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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$125 individual / $375 family per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain preventive care and those services listed below as &quot;deductible does not apply&quot; or as &quot;No charge.&quot;</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,000 individual / $4,000 family per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover. Prescription drugs do not apply to the medical out-of-pocket limit and are subject to their own out-of-pocket limit.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. Find a doctor at ump.regence.com/go/pebb/ump-plus-uwmacn or call 1-888-849-3681 (TRS: 711) for a list of network providers (preferred providers). For a list of network pharmacies, visit the pharmacy-locator webpage at ump.regence.com/go/2023/pharmacy-locator or call 1-888-361-1611 (TRS: 711).</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
</tbody>
</table>
Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral.

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

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>0% coinsurance, deductible does not apply</td>
<td>Primary care provider must be contracted with UMP Plus–UW Medicine ACN to avoid cost sharing.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit Preventive care/screening/ immunization</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>Certain tests aren't covered and other tests require preauthorization. Please refer to your plan document. *See section Radiology.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Value Tier (High value prescription drugs for chronic condition)</td>
<td>5% coinsurance or $10 copay, whichever is less / prescription</td>
<td>*Coinsurance for Tier 2 covered insulins are capped at $35 per 30-day supply. Preauthorization may be required. Please refer to your plan document. *See section Your prescription drug benefit.</td>
</tr>
<tr>
<td></td>
<td>Tier 1 (Low cost generic prescription drugs)</td>
<td>10% coinsurance or $25 copay, whichever is less / prescription</td>
<td>Up to a 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / mail order prescription</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand drugs and high cost generic drugs)</td>
<td>30% coinsurance or $75 copay, whichever is less, up to 30 day supply / prescription*</td>
<td>Postal Prescription Services (PPS) and Costco Mail Order Pharmacy are the plan's only network mail-order pharmacies. Specialty drugs must be filled from the specialty pharmacy, Ardon Health, except when a drug can only be dispensed by a certain pharmacy. Covers up to a 30-day supply for most specialty prescription drugs.</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>5% coinsurance or $10 copay, whichever is less / value tier drugs</td>
<td>10% coinsurance or $25 copay, whichever is less / tier 1 drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30% coinsurance or $75 copay, whichever is less / tier 2 drugs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-pebb-coc.
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>15% coinsurance after $75 copay / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$200 copay per day up to $600 per individual per calendar year</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$200 copay per day up to $600 per individual per calendar year; Professional services: No charge</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$200 copay per day up to $600 per individual per calendar year</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>15% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at hca.wa.gov/ump-pebb-coc.
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</tr>
</thead>
</table>
|                      |                       | In-Network Provider | Out-of-Network Provider | 60 inpatient days / year  
60 outpatient visits / year (combined with habilitation services)  
Professional and outpatient services are covered at the coinsurance specified, after deductible. Includes physical therapy, occupational therapy and speech therapy.  
Inpatient admissions for rehabilitation services must be preauthorized. *See section Therapy: Habilitative and rehabilitative. |
|                      |                       | (You will pay the least) | (You will pay the most) | 60 professional neurodevelopmental visits / year (combined with outpatient rehabilitation services)  
Includes physical therapy, occupational therapy and speech therapy.  
Preauthorization is required. *See section Therapy: Habilitative and rehabilitative. |
|                      |                       | 50% coinsurance | 50% coinsurance | 150 inpatient days / year  
Preauthorization is required. *See section Skilled nursing facility. |
|                      |                       | 50% coinsurance | 50% coinsurance | None |
|                      |                       | 50% coinsurance | 50% coinsurance | Hospice care / 6 months  
14 respite inpatient or outpatient days / lifetime |
|                      |                       | 50% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Rehabilitation services | Inpatient: $200 copay per day up to $600 per individual per calendar year  
Professional services: 15% coinsurance  
Outpatient services: 15% coinsurance | 50% coinsurance | |
|                      | Habilitation services | 15% coinsurance | 50% coinsurance | |
|                      | Skilled nursing care  | Inpatient: $200 copay per day up to $600 per individual per calendar year  
Professional services: 15% coinsurance | 50% coinsurance | |
|                      | Durable medical equipment | 15% coinsurance | 50% coinsurance | |
|                      | Hospice services | No charge | 50% coinsurance | |
|                      | Children's eye exam | No charge | Not covered | 1 routine eye exam / year  
Limited to individuals under age 19. |
|                      | Children's glasses | No charge | Not covered | 1 pair of standard lenses and frames / year  
1 year supply of contact lenses in lieu of standard lenses and frames  
Limited to individuals under age 19. |
|                      | Children's dental check-up | Not covered | Not covered | None |

* 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
- 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-visit limitation)
- Bariatric surgery (24-visit limitation)
- Chiropractic care (24-visit limitation)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.

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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**: $125
- **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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$125</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
</tbody>
</table>

What isn't covered: $60

The total Peg would pay is $1,185

---

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

- **The plan's overall deductible**: $125
- **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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$125</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

What isn't covered: $200

The total Joe would pay is $1,425

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

- **The plan's overall deductible**: $125
- **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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$125</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
</tbody>
</table>

What isn't covered: $0

The total Mia would pay is $605

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, gender identity or sexual identity. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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, gender identity or sexual orientation, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 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, DC 20201
  1-800-368-1019, 800-537-7697 (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)。

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

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。

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

NOTICE: If you speak afrikaans, you are eligible for free language services. Call 1-888-344-6347 (TTY: 711).

注意: 若您说孟加拉语，请拨打 1-888-344-6347 (TTY: 711)。公司免费提供语言服务。