Inpatient: $200 copayment per day up to $600 per member per calendar year Professional services: 15% coinsurance	40% coinsurance	Coverage is limited to 150 days per calendar year. Services must be preauthorized. *See section Skilled nursing facility.
	Durable medical equipment	15% coinsurance	40% coinsurance	Foot orthotics are covered only for prevention of diabetic complications.
	Hospice services	No charge	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	No charge	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 document for more information and a list of any other excluded services.)

- Computed Tomographic Colonography for routine colorectal cancer screening
- Coronary or cardiac artery calcium scoring
- Cosmetic services or supplies
- Custodial care
- Dental care (Adult)
- Immunizations for travel or employment
- Infertility or fertility testing or treatment after initial diagnosis
- Long-term care
- Maintenance care
- Marriage or family counseling
- Massage therapy services when the massage therapist is not a preferred provider
- Medical foods or food supplements
- Medications for sexual dysfunction
- MRI, upright
- Private-duty nursing or continuous care in the member's home
- Replacement of lost, stolen, or damaged durable medical equipment
- Routine eye care (Adult)
- Vitamins
- Weight loss programs and drugs

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

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 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 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 receive for that medical claim. Your plan document 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.**
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 1-800-628-3481 (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, kwiijigo 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 in-network pre-natal 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,210**

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) copayment	$200
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 *(insulin pumps and insulin pump supplies)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,650**

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

The plan's overall deductible	$250
Specialist coinsurance	15%
Hospital (facility) copayment	$200
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	$250
Copayments	$80
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$730**

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