

UMP offers programs to keep you healthy

Get rewards for living well

SmartHealth is Washington State's voluntary wellness program that supports whole person well-being. Participate in activities that support all of you, including managing stress, building resiliency, and adapting to change. As you progress in your wellness journey, you may qualify for wellness incentives. Learn more on the SmartHealth webpage. PEBB members visit hca.wa.gov/pebb-smarthealth. SEBB members visit hca.wa.gov/sebb-smarthealth.

Talk to a nurse anytime

Nurse line provides access to registered nurses by phone 24 hours a day, 7 days a week, or by secure chat from 8 a.m. to 10 p.m. (Pacific) at no cost to you. Nurses provide immediate symptom assessment, health information, and advice. They can help you decide if you need to go to the emergency room, see a doctor either virtually or in-person, or care for your symptoms at home. Access the nurse line by calling **1-877-375-2599** (TRS: 711) or through live chat by signing in or creating an account at ump.regence.com/ump/signin.

Explore telemedicine (virtual care)

Doctor On Demand is a virtual care service that gives you access to high quality virtual primary care, on-demand urgent care, and behavioral health providers 24 hours a day, 7 days a week. On-demand urgent care and behavioral health services are a good option to consider when you need medical attention, but not emergency room care. First-time primary care appointments can be scheduled within days, and you are able to choose a provider for an annual preventive exam and ongoing routine care. Doctor On Demand providers are board certified, U.S.-based providers who are specifically trained in video medicine. You can schedule or connect in minutes with doctors face-to-face through a smartphone, tablet, or computer via the Regence website or Doctor On Demand smartphone application. To learn more, visit ump.regence.com, select your group, then select **Telemedicine (Virtual care)** within the **Explore your benefits** menu.

Find the right behavioral health care for you

As a UMP member, you have access to tools and resources that make it easier to get the behavioral health care you need. Whether you need to find a virtual or in-person therapist in your network or see what your plan covers, we can help. Check out our behavioral health resources by signing in or creating an account at ump.regence.com/ump/signin. You can also visit the UMP website at ump.regence.com, select your group, then select **Behavioral health** within the **Explore your benefit** menu.

Try self-guided mental health tools

Teladoc Health is a self-guided health and resiliency online tool clinically proven to improve emotional health. This secure resource is available 24 hours a day, 7 days a week for members age 13 or older at no cost to you. Teladoc Health's interactive and activity-based tools are personalized to you and address conditions such as depression, anxiety, stress, substance use disorders, and chronic pain. Visit the Teladoc Health website at TeladocHealth.com/start/mental-health-digital, click Register Now and use the Teladoc Health registration code to sign up and learn more. PEBB members use registration code: **WAPEBB**. SEBB members use registration code: **WASEBB**. The registration code is required for your initial enrollment.

Get support preventing or managing diabetes

If you are age 18 or older, Medicare is not your primary coverage, and your provider ordered a blood sugar test in the last 12 months and the results show you are in the prediabetes range, you may be eligible to enroll in the **Diabetes Prevention Program**. If you meet the criteria, you may participate in the program at no cost to you. The virtual program includes a professional health coach, a wireless scale, and weekly online classes with a small group of participants who provide real-time support.

If you are age 18 or older, have Type 1 or Type 2 diabetes, and Medicare is not your primary coverage, you may be eligible to participate in the online **Diabetes Management Program**. If you meet the criteria, you may participate in the program at no cost to you. The virtual program includes extensive support tools such as glucose tracking, live coaching, and mental and emotional care to help you improve your health and manage your diabetes.

Visit **Omada Health's** website to learn if you are eligible for either of these programs. PEBB members visit: go.omadahealth.com/wapebb. SEBB members visit: go.omadahealth.com/wasebb.

Quit tobacco and nicotine for good

If you are age 18 or older and Medicare is not your primary coverage, you may participate in a virtual **Tobacco Cessation** program to help you quit tobacco and nicotine use. The program offers a variety of resources, including unlimited 1:1 personalized support with a dedicated certified tobacco treatment specialist, access to digital cognitive behavioral therapy (24 hours a day, 7 days a week) through app-based tools, educational materials, nicotine replacement therapy, and other resources to help you stop tobacco use. To learn about the program and register call **1-877-349-7755** or visit the **Pelago** website at my.pelagohealth.com/regence.com/regence-bswa. UMP members age 17 and under may access support through teen.smokefree.gov or by calling **1-800-QUIT-NOW (784-8669)** (TRS: 711).

Prepare for baby

As an expectant parent, the **Pregnancy Program** helps you manage your health throughout pregnancy and offers access to a nurse line, pregnancy support, and education 24 hours a day, 7 days a week. It also includes a smartphone application to help you track milestones, identify symptoms, access education, and get one-click access to the nurse line. To enroll in the program, call **1-888-JOY-BABY (569-2229)** (TRS: 711) or by signing in or creating an account at ump.regence.com/ump/signin. This program is covered at no cost to you.

For more information about any of these programs or services

Call UMP Customer Service Monday through Friday 5 a.m.- 8 p.m. and Saturday 8 a.m.- 4:30 p.m. (Pacific). PEBB members call **1-888-849-3681** (TRS: 711). SEBB members call **1-800-628-3481** (TRS: 711). You can also visit the UMP website at ump.regence.com for more information.

Doctor On Demand is a separate company that provides telehealth services.

Omada Health is a separate company that provide care and disease management services.

Pelago is a separate company that provides tobacco cessation/addiction services.

SmartHealth is provided through WebMD which is a separate company that provides health education services and materials.

Teladoc Health is a separate company that provides care and disease management services.



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:
<p>What is the overall deductible?</p>	<p>\$250 individual / \$750 family per calendar year.</p>	<p>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 deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Certain <u>preventive care</u> and those services listed below as "<u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u>, regardless of <u>deductible</u> applicability.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$100 individual / \$300 family per calendar year for <u>prescription drug coverage</u>. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$2,000 individual / \$4,000 family per calendar year. <u>Prescription drugs</u>: \$2,000 individual / \$4,000 family per calendar year.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, member <u>coinsurance</u> paid to <u>out-of-network providers</u> and <u>non-network pharmacies</u>, 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>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. Find a doctor at ump.regence.com/go/pebb/ump-classic or call 1-888-849-3681 (TRS: 711) for a list of <u>network providers (preferred providers)</u>. For a list of network pharmacies, visit the <u>pharmacy-locator webpage</u> at https://ump.regence.com/go/pharmacy-locator or call 1-888-361-1611 (TRS: 711).</p>	<p>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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

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

! 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	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Specialist visit	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from <u>out-of-network providers</u> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain tests aren't covered, and other tests require <u>preauthorization</u> . Please refer to your <u>plan</u> document. *See section Radiology.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	40% <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 (Specific high value <u>prescription drugs</u> used to treat certain chronic conditions)	5% <u>coinsurance</u> or \$10 <u>copay</u> , whichever is less / <u>prescription</u> , <u>deductible</u> does not apply	5% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Deductible</u> does not apply for certain covered <u>prescription drugs</u> (see Preferred Drug List). * <u>Coinsurance</u> for certain Tier 2 <u>prescription drugs</u> (see Preferred Drug List), are capped at \$35 per 30-day supply.
	Tier 1 (Low-cost generic <u>prescription drugs</u>)	10% <u>coinsurance</u> or \$25 <u>copay</u> , whichever is less / <u>prescription</u> , <u>deductible</u> does not apply	10% <u>coinsurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> may be required. Please refer to your <u>plan</u> document. *See section Your <u>prescription drug</u> benefit.
	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 / <u>prescription</u> *	30% <u>coinsurance</u>	Up to a 90-day supply / retail <u>prescription</u> (your <u>cost</u> share is per 30-day supply) 90-day supply / mail-order <u>prescription</u> Postal <u>Prescription Services</u> (PPS) and Costco Mail Order Pharmacy are the <u>plan's</u> only <u>network</u> mail-order pharmacies.
	Specialty drugs	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	<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> .

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/lump-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>	40% <u>coinsurance</u>	<u>Prescription drugs</u> filled at excluded pharmacies are not covered.
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<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>Preauthorization</u> may be required. *See section Surgery.
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Urgent care</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is not provided for air or water ambulance if ground ambulance would serve the same purpose.
	Facility fee (e.g., hospital room)	\$200 <u>copay</u> per day up to \$600 per individual per calendar year	40% <u>coinsurance</u>	Ambulance services for personal or convenience purposes are not covered.
If you have a hospital stay	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Provider</u> must notify <u>plan</u> on admission.
	Inpatient services	Professional services: No charge	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
If you need mental health, behavioral health, or substance abuse services	Office visits	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Behavioral health.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient admissions.
	Childbirth/delivery facility services	\$200 <u>copay</u> per day up to \$600 per individual per	40% <u>coinsurance</u>	<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>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	15% <u>coinsurance</u>	40% <u>coinsurance</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 facility services	\$200 <u>copay</u> per day up to \$600 per individual per	40% <u>coinsurance</u>	

* 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 need help recovering or have other special health needs	<u>Home health care</u>	calendar year 15% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<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>	40% <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 deductible. 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>	40% <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>	40% <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>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime

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

If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Cosmetic surgery, except congenital anomalies
- Infertility treatment
- Dental care
- Long-term care
- Private-duty nursing
- Routine eye care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, 24 visits / year
- Hearing aids, 1 prescribed per ear up to allowed amount / 36 months
- Bariatric surgery
- Chiropractic care, 24 spinal manipulation visits / year
- 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 Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or ccio.cms.gov or your state insurance department. You may also contact the plan at 1-888-849-3681 (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 will receive for that medical claim. Your plan documents also provide 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 the plan at 1-888-849-3681 (TRS: 711) or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1-800-562-6900, or through the Internet at: www.insurance.wa.gov.

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 1-866-240-9580.

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
<i>What isn't covered</i>	
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 (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिपिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ອຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.


توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)



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:
<p>What is the overall deductible?</p>	<p>\$750 individual / \$2,250 family per calendar year.</p>	<p>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 deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Certain <u>preventive care</u> and those services listed below as "<u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u>, regardless of <u>deductible</u> applicability.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the deductible 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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$250 individual / \$750 family per calendar year for <u>prescription drug coverage</u>. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$3,500 individual / \$7,000 family per calendar year. Prescription drugs: \$2,000 individual / \$4,000 family per calendar year.</p>	<p>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 plan, 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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, member <u>coinsurance</u> paid to <u>out-of-network</u> providers and <u>non-network</u> pharmacies, 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>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes. Find a doctor at ump.regence.com/go/pebb/ump-select or call 1-888-849-3681 (TRS: 711) for a list of <u>network providers</u> (<u>preferred providers</u>). For a list of <u>network pharmacies</u>, visit the <u>pharmacy-locator</u> webpage at https://ump.regence.com/go/pharmacy-locator or call 1-888-361-1611 (TRS: 711).</p>	<p>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>providers 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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>
<p> All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.</p>		

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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Specialist visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coinsurance and <u>deductible</u> do not apply for childhood immunizations from out-of-network providers. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Preventive care/screening/immunization	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> , <u>deductible</u> does not apply	Certain tests aren't covered, and other tests require <u>preauthorization</u> . Please refer to your <u>plan</u> document. *See section Radiology.
	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>

*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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at ump.regence.com/pebb/benefits/prescriptions</p>	Value Tier (Specific high value <u>prescription drugs</u> used to treat certain chronic conditions)	5% <u>coinsurance</u> or \$10 <u>copay</u> , whichever is less / <u>prescription</u> , <u>deductible</u> does not apply	5% <u>coinsurance</u> , <u>deductible</u> does not apply	<p><u>Deductible</u> does not apply for certain covered <u>prescription drugs</u> (see Preferred Drug List).</p> <p>*<u>Coinsurance</u> for certain Tier 2 <u>prescription drugs</u> (see Preferred Drug List), are capped at \$35 per 30-day supply.</p> <p><u>Preauthorization</u> may be required. Please refer to your <u>plan document</u>. *See section Your <u>prescription drug benefit</u>.</p> <p>Up to a 90-day supply / retail <u>prescription</u> (your <u>cost share</u> is per 30-day supply)</p> <p>90-day supply / mail-order <u>prescription</u></p> <p>Postal <u>Prescription Services</u> (PPS) and Costco Mail Order Pharmacy are the <u>plan's only network</u> mail-order pharmacies.</p> <p><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.</p> <p>Covers up to a 30-day supply for most specialty <u>prescription drugs</u>.</p> <p><u>Prescription drugs</u> filled at excluded pharmacies are not covered.</p>
	Tier 1 (Low-cost generic <u>prescription drugs</u>)	10% <u>coinsurance</u> or \$25 <u>copay</u> , whichever is less / <u>prescription</u> , <u>deductible</u> does not apply	10% <u>coinsurance</u> , <u>deductible</u> does not apply	
	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 / <u>prescription</u> *	30% <u>coinsurance</u>	
	<u>Specialty drugs</u>	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	Refer to Value Tier, Tier 1, and Tier 2 drugs above.	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$75 <u>copay</u> / visit	20% <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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

*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 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 <u>plan</u> on admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	<u>Preauthorization</u> may be required. *See section Surgery.
	Outpatient services	20% coinsurance	40% coinsurance	<u>Preauthorization</u> may be required. *See section Behavioral health.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$200 copay per day up to \$600 per individual per calendar year Professional services: No charge	40% coinsurance	<u>Preauthorization</u> required for inpatient admissions. Provider must notify the <u>plan</u> for detoxification, intensive outpatient program, and partial <u>hospitalization</u> . *See section Behavioral health.
	Office visits	20% coinsurance	40% coinsurance	Cost sharing 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).
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	\$200 copay per day up to \$600 per individual per calendar year	40% coinsurance	

*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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 20% <u>coinsurance</u> Outpatient services: 20% <u>coinsurance</u>	40% <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: <u>Habilitative and rehabilitative</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <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: <u>Habilitative and rehabilitative</u> .
	<u>Skilled nursing care</u>	Inpatient: \$200 <u>copay</u> per day up to \$600 per individual per calendar year Professional services: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	150 inpatient days / year <u>Preauthorization</u> is required. *See section Skilled nursing facility.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

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.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, 24 visits / year
- Bariatric surgery
- Chiropractic care, 24 spinal manipulation visits / year
- Hearing aids, 1 prescribed per ear up to allowed amount / 36 months
- 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 Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or ccio.cms.gov or your state insurance department. You may also contact the plan at 1-888-849-3681 (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 will receive for that medical claim. Your plan documents also provide 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 the plan at 1-888-849-3681 (TRS: 711) or visit.regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1-800-562-6900, or through the Internet at: www.insurance.wa.gov.

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 1-866-240-9580.

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** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other coinsurance** 20%

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	\$750
Copayments	\$200
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,910

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,150

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) copayment** \$200
- **Other coinsurance** 20%

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	\$750
Copayments	\$80
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,230

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

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ- 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिडिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.


توجه: اگر بہ زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)



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?	\$1,700 individual (single coverage) / \$3,400 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 policy, the overall family deductible must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	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 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$4,200 individual (single coverage) / \$8,400 family* per calendar year. *An individual on family coverage will not have their <u>out-of-pocket limit</u> exceed \$7,000.	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, member <u>coinsurance</u> paid to <u>out-of-network providers</u> and <u>non-network pharmacies</u> , and health care this <u>plan</u> doesn't cover.	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 network provider?	Yes. Find a doctor at ump.regence.com/go/pebb/ump-cdhp or call 1-888-849-3681 (TRS: 711) for a list of <u>network providers</u> (preferred providers). For a list of network pharmacies, visit the <u>pharmacy-locator webpage</u> at https://ump.regence.com/go/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> .	
 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None	<u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from <u>out-of-network providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	Specialist visit	15% <u>coinsurance</u>	40% <u>coinsurance</u>		
If you have a test	Preventive care/screening/immunization	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> , <u>deductible</u> does not apply		Certain tests aren't covered, and other tests require preauthorization. Please refer to your <u>plan</u> document. *See section Radiology.
	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u>	40% <u>coinsurance</u>		
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	40% <u>coinsurance</u>		
	Value Tier (Specific high value <u>prescription drugs</u> used to treat certain chronic conditions)	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 5% <u>coinsurance</u> up to \$10 maximum	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 5% <u>coinsurance</u>	<u>Deductible</u> does not apply for certain covered <u>prescription drugs</u> (see Preferred Drug List). * <u>Coinsurance</u> for certain Tier 2 <u>prescription drugs</u> , (see Preferred Drug List), are capped at \$35 per 30-day supply. <u>Preauthorization</u> may be required. Please refer to your <u>plan</u> document. *See section Your <u>prescription drug</u> benefit.	
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	Tier 1 (Low-cost generic <u>prescription drugs</u>)	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 10% <u>coinsurance</u> up to \$25 maximum	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 10% <u>coinsurance</u>	Up to a 90-day supply / retail <u>prescription</u> (your <u>cost share</u> is per 30-day supply)	<u>Postal Prescription Services (PPS)</u> and Costco Mail Order Pharmacy are the <u>plan's only 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.
	Tier 2 (Preferred brand drugs and high-cost generic drugs)	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 30% <u>coinsurance</u> up to \$35 maximum	15% <u>coinsurance</u> for all other <u>prescription drugs</u> Covered insulins: 30% <u>coinsurance</u>		

*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	<u>Specialty drugs</u>	15% <u>coinsurance</u>	Not covered	Covers up to a 30-day supply for most specialty <u>prescription drugs</u> . <u>Prescription drugs</u> filled at excluded pharmacies are not covered.
	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
	<u>Emergency room care</u>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	<u>In-network deductible</u> applies to <u>in-network</u> and out-of-network services.
If you need immediate medical attention	<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>	40% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Provider</u> must notify <u>plan</u> on admission.
If you have a hospital stay	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Surgery.
	Outpatient services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. *See section Behavioral health.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	15% <u>coinsurance</u>	40% <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 hospitalization. *See section Behavioral health.
	Office visits	15% <u>coinsurance</u>	40% <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. <u>Maternity care</u> may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	

*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 need help recovering or have other special health needs	<u>Home health care</u>	15% coinsurance	40% coinsurance	None
	<u>Rehabilitation services</u>	15% coinsurance	40% coinsurance	60 inpatient days / year 60 outpatient visits / year (combined with <u>habilitation services</u>) Includes physical therapy, occupational therapy and speech therapy. Inpatient admissions for rehabilitation services must be preauthorized. *See section Therapy: Habilitative and rehabilitative.
	<u>Habilitation services</u>	15% coinsurance	40% coinsurance	60 professional neurodevelopmental visits / year (combined with outpatient <u>rehabilitation services</u>) Includes physical therapy, occupational therapy and speech therapy. Preauthorization is required. *See section Therapy: Habilitative and rehabilitative.
	<u>Skilled nursing care</u>	15% coinsurance	40% coinsurance	150 inpatient days / year Preauthorization is required. *See section Skilled nursing facility.
	<u>Durable medical equipment</u>	15% coinsurance	40% coinsurance	None
	<u>Hospice services</u>	No charge	40% coinsurance	Hospice care / 6 months 14 respite inpatient or outpatient days / lifetime
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

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.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, 24 visits / year
- Bariatric surgery
- Chiropractic care, 24 spinal manipulation visits / year
- Hearing aids, 1 prescribed per ear up to allowed amount / 36 months
- 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 Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or cchio.cms.gov or your state insurance department. You may also contact the [plan](http://www.healthcare.gov) at 1-888-849-3681 (TRS: 711). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), visit [HealthCare.gov](http://www.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](http://www.healthcare.gov) for a denial of a [claim](http://www.healthcare.gov). This complaint is called a [grievance](http://www.healthcare.gov) or [appeal](http://www.healthcare.gov). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](http://www.healthcare.gov). Your [plan](http://www.healthcare.gov) documents also provide complete information to submit a [claim](http://www.healthcare.gov), [appeal](http://www.healthcare.gov), or a [grievance](http://www.healthcare.gov) for any reason to your [plan](http://www.healthcare.gov). For more information about your rights, this notice, or assistance, contact the [plan](http://www.healthcare.gov) at 1-888-849-3681 (TRS: 711) or visit [regence.com](http://www.regence.com) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1-800-562-6900, or through the Internet at: www.insurance.wa.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](http://www.healthcare.gov) generally includes [plans](http://www.healthcare.gov), [health insurance](http://www.healthcare.gov) available through the [Marketplace](http://www.healthcare.gov) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](http://www.healthcare.gov), you may not be eligible for the [premium tax credit](http://www.healthcare.gov).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](http://www.healthcare.gov) doesn't meet the [Minimum Value Standards](http://www.healthcare.gov), you may be eligible for a [premium tax credit](http://www.healthcare.gov) to help you pay for a [plan](http://www.healthcare.gov) through the [Marketplace](http://www.healthcare.gov).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-240-9580.

To see examples of how this [plan](http://www.healthcare.gov) 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** \$1,700
- **Specialist coinsurance** 15%
- **Hospital (facility) coinsurance** 15%
- **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	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,700
- **Specialist coinsurance** 15%
- **Hospital (facility) coinsurance** 15%
- **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 (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$2,100

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$1,700
- **Specialist coinsurance** 15%
- **Hospital (facility) coinsurance** 15%
- **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	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at
<https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínizin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711).

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)