2017

Uniform Medical Plan Classic

Certificate of Coverage

Self-insured by the State of Washington
Effective January 1, 2017

Printed under the direction of the Washington State Health Care Authority Public Employees Benefits Board

HCA 54-550 (10/16)

Directory

Customer service	**1-888-849-3681** (TTY 711)	Monday–Friday 7 a.m. to 5 p.m. (Pacific)
Network Provider Directory *Use any of the options shown*	Use the Provider Search at **www.hca.wa.gov/ump** Log in to your **regence.com** account	24 hours, 7 days a week
	Call 1-888-849-3681 (TTY 711) Live chat via **www.regence.com**	Monday–Friday 7 a.m. to 5 p.m. (Pacific)
Medical appeals and general correspondence	Correspondence and Appeals PO Box 2998 Tacoma, WA 98401-2998	Fax 1-877-663-7526
Preauthorization (medical services)	**Providers call 1-888-849-3682**	Fax 1-844-679-7763
Online access to medical claims	**Your account at www.regence.com**	
Claims mailing address (Medical services) *Member submitted*	Regence BlueShield PO Box 1106 Lewiston, ID 83501-1106	Fax 1-877-357-3418
Prescription drugs **Customer service, network pharmacies, preferred drug questions, complaints**	Washington State Rx Services	1-888-361-1611 *See end of prescription drug section for more detailed contact information*
Network mail-order pharmacy	Postal Prescription Services (PPS)	1-800-552-6694
Paper claims **Prescription drug appeals**	Washington State Rx Services PO Box 40168 Portland, OR 97240-0168	1-888-361-1611 Fax claims 1-800-207-8235 Fax appeals 1-866-923-0412
Drug preauthorization *Providers and pharmacists only*	Washington State Rx Services	1-888-361-1611 Fax 1-800-207-8235
Online access to prescription drug claims	Your pharmacy account at **www.hca.wa.gov/ump**	24 hours, 7 days a week
Medicare	**www.medicare.gov** **www.MyMedicare.gov**	1-800-MEDICARE (1-800-633-4227)
Eligibility and enrollment, address changes **www.hca.wa.gov/pebb**	**Employees:** Contact your personnel, payroll, or benefits office	**All other members:** PEBB Program 1-800-200-1004 (TTY 711) Monday–Friday 8 a.m. to 5 p.m. (Pacific)
Tobacco cessation	***Quit for Life*** *See "Tobacco Cessation Services" in the Benefits: What the Plan Covers section for detailed information*	**www.quitnow.net/ump** 1-866-784-8454 Monday–Friday 8 a.m. to 6 p.m. (Pacific)

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004. People who have hearing or speech disabilities please call 711 for relay services.

How to Use This Book

Finding Information

- For general topics, check the Table of Contents; for example, "How to Find a Preferred Provider," "How Much Will I Pay for Prescription Drugs?"
- For an at-a-glance view of the most common benefits, see the "Summary of Benefits" (pages 24–35). The table also shows how much you will pay, any limits on the benefit (such as number of visits or dollar amount), whether preauthorization or notification is required, and the page numbers where you can find more about that benefit.
- To look up unfamiliar terms, see the "Definitions" section beginning on page 173.

Helpful Symbols

TIP: Indicates information that may be helpful in understanding a subject.

FOR MORE INFORMATION: Refers you to information found elsewhere.

ALERT! Important information you should know or something you need to do.

Special Section for Medicare Retirees

See our special section just for retirees enrolled in Medicare on pages 116–124. In addition, throughout the rest of the book look for the symbol below with accompanying blue text. This indicates information specific to Medicare retirees.

FOR MEDICARE RETIREES: Information especially for Medicare retirees.

If You Still Have Questions

If you have a specific question for which you can't find the answer:

- Use our online search function at **www.hca.wa.gov/ump**
- Call Customer Service at 1-888-849-3681 (Monday–Friday, 7 a.m. to 5 p.m. Pacific Time)

See the Directory page on the inside front cover of this document for more contact information.

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About Uniform Medical Plan Classic

Uniform Medical Plan Classic (UMP Classic) is a self-insured health plan offered through the Washington State Health Care Authority's Public Employees Benefits Board (PEBB) Program and administered by Regence BlueShield and Washington State Rx Services.

UMP Classic is available only to people eligible for coverage through the PEBB Program, including employees and retirees of state government and higher-education institutions, school district retirees, and employees of certain local governments and school districts that participate in the PEBB Program, as well as their eligible dependents.

This plan is designed to keep you and your family healthy, as well as provide benefits in case of injury or illness. Please review this booklet carefully so you can get the most from your health care benefits.

UMP Classic is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

Online Services

You can access many services on the plan's website at **www.hca.wa.gov/ump**. Visit the site when you want to:

- Find a preferred provider.
- Find a network pharmacy.
- Find out what your prescription will cost.
- Order prescription refills through your mail-order pharmacy account.
- Search our extensive collection of frequently asked questions.
- Download or print documents and forms.
- Review Regence BlueShield medical policies.
- Review decisions on coverage of health technology.
- Access the Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms (UGT).

You'll also find a link on the UMP website to **regence.com**, which helps you efficiently manage your health care by providing access to:

- Your Explanation of Benefits (medical claims processing details).
- Customer service via Live chat.
- Wellness tools.
- Preferred providers.
- Cost estimates for treatment of common medical conditions.

Finding a Health Care Provider

FOR MEDICARE RETIREES: If you are retired and enrolled in Medicare, see "Should I See a Preferred Provider?" on page 121 for information on choosing providers.

How to Find a Preferred Provider

UMP Classic members have access to Regence BlueShield preferred providers and Blue Cross and Blue Shield Plan providers worldwide through the BlueCard® and BlueCard Worldwide programs, so your health coverage is with you wherever you are. Your access to care includes most acute care hospitals, urgent care and ambulatory surgery centers, physicians, and other health care professionals.

To find a preferred provider, choose one of the following:

- Use the Provider Search at **www.hca.wa.gov/ump.**
- Call Customer Service at 1-888-849-3681.
- Log in to your account on **regence.com**, where you have access to more information about providers, as well as other tools (see page 8).

To find a network pharmacy, see pages 83–84.

Services Received Outside the U.S.

ALERT! The plan does not cover prescription drugs ordered through foreign (non-U.S.) mail-order pharmacies.

Contact BlueCard Worldwide®

BlueCard Worldwide Service Center *Available 24 hours a day, 7 days a week*	1-800-810-BLUE (2583) (or call collect 1-804-673-1177)
Online provider search	Go to **http://provider.bcbs.com/** and select "Locate Doctors Worldwide"
▪ Get an international claim form ▪ BlueCard Worldwide information	**www.bcbs.com/already-a-member/traveling-outside-of-the.html**

When Are Services Outside the U.S. Covered By the Plan?

The plan covers the same benefits as described in this *Certificate of Coverage* that are received outside the United States (U.S.) when the services are:

- Medically necessary (see definition on pages 182–184).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by U.S. standards.
- Meeting all medical policy criteria.
- Otherwise covered by the plan.

Finding a Preferred Provider Outside the U.S.—BlueCard Worldwide®

Under BlueCard Worldwide, you have access to network providers outside the U.S., including hospital care (inpatient and outpatient) and professional provider services at network reimbursement rates.

To find a contracted provider outside the U.S., go to **http://provider.bcbs.com/** and select "Locate Doctors Worldwide." Or you may call the BlueCard Worldwide service center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177.

Important Tips for Receiving Care Outside the U.S.

- Always carry your UMP identification (ID) card.
- If you need emergency medical care, go to the nearest hospital.
- If you are admitted to the hospital, call the BlueCard Worldwide Service Center (see "Contact BlueCard Worldwide" on page 9) to notify the plan of your admission.
- For non-emergency medical care outside the U.S., call the BlueCard Worldwide Service Center (see "Contact BlueCard Worldwide" on page 9). The service center will help you find the care you need, including hospital care if necessary or an appointment with a professional provider.

Paying For Care Outside the U.S.

Inpatient Services at a BlueCard Contracted Hospital

When you receive inpatient care at a hospital contracted with BlueCard Worldwide, you will pay your normal out-of-pocket costs, such as deductible, copayment, coinsurance, and any services not covered by the plan. Contracted hospitals will verify your benefits and eligibility with BlueCard Worldwide and submit a claim; you will pay the provider after the plan processes the claim.

Services at a Non-Contracted Hospital

When you receive services at a hospital not contracted with BlueCard Worldwide, you pay the hospital at the time of service, then submit a claim with an itemized bill from the hospital to the plan for reimbursement (see "How Do I Submit a Claim?" on page 125). You may ask the non-contracted hospital if they will submit a claim on your behalf.

Outpatient and Professional Provider Services

If you receive outpatient care outside the U.S., you pay the facility or professional provider at the time of service, then submit a claim to the plan for reimbursement (see "How Do I Submit a Claim?" on page 125). Covered services by BlueCard contracted providers are paid the same as preferred providers, but the allowed amount may vary.

When and How Do I Submit a Claim for Services Outside the U.S.?

If you receive inpatient services at a contracted hospital, the hospital will submit claims on your behalf. See "Inpatient Services at a BlueCard Contracted Hospital" on page 10.

For care from non-contracted hospitals and all outpatient care, you pay the provider at the time of service. To receive reimbursement from the plan for covered services, you must submit an international claim to the BlueCard Worldwide service center; see "Contact BlueCard Worldwide" on page 9 for contact information and where to find a claim form.

When a claim for services received outside of the U.S. is submitted, the claim and all accompanying documentation (such as medical records) must be translated into English, and the relevant currency exchange rate provided. Specific services, charges, drugs and dosage must be documented. The plan does not pay for translation or other documentation.

If you have questions about submitting a claim for services outside the U.S., you can find instructions at **www.hca.wa.gov/ump/ump-administration/submitting-claim**, or call UMP Customer Service at 1-888-849-3681.

ALERT! The plan does not cover prescription drugs ordered through foreign (non-U.S.) mail-order pharmacies. See "Drugs Purchased Outside the U.S." on page 85 for how coverage of prescription drugs purchased outside the U.S. works.

Why Choose a Preferred Provider?

You get the most from your plan when you choose preferred providers. Here's why:

- You pay 15% of the allowed amount for most services by a preferred provider, after you pay your medical deductible.

- You pay nothing for covered preventive care services and immunizations, as described on page 66, when you see a preferred provider. See "Preventive Care" on pages 65–67 for examples of services covered.
- A preferred provider can't bill you for more than the plan's allowed amount.
- You won't have to file a claim if the plan is your primary coverage.

Note: You will have to pay for services or supplies that exceed benefit limits or are not covered, even if you see a preferred provider.

ALERT! Some providers are considered preferred at one practice location but not another. If you see a provider at an out-of-network location, services will be covered as out-of-network, even if the provider is preferred elsewhere. If you see a provider at a new or different location than usual, make sure he or she is a preferred provider at the alternate location as well.

Using Out-of-Network Providers Costs You the Most Money

When you see an out-of-network provider:

- For most covered services, you pay 40% of the allowed amount, **plus** any amount the out-of-network provider charges above the allowed amount; this is called balance billing (see TIP below).
- The 40% coinsurance you pay to out-of-network providers does not count toward your medical out-of-pocket limit.
- You still have to meet your medical deductible before the plan begins to pay. Any amount you pay above the allowed amount does not count toward your medical deductible or medical out-of-pocket limit.
- You may have to pay upfront and send the claim to the plan yourself.
- The provider may not request preauthorization for services that require it; payment may be delayed or denied.
- The provider may not be familiar with UMP prescription drug guidelines and prescribe drugs subject to higher cost, or that aren't covered by the plan.

Note: Payment for out-of-network services may be sent to you or the provider.

TIP: The allowed amount is the amount preferred providers agree to accept as payment in full (definition on pages 173–174). Out-of-network providers may charge more than this amount, and you are responsible for paying that difference. This is called "balance billing" (see definition on page 175).

Preferred Providers Cost You Less Than Participating Providers

What Is a Participating Provider?

A participating provider contracts with Regence BlueShield or another BlueCard network, but is not preferred under the Preferred Provider Organization (PPO) network that applies to UMP Classic members. These providers are designated in the online provider directory with a bar icon.

Comparing Your Cost

This example assumes you have met your medical deductible.

Preferred Providers	Participating Providers
You pay 15% of the plan allowed amount for covered services.	You pay 40% of the plan allowed amount for covered services.

See page 16 under "Comparing Payments to Preferred, Participating, and Out-of-Network Providers" for examples.

How Are Preferred and Participating Providers the Same?

The following rules apply to both preferred and participating providers:

- **Balance billing** (see definition on page 175): Preferred and participating providers may not charge you more than the plan allowed amount.
- **Preventive care:** Services covered as preventive by the plan are paid at 100%; you pay nothing.
- **Medical out-of-pocket limit:** Once you meet your medical out-of-pocket limit (see page 21), covered services are paid at 100%; you pay nothing.
- **Mental health services:** You pay 15% for covered mental health services.

When You Don't Have Access to a Preferred Provider: Network Waiver

ALERT! When requesting a network waiver after services are processed, you must submit your request within 180 days of receiving notice of payment (your Explanation of Benefits, see page 178) for the related services. See "After Services Are Provided" below for details.

What Is a Network Waiver?

An approved network waiver allows the plan to pay for services provided by an out-of-network provider at the network rate. You may request a network waiver *only* when you do not have access to a preferred provider able to provide medically necessary services within 30 miles of the patient's residence.

When the plan approves the network waiver *prior* to your receiving medical services from an out-of-network provider:

- For most medical services, you will pay your cost share as though the provider was preferred.
- For preventive services, the plan covers services at 100%.
- When you receive medical services from an out-of-network provider *before* the network waiver is approved, you will pay a cost share plus any balance billing (see definition on page 175).

TIP: Save money by making sure the network waiver is approved by the plan before receiving medical services by an out-of-network provider.

When May I Request a Network Waiver?

Before Services Are Provided

You may request a network waiver before services are provided ***only*** when the services require preauthorization by the plan; see page 99 for how to find the list of services requiring preauthorization. Your network waiver request should be included with the preauthorization request. See "Information Needed to Submit a Network Waiver Request" below for what information needs to be included in your request.

After Services Are Provided

If the services for which you need care by an out-of-network provider do not require preauthorization, you may request a network waiver only ***after*** related claims have been processed. These requests are considered an appeal and must be submitted within 180 days of receiving notice of payment (an Explanation of Benefits). See "Complaint and Appeal Procedures" beginning on page 134 for how to submit an appeal, and "Information Needed to Submit a Network Waiver Request" below for additional information to include in your request.

Information Needed to Submit a Network Waiver Request

See above for the circumstances under which you may request a network waiver; you should include the following documentation in your request:

- A letter of explanation from you or your provider stating why the patient saw or needs to see the out-of-network provider.

- Details of the research conducted by you or your provider to locate a preferred provider (in effect, names and phone numbers of preferred providers that were researched and may have been contacted before receiving services from the out-of-network provider).

Additional Information Needed For Preauthorization Requests

When submitting a request for preauthorization that includes a network waiver, the following information should also be included:

- Performing provider's name, address, phone number, and National Provider Identifier (NPI) or Tax ID number (TIN).
- Diagnosis codes.
- Procedure codes.
- Length of treatment requested or required for services.
- Estimated charges.

See the "Preauthorizing Medical Services" section on pages 98–100 for more information about requesting medical services preauthorization from the plan.

Where to Send Your Network Waiver Request

Regence BlueShield
Attn: Correspondence, Intake, and Appeals
PO Box 2998
Tacoma, WA 98401-2998

ALERT! If a network waiver is approved, you must still pay your cost share for most medical services. See "What Is a Network Waiver?" on page 13 for more information. Services provided under an approved network waiver do count toward your medical out-of-pocket limit. Network waivers for ongoing services may require periodic review.

Covered Provider Types

TIP: All preferred providers are covered provider types, but not all covered provider types are preferred. Find preferred providers by using the Provider Search at **www.hca.wa.gov/ump**, at **regence.com**, or by calling 1-888-849-3681.

The plan pays for covered services only when performed by a covered provider type. All preferred providers are covered provider types. If you see an out-of-network provider that is not a covered provider type, the plan will not pay for any of the services received; you will be responsible for all charges. As with all noncovered services, any payments you make to a noncovered provider type will not apply toward your medical deductible or medical out-of-pocket limit. See the list of

covered provider types at **www.hca.wa.gov/ump**. See page 38 for approved providers of Applied Behavior Analysis Therapy.

What Is a Primary Care Provider?

A primary care provider (PCP) is a medical professional who provides services directly to patients, as well as coordinating access to a range of other health care services. To be designated as a PCP, a provider must be one of the provider types and practice under one of the specialties listed in the table below.

Provider Type	Specialties
Medical Doctor (M.D) Doctor of Osteopathic Medicine (D.O.) Naturopathic Physician (N.D.) Nurse Practitioner (A.R.N.P.) Physician Assistant (P.A.)	Adult Medicine Family Practice General Practice Internal Medicine OB/GYN or Obstetrics Pediatrics (for patients under age 18)

Comparing Payments to Preferred, Participating, and Out-of-Network Providers

The chart below shows how much you pay for professional services when UMP Classic is your primary insurance. For these examples, assume you have paid your medical deductible and haven't reached your medical out-of-pocket limit.

Preferred Provider				
Billed Charge	**Allowed Amount**	**Must Provider Accept Allowed Amount?**	**Plan Pays**	**You Owe Provider**
$1,000	$900	Yes (Provider discount = $100)	$765 (85% x $900)	$135 (15% x $900) Member coinsurance (15% of plan allowed)

Participating Provider				
Billed Charge	**Allowed Amount**	**Must Provider Accept Allowed Amount?**	**Plan Pays**	**You Owe Provider**
$1,000	$900	Yes (Provider discount = $100)	$540 (60% x $900)	$360 Member coinsurance (40% of plan allowed) *The provider may not balance bill you*
Out-of-Network Provider				
Billed Charge	**Allowed Amount**	**Must Provider Accept Allowed Amount?**	**Plan Pays**	**You Owe Provider**
$1,000	$900	No (No provider discount)	$540 (60% x $900)	$360 Member coinsurance (40% of plan allowed) ***plus*** Difference between allowed amount and billed charge: $100 (balance billing) Total you pay: $460*

**This amount does not apply to your medical out-of-pocket limit.*

Please note that these are examples only and may not reflect your specific situation.

What You Pay for Medical Services

Your Deductibles

A deductible is a fixed dollar amount you pay each calendar year before the plan begins paying most benefits. The medical deductible amount is $250 per person, with a maximum of $750 for a family of three or more people; see "How Does the Medical Deductible Work With Families?" on page 19. When you first get services, you pay your provider the first $250 in charges. After you pay that first $250, the plan begins to pay benefits for your care. This applies to each covered family member, up to the $750 maximum.

You also pay a separate deductible for prescription drugs when you purchase Tier 2 and Tier 3 drugs. The prescription drug deductible is $100 per person, with a maximum of $300 for a family of three or more people, and does not apply to Value Tier or Tier 1 drugs (see pages 77–78).

If You Qualified for the SmartHealth Wellness Incentive

The subscriber (see definition on page 193) is the only family member eligible to earn the SmartHealth wellness incentive. The 2017 incentive reduces the subscriber's medical deductible by $125. For details and examples of how the deductible reduction works for accounts with more than one member, visit **www.hca.wa.gov/ump-classic/wellness-programs**.

What Doesn't Count Toward My Medical Deductible?

The following out-of-pocket expenses do **not** count toward your $250 medical deductible:

- Services you pay for that aren't covered by the plan (see pages 102–107 for some examples).
- Services that are exempt from the medical deductible, even if you had out-of-pocket costs. For example, preventive care received from an out-of-network provider.
- Charges for services exceeding benefit maximums. For example, the maximum for adult vision hardware is $150 every two calendar years; charges over $150 do not count toward your medical deductible.
- Charges for services beyond benefit limits. For example, the annual benefit limit for acupuncture is 16 visits. Costs for more than 16 visits are not covered by the plan and do not count toward your medical deductible.
- Out-of-network provider charges that exceed the allowed amount (see table on page 16).
- Your inpatient hospital copayment (see page 20).

- Your emergency room copayment (see page 48).
- Prescription drug costs (see pages 77–78 for the prescription drug deductible).

Which Services Are Exempt From the Medical Deductible?

TIP: The plan pays the services (subject to cost share) listed below even if you have not met your deductible. This means that you do not have to pay the first $250 of covered services before the plan begins to pay.

You do not have to pay the medical deductible before the plan pays for these services:

- Preventive care and immunizations as described on pages 65–67.
- Routine vision care: exams, glasses, and contacts (pages 73–74).
- Routine hearing care: exams and hearing aids (page 51).
- Select contraceptive supplies and services (pages 49–50).
- Certain products available from network pharmacies (page 94).
- Prescription drugs (however, there is a prescription drug deductible that applies to Tier 2 and Tier 3 drugs only; see page 77).
- Tobacco cessation services (page 70).
- Diabetes Prevention Program (page 44).
- Required second opinions (page 67).

How Does the Medical Deductible Work With Families?

If you have three members in your family enrolled in UMP Classic, each family member must pay the $250 medical deductible for a family maximum of $750. Once any one person spends $250 that applies toward the medical deductible, the plan will begin paying benefits for that person only. Because the plan is now paying for this person's covered services, he or she is no longer contributing toward the family deductible.

If your family has four or more members, each person has an individual medical deductible of $250 and the maximum the family pays towards medical deductibles is $750. Once a particular individual pays his or her $250 deductible, the plan begins paying for covered services for that person. Because the plan is now paying for this person's covered services, he or she is no longer contributing toward the family deductible. If the combined amount paid toward the deductible for everyone in the family reaches $750—even if no one reached $250 on their own—the plan begins paying for covered services for everyone in the family; no more deductible is owed.

Note: Only services that are covered and are subject to the medical deductible count; see page 18 for a list of services that don't count.

If the subscriber earned the SmartHealth wellness incentive, the subscriber's medical deductible is reduced to $125. For details and examples of how the deductible reduction works for accounts with more than one member, visit **www.hca.wa.gov/ump-classic/wellness-programs**.

ALERT! If you receive services with a benefit limit (such as spinal or extremity manipulation, massage therapy, or physical therapy) before meeting your medical deductible, those visits will count toward the benefit limit. For example, if you pay out of pocket for a massage therapy visit because you haven't met your medical deductible, that visit **will** count toward the maximum of 16 visits per calendar year. See definition of "Limited Benefit" on page 181 for more information. **Note:** If you have other primary coverage, including Medicare, visits paid by your primary plan also count toward UMP Classic benefit limits.

What Is Coinsurance?

Coinsurance refers to the percentage of the allowed amount that you pay for most medical services and for prescription drugs, when the plan pays less than 100%.

How Much Coinsurance Do I Pay?

After you've paid your medical deductible, you pay the following percentages for most services:

- **For preferred providers:** 15% of the allowed amount.
- **For participating providers:** 40% of the allowed amount; see table on page 16 for details.
- **For out-of-network providers:** 40% of the allowed amount. ***Note:*** Most out-of-network providers charge more than the allowed amount. You will be responsible for paying any amount an out-of-network provider bills that is above the allowed amount, in addition to your 40% coinsurance; see definition of balance billing on page 175.

See pages 75–97 for how much you pay for prescription drugs.

What Is a Copayment?

A copayment is a flat dollar amount you pay when you receive specific services, treatments, or supplies, including:

- Emergency room copay: $75 per visit. See "Emergency Room" on page 48 for details.
- Facility charges for services received while an inpatient at a hospital, mental health, chemical dependency, or skilled nursing facility: $200 per day copay (see "Inpatient Copay" below).

Inpatient Copay

FOR MEDICARE RETIREES: For retirees enrolled in Medicare, the maximum inpatient copay is $600 **per facility admission,** up to your medical out-of-pocket limit.

The inpatient copay is what you pay for inpatient services at a preferred facility—hospital, skilled nursing, mental health, chemical dependency: $200 per day for facility charges. Employees and retirees not enrolled in Medicare pay up to $600 maximum per person per calendar year; retirees enrolled in Medicare pay up to a $600 maximum per admission up to the medical out-of-pocket limit.

The inpatient copay does not count toward your medical deductible, but does apply to your medical out-of-pocket limit.

Note: Professional charges, such as for physicians or lab work, may be billed separately and are not included in this copay.

When Do I Pay?

Most of the time, you pay ***after*** your claim is processed.

- You'll receive an Explanation of Benefits (EOB) from the plan that explains how much the plan paid the provider. (The Member Responsibility section of your EOB tells you how much you owe the provider.)
- The provider sends you a bill.
- You pay the provider.

Note: In some circumstances, the provider may ask you to pay at the time of service. In these cases, you should check your EOB when it arrives to make sure that the amount you paid isn't higher than the amount shown in the Member Responsibility section.

Your Medical Out-of-Pocket Limit

ALERT! See page 78 for how the prescription drug out-of-pocket limit works. Prescription drug costs do not count toward your medical out-of-pocket limit.

How Does It Work?

The medical out-of-pocket limit is the most you pay during a calendar year for covered services from preferred providers. After you meet your medical out-of-pocket limit for the year, the plan pays covered services by preferred providers at 100% of the allowed amount. ***Expenses are counted from January 1, 2017, or your first day of enrollment, whichever is later; and December 31, 2017, or your last day of enrollment, whichever is first.***

How Much Is the Medical Out-of-Pocket Limit?

Enrollee Type	How much is it?
Employees and retirees not enrolled in Medicare, including dependents	$2,000 per person $4,000 per family* (2 or more enrolled)
Retirees enrolled in Medicare Part A and Part B, including dependents	$2,500 per person $5,000 per family* (2 or more enrolled)

**"Family" means all members combined under one subscriber's account.*

What Counts Toward the Medical Out-of-Pocket Limit and What Doesn't?

What counts toward the medical out-of-pocket limit?	▪ Your coinsurance paid to preferred and participating providers (see page 16). ▪ Inpatient and emergency room copays. ▪ Your medical deductible.
What doesn't count toward the medical out-of-pocket limit? *See "Exceptions: Out-of-Network Provider Services That Count" on page 23.*	1. Amounts paid by the plan, including services covered in full (preventive). 2. Prescription drug costs, including the prescription drug deductible. See page 78 for how the prescription drug out-of-pocket limit works (which is counted separately by Washington State Rx Services). 3. Your coinsurance paid to out-of-network providers (note that out-of-network coinsurance does count toward your medical deductible; see page 16). 4. Balance billed amounts (see definition of balance billing below). For exceptions, see "Exceptions: Out-of-Network Provider Services That Count" on page 23. 5. Services not covered by the plan; for examples, see pages 102–107. 6. Amounts that are more than a maximum dollar amount paid by the plan. For example, the plan pays a maximum of $150 for adult vision hardware once every two calendar years. Any amount you pay over $150 does not count toward the medical out-of-pocket limit. 7. Amounts paid for services exceeding a benefit limit. For example, the benefit limit for acupuncture is 16 visits. If you have more than 16 acupuncture visits in one year, you will pay in full for those visits, and what you pay will not count toward this limit. See "Limited Benefit" on page 181 for more benefits with this type of limit.
What will I pay for after reaching my medical out-of-pocket limit?	You will still be responsible for paying numbers 2–7 above after you meet your medical out-of-pocket limit. *See page 78 for how the prescription drug out-of-pocket limit works.*

Balance billing is a provider billing you for the difference between the provider's charge and the allowed amount (see definition beginning on page 173). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Preferred

and participating providers may not balance bill you for covered services above the allowed amount. See an example of how this works on page 16.

You Still Pay For Out-of-Network Provider Services

Services by out-of-network providers are paid by the plan at 60% of the allowed amount (unless noted under "Exceptions: Out-of-Network Provider Services That Count" below). Even after you meet your medical out-of-pocket limit, you will pay 40% coinsurance for out-of-network provider services and the provider may still balance bill you (see definition on page 22). Note that the 40% you pay and balance billed amounts do not count toward your medical out-of-pocket limit. However, coinsurance paid to out-of-network providers does count toward your medical deductible. Balance billed amounts never apply toward your medical deductible.

Exceptions: Out-of-Network Provider Services That Count

In certain cases, your coinsurance and balance billed amounts for out-of-network provider services will count toward your medical out-of-pocket limit. In addition, the plan will pay 100% of billed charges for these services after you meet your medical out-of-pocket limit.

- Ambulance (see page 37).
- Dialysis (see page 45).
- Services for which you have an approved network waiver (see page 13).
- Cochlear Implant Processor Supplier
- Ocularists (creation and fitting of prosthetic eyes).

Summary of Benefits

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Please review this *Certificate of Coverage* or call Customer Service at 1-888-849-3681 if you have questions about benefits or limitations.

On the next several pages, you'll find a summary of your plan benefits, a convenient reference to help you find the information you need. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For More Information" column.

Not all benefits are listed. For services not listed, see the Table of Contents or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 182–184).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 173–194.

This *Certificate of Coverage* applies only to dates of service between the day your coverage begins (but no earlier than January 1, 2017) and the day your coverage ends (but no later than December 31, 2017).

ALERT! If you have coverage under another health plan, see pages 108–115. If your other coverage is Medicare, see pages 116–124.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical deductible	$250 per person (maximum of $750 for a family of three or more) See page 18 if you qualified for the 2017 SmartHealth $125 wellness incentive.	▪ You pay toward the medical deductible before the plan pays for covered medical services. ▪ You don't have to pay the medical deductible for some services. ▪ Not all services count toward this deductible.	18–20

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Prescription drug deductible	$100 per person (maximum of $300 for a family of three or more)	▪ You pay the costs for Tier 2 and Tier 3 drugs until you reach this amount. ▪ The plan pays its share for Value Tier and Tier 1 drugs right away; you don't pay the deductible.	77–78
Medical out-of-pocket limit	$2,000 per person (maximum of $4,000 for a family of two or more) For Medicare-primary members: $2,500/$5,000	Your medical deductible and all coinsurance and copays for covered in-network services count toward this limit.	21
Prescription drug out-of-pocket limit	$2,000 per person (no family maximum)	Your prescription drug deductible and coinsurance count toward this limit; see page 78 for details.	78
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by a preferred provider, and services are subject to the medical deductible. See the Summary of Benefits table on pages 28–35 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
Standard **Subject to the medical deductible:** You must pay the first $250 in covered services before the plan begins to pay.	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 175). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill.

Type of Service	How Much You Pay
Preventive Preventive services **are not subject to the medical deductible** (you don't have to pay your deductible before the plan pays). See pages 65–67 for a description of services designated preventive.	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred and participating providers**—You pay $0: the plan pays in full. ▪ **Out-of-network providers**—You pay 40%; the provider may balance bill.
Outpatient Subject to the medical deductible.	If you receive services at a facility that offers inpatient services but you are not admitted as an inpatient, the services are covered as outpatient. See the specific benefit—for example, diagnostic tests—for how much you will pay.
Inpatient **Subject to the medical deductible.** You pay the inpatient copay and separate charges for professional services, such as doctor consultations and lab tests. See the specific benefit—for example, diagnostic tests—for how the plan covers these related services. ▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be. ▪ Most inpatient services require both: • **Preauthorization:** See page 98 for a description of how this works. • **Notification:** Your provider must notify the plan upon admission to a facility; see page 99 for a description of how this works.	The inpatient copay is $200 per day at preferred facilities. ▪ Employees and retirees not enrolled in Medicare: $600 maximum per calendar year. ▪ Retirees enrolled in Medicare: $600 maximum per admission up to the medical out-of-pocket limit. Note: The inpatient copay counts toward your medical out-of-pocket limit. When you are admitted to a preferred facility as an inpatient, you will pay: ▪ Any remaining medical deductible; ▪ The inpatient copay; AND ▪ Your coinsurance for professional services; depends on the provider's network status as described under the Standard type of service, listed above. If you receive non-emergency inpatient care at an out-of-network facility, you will pay according to the Standard benefit above. See page 12 and page 16 for details of coverage of out-of-network facility charges. Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 180.
Facility Fees Facility fees may be charged in addition to provider fees when accessing hospitals or clinics.	How much you pay (your coinsurance) depends on the provider's* network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 16). **A facility, such as a hospital, may be referred to as a "provider" on Explanation of Benefits or facility bills.*
Special Subject to the medical deductible.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 28–35.

What else do I need to know?

- Some services aren't covered; see pages 102–107 for some of the services not covered by the plan.
- You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services; see page 11.
- Preexisting conditions: There is no waiting period; medically necessary covered services are eligible for benefits from the effective date of your medical enrollment.

Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 36–74 or call Customer Service at 1-888-849-3681.

Please read the pages listed in the "For more information" column for each benefit. Not all details are included in the table. We recommend that you also review:

- Services that require preauthorization (see page 98 for how this works); see page 99 for how to find the current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services for which your provider must notify the plan; see the current list at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization** and click the notification link, or call 1-888-849-3681.
- Services that aren't covered (exclusions); see pages 102–107.

If you have questions about services that require preauthorization or plan notification, or services not covered by the plan, call Customer Service at 1-888-849-3681.

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Ambulance	**Special:** 20% of the allowed amount for preferred or out-of-network providers. Out-of-network providers may balance bill.	37, 102, 106	Covered only for a medical emergency (see definition on page 182).
Applied Behavior Analysis (ABA) Therapy	Standard	38	Specific preauthorization requirements; see page 38. Only specified providers are covered; see page 38.
Breast Health See "Mammograms" below			
Chemical Dependency Treatment			
Inpatient Services	Inpatient	40, 105, 121	See page 40 for preauthorization of inpatient services. Plan notification is required at the time of admission.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Outpatient Services	Standard	40, 105, 121	See page 40 for services that may require preauthorization.* May be subject to review for medical necessity.
Chiropractic Physician Services		68	See "*Spinal and Extremity Manipulations*" on page 34.
Contraceptive Services for Women	Preventive or Standard	49–50, 65	See page 49 for services that are covered as preventive. Some contraceptive services may be covered as Standard.
Dental Services	**Special:** You pay 20% of the allowed amount when you see a preferred provider for medical services. Dentists and other dental providers are not included in the UMP provider network.	42, 102	See "Dental Services" on page 42 for limitations on covered services.
Diabetes Care Supplies	**Special:** Paid under the prescription drug benefit; see pages at right.	43, 113, 120	See page 120 if Medicare is your primary coverage.
Diabetes Prevention Program	Preventive	44	Only the plan's diabetes prevention program is covered.
Diagnostic Tests, Laboratory, and X-Rays	Standard	44, 63, 102, 104, 106	Usually billed separately from related office visits or inpatient services.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Durable Medical Equipment, Supplies, and Prostheses	Standard	46–48, 73, 103, 105, 177	May require preauthorization.* Some breast pumps are covered as preventive; see "Services Covered as Preventive" on page 63.
Emergency Room (ER) *You pay a $75 copay per visit (in addition to coinsurance)* See page 48 for coverage of emergency services at out-of-network facilities.	Standard plus the ER copay ($75) You are usually billed separately for: ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests	48, 182	If you are admitted as an inpatient directly from the ER, you won't owe the ER a copay (but will pay the inpatient copay). If your emergency room visit is determined to be a medical emergency, it will be paid at the preferred level for both preferred and out-of-network facilities. Services determined not to be due to a medical emergency (page 182) are not covered in an emergency room setting.
End-of-Life Counseling	▪ If received as part of hospice: Paid at 100% after meeting medical deductible. ▪ If received outside of hospice services: Standard.	48	Total of 30 visits, all services combined.
Family Planning Services	Standard *Some contraceptive services are covered as preventive; see page 49.*	49–50, 104	Not covered: ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids Not subject to medical deductible	**Special:** Plan pays up to $800.	51, 120	Limited to $800 plan payment per three calendar years.
Hearing Exams, Routine	Preventive	51, 65, 120	One per calendar year.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Home Health Care	Standard	52, 69, 104, 176, 180, 181	See page 52 for what is covered. Specific services are not covered; see exclusion 26 on page 104. Maintenance care (page 181) and custodial care (page 176) are not covered.
Hospice Care (Includes respite care and prescription drugs)	**Special:** Medical services paid at 100% after meeting medical deductible. Prescription drugs paid at 100% after meeting the prescription drug deductible.	52, 180, 192	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime. Prescription drugs: 100% coverage is limited to covered drugs purchased through a network pharmacy.
Hospital Services			
Inpatient Services	Inpatient	53, 61–63, 104, 121	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Inpatient rehabilitation services require preauthorization.*
Outpatient Services	Standard	53	Some services require preauthorization.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Immunizations (Vaccines)	Preventive (usually)	66, 104, 184	Covered under CDC recommendations; see page 66. *Not covered for travel or employment.*
Mammograms (Diagnostic)	Standard	59	Must be billed as diagnostic by the provider.
Mammograms (Screening) *See "Breast Health Screening Tests" on page 39 for additional services covered or not covered by the plan.*	Preventive	39, 59	**Women age 40 and older:** Covered every one to two years. **Women under age 40:** Covered as preventive only for women at increased risk; see page 59 for details. For women under age 40 and not at increased risk, see page 59. *See "Breast Health Screening Tests" on page 39 for additional services covered or not covered by the plan.*
Massage Therapy	Standard	59, 104	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Inpatient (Standard for related outpatient visits)	46, 60	All inpatient services require plan notification.*
Mental Health Treatment			
Inpatient Services	Inpatient	60, 105, 121	See page 60 about preauthorization of inpatient services. Plan notification is required at the time of admission.*

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Outpatient Services	Standard	60, 104, 105, 121	See page 60 for services that require plan notification.*
Naturopathic Physician Services	Standard	16, 61, 95, 103, 120	Herbs, vitamins, and other supplements are not covered. See "Exceptions Covered" on page 92 for exceptions.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) *Some breast pumps are covered as preventive; see page 63.*	61–63, 106	For non-routine services for a newborn, you may pay toward the baby's medical deductible or inpatient copay; see page 62. See page 62 for coverage of circumcision for males, which is not a preventive service.
Office Visits	Standard	64, 105	See pages 65–67 for routine exams covered as preventive.
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard *Charges for inpatient services are not included in the inpatient copay.*	64, 104, 181	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription Drugs	See "Your Prescription Drug Benefit" on pages 75–97.		See exclusions on pages 102–107, and other limits on pages 86–90.
Preventive Care Includes vaccines, routine exams, some screening tests	Preventive	59, 63, 65–67, 94, 120, 190	Only certain services are covered as preventive; see pages 65–67. See page 63 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient *Some services may be billed separately (such as physical therapy).*	67, 104, 106, 192	Maintenance care (page 181) and custodial care (page 176) are not covered.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Spinal and Extremity Manipulations	Standard	68, 104	Limited to 10 visits per calendar year.
Surgery		43, 53, 60, 64, 68, 72, 104, 107, 174, 186, 191	Bariatric surgery: page 39. Transgender surgery: page 72.
Inpatient Services	Inpatient		Some services require preauthorization and/or plan notification.*
Outpatient Services	Standard		Some services require preauthorization.*
Telemedicine Services	Standard	69	
Tobacco Cessation Services	Preventive	70	See page 70 for coverage of drugs and nicotine replacement supplies. See page 71 for tobacco cessation services for members ages 17 and under.
Transgender Services	Standard	72	Some services require preauthorization and/or plan notification. See page 72 for covered services.
Urgent Care You don't pay the ER copay for urgent care services.	Standard	72	
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	73, 102, 103, 105	

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefit/Service	How much will I pay? (See pages 25–26 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Vision Exams, Routine	Preventive	73, 103, 105	One per calendar year. The plan pays up to $65 per year for contact lens fitting fees; you pay any additional charges.
Vision Hardware, Adults (Over age 18) Glasses, contact lenses	**Special:** You pay any amount over $150; network status of provider does not matter. No medical deductible.	73	Plan pays up to $150 per two calendar years (resets every even year).
Vision Hardware, Children (Age 18 and under) Glasses, contact lenses	**Special:** No medical deductible. **Eyeglasses:** You pay $0 for one set of standard or deluxe frames and lenses per year. Reflective coating is included. **Contact lenses:** You pay 15% of the allowed amount.	74	Plan pays for one pair of eyeglasses per year at 100% of the allowed amount. See page 74 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits	Preventive	65–67	See pages 65–67.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 98–100 for how this works.*

Benefits: What the Plan Covers

Guidelines for Coverage

ALERT! The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply does not mean it is covered or medically necessary (see pages 182–184).

For this plan to cover a service or supply, it must meet all of the following conditions. The service or supply is:

- Received by an enrolled member on a day between the date your coverage begins (but no sooner than January 1, 2017) and the date your coverage ends (but no later than December 31, 2017); and
- Listed as covered; and
- Consistent with the plan's coverage policies and preauthorization requirements; and
- Medically necessary (see definition on pages 182–184).

Limits and exclusions may apply to plan benefits. See both the benefit description and "What the Plan Doesn't Cover" starting on page 102. Some services require preauthorization and/or plan notification prior to receiving treatment; see page 99 for how to find the list at **www.hca.wa.gov/ump** or call Customer Service to ask if a particular service is covered.

The following sections describe the benefits provided by this plan. Be sure to read them carefully for important information that can help you get the most from your health coverage. ***If you do not understand the benefits, it is your responsibility to ask for help before receiving services by calling Customer Service at 1-888-849-3681.***

FOR MEDICARE RETIREES: If you also have Medicare coverage, see "For Retirees Enrolled in Medicare" on pages 116–124.

Health Technology Clinical Committee (HTCC)

ALERT! HTCC decisions are usually implemented by UMP at the beginning of the next calendar year after the HTCC decision is issued. If UMP implements an HTCC decision mid-year, the plan will notify you in writing before the change in coverage becomes effective.

Under state law, Uniform Medical Plan follows decisions by the Washington State Health Technology Clinical Committee (HTCC). You may view the list of services that have been

reviewed or are currently under review by the HTCC at **www.hca.wa.gov/about-hca/health-technology-assessment.**

If you have questions about services affected by HTCC decisions, call UMP Customer Service at 1-888-849-3681.

ALERT! HTCC decisions implemented by the plan take precedence over any other coverage policies.

List of Benefits

Acupuncture

The plan covers up to 16 visits for acupuncture treatment per calendar year. See definition of "Limited Benefit" on page 181.

Ambulance

TIP: You pay 20% for ambulance services, which must be medically necessary (see definition on pages 182–184). Out-of-network providers may balance bill you (see page 175 for how this works). For these services, balance billed amounts will count toward your medical out-of-pocket limit. Ambulance services for personal or convenience purposes are not covered.

Ground Ambulance

Professional ground ambulance services are covered in a medical emergency:

- From the site of the medical emergency to the nearest facility equipped to treat the medical emergency (see definition of medical emergency on page 182).
- From one facility to the nearest other facility equipped to give further treatment.

In addition, when other means of transportation are considered unsafe due to your medical condition, the plan covers professional ambulance services:

- From one facility to another facility, for inpatient or outpatient treatment.
- From home to a facility.
- From a facility to your home.

Air or Water Ambulance

Air and water professional ambulance services are covered only when all of the following conditions are met:

- Ground ambulance is not appropriate.
- The situation is a medical emergency (see definition on page 182).

- Air or water ambulance is medically necessary (see definition on pages 182–184).
- Transport is to the nearest facility able to provide the care you need.

ALERT! The plan pays for air ambulance only to the nearest facility able to provide the care you need. This means if you require care while traveling, the plan would pay for medically necessary air ambulance services only to the nearest hospital (facility) capable of treating your condition. The plan would not pay for air ambulance or other forms of air transport to a facility closer to your home residence. If you travel outside the U.S., consider getting separate insurance that covers such air ambulance services.

Applied Behavior Analysis (ABA) Therapy

The plan covers Applied Behavior Analysis (ABA) Therapy only for a diagnosis of autism spectrum disorder. ABA Therapy services must be preauthorized by the plan before services are performed, or all claims will be denied.

Like other preauthorized services, approved preauthorization is specific to the provider who made the preauthorization request. ABA therapy hours preauthorized for one provider are not automatically transferable to another provider. A change in the provider requires a new preauthorization.

Providers of ABA Therapy services must be appropriately credentialed and qualified to prescribe or perform ABA Therapy services.

As for other covered services, you receive the best benefit by using preferred providers. See page 16 for differences in your cost for preferred, participating, and out-of-network providers. To find a preferred provider, call UMP Customer Service at 1-888-849-3681.

Additional information on ABA Therapy, including how to request preauthorization, is available at **www.hca.wa.gov/ump**; type "ABA Therapy" in the Search box at the upper right.

ALERT! All ABA Therapy services must be preauthorized before services are provided, including those by plan-approved out-of-network providers. The plan will deny coverage when services are not preauthorized, or when preauthorization is requested but is denied by the plan. You (the patient) will pay all charges associated with noncovered ABA Therapy services, and these noncovered services do not count toward your medical deductible or medical out-of-pocket limit.

Autism Treatment

To determine how a particular service, supply, or intervention is covered, please see that specific benefit. For example, speech or occupational therapy is addressed on page 64 under the "Physical, Speech, Occupational, or Neurodevelopmental Therapy" benefit; mental health coverage is found under "Mental Health Treatment" on page 60. If a specific benefit is subject to limits, such as

number of visits, these limits apply to services, supplies, or interventions for an autism diagnosis the same as for any other diagnosis.

TIP: This description does not apply to applied behavior analysis (ABA) therapy. See "Applied Behavior Analysis (ABA) Therapy" on page 38 for details.

Bariatric Surgery

Bariatric (obesity) surgery is covered only in very specific clinical circumstances, including co-morbid conditions, and must be preauthorized by the plan according to plan medical policy.

For the plan to cover bariatric surgery, you must follow all of your chosen facility's bariatric surgery requirements. This includes working with a multidisciplinary bariatric surgery team, ensuring that your surgery and postsurgical treatment meet all plan medical policies.

The plan covers only certain types of bariatric surgery procedures. If you meet the plan's clinical criteria, non-Medicare adults age 18 and over are covered for Roux-en-Y, sleeve gastrectomy, and laparoscopic adjustable gastric banding procedures as determined by the bariatric surgeon. No other procedure will be considered for coverage.

If you are Medicare-eligible or close to becoming eligible for Medicare and are considering bariatric surgery coverage, contact Customer Service at 1-888-849-3681.

Related Care Following Bariatric Surgery

If you need surgical follow-up care related to bariatric surgery, any follow-up surgery must be appropriate and essential to the long-term success of the initial bariatric surgery. Such surgery must be preauthorized by the plan as meeting plan medical policy and criteria.

Panniculectomy (removal of loose skin) is covered following bariatric surgery only when specific medical criteria are met. Most panniculectomies are considered cosmetic and are not covered.

UMP will cover surgical follow-up care related to a bariatric procedure (Roux-en-Y Sleeve, gastrectomy, or laparoscopic adjustable gastric banding) such as complications, needed revisions, and Lap Band fills to prior bariatric surgery if the follow-up surgery is appropriate and essential to the long-term success of the initial bariatric surgery.

Members who had a bariatric procedure prior to coverage under a UMP plan and have complications, need for revision, or require Lap Band fills for ongoing medically necessary services are not required to verify prior coverage or that they met Regence medical policy criteria for the bariatric procedure. However, you must follow plan requirements, including requesting preauthorization.

Breast Health Screening Tests

See also "Mammograms" on page 58 for more information about breast health testing. The tests listed below may be covered for diagnostic purposes as indicated under plan medical policy.

Services Covered

Digital Breast Tomosynthesis (DBT) is covered supplementary (in addition) to digital mammography in women ages 40 to 74 who are candidates for screening mammography.

Women ages 40 and older: Covered as preventive in addition to a digital mammogram; see "How Much Will I Pay?" on page 59.

See ***For women under age 40*** on page 59 under "Screening (Preventive) Mammograms" for how preventive breast health testing is covered for high-risk women.

Services Not Covered

When performed supplementary to digital mammography for screening purposes for women with or without dense breasts, the following procedures are **not covered** by the plan:

Non-high-risk patients:

- Magnetic Resonance Imaging (MRI)
- Hand Held Ultrasound (HHUS)
- Automated Breast Ultrasound (ABUS)

High-risk patients:

- Hand Held Ultrasound (HHUS)
- Automated Breast Ultrasound (ABUS)

If you have questions about what services are covered, call UMP Customer Service at 1-888-849-3681.

Chemical Dependency Treatment

Chemical dependency is defined as an illness characterized by a physiological or psychological dependence on a controlled substance or alcohol. Chemical dependency does not include dependence on tobacco, caffeine, or food.

Non-emergency inpatient services must be preauthorized by the plan; see page 98 for details. Contact UMP Customer Service at 1-888-849-3681 about preauthorization requirements.

Your provider must notify the plan upon admission when you receive the following services:

- Detoxification.
- Inpatient admission, including to a Residential Treatment Facility.
- Intensive Outpatient Program (IOP).
- Partial Hospitalization Program (PHP).

Inpatient

ALERT! Your provider must notify the plan upon admission when you receive inpatient services for chemical dependency treatment. Inpatient services for which the plan is not notified may not be covered. Inpatient chemical dependency treatment is subject to clinical review (see definition on page 175).

Services are considered "inpatient" when you are admitted to a facility. You pay an inpatient copay for facility charges at a preferred facility; see page 20 for details. Professional services (for example, doctors or lab tests) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 182).

FOR MEDICARE RETIREES: For retirees enrolled in Medicare, the maximum inpatient copay is $600 ***per facility admission***, up to the medical out-of-pocket limit.

Outpatient

Outpatient chemical dependency services are covered the same as any other medical service. The plan pays based on the allowed amount and the network status of the provider.

Preauthorization for outpatient chemical dependency services is not required in most cases. However, the plan may require that your provider submit a treatment plan in order to determine medical necessity. The plan will review your provider's treatment plan to determine if it meets the following conditions:

- The purpose of the service is to treat or diagnose a medical condition;
- Outpatient services are the appropriate level of services considering the potential benefits of the services;
- The level of service is known to be effective in improving health outcomes; and
- The level of service recommended for your condition is cost-effective compared to alternative interventions including no intervention. See the definition of "Medically Necessary Services, Supplies, Drugs, or Interventions" on pages 182–184.

Chiropractic Physician Services

See "Spinal and Extremity Manipulations" on page 68.

Dental Services

ALERT! Dentists and other dental providers are not included in the UMP provider network, even if they are listed in the Regence provider directory. When you see a preferred provider, the plan pays 80% of the allowed amount.

Most dental services are not covered. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these is not covered. However, your PEBB dental plan may cover these services.

Under certain circumstances, the plan may cover fluoride supplements; see page 92. The application of fluoride varnish may be covered for infants and children starting at the age of primary tooth eruption in primary care practices, for prevention of dental caries (tooth decay); coverage depends on the network status of the provider as described on pages 25–26. Note that health care providers other than dentists may apply fluoride varnish.

For dental services that are covered by the plan, you pay 20% of the allowed amount and the provider may balance bill you (see definition on page 175). ***Only the following dental services are covered:***

General Anesthesia During a Dental Procedure

General anesthesia performed during a dental procedure is covered ***only*** when:

- It is provided by an anesthesiologist in a hospital or ambulatory surgery center.
- The charges for the hospital or ambulatory surgery center are covered by the plan (see "Dental Procedures Performed in a Hospital or Ambulatory Surgery Center" below).

Dental Procedures Performed in a Hospital or Ambulatory Surgery Center

Dental procedures performed in a hospital or ambulatory surgery center are covered ***only*** when the enrollee:

- Is under age 7 with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a dental condition that cannot be safely and effectively treated in a dental office because of a physical or developmental disability; or
- Has a medical condition that would put the enrollee at undue risk if the procedure were performed in a dental office.

Accidental Injuries

To receive coverage for repair of an accidental injury to natural teeth, the injury must be evaluated and a treatment plan developed and finalized within 30 days of the injury.

The actual treatment may extend beyond 30 days if your provider determines treatment should start later or continue longer. Treatment must be completed by the end of the calendar year

following the accident, and you must be currently enrolled in UMP Classic during the entire course of treatment. The plan does not cover treatment after UMP coverage ends.

Example: You have an accident on March 12, 2017, resulting in injuries that are covered by the plan. Your treatment plan must be finalized no later than April 11, 2017. All related treatment must be completed by December 31, 2018 (the calendar year following the accident).

The plan ***does not*** cover treatment that:

- Was not included in the treatment plan developed within the first 30 days following the accident.
- Extends past the end of the calendar year following the accident or your enrollment in UMP Classic.

Oral Surgery

TIP: See page 70 for information about TMJ disorder treatment.

Only the following oral surgery procedures are covered, whether performed by a dentist or a medical professional:

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate.
- Gum reduction for gingival hyperplasia due to Dilantin® or phenytoin use.
- Services related to cancer and treatment of cancer, including but not limited to jaw reconstruction.
- Treatment of a fracture or dislocation of the jaw or facial bones.
- Treatment related to chronic conditions that result in loss or damage of teeth.

Note: *UMP Classic is not affiliated with the Uniform Dental Plan (UDP). If you are enrolled in UDP, please contact UDP for information.*

Diabetes Care Supplies

FOR MORE INFORMATION: If a health plan other than UMP Classic is your primary payer (see definition on page 190), claims for diabetes care supplies may be paid differently. See page 113 for more information.

Diabetic supplies listed on page 44 are covered under your plan's prescription drug benefit according to the designated tier in the *UMP Preferred Drug List*. To be covered, you must get a written prescription for these medications and supplies and purchase them from a pharmacy. To find out the tier of a product, see the online list or call Washington State Rx Services at 1-888-361-1611.

You save money and avoid having to submit your own claims when you purchase these diabetic supplies from a Washington State Rx Services network pharmacy. Find a network pharmacy at **www.hca.wa.gov/ump/find-drugs** or call 1-888-361-1611.

When covered under the prescription drug benefit, the following diabetes care supplies are covered under the tier listed in the *UMP Preferred Drug List*:

- Glucose meters
- Test strips
- Insulin syringes
- Lancets

Select nonpreferred diabetes care supplies may be available through preauthorization (see page 87).

FOR MEDICARE RETIREES: If Medicare is your primary health coverage, see page 120 for information on how claims for diabetes care supplies are processed.

- ***Continuous Glucose Monitors must be preauthorized and are covered only under the medical benefit (see page 181).***

See page 47 for coverage of insulin pumps and related supplies.

Diabetes Education

The plan covers diabetic self-management training and education, including nutritional therapy by registered dieticians. When diabetes education includes nutritional therapy, the nutritional therapy services are not subject to the three-visit lifetime limit stated under "Nutrition Counseling and Therapy" on page 61.

Diabetes Prevention Program

For members ages 18 and older (except Medicare enrollees), the plan covers 100% for the Diabetes Prevention Program (DPP). The program offers screening to determine if you meet program criteria that indicate you may be at high risk for or have prediabetes. Diabetes screening is covered at 100%.

If you meet the program's screening criteria, you will be encouraged to participate in the program at no cost to you.

The PEBB Program may schedule screening events at sites around the state. You may also qualify for classes if a blood sugar test ordered by your provider in the previous 12 months is in the prediabetes range. Contact Customer Service at 1-888-849-3681 for more information.

Diagnostic Tests, Laboratory, and X-Rays

This benefit covers tests that are appropriate for your diagnosis or symptoms reported by the ordering provider and must be medically necessary as defined on pages 182–184. If there are alternative diagnostic approaches with different fees, the plan will cover the least expensive,

evidence-based diagnostic method. See **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization** or call 1-888-849-3681 for a list of services requiring preauthorization.

ALERT! Genetic tests require preauthorization and some are not covered; you may call Customer Service at 1-888-849-3681 to check.

Covered services include:

- Diagnostic laboratory tests, X-rays (including diagnostic mammograms), and other imaging studies.
- Colonoscopy performed to diagnose disease or illness; see the list on page 65 for coverage of preventive or screening colonoscopy.
- Electrocardiograms (EKG, ECG).
- Prostate cancer screening (prostate-specific antigen [PSA] testing): All PSA testing is covered under the medical benefit (subject to the medical deductible and coinsurance), even if billed as preventive.
- Skin allergy testing.

FOR MORE INFORMATION: See page 58 for information about how the plan covers mammograms.

Tests Not Covered

The plan does ***not*** pay for the following tests (this list does not include all tests not covered by the plan):

- Carotid Intima Media Thickness testing.
- Computed Tomographic Colonography (CTC) (also called a virtual colonoscopy) for routine screening.
- Upright Magnetic Resonance Imaging (uMRI): Also known as "positional," "weight-bearing" (partial or full), or "axial loading."

Dialysis

For covered professional and facility services necessary to perform dialysis you pay:

- 15% for preferred facilities.
- 20% for out-of-network facilities. For dialysis services, amounts paid to out-of-network facilities (including balance-billed amounts; see page 175) will count toward your medical out-of-pocket limit.

Durable Medical Equipment, Supplies, and Prostheses

TIP: The plan covers durable medical equipment (DME) at the preferred benefit rate only if you get the equipment or supply from a preferred DME supplier or other preferred medical provider. To find preferred DME providers, use the Provider Search at **www.hca.wa.gov/ump/ump-classic/find-providers,** at **regence.com,** or call 1-888-849-3681.

If you receive a higher-cost durable medical equipment item when a less expensive, medically appropriate option is available, the plan may not pay for the more expensive item. Some items require preauthorization; see page 99 for how to find the list at **www.hca.wa.gov/ump** or call 1-888-849-3681.

The durable medical equipment benefit covers services and supplies that are prescribed by a provider practicing within his/her scope of practice, medically necessary, and used to treat a covered condition, including:

- Automatic Positive Airway Pressure (APAP) devices and related supplies.
- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Bilevel Positive Airway Pressure (BiPAP) devices and related supplies.
- Bone growth (osteogenic) stimulators (requires preauthorization).
- Breast prostheses and bras as required by mastectomy. (See "Mastectomy and Breast Reconstruction" on page 60.)
- Breast pumps for pregnant and nursing women (see page 63).
- Casts, splints, crutches, trusses, and braces.
- Continuous Positive Airway Pressure (CPAP) devices and related supplies.
- Diabetic shoes, only as prescribed for a diagnosis of diabetes (see "Orthotics" on page 47).
- Insulin pumps and related pump supplies (see "Insulin Pumps and Related Pump Supplies" on page 47).
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when other accepted treatment has been unsuccessful and the impotence is:
  - Caused by a covered medical condition.
  - A complication directly resulting from a covered surgery.
  - A result of an injury to the genitalia or spinal cord.
- Rental or purchase (at the plan's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment. (The combined rental fees cannot exceed full purchase price; may require preauthorization.)
- Wheelchairs.
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100. Other wigs and hairpieces are not covered.

The plan limits coverage of durable medical equipment to one item of a particular type of equipment and the accessories needed to operate the item. The plan also covers the repair or replacement of durable medical equipment due to normal use or a change in the patient's condition (including the growth of a child). You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. **Note:** The plan does not cover replacement of lost, stolen, or damaged durable medical equipment.

Orthotics

Coverage of orthotics: Items such as shoe inserts and other shoe modifications are covered only when ***all*** of the following conditions are met:

- The patient has been diagnosed with diabetes.
- Specific clinical criteria are met.
- Specialized (including customized) orthotics are prescribed to treat or reduce the risk of diabetic complications.

If you have questions about what services are covered, call UMP Customer Service at 1-888-849-3681.

Insulin Pumps and Related Pump Supplies

Insulin pumps and related pump supplies are covered as durable medical equipment. For the highest benefit level, use a preferred durable medical equipment supplier.

Finding a Preferred Durable Medical Equipment Supplier

TIP: For advanced search through your **regence.com** account, see instructions at **www.hca.wa.gov/ump/ump-classic/find-providers**. Or, you can call Customer Service at 1-888-849-3681.

To find a preferred DME supplier without logging in to your **regence.com** account:

- Go to **www.hca.wa.gov/ump**.
- Select *Find Providers* under the "Plan: UMP Classic" section.
- Click on the *Find preferred providers* link.

The Regence site then gives you the following options to fill in:

- "Choose a network" will automatically display Uniform Medical Plan.
- Location.
- "Search for a doctor, hospital name or specialty:"

  Begin typing "durable medical"; will display a drop down list. Select "Durable Medical Equipment & Supplies Supplier" from the list.
- Click "Search."

You should now have a list of preferred durable medical equipment suppliers. Note that different DME suppliers carry different types of supplies; you may need to call to confirm that a particular DME supplier has what you need.

Note: These supplies are not available through PPS, the network mail-order pharmacy.

Emergency Room

TIP: If you need immediate care but your situation isn't a medical emergency (definition on page 182), see "Urgent Care" on page 72 for how to get treatment at a lower cost than in an emergency room.

Facility charges for emergency room treatment are covered for diagnosis and treatment of an injury or illness covered by the plan. You must pay a $75 copay and coinsurance for each emergency room visit, in addition to any amount owed toward your medical deductible.

Charges for professional services (provided by doctors and other provider types) may be billed separately from facility (hospital or emergency room) charges. The plan pays these professional services based on the allowed amount, payment rules, and services provided.

If your emergency room visit is determined to be a medical emergency, it will be paid at the preferred level for both preferred and out-of-network facilities.

If your emergency room visit is not the result of a medical emergency (see definition on page 182), the plan may not pay for emergency services.

If you are admitted to the hospital directly from the emergency room, the $75 emergency room copay will be waived. However, you must pay the inpatient copay (see page 20).

ALERT! Medical emergencies treated at an out-of-network hospital will be paid at the preferred rate. However, you may still be balance billed (see definition on page 175). Non-medical emergencies treated at an out-of-network hospital may not be covered by the plan. If the plan does pay, it will be at the out-of-network rate.

End-of-Life Counseling

The plan covers end-of-life counseling for all members up to 30 visits per year. There is no requirement to be terminally ill, on hospice, or in the final stages of life to receive end-of-life counseling services. End-of-life counseling associated with hospice services is paid at 100% after you meet your medical deductible. Outside of hospice, these services are paid as a medical benefit (see page 181), subject to the medical deductible and coinsurance.

Family Planning Services

The plan covers a variety of contraceptive drugs and devices. Some are covered as preventive—you don't pay a deductible (medical or prescription) or coinsurance. Others are covered under either the medical or prescription drug benefits, depending on the service.

Services related to voluntary and involuntary termination of pregnancy (abortion or miscarriage) are covered under the medical benefit (see definition on page 181).

Education and counseling related to contraception are covered as preventive (see page 65).

If you receive care from an out-of-network provider or non-network pharmacy, you may have to pay upfront and submit a claim for reimbursement (see pages 125–129). However, note that you must get over-the-counter contraceptive supplies from a network pharmacy for these items to be covered (see "Over-the-Counter Products" on page 50).

Contraceptive Drugs

ALERT! Visits for placement and removal of contraceptive devices that require professional insertion and removal are covered as preventive.

Contraceptive drugs include birth control pills, emergency contraception (the "morning after" pill), vaginal rings, patches, implants, and injectables (such as Depo-Provera).

Contraceptive drugs are covered under the prescription drug benefit; those not covered as preventive are subject to the prescription drug deductible and coinsurance as described on pages 76–81. Your coinsurance is determined by the tier level of the drug on the *UMP Preferred Drug List*.

Generally, only generic drugs are covered as preventive, which are indicated on the *UMP Preferred Drug List* posted on **www.hca.wa.gov/ump/find-drugs**, or you can call Washington State Rx Services at 1-888-361-1611. Brand-name contraceptive drugs are covered as preventive only when authorized by the plan (see "Preauthorizing Drugs" on page 87). Otherwise, they are covered according to their tier on the *UMP Preferred Drug List*.

Women may receive emergency contraception over the counter without a prescription. Only the generic version of emergency contraception is covered under the preventive benefit. If you choose a brand-name version, you will pay coinsurance according to its tier on the *UMP Preferred Drug List*.

Requesting an Exception

The plan requires preauthorization to cover contraceptives covered under the medical benefit as preventive. If you have a medical condition that prevents you from using a generic product that is covered as preventive, see "Preauthorizing Drugs" on page 87 for how to request an exception.

Barrier Devices

Barrier devices requiring a prescription or fitting: This includes intrauterine devices (IUDs), diaphragms, and cervical caps. All barrier devices requiring a prescription or fitting are covered as preventive when you see a preferred provider or use a network pharmacy.

For barrier devices that require insertion and removal by a healthcare professional (such as IUDs), insertion and removal are covered as preventive. Fitting for a barrier device (such as a diaphragm or cervical cap) is covered as preventive.

Over-the-Counter Products

Only over-the-counter products that are approved by and registered with the U.S. Food and Drug Administration (FDA) and intended for use by females are covered.

For the plan to cover FDA-registered over-the-counter contraceptives, you must present a prescription from a covered provider type (see page 15) to the pharmacist at the time of purchase.

ALERT! To receive plan coverage for an over-the-counter contraceptive, you must:

- Purchase from a network pharmacy, and
- Present a prescription from a covered provider type at the time of purchase.

Sterilization

When you see a preferred provider, sterilization procedures such as tubal ligation or vasectomy are covered at 100% and are not subject to the medical deductible.

What Is Not Covered Under The Family Planning Benefit?

The following services and products are not covered by the plan:

- Over-the-counter products not approved by and registered with the FDA.
- Over-the-counter products for use by males, such as male condoms.
- Reversal of voluntary sterilization.
- Diagnosis or treatment of infertility.

Foot Care, Maintenance

Maintenance foot care includes services such as trimming of toenails and removal or trimming of corns or calluses. These services are covered only under specific medical criteria, such as for a diagnosis of diabetes, and when provided by an approved provider type. Maintenance foot care provided outside approved medical criteria is not medically necessary and is not covered. See page 47 for coverage of orthotics for the prevention of diabetes complications.

Genetic Services

Genetic tests may require preauthorization; you may call Customer Service at 1-888-849-3681 to check. With preauthorization, the plan covers medically necessary, evidence-based genetic testing services.

Hearing Care (Related to Diseases and Disorders of the Ear)

The plan covers treatment for diseases and disorders of the ear or auditory canal not related to routine hearing loss under the medical benefit. Routine hearing care benefit limits (see "Hearing Exams and Hearing Aids" below) do not apply.

Hearing Exams and Hearing Aids

This benefit is exempt from the medical deductible, and includes the following services and supplies:

Hearing Exams (Routine)

One routine hearing exam is covered per calendar year. When you see a preferred provider, these services are paid at 100% of the allowed amount. However, if you see an out-of-network provider, you pay 40% of the allowed amount and the provider may balance bill you.

Hearing Aids

The plan pays up to $800 per member every three calendar years for:

- Purchase of a hearing aid (monaural or binaural) prescribed as a result of an exam when necessary for the treatment of hearing loss, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty (only as included with the initial purchase).
  - Follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

The maximum benefit of $800 applies no matter where you shop for your hearing aids and supplies.

Hearing Aid Items Not Covered

The following hearing-related items are not covered:

- Charges incurred after your UMP coverage ends, unless you ordered the hearing aid before that date and it is delivered within 45 days after your coverage ended.
- Extended warranties, or warranties not related to the initial purchase of the hearing aid(s).

- Purchase of replacement batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

Home Health Care

ALERT! See exclusion 26 on page 104 for services not covered by the plan.

UMP Classic covers medically necessary services provided and billed by a licensed home health agency for medical treatment of a covered illness or injury. These services must be part of a treatment plan written by your provider (such as a physician or advanced registered nurse practitioner [ARNP]). The provider must certify that you are homebound and would require hospital or skilled nursing facility care if you did not receive home health care. Examples of covered services are:

- Visits for part-time or occasional skilled nursing care and for physical, occupational, and speech therapy.
- Related services such as occasional care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of a registered nurse (RN), licensed practical nurse (LPN), or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.
- End-of-life counseling (see page 48).

For services that may be covered under another benefit, such as nutritional counseling or follow-up care for bariatric surgery, see that benefit in this *Certificate of Coverage* for coverage rules and limitations. These limitations apply even if the services are provided in the home or by a home health provider. Call Customer Service at 1-888-849-3681 if you have questions.

Hospice Care (Inpatient, Outpatient, and Respite Care)

Medical

Services received from preferred providers are covered at 100% of the allowed amount after you meet your medical deductible. The plan covers hospice care for terminally ill enrollees for up to six months. See page 48 for coverage of end-of-life counseling.

Prescription Drugs

For covered prescription drugs, UMP Classic members in hospice care receive special coverage when using network pharmacies, including the network specialty pharmacy and the network mail-order pharmacy. Until the prescription drug deductible is met:

- The member pays the normal coinsurance for Value Tier (5%) and Tier 1 (10%) covered prescription drugs, subject to the prescription cost-limit (page 80).
- The member pays the full cost (allowed amount) for covered Tier 2 and Tier 3 drugs.

After the prescription drug deductible is met, the plan pays for all covered prescription drugs purchased through a network pharmacy at 100%.

This applies only to the member in hospice care. Other family members covered under the same account will pay for their covered prescription drugs as described on pages 75–97.

All quantity limits, preauthorization requirements, and coverage limits apply.

ALERT! The member still pays the full cost for noncovered drugs. If the member purchases covered prescription drugs from a non-network pharmacy (see page 84), the plan covers under normal benefits as described on pages 76–81.

Respite Care

Respite care is continuous care of more than four hours a day to give family members temporary relief from caring for a homebound hospice patient. The plan covers these services at 100% of the allowed amount after you pay the medical deductible, up to 14 visits per the patient's lifetime.

Hospital Services

ALERT! Many services provided in a hospital setting require preauthorization or plan notification, or both. Failure to request or receive preauthorization, or to notify the plan, may result in complete denial of claims. See pages 98–100 for a description of how preauthorization and plan notification work.

This benefit covers hospital accommodations and inpatient, outpatient, and ambulatory care services, supplies, equipment, and prescribed drugs to treat covered conditions. Room and board is limited to the hospital's average semiprivate room rate, except where a private room is determined to be medically necessary (see definition on pages 182–184). Some services require preauthorization; see page 99 for how to find the list at **www.hca.wa.gov/ump** or call 1-888-849-3681.

If you receive a higher-cost service or device at a hospital when a less expensive, medically appropriate option is available, you may have to pay the difference in cost. A preferred hospital can't charge you for the difference in cost between the standard and higher-cost item (unless you agreed in writing to pay before receiving the services).

If benefits change under the plan while you are in the hospital (or any other facility as an inpatient), coverage will be provided based on the benefit in effect when the stay began.

Inpatient

Services are considered "inpatient" when you are admitted as an inpatient to a hospital; your provider must notify the plan upon admission, and all elective surgeries must be preauthorized (see page 98). You pay an inpatient copay for facility charges at a preferred facility; see page 20 for details. Professional services (such as lab tests, surgery, or other services) may be billed separately from the facility charges. The plan pays these services according to the network status of the provider, unless your condition is a medical emergency (see page 182). All covered professional services are paid based on the allowed amount.

FOR MEDICARE RETIREES: For retirees enrolled in Medicare, the inpatient copay is $200 per day, with a maximum of $600 ***per inpatient admission***, up to the medical out-of-pocket limit.

Outpatient

Services are considered "outpatient" when you are not admitted to the hospital. Your cost depends on the services provided, such as lab tests, and the network status of the provider(s) involved in your care. You do not pay the inpatient copay for outpatient services. Some services require preauthorization; see page 99 for how to find the list at **www.hca.wa.gov/ump** or call 1-888-849-3681.

Not All Providers at a Preferred Hospital Are Preferred Providers

Some hospital-based physicians (such as anesthesiologists and emergency room doctors) who work in a preferred hospital, or other preferred facility, may not be preferred providers. If a participating or out-of-network provider bills separately from the hospital, you will pay 40% of the allowed amount. For out-of-network providers, you may also be balance billed (see definition on page 175). For examples of how much you pay, see "Comparing Payments to Preferred, Participating, and Out-of-Network Providers" on page 16.

To see the network status of anesthesiologists and emergency room doctors in Washington State hospitals, use the Provider Search at **www.hca.wa.gov/ump/ump-classic/find-providers**, at **regence.com**, or call Customer Service at 1-888-849-3681.

Joint Replacement Surgery, Knees and Hips– Center of Excellence (COE) Program

FOR MEDICARE RETIREES: The COE Program is not available to UMP Classic members who are enrolled in Medicare as their primary coverage (see page 120).

The Center of Excellence (COE) Program is a comprehensive program that covers services related to knee or hip total joint replacement surgery. The Program includes, but is not limited to:

- Presurgical consultations.

- Hospitalization and surgery.
- Postsurgical assessments.

Patients work with a team of professionals at Premera Blue Cross (Premera) and Virginia Mason—the Center of Excellence—to ensure that all aspects of treatment are consistent with established standards of care.

Services under the COE Program are covered in full by UMP; you do not pay your usual cost share (deductibles, coinsurance, or copays).

If you receive services related to joint replacement that are not covered under the COE Program, you will pay your normal UMP cost share, depending on the services received and the network status of the provider(s). This may be a deductible (page 18), coinsurance (page 20), copay (page 20), or amounts not covered by the plan.

Center of Excellence: Virginia Mason

Virginia Mason is the only provider approved to perform knee and hip replacement under the COE Program. Virginia Mason has demonstrated an ability to provide high-quality joint replacement services at predictable costs, using the most up-to-date clinical guidelines and medical services.

Who Is Involved in the COE Program?

Premera is the administrator for the COE program. Medical services are provided only through Virginia Mason, the approved Center of Excellence for knee and hip replacement.

Who Is Eligible to Participate in the COE Program?

You are a candidate for the COE Program if you are:

- A UMP Classic member.
- Not enrolled in Medicare as your primary coverage (see page 120).
- Age 18 or older.

Virginia Mason must also determine if surgery for knee and hip replacement is appropriate based on established medical guidelines.

How Do I Apply to Participate in the COE Program?

If you are interested in participating in the COE Program:

- You may self-refer by calling Premera at 1-855-784-4563.
- Your regular provider may refer you.
- Premera may contact you directly by letter if you are identified as a potential participant in the COE Program. The letter will explain how the program works and whom to contact for more information.

After applying:

- Premera provides prequalifying screening of potential participants.
- Premera refers prequalified potential participants to Virginia Mason.

- Virginia Mason assesses potential participants to determine if they qualify for surgery under the COE Program.

Virginia Mason providers decide if you qualify for, and are approved, for surgery under the COE Program.

TIP: If Virginia Mason determines you need surgery but you do not meet the established medical guidelines under the COE Program, you may still have surgery at Virginia Mason covered in full.

Who Determines My Eligibility to Participate in the COE Program?

Premera will determine if you are eligible to participate in the COE Program.

Virginia Mason will review your medical records to determine if you are eligible for surgery.

Note: You may be required to follow a plan Virginia Mason gives you as a condition of approval for surgery.

ALERT! Being eligible to participate in the COE Program and being eligible for surgery are two separate processes. If Premera determines you are eligible to participate in the COE Program, you must still meet Virginia Mason's established medical guidelines before being approved for surgery.

Can I Choose to See a Different Provider?

To receive services under the COE Program, you must select a surgeon from the list provided by your Premera case manager. COE Program services will be provided only at Virginia Mason. If you receive services from a provider not with Virginia Mason, the services are covered based on normal UMP benefits (subject to deductibles, coinsurance, and copays).

If you want to get your surgery performed somewhere other than Virginia Mason, you cannot participate in the COE Program and will pay for services based on normal UMP benefits (subject to deductibles, coinsurance, and copays).

TIP! Participation in the COE Program is voluntary; you can still receive your total knee or hip replacement surgery from any preferred provider. However, you will receive the COE Program benefits only if you are approved by Virginia Mason to have your surgery covered under the COE Program.

What Is My Travel Benefit?

Members having surgery under the COE Program may qualify for assistance with travel and lodging expenses. These expenses may include partial coverage by Premera for mileage, flights, parking and lodging. To be covered by the Program, *all travel must be arranged through Premera*.

You must have an approved adult travel companion, whose travel expenses are also covered as described below.

FOR MORE INFORMATION:	Reimbursement for travel expenses is based on cost or current IRS rates for medical expenses, whichever is less, and may not cover all of your costs. See the UMP website at **www.hca.wa.gov/ump-classic/knee-and-hip-replacement** for links to rates.

Premera may partially reimburse expenses related to:

- Mileage for driving within Washington. To qualify for mileage reimbursement, members must live at least 60 driving miles from Virginia Mason, located at 1100 9th Ave, Seattle, WA 98101.
- Flights departing from and arriving at airports within Washington, or from and back to Portland International Airport. You must depart from the airport closest to your residence; see a list of airports at **www.hca.wa.gov/ump-classic/knee-and-hip-replacement**.
- Ground transportation from Seattle-Tacoma International Airport to Virginia Mason.
- Lodging expenses (excluding meals) at The Inn at Virginia Mason. You may qualify for lodging reimbursement even if you do not live more than 60 driving miles from Virginia Mason in Seattle. Premera must arrange all lodging. If The Inn at Virginia Mason is at full capacity, Premera will make alternate hotel arrangements.
- Parking at Virginia Mason and parking at your departing airport, even if you do not live more than 60 driving miles from Virginia Mason.

What Is Included in the COE Program?

Premera will work with you to help you understand how the COE Program works, what's covered and what isn't, connect you with Virginia Mason providers, and resolve any questions or issues you may have.

In general, all eligible expenses associated with knee or hip replacement surgery under the COE Program are covered. This includes expenses from the day you arrive for your pre-operative visit through discharge, including your:

- Assessment(s).
- Surgery.
- Hospital stay.
- Hospital discharge (excluding take home drugs, which are covered under your UMP prescription drug benefit).

What Is Not Included in the COE Program?

If you receive services not arranged through your Premera case manager, or choose to receive services at Virginia Mason that are not related to your hip or knee replacement surgery, the services will be covered under your normal UMP Classic benefits.

The following services are *not* included in the COE Program:

- Care received as part of the plan Virginia Mason gives you as a condition of program approval, regardless of where you receive care. Examples of plan requirements include smoking cessation and medical tests.
- Rehabilitative therapies that are not provided during your hospitalization.
- Follow-up care other than the initial postsurgical checkup at Virginia Mason. An example of follow-up care is a visit with your regular doctor.
- Medications received from a pharmacy upon discharge from the hospital.
- Convenience items, such as a personal phone.

Appeals Related to the COE Program

UMP members can appeal denials made by Premera. Appeals must be submitted to Premera rather than to the plan (Regence). Decisions made by your Virginia Mason provider(s) regarding your eligibility for surgery under the Program are not made by the plan and are therefore not appealable to the plan.

TIP: Deadlines and other rules remain the same; see pages 134-142 for details of how appeals work.

An appeal for services related to the COE Program must be submitted to Premera at the address below (rather than to Regence):

Eligibility Appeals:
Attn: Appeals Department - MS 123
PO Box 91102
Seattle, WA 98111-9102

Knee Arthroplasty

Treatment of end-stage osteoarthritis and rheumatoid arthritis of the knee is covered only as follows:

- Total knee arthroplasty, performed with or without computer navigation is covered.
- For individuals with unicompartmental disease, unicompartmental partial knee arthroplasty is covered.
- Multi-compartmental partial knee arthroplasty (including bicompartmental and bi-unicompartmental) is ***not*** covered.

TIP: You may be eligible to have your knee or hip joint replacement surgery covered in full. See "Joint Replacement Surgery, Knees and Hips–Center of Excellence (COE) Program" on pages 54–58.

Mammograms

ALERT! See "Breast Health Screenings" on page 39 for coverage of breast screenings performed in addition to digital mammography.

Screening (Preventive) Mammograms

For women ages 40 and older, with or without a clinical breast exam, the plan covers screening mammograms every one to two years, not subject to the medical deductible.

For women under age 40, the plan covers screening mammograms for women who are at an increased risk for breast cancer. The service must be ordered by a health care provider, and the claim must be billed with an "at risk" diagnosis to be covered under the preventive care benefit.

How Much Will I Pay?

For all women, if you see a:

- **Preferred provider:** You pay nothing.
- **Participating provider:** You pay nothing.
- **Out-of-network provider:** You pay 40% of the allowed amount and the provider may balance bill you.

ALERT! A mammogram is considered screening or diagnostic based on how it is billed by your provider.

Diagnostic (Medical) Mammograms

The plan pays for medically necessary mammograms to diagnose a medical condition under the "Diagnostic Tests, Laboratory, and X-Rays" benefit, subject to the medical deductible and coinsurance. Coverage of diagnostic mammograms is not related to age.

Women under age 40 who receive a mammogram that is not for an "at risk" diagnosis may have services paid as a diagnostic (medical) mammography under the "Diagnostic Tests, Laboratory, and X-Rays" benefit, subject to the medical deductible and coinsurance. The service must be ordered by a health care provider and billed as a diagnostic mammogram.

ALERT! See "Breast Health Screening Tests" on page 39 for coverage of diagnostic testing other than mammograms.

Massage Therapy

The plan covers no more than 16 massage therapy visits per calendar year. If you pay for visits before you meet your medical deductible, those visits count toward the 16-visit limit. See the definition of "Limited Benefit" on page 181. You must have a prescription for massage therapy treatment from another covered provider type, such as a physician.

ALERT! Only preferred massage therapists are covered. To find a preferred massage therapist, use the Provider Search at **www.hca.wa.gov/ump/ump-classic/find-providers,** at **regence.com,** or call Customer Service at 1-888-849-3681.

Mastectomy and Breast Reconstruction

ALERT! See page 72 for coverage of breast reconstruction or mastectomy services related to transgender services.

This benefit covers mastectomy as treatment for disease, illness, or injury, as well as:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Physical complications of all stages of mastectomy.

Please note that you must use a covered provider type (see page 15) for services to be covered.

Mental Health Treatment

The plan covers mental health services for treatment of neuropsychiatric, mental, and personality disorders, including eating disorders. Marriage or family counseling is not covered. The amount the plan pays depends on the provider's network status; see the Summary of Benefits chart on page 32.

Your provider must notify the plan upon admission when you receive the following services:

- Inpatient admission, including to a Residential Treatment Facility.
- Partial Hospitalization Program (PHP).

Inpatient

Services are considered "inpatient" when you are admitted to a facility. Non-emergency inpatient services must be preauthorized by the plan; see page 98 for details. Contact UMP Customer Service at 1-888-849-3681 about preauthorization requirements. See the bullets above for services that require plan notification.

You pay an inpatient copay for facility charges at a preferred facility; see page 20 for details. Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 182). All covered professional services are paid based on the allowed amount.

FOR MEDICARE RETIREES: For retirees enrolled in Medicare, the inpatient copay is $200 per day, with a maximum of $600 ***per inpatient admission***, up to the medical out-of-pocket limit.

Outpatient

ALERT! See page 38 for preauthorization requirements related to Applied Behavior Analysis (ABA) Therapy services.

Outpatient mental health services are covered the same as any other medical service. The plan pays based on the allowed amount and the network status of the provider. Most outpatient mental health services do not require preauthorization; see bullets on page 60 for services requiring plan notification.

Naturopathic Physician Services

Naturopaths may recommend services that the plan doesn't cover. You will pay all costs for excluded and non-medically necessary services, even if your naturopathic physician recommends or prescribes them (see definition of medical necessity on pages 182–184).

The plan does not cover herbal, homeopathic, or other dietary supplements (including vitamins and minerals, except as described on page 92), even if prescribed by a covered provider type.

Nutrition Counseling and Therapy

TIP: See "Diabetic Education" on page 44 for how these services are covered for diabetics.

The plan covers up to three visits per lifetime for nutrition counseling and therapy services. Similar services are covered under other benefits that are not subject to the three visit limit, including but not limited to "Diabetes Education" (page 44) and the "Diabetes Prevention Program" (page 44).

Obstetric and Newborn Care

Services for pregnancy and its complications are covered. See "Covered Provider Types" on page 15 for providers whose services are covered by the plan. Professional services covered include:

- Prenatal and postnatal care.
- Amniocentesis and related genetic counseling and testing during pregnancy.

- Prenatal testing (follows state regulations in Washington Administrative Code 246-680-020).
- Vaginal or Cesarean delivery.
- Care of complications associated with pregnancy, including pregnancies resulting from infertility treatment.

Early elective deliveries may not be covered; see "When Deliveries Before 39 Weeks Gestation May Not Be Covered" on page 62.

For inpatient hospital charges related to a routine childbirth, you pay:

- Any remaining medical deductible for the mother.
- The mother's inpatient copay (see page 20).
- Coinsurance for professional services for the mother while hospitalized.
- The medical deductible for the newborn; however, if only preventive care services (see pages 65–67) are billed for the newborn, you will not pay the newborn's medical deductible, inpatient copay, or coinsurance when you see a preferred provider.

For non-routine hospitalization of the newborn, you will also pay a separate inpatient copay for the newborn.

Circumcision is covered as a medical benefit for males only (subject to the medical deductible and coinsurance). As this is not a preventive service, your out-of-pocket cost may include the newborn's medical deductible, coinsurance for professional provider services, and an inpatient copay for inpatient services.

A newborn dependent of a female enrollee is covered from birth to at least 21 days following birth. Even if the newborn is later enrolled in different coverage, the newborn will still be covered under the mother's UMP coverage for the first 21 days. See "Adding a New Dependent to Your Coverage" on page 63 for what you need to do for continued coverage.

If your obstetric care began while covered under another health plan, and the providers are not part of the plan network, call Customer Service at 1-888-849-3681.

When Deliveries Before 39 Weeks Gestation May Not Be Covered

Vaginal or Cesarean deliveries before 39 weeks of gestation are covered when the services are medically necessary; examples include:

- Due to a medical emergency (see definition on page 182) affecting the mother or baby.
- Indicated due to a medical condition of the mother or baby for which a delivery is medically necessary (see definition on pages 182–184).
- Labor begins spontaneously (without medical intervention) before the mother reaches 39 weeks of gestation.

Vaginal or Cesarean deliveries before 39 weeks of gestation are ***not covered*** when the services are:

- Scheduled for convenience and not for medical necessity or medical emergency.
- Neither the mother or baby have a medical condition for which immediate delivery is medically necessary.
- Not due to a medical emergency affecting the mother or baby.

Talk to your doctor about whether early delivery is for a medically necessary reason. For questions about this policy, call UMP Customer Service at 1-888-849-3681.

Services Covered as Preventive

The following services are covered as preventive (not subject to the medical deductible or coinsurance when you see a preferred provider):

- Screening for gestational diabetes during pregnancy.
- Counseling and HIV screening.
- Purchase of manual and electric breast pumps for pregnant and nursing women, plus supplies included with the initial purchase. Hospital-grade pumps are not covered.
- Use of low dose aspirin (81mg/day) after 12 weeks' gestation in women at high risk of preeclampsia. You must have a prescription from your provider and purchase from a network pharmacy to get the medication at no cost; see "Products Covered Under the Preventive Care Benefit" on page 94.

See pages 65–67 for more prenatal, newborn, and well-baby services that are covered as preventive. See page 92 for coverage of prenatal vitamins.

Limitations on Ultrasounds During Pregnancy

The following limits do not apply to high-risk pregnancies. For example, a multiple pregnancy is considered high risk.

Ultrasounds during pregnancy are covered as follows:

- One in week 13 or earlier.
- One during weeks 16-22.

Adding a New Dependent to Your Coverage

If the birth or adoption of a child increases your premium, you should submit the appropriate enrollment form and any necessary documents no later than 12 months after the birth or adoption to:

Employees:
Your personnel, payroll, or benefits office.

All other members:
Mail: PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684
Phone: 1-800-200-1004

For subsequent children whose enrollment doesn't affect your premium, you should submit the appropriate enrollment forms and any necessary documents to the appropriate office (see above) no later than 60 days after the birth or adoption.

TIP: To ensure timely payment of services, please enroll a newly eligible dependent as soon as possible.

Office Visits

The plan pays for office visits for covered conditions under the medical benefit (see page 181). Preventive care visits to preferred providers as described under "Preventive Care" beginning on page 65 are covered in full and are not subject to the medical deductible.

Orthognathic Surgery

Orthognathic surgery (see definition on page 186) must be preauthorized by the plan according to the plan's medical policy. Call UMP Customer Service at 1-888-849-3681 if you have questions. See page 70 for treatment of temporomandibular joint syndrome (TMJ) disorder.

Physical, Occupational, Speech, and Neurodevelopmental Therapy

The plan covers inpatient and outpatient services to improve or restore function lost due to:

- An acute injury or illness.
- Worsening or aggravation of a chronic injury.
- A congenital anomaly (such as cleft lip or palate).
- Conditions of developmental delay, including autism.

You must have a prescription for the above therapies from another covered provider type (see page 15), such as a physician.

Inpatient Services

Preauthorization is required for inpatient admissions for physical, occupational, speech, and neurodevelopmental therapy services. The plan covers rehabilitation therapy services provided during inpatient hospitalization up to 60 days per calendar year (see definition of "Limited Benefit" on page 181). You must pay the inpatient copay (see page 20) and your coinsurance for inpatient services.

Outpatient Services

The plan covers outpatient physical, occupational, speech, and neurodevelopmental therapy services up to 60 visits per calendar year, counting all types of therapies listed here (see definition of "Limited Benefit" on page 181).

For the purposes of this benefit, developmental delay (see definition on page 176) means a significant lag in achieving skills such as:

- Language (speech, reading, writing).
- Motor (crawling, walking, feeding oneself).
- Cognitive (thinking).
- Social (getting along with others).

Prescription Drugs

Please see "Your Prescription Drug Benefit" starting on page 75.

Preventive Care

ALERT! This benefit covers ***only*** services that meet the criteria below. If you receive services during a preventive care visit that do not meet these requirements, they will not be covered as preventive care. Instead, when medically necessary, the services are subject to the medical deductible and are covered under the specific benefit the charges apply to (such as diagnostic tests, laboratory, or X-rays). If your provider bills for your visit as medical treatment instead of an annual physical exam or other preventive service, it will be covered under the medical benefit and subject to the medical deductible and coinsurance.

You don't have to meet your medical deductible before the plan pays for services covered under the preventive care benefit. When you see a preferred provider for these services, you pay nothing. If you see an out-of-network provider, you pay 40% of the allowed amount (definition on pages 173–174), and the provider may balance bill you. However, if you do not have access to a preferred provider for preventive services, the plan may pay 100% of billed charges. See page 13 for how to request a network waiver.

For a list of services covered as preventive, see **www.healthcare.gov/ preventive-care-benefits/adults**. This site also features links to specific preventive services covered for women and children. Note that recommendations added during the calendar year may not be covered as preventive until later years.

Examples of services covered under the preventive care benefit include:

- Preventive visits such as well-baby care and annual physical exams.
- Preventive vision acuity screening from birth through 18 years of age.
- Intensive behavioral counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors.
- Screening for hepatitis B for non-pregnant adolescents and adults at high risk.
- Routine screenings for women (see list on page 66 for examples).
- Certain radiology and lab tests such as screening mammograms (see page 59).
- Screening procedures such as colonoscopy; see page 45 for coverage of colonoscopy performed to diagnose or treat disease or illness.
- One-time screening by ultrasound for abdominal aortic aneurysm, for men ages 65-75 who have ever smoked.
- Immunizations as specified under "Covered Immunizations" on page 66.
- Hearing tests as part of a newborn screening.
- Fluoride for prevention of caries (dental decay): prescribed by primary care provider to children age 6 months and older, when water is fluoride deficient; see page 92 for coverage. See page 42 for coverage of fluoride varnish.

- Certain screening tests performed during pregnancy; see pages 61–63 for more on prenatal care.

You may call Customer Service at 1-888-849-3681 to ask if a service is covered as preventive.

The following specific services for women are covered as preventive:

- Human Papillomavirus (HPV) testing for women ages 30 and over, once every three years.
- Chlamydia and gonorrhea testing in sexually active women age 24 years and younger, and for women age 25 and older who are at increased risk for infection.
- Education and counseling regarding contraception.
- Counseling and screening for HIV; counseling and screening for interpersonal and domestic violence; and counseling for sexually transmitted infections.

For additional services covered as preventive for women, see "Family Planning Services" on pages 49–50, "Mammograms" on page 58, and "Obstetric and Newborn Care" on page 61.

Note: Prostate cancer screening (prostate-specific antigen [PSA] testing) is not covered under the preventive care benefit, but is covered as a medical benefit (subject to the medical deductible and coinsurance).

ALERT! Follow-up visits or tests are not covered under the preventive care benefit. If the test or visit is normally covered by the plan and is medically necessary, the plan pays under the medical benefit (see definition on page 181).

Covered Immunizations

The plan covers immunizations as included on the applicable immunization schedule (children, adolescents, adults) for U.S. residents by the Centers for Disease Control and Prevention (CDC). For the list of covered immunizations, see the UMP website or call Customer Service at 1-888-849-3681. Immunizations covered under the preventive care benefit are not subject to either the medical or the prescription drug deductibles. Immunizations given by the providers listed under "Where Can I Get Immunizations?" below are paid under the preventive care benefit. If you see an out-of-network provider for covered immunizations, you pay 40% of the allowed amount and the provider may balance bill you.

FOR MORE INFORMATION: For a list of immunizations covered as preventive, see links to the CDC immunization schedules on the UMP website or call 1-888-849-3681.

Where Can I Get Immunizations?

Immunizations covered under the preventive care benefit are ***free*** when received from a:

- Preferred provider.
- Network vaccination pharmacy (see definition on page 184); check at **www.hca.wa.gov/find-drug** or call Washington State Rx Services at 1-888-361-1611 to find a pharmacy.

- Public health department.

The plan does not cover immunizations for travel or employment, even when recommended by the CDC or required by travel regulations.

TIP: Flu shots are covered as included on the applicable CDC immunization schedule.

Second Opinions

This benefit covers:

- **Second opinions you choose to get.** The plan covers these under the medical benefit subject to the medical deductible and coinsurance.
- **Second opinions required by the plan.** The plan covers these at 100% (you don't pay toward your medical deductible or coinsurance). If you don't get a second opinion when required by the plan, coverage for services may be denied.

Skilled Nursing Facility

Services must be preauthorized by the plan before you are admitted to a skilled nursing facility; see page 98. In addition, the facility must notify the plan within 24 hours of your admission; see page 99.

This benefit covers skilled nursing facility charges for services, supplies, and room and board, including charges for services such as general nursing care made in connection with room occupancy. UMP Classic covers up to 150 days per calendar year. Room and board is limited to the skilled nursing facility's average semiprivate room rate, except where a private room is determined to be medically necessary (see definition on pages 182–184).

Skilled nursing facility confinement that is primarily convalescent or custodial in nature is not covered.

Skilled Nursing Care Limits for Medicare Retirees

Medicare covers the first 100 days during a benefit period. A Medicare benefit period begins the day of skilled nursing facility admission and ends based on the time period between skilled nursing facility admissions. There may be multiple benefit periods in a year. The benefit period ends when you have not received any skilled care in a nursing facility for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods in a year.

If Medicare is your primary coverage, this plan covers your first 100 days in a skilled nursing facility as your secondary insurer. Those 100 days count against the 150-day maximum allowed by UMP Classic.

After you have reached your Medicare maximum of 100 days, UMP Classic covers an additional 50 days if services are medically necessary and meet the plan's criteria for skilled nursing facility coverage.

Spinal and Extremity Manipulations

Up to 10 visits per calendar year for manipulations (adjustments) of the spine and extremities (arms and legs) are covered. When you have reached your 10-visit limit, no further payment for manipulations of the spine and extremities will be made.

Visits that count toward your medical deductible also count toward your 10-visit limit (see "Limited Benefit" on page 181).

Spinal Injections

Some spinal injections must be preauthorized by the plan (see page 98 for how this works). The following therapeutic injections are covered for treatment of chronic pain:

- Lumbar epidural injections
- Cervical-thoracic epidural injections
- Sacroiliac joint injections

See exclusion 68 on page 106 for a list of spinal injections that are not covered by the plan.

Spinal injections not specified above may be covered subject to the plan's medical review. Call 1-888-849-3681 for more information.

Surgery

ALERT! Even if your doctor is preferred, the facility or other providers such as anesthesiologists might not be. Make sure you confirm that all of the providers who will participate in your care and the facility are preferred before you receive services. Out-of-network providers and facilities can bill you for all charges not paid by the plan, while preferred providers and facilities agree to accept the payment amounts negotiated by the plan, which saves you money.

The plan pays for covered surgical services according to the network status of the provider (see page 16 for coinsurance amounts). The surgeon and other professional providers may bill separately from the facility.

All elective inpatient surgeries and some outpatient procedures require preauthorization; see page 98. In addition, your provider must notify the plan (see page 99) when you receive certain services, including admission as an inpatient. See the list of services that require preauthorization at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization**. Call Customer Service at 1-888-849-3681 if you have questions.

If services are inpatient (see definition of "Inpatient Stay" on page 180), you will also pay an inpatient copay for facility charges at a preferred facility (see page 20).

The plan covers the following services as outpatient:

- Outpatient surgery at a hospital.
- Surgery and procedures performed at an ambulatory surgery center.
- Short-stay obstetric (childbirth) services (released within 24 hours of admission).

ALERT! All surgeries must follow the plan's coverage rules. We recommend that you contact UMP Customer Service at 1-888-849-3681 before any procedure to ask if it's covered or requires preauthorization.

Telemedicine Services

The plan covers store and forward technology and telemedicine from authorized originating sites under the medical benefit if the plan provides coverage for the service when provided in person by the provider, the health care services are medically necessary, and the health care services are recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act (PPACA).

Telemedicine is the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and a distant site provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile, or email.

Store and forward technology means use of asynchronous transmission of a covered person's medical information from an originating site to a health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.

If services are provided through store and forward technology, there must be an associated office visit between the covered person and the referring health care provider.

The originating site (the physical location where the patient is) for a telemedicine health care services must be one of the following sites:

- Hospitals.
- Rural health clinics.
- Federally qualified health centers.
- Physician's or other health care provider's offices.
- Community mental health centers.
- Skilled nursing facilities.
- Renal dialysis centers (except independent renal dialysis centers).

Any originating site may charge a facility fee for infrastructure and preparation of the patient.

The following are not covered by the plan:

- Audio-only telephone, email or facsimile transmissions between doctor and patient.
- Originating sites' professional fees.
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.
- Telemedicine visits originating from a location other than the defined originating sites.
- Noncovered services.

Temporomandibular Joint (TMJ) Treatment

The plan covers diagnosis and medically necessary treatment of temporomandibular joint (TMJ) disorders, including surgery and non-surgical services. Treatment must follow plan medical policy and requires preauthorization.

Treatment that is experimental or investigational, or primarily for cosmetic purposes, is not covered.

Tobacco Cessation Services

ALERT! If you get nicotine replacement therapy or prescription drugs for tobacco cessation at a non-network pharmacy, or purchase at a regular register and submit a claim, you may not receive full reimbursement from the plan. See pages 83–84 for how to find a network pharmacy.

The services described below are covered only for tobacco cessation. Nicotine replacement therapy and prescription drugs for tobacco cessation that are designated as preventive on the *UMP Preferred Drug List* (with a "PV" in the Tier column) are not subject to the prescription drug deductible or coinsurance.

TIP: You do not have to enroll in the *Quit for Life* program to get coverage of nicotine replacement therapy or prescription drugs for tobacco cessation. See below for limits and rules on accessing these services.

Nicotine Replacement Therapy

The plan covers only certain nicotine replacement therapy products as preventive (at no cost to you), designated on the *UMP Preferred Drug List* with "PV" in the Tier column. Nicotine replacement products are over-the-counter drugs, which are normally not covered by UMP; these products must be purchased at a pharmacy using your UMP ID card to be covered.

You may get nicotine replacement therapy directly from the *Quit for Life* program (see "*Quit for Life* Program" below), or by following these steps:

1. Get a prescription from your provider.
2. Take the prescription to a network pharmacy.
3. Make your purchase at the pharmacy counter of the network pharmacy; give your prescription along with your UMP ID card to the pharmacist. The purchase must be submitted through the prescription drug system to be covered.

If you get a nicotine replacement therapy product not designated as preventive, you will pay any remaining amount on your prescription drug deductible and Tier 3 coinsurance. To request full coverage of non-preventive nicotine replacement therapy for a medical reason, see "How to Request an Exception" below

The plan does not cover e-cigarettes or vaporizers ("vapes").

Prescription Drugs

The plan covers only select prescription drugs for tobacco cessation, designated on the *UMP Preferred Drug List* with "PV" in the Tier column. To get covered drugs at no cost to you:

1. Get a prescription for a covered drug from your provider.
2. Take the prescription to a network pharmacy.
3. Using your UMP ID card, fill your prescription at the pharmacy counter of the network pharmacy.

If you get a prescription drug for tobacco cessation that is not designated as preventive, you will pay any remaining amount on your prescription drug deductible and Tier 3 coinsurance. To request full coverage of tobacco cessation prescription drugs not designated as preventive for a medical reason, see "How to Request an Exception" below.

Counseling

The plan covers in-person counseling related to tobacco cessation at the preventive rate (see table on pages 25–26).when you see a preferred provider.

Phone or online counseling is covered only through the *Quit for Life* program described below. UMP Classic members age 17 and under may use the Smokefree Teen program as explained below.

How to Request an Exception

To request coverage of a prescription drug or nicotine replacement therapy not usually covered under this benefit, see "Preauthorizing Drugs" on page 87 for how to request an exception. If your exception is approved, you will receive the approved product or drug at no cost.

Quit for Life Program

TIP: UMP Classic members age 17 and under may access similar support services through the Smokefree Teen program at **http://teen.smokefree.gov/,** in addition to the services described above.

UMP Classic members age 18 and older may participate in the *Quit for Life* tobacco cessation program. This program offers phone counseling in addition to the services described above at no cost to members. If you get nicotine replacement therapy or prescription drugs for tobacco cessation that are not designated as preventive on the *UMP Preferred Drug List* ("PV" in the Tier column), you will pay as described above.

For nicotine replacement therapy, you may get supplies sent to you from *Quit for Life*, or get a prescription from your provider and purchase as described under "Nicotine Replacement Therapy" above. See "Prescription Drugs" above for how to get prescription drugs for tobacco cessation.

FOR MORE INFORMATION: The general rule about the PEBB tobacco premium surcharge is that you must be tobacco-free for two months to reattest for an exemption. Contact PEBB at 1-800-200-1004 or visit **www.hca.wa.gov/public-employee-benefits** for more information.

Transgender Health

The following services associated with a diagnosis of gender dysphoria are covered. Some services and drugs may require preauthorization:

- Non-surgical services, including but not limited to hormone therapy, office visits, mental health/counseling, and tests.
- Surgical services.

Transplants

You must receive preauthorization from the plan for all transplants (except kidney and cornea). This benefit covers services related to transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care.

Donor Coverage

If a UMP Classic member receives an organ from a live donor, UMP Classic pays the donor's covered expenses as primary, regardless of any other coverage the donor may have. Covered donor expenses include costs to remove the donor's organ and treat complications directly resulting from the donor's surgery.

Urgent Care

See "Emergency Room Services" on page 48 for care during a medical emergency (definition on page 182).

If you need immediate care or when your usual provider is closed, and your situation is not a medical emergency (see definition on page 182), you may use Urgent Care facilities to receive care at a lower cost than an emergency room. You don't pay the emergency room copay for urgent care services; these services are paid at the Standard rate as described in the table on pages 25–26, according to the provider's network status.

See Find Providers at **www.hca.wa.gov/ump/ump-classic/find-providers** to find preferred Urgent Care facilities.

Vision Care (Related to Diseases and Disorders of the Eye)

The plan covers treatment for diseases and disorders of the eye that are not part of a routine vision exam under the medical benefit. Orthoptic therapy is not covered except for the diagnosis of strabismus, a muscle disorder of the eye. LASIK surgery is not covered.

Following cataract surgery, vision hardware (contact lenses or eyeglasses, including frames and prescription lenses) is covered as durable medical equipment (pages 46–48). These services are subject to the medical deductible; coinsurance depends on the network status of the provider. Contact the plan at 1-888-849-3681 if you have questions.

Vision Exams (Routine)

ALERT! The plan pays up to $65 per year for contact lens fitting fees; you may pay for charges exceeding that amount. For example, if the additional charge for a contact lens fitting is $100, you will pay $35 for the vision exam (the amount over $65).

The plan covers one routine eye exam for each enrollee per calendar year, which is exempt from the medical deductible. You pay nothing for services by a preferred provider. For an out-of-network provider, you pay 40% of the allowed amount and the provider may balance bill you (see costs in the table "How Much Will I Pay?" on page 25).

Vision Hardware (Eyeglasses and Contact Lenses)

Adults (Over Age 18)

The plan pays up to $150 every two calendar years for prescription eyeglass lenses, frames, and contact lenses, including repairs; you do not need to meet your medical deductible. This $150 limit is renewed on January 1 of even years (2016, 2018, etc.). Any unused amount does not carry over into the next even plan year. The plan will not pay more than your actual cost for these items and services. You are responsible for any costs above the $150 limit. **Note:** See "Vision Care (Related to Diseases and Disorders of the Eye)" above for vision hardware coverage following cataract surgery.

You can buy your vision hardware anywhere; the maximum benefit of $150 applies no matter where you shop. If you go to a provider that does not bill the plan directly, you can submit a claim for glasses or contacts; see "Billing & Payment: Filing a Claim" starting on page 125 for instructions.

Children Ages 18 and Under

Vision hardware (eyeglasses: frames and lenses; contact lenses) is not subject to the medical deductible.

The following services are covered each calendar year for children ages 18 and under:

- **Eyeglasses:** The plan pays 100% of the allowed amount for one pair of standard or deluxe frames plus lenses (including high-index); you pay nothing. The only added feature covered under this benefit is scratch-resistant coating. You will pay for any other additional features, such as but not limited to anti-reflective coating or tints.
- **Contact lenses:** No limit to number purchased, but the plan pays 85% of the allowed amount, and you pay 15% coinsurance.

TIP: ***For members with other primary coverage:*** If your primary coverage has a vision hardware benefit and you submit a claim to UMP Classic as your secondary coverage, any charges paid by your primary plan will also count against your UMP Classic vision hardware limit.

Your Prescription Drug Benefit

FOR MEDICARE RETIREES: If Medicare is your primary coverage, see "How UMP Classic Prescription Drug Coverage Works With Medicare" starting on page 123 for important information.

See page 96 for prescription drug contact information.

Your plan's drug benefit is administered and coordinated by a partnership of companies known as Washington State Rx Services. These companies are:

- **Moda Health**—Administration and customer service.
- **MedImpact Healthcare Systems Inc.**—Pharmacy network management and prescription drug claims processing.
- **Mail-order pharmacy**—PPS (Postal Prescription Services).
- **Specialty drug pharmacy**—Ardon Health.

When you have questions about your prescription drug coverage or need help finding a network pharmacy, call Washington State Rx Services at 1-888-361-1611. Contact the mail-order or specialty pharmacy directly for help placing or tracking prescription orders.

Note: Regence BlueShield does not provide prescription drug benefits for UMP Classic. Always contact Washington State Rx Services with questions about your prescription drug coverage.

TIP: The *UMP Preferred Drug List* is available at **www.hca.wa.gov/ump/find-drugs**. You can also check drug prices online with the Prescription Price Check tool.

What Drugs Are Covered? The *UMP Preferred Drug List*

ALERT! Not all drugs are listed on the *UMP Preferred Drug List*. If your drug isn't listed, call 1-888-361-1611.

The *UMP Preferred Drug List* (sometimes called a "formulary") lists the following:

- If a drug is covered by the plan.
- How much you will pay for a drug based on the drug's tier.
- If the drug must be preauthorized (see "Preauthorizing Drugs" on page 87).
- If the drug must be purchased from the plan's specialty pharmacy (see page 88).
- If there are any limits on a drug's coverage (see pages 86–90 under "Limits on Your Prescription Drug Coverage").
- If there are less expensive alternatives.

The *UMP Preferred Drug List* is updated online at least monthly. However, a drug may change tiers at any time, in particular when a generic equivalent becomes available. You can look up your prescription drugs online at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services. New brand-name drugs may not be covered during the first 180 days they are available. To check if a new drug is covered, call Washington State Rx Services at 1-888-361-1611.

ALERT! When a generic equivalent for a brand-name drug becomes available, the brand-name drug *immediately* becomes Tier 3. Always ask your doctor to allow substitution on your prescriptions to save you money.

Who Decides Which Drugs Are Preferred?

As a state-sponsored health plan, UMP Classic must follow coverage recommendations made by the Washington State Pharmacy & Therapeutics Committee (P&T Committee), which consists of Washington health care professionals, including physicians and pharmacists. The *UMP Preferred Drug List* includes these coverage recommendations.

Not all drug classes are reviewed by the Washington State P&T Committee. For these drugs, the Washington State Rx Services P&T Committee makes coverage recommendations for UMP's review and final determination of a drug's tier level.

For the plan to approve a drug for you, it must be medically necessary for your health condition. Your provider may prescribe a drug or drug does that is not medically necessary (see definition on pages 182–184).

ALERT! A drug may be designated as Tier 3 (nonpreferred brand name) even if no generic equivalent is available. See page 81 for how you may request an exception.

How Much Will I Pay for Prescription Drugs?

The amount you pay for your prescription depends on the drug's tier and where you purchase your prescriptions. The *UMP Preferred Drug List* classifies drugs into four tiers:

- Value Tier drugs are specific high-value generic medications used to treat certain chronic conditions.
- Tier 1 are primarily low-cost generic drugs.
- Tier 2 are preferred drugs (brand-name and high-cost generics).
- Tier 3 are nonpreferred drugs.

In general, Value Tier and Tier 1 drugs are the least expensive for you and Tier 3 are the most expensive. Even though Tier 3 drugs are called "nonpreferred," the plan still covers them, but you pay more.

You can find a drug's tier by checking the searchable *UMP Preferred Drug List* at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611. You can purchase up to a 90-day supply for most drugs, except for specialty drugs.

You pay for all covered prescription drugs based on coinsurance, which is a percentage of the drug's cost. If your prescription drug costs more than $1,500, it must be reviewed by the plan before being filled. Your provider can call Washington State Rx Services at 1-888-361-1611 to request coverage.

To check your cost:

- Call Washington State Rx Services at 1-888-361-1611, or
- Use the Prescription Price Check tool at **www.hca.wa.gov/ump/find-drugs**.

See the table on page 79 for how much you pay for each of the drug tiers. Using Value Tier and Tier 1 drugs reduces prescription costs for both you and the plan. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive.

Prescription Drug Deductible

You don't pay any deductible for Value Tier or Tier 1 drugs. If you get only Value Tier and Tier 1 drugs during the year, you won't need to pay the prescription drug deductible.

How Much Is My Prescription Drug Deductible?

The prescription drug deductible is $100 per person, with a maximum of $300 for a family of three or more people covered under the same account. You pay this deductible to the pharmacy when you purchase a drug to which it applies.

How Does the Prescription Drug Deductible Work?

You pay the prescription drug deductible for most brand-name drugs and a few generic drugs covered under Tier 2; see table below.

For Tier 2 and Tier 3 drugs, until you reach your $100 prescription drug deductible, you pay the deductible ***plus*** any applicable coinsurance, up to the cost of the drug. For drugs that cost less than $100, you will pay the cost of the drug, until you have met the $100 prescription drug deductible in full.

Exempt from the prescription drug deductible (you don't pay)	▪ Value Tier and Tier 1 drugs (see table on page 79).* ▪ You pay the coinsurance shown in the table on page 79.
Subject to the prescription drug deductible (you must pay)	▪ Tier 2 and Tier 3 drugs (see table on page 79). ▪ Once you meet your prescription drug deductible, you pay the coinsurance shown in the table on page 79.

**What you pay for Value Tier and Tier 1 drugs does not count toward your prescription drug deductible.*

Where Do I Pay the Prescription Drug Deductible?

You pay the prescription drug deductible at any prescription drug provider (pharmacy).

- If you use a non-network pharmacy (see page 84) and submit a paper claim, the prescription drug deductible must be met before the plan begins paying benefits for Tier 2 and Tier 3 drugs.
- Network pharmacies will know if you've met your prescription drug deductible, or if it doesn't apply to your prescription. This means that you pay only the amount remaining after the plan pays.

What Counts Toward the Prescription Drug Deductible and What Doesn't?

What counts toward my prescription drug deductible?	▪ Amounts paid toward Tier 2 and Tier 3 covered prescription drugs. ▪ Amounts paid toward supplies designated as Tier 2 or Tier 3 and covered under the prescription drug benefit.
What doesn't count toward my prescription drug deductible?	▪ Coinsurance amounts paid for Value Tier or Tier 1 drugs. ▪ Amounts exceeding the allowed amount (see page 174) paid to non-network pharmacies.* ▪ Costs for medical services, including drugs covered under the medical benefit. ▪ Costs for drugs not covered by the plan (see pages 102–107).
What will I pay for after reaching my prescription drug deductible?	▪ Any drugs or other products not covered by the plan. See pages 102–107 for examples. Also; see "Guidelines for Drugs Not Covered" beginning on page 95. ▪ Costs for other enrolled family members who have not met their prescription drug deductible (and the family maximum has not been met). *Note that the medical deductible (page 18) and prescription drug deductible are completely separate.*

**Non-network pharmacies may charge more than the allowed amount for prescription drugs; you are responsible for paying this amount in addition to your coinsurance.*

Your Prescription Drug Out-of-Pocket Limit

Expenses are counted from January 1, 2017, or your first day of enrollment, whichever is later; and December 31, 2017, or your last day of enrollment, whichever is first.

For each person enrolled in UMP Classic, the prescription drug out-of-pocket limit is $2,000 per person, with no family maximum. Each member must meet their own prescription drug out-of-pocket limit separately.

After you reach this limit, the plan pays 100% of the allowed amount for covered drugs and products. If you receive prescription drugs from a non-network pharmacy that charges more than the allowed amount, you must still pay the difference (see #2 in the table below).

How Does the Prescription Drug Out-of-Pocket Limit Work?

What counts toward my prescription drug out-of-pocket limit?	▪ Your prescription drug coinsurance up to the prescription cost-limit, when it applies (see table on page 79). ▪ Your prescription drug deductible.
What doesn't count toward my prescription drug out-of-pocket limit?	1. Amounts paid by the plan, including services covered in full (preventive). 2. Amounts exceeding the allowed amount for drugs (see page 174) paid to non-network pharmacies.* 3. Drugs and products not covered by the plan; see "Guidelines for Drugs Not Covered" beginning on page 95. 4. Costs for medical services, including drugs covered under the medical benefit. (See page 21 for how the medical out-of-pocket limit works.) 5. Costs paid for other enrolled family members' prescription drugs and products.
What will I pay for after reaching my prescription drug out-of-pocket limit?	You will still be responsible for paying numbers 2-5 above after you meet your individual prescription drug out-of-pocket limit.

**Non-network pharmacies may charge more than the allowed amount for prescription drugs; you are responsible for paying this amount in addition to your coinsurance.*

What You Pay for Prescription Drugs

ALERT! Hospice care: See page 52 for special prescription drug coverage while in hospice.

You may get up to a 90-day supply for most drugs, except for specialty drugs; see page 88.

Tier	All Network Pharmacies Retail and Mail-Order	The Most You'll Pay (Prescription Cost-Limit) *Network Pharmacies Only*
Value Tier	5% coinsurance *No deductible*	**$10** Up to a 30-day supply **$20** 31-60 days' supply **$30** 61-90 days' supply
Tier 1 Select Generic Drugs	10% coinsurance *No deductible*	**$25** Up to a 30-day supply **$50** 31-60 days' supply **$75** 61-90 days' supply

Tier 2 Preferred Drugs	30% coinsurance *Deductible applies*	**$75** Up to a 30-day supply **$150** 31-60 days' supply **$225** 61-90 days' supply
Tier 3 Nonpreferred Drugs	50% coinsurance *Deductible applies*	Specialty drugs* **only**: $150 No cost-limit for non-specialty drugs

**Specialty drugs must be purchased through the plan's network specialty pharmacy, Ardon Health; see page 88.*

How Does the Prescription Cost-Limit Work?

ALERT! For annual limits to your prescription drug costs, see "Your Prescription Drug Out-of-Pocket Limit" on page 78.

The prescription drug cost-limit is the maximum you pay for an individual prescription at a network pharmacy. See "The Most You'll Pay" column in the table on page 79 for the dollar amounts according to the tier and days' supply.

For Tier 2 and Tier 3 drugs, you must meet your prescription drug deductible first. The prescription cost-limit applies in the following circumstances:

- **Value Tier drugs:** No deductible, all network pharmacies.
- **Tier 1 drugs:** No deductible, all network pharmacies.
- **Tier 2 drugs:** Must meet your prescription drug deductible first, all network pharmacies.
- **Tier 3 drugs:** Only for specialty drugs; see "Prescription Cost-Limit for Specialty Drugs" on page 89. (Non-specialty Tier 3 drugs do not have a cost limit per prescription.)

ALERT! If you get your prescription filled at a non-network pharmacy, the prescription cost-limit does not apply. See "Non-Network Pharmacies—Retail or Mail-Order" on page 84 for details.

If your normal coinsurance is ***less than*** the prescription cost-limit, you pay the normal coinsurance. If the normal coinsurance is ***more than*** the prescription cost-limit, you pay the prescription cost-limit. See below for examples (these examples assume you've met your prescription drug deductible when it applies).

Tier of Drug	Allowed amount	Normal Coinsurance	The Most You'll Pay (Prescription Cost-Limit) *(90-day supply)*	You pay…
Tier 1	$300	10% (10% x $300=**$30**)	$75	**$30**
Tier 1	$1500	10% (10% x $1500=$150)	**$75**	**$75**

Tier 2 *Must meet prescription drug deductible first*	$500	30% (30% x $500=**$150**)	$225	**$150**
Tier 2 *Must meet prescription drug deductible first*	$2500	30% (30% x $2500=$750)	**$225**	**$225**

Requesting Preauthorization for an Exception to the Tier 3 Drug Cost-Share

ALERT! The online *UMP Preferred Drug List* may not show every alternative drug you must try and fail before an exception may be granted. If your tier exception request is denied, the plan's response letter will list every drug that must be tried.

You may request an exception to the cost-share (50% of the allowed amount) for Tier 3 (nonpreferred) brand-name drugs.

Your prescribing provider must submit clinical information to request preauthorization of an exception. When an exception is approved by the plan based on the criteria below, you will pay based on the Tier 2 cost-share (30% of the allowed amount, $75 maximum payment per 30-day supply).

Because requesting a Tier 3 exception requires medical information and knowledge, only your prescribing provider may submit the request.

The following criteria must be established before the plan will grant a Tier 3 cost-share exception:

1. An explanation from your prescribing provider of why an exception should be granted, including documentation of medical necessity for the requested drug over all other preferred products (Value Tier, Tier 1, and Tier 2).

And at least one of the following:

2A. Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives (Value Tier, Tier 1, and Tier 2) have been tried for a clinically appropriate duration of treatment and failed to produce a therapeutic response. If the requested exception is for a brand name drug that has an FDA approved generic equivalent, your prescribing provider must document your inadequate response to at least 5 manufacturers of the generic equivalent, or to all manufacturers of generic equivalents if there are fewer than 5 manufacturers, in addition to all other preferred therapeutic alternatives before an exception will be granted.

OR

2B. Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives (Value Tier, Tier 1, and Tier 2), including the required number of manufacturers of the same generic product, caused an adverse drug reaction that prevents

the patient from taking the medication as directed. If the requested exception is for a brand name drug that has an FDA approved generic equivalent, your prescribing provider must document your adverse drug reaction to at least 5 manufacturers of the generic equivalent, or to all manufacturers of the generic equivalents if there are fewer than 5 manufacturers, in addition to all other preferred therapeutic alternatives before an exception will be granted.

If You Have Other Medical Coverage

If you have primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on pages 86–90 will apply when UMP Classic pays secondary to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 127 for how to submit your prescription drug claim.

Using Network Pharmacies When UMP Classic Is Your Secondary Coverage

If you have primary coverage through another plan that covers prescription drugs, show both plan cards to the pharmacy and make sure they know which plan is primary. It is important that the pharmacy bills the plans in the correct order, or claims may be denied or paid incorrectly.

Using Mail-Order Pharmacies When UMP Classic Is Secondary

FOR MEDICARE RETIREES: See the Tip on page 123 about using PPS when Medicare is your primary coverage.

If your primary plan uses PPS, the plan's network mail-order pharmacy, PPS can process payments for both plans and charge you only what's left. Make sure that PPS has your information for both plans and knows which plan is primary.

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP Classic; see "Submitting a Claim for Prescription Drugs" beginning on page 127 for how to do this.

Where to Purchase Your Prescription Drugs

ALERT! If you use a non-network pharmacy of any type, you will pay the entire cost of the drug upfront and must submit a claim. However, only the allowed amount for covered drugs (see page 174) will count toward your prescription drug deductible or prescription drug out-of-pocket limit.

Retail Pharmacies

FOR MEDICARE RETIREES: If you are retired and enrolled in Medicare, please see page 123 for more information on pharmacies.

Washington State Rx Services has a large network of retail pharmacies, which includes many independent and regional pharmacies in Washington State as well as national chains. Search for a network pharmacy at **www.hca.wa.gov/ump/find-drugs** or call 1-888-361-1611.

You can use any pharmacy, but you will save money if you use a network pharmacy. When you get your prescriptions at a network pharmacy, the pharmacy sends the claim to the plan for you, and you pay only your cost-share (coinsurance and prescription drug deductible).

Many network retail pharmacies have vaccinating pharmacists able to administer preventive immunizations at no cost to you. Find a list of network vaccination pharmacies (see definition on page 184), at **www.hca.wa.gov/ump/find-drugs**, or call Washington State Rx Services at 1-888-361-1611.

TIP: If you take an ongoing prescription drug and purchase between an 84 and 90-day supply, you may be able to save money by using a **Choice90 network pharmacy** or PPS mail-order pharmacy. Search for a network pharmacy at **www.hca.wa.gov/ump/find-drugs** or call Washington State Rx Services at 1-888-361-1611.

Mail-Order Pharmacy

ALERT! PPS cannot ship outside of the United States. See "Travel Overrides for Prescription Drugs" on page 91 if you will be traveling.

Contact:

Postal Prescription Services (PPS): 1-800-552-6694

Washington State Rx Services: 1-888-361-1611

Postal Prescription Services (PPS) is the plan's network mail-order pharmacy. You may call PPS or Washington State Rx Services for more information about mail order.

Steps to get started:

1. Set up an account with PPS by going to **www.ppsrx.com** or calling PPS at the phone number listed above.
2. Mail your prescription to PPS. Your provider can also electronically send or fax your prescription to PPS at 1-800-723-9023. Prescriptions faxed to PPS must:
   - Be faxed from the provider's office fax machine.
   - Be on the provider's letterhead.

- Include the patient's name, address, phone number, plan ID number, and date of birth.

Note: Only a provider can fax in a prescription. Not following these instructions may cause a delay in filling your prescription.

Refills can be ordered through your online pharmacy account at **www.ppsrx.com**, or by calling PPS directly.

Prescriptions are usually delivered within 7 to 10 days after the pharmacy receives your prescription.

When using PPS, the same prescription drug deductible, coinsurance, preauthorization requirements, and limits on coverage apply as for prescription drugs purchased at retail network pharmacies.

ALERT! If there is a shortage of a specific drug that PPS cannot control and it doesn't have the quantity you ordered, PPS will contact you to discuss your options for obtaining your prescription(s).

Prescriptions mailed or orders placed in December but not filled until January 1 or after will be subject to the prescription drug deductible applicable on the date the prescription is processed. Because of increased volume at the end of the year, prescriptions submitted to PPS in December may not be processed during the current benefit year.

ALERT! Some durable medical equipment items are not available through PPS; you will need to get them through a network retail pharmacy or preferred durable medical equipment provider.

Use Network Pharmacies and Show Your ID Card to Get the Plan Discount

The plan pays for prescription drugs based on the allowed amount (Washington State Rx Services' standard reimbursement). If you use a non-network pharmacy or do not show your ID card at a network pharmacy, and the amount charged is more than the allowed amount, you will pay the difference in addition to your coinsurance.

Non-Network Pharmacies—Retail or Mail-Order

ALERT! The plan does not cover prescription drugs ordered through foreign (non-U.S.) mail-order pharmacies.

You can purchase your prescriptions (except specialty drugs) at a non-network pharmacy, but you'll pay more if you do. If you get your prescriptions filled at a non-network pharmacy, whether a retail, internet, or mail-order pharmacy (other than PPS), the following applies:

- You will need to submit your own claim to Washington State Rx Services for reimbursement (see "Submitting a Claim for Prescription Drugs" starting on page 127).
- You don't get the plan discount.
- You'll pay the difference between the allowed amount (see page 174) and what the pharmacy charges, and it won't count toward your prescription drug deductible or prescription drug out-of-pocket limit.
- The plan pays for prescription drugs covered by the plan, whether from a network or non-network pharmacy, under the coinsurance percentages as shown in the table on page 79.
- The prescription cost-limit (see table on page 78) does not apply to prescriptions filled at non-network pharmacies.
- Non-network pharmacies will not know if a drug must be preauthorized, has a quantity limit, or has other coverage limits. If you purchase a drug from a non-network pharmacy and limits apply, the plan may not cover it.
- Unless noted on the *UMP Preferred Drug List*, specialty drugs purchased anywhere but through the plan's network specialty drug pharmacy are not covered (see "Specialty Drugs" on page 88).

TIP: To submit claims for prescriptions purchased from non-network pharmacies (U.S. retail, internet, or mail-order pharmacies, or foreign retail pharmacies), see "Submitting a Claim for Prescription Drugs" on page 127.

Drugs Purchased Outside the U.S.

If you purchase drugs outside the U.S. (including Canada and Mexico) for any reason, the following rules apply:

- If the drug is available only by prescription in the U.S. but does not require one outside the U.S., the drug is covered only if prescribed by a provider practicing within his/her scope of practice.
- If you get a drug that is approved for use in another country but not in the U.S., the plan will not cover it.
- If you get a drug that is available over-the-counter in the U.S., the plan will not cover the drug, even if you have a prescription from a provider prescribing within his/her scope of practice. The plan does not cover over-the-counter drugs except for certain preventive medicines as required by the Accountable Care Act. These drugs are indicated with a "PV" in the *UMP Preferred Drug List*.
- If you get a drug that is designated as not covered in the *UMP Preferred Drug List*, the plan will not cover the drug.

To submit a claim for a prescription drug purchased outside the U.S., see "Submitting a Claim for Prescription Drugs" beginning on page 127. All necessary information must be included on the prescription drug claim form and translated into English, with drugs and dosage documented,

along with the currency exchange rate. The plan does not pay for that translation and documentation.

ALERT! The plan does not cover prescription drugs purchased through foreign (outside the U.S.) mail-order pharmacies.

Limits on Your Prescription Drug Coverage

The plan may exclude, discontinue, or limit coverage for any drug—or shift a drug to a different tier—for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- A nonprescription alternative (see definition on page 185), including an over-the-counter alternative (see definition on page 186) becomes available.
- There is a sound medical reason.
- There is lack of scientific evidence a drug works as well and is as safe as existing drugs used to treat the same or similar conditions.
- One of the following recommends a change: The Washington State Pharmacy & Therapeutics (P&T) Committee, or a P&T Committee of a Washington State Rx Services partner (see list on page 75).
- The Washington State Health Technology Clinical Committee (see page 36) requires such a change.
- A drug receives federal Food and Drug Administration (FDA) approval for a new use.
- A drug is found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
- The FDA denies, withdraws, or limits the approval of a product.

For the plan to approve a drug for you, the drug must be covered by the plan and be medically necessary for your health condition. Your provider may prescribe a drug or drug dose that is not medically necessary (see definition on pages 182–184).

ALERT! If you use manufacturer drug samples, you must still meet all plan prescription drug coverage rules.

Programs Limiting Drug Coverage

The limits and restrictions described from "Limits on Your Prescription Drug Coverage" above through "Refill Too Soon" on page 91 help us monitor drug usage, safety, and costs. Drugs may be added to any of these programs at any time. You can find out if your drug falls under any of these limits and restrictions by checking the *UMP Preferred Drug List* (PDL) or calling Washington State Rx Services at 1-888-361-1611.

Risk Evaluation and Mitigation Strategies (REMS) Program

The Food and Drug Administration (FDA) can require a Risk Evaluation and Mitigation Strategies (REMS) program if the FDA determines that safety measures are needed beyond the professional labeling to ensure that the benefits of the drug outweigh its risks. Each REMS has specific safety measures unique to the safety risks associated with a particular drug or class of drugs. Under certain REMS programs, drugs may not be prescribed, dispensed, or used outside of REMS program components or elements to ensure safe use. UMP may not cover drugs that are restricted under a REMS program when the REMS program is not followed.

Preauthorizing Drugs

Some medications require preauthorization to determine whether the medication meets medical necessity and appropriateness criteria or the plan will not cover them. You can find out if your drug requires preauthorization by calling Washington State Rx Services, or checking the *UMP Preferred Drug List* at **www.hca.wa.gov/ump/find-drugs**. You and your prescribing provider can also find the coverage criteria for your drug at **www.hca.wa.gov/ump**.

Some examples (not at complete list) of the drugs requiring preauthorization include:

- Certain injectable drugs when obtained through a retail pharmacy or a network mail-order pharmacy.
- Drugs costing more than $1,500 and compounded drugs costing more than $150.

If your drug requires preauthorization, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611 to request it. **Note:** Drugs covered under the medical benefit rather than the prescription drug benefit have different rules for preauthorization; call Regence Customer Service at 1-888-849-3681 for more information.

ALERT! Preauthorization of drug coverage determines only that the plan will cover the drug and does not change the drug's tier. You still pay according to the drug's tier as designated in the *UMP Preferred Drug List*. See page 81 for how to request an exception for some Tier 3 drugs.

Emergency Fill

Emergency fill applies while the plan processes your preauthorization request and you need a limited quantity of a medication because a delay could result in emergency care, hospital admission, or a serious threat to your health or others in contact with you.

How Does It Work?

A list of emergency medications is available at **www.hca.wa.gov/ump /ump-classic/what-you-pay-drugs** or by calling 1-888-361-1611.

- You must bring your prescription to a network pharmacy and state that you need an emergency fill while the plan processes your preauthorization request. You pay your coinsurance under the drug's tier.
- Emergency fills are limited to a maximum 7-day medication supply; preauthorization requests are usually resolved within three to five business days.

- If your preauthorization request is denied, you will pay the full cost of the drug for any quantity you receive after the emergency fill.

Emergency Fill Limits

Note that the following limits still apply to emergency fill medications:

- **Refill too soon:** If you have a filled prescription for a medication (or its therapeutic equivalent), you cannot get an emergency fill until you have used 84% or more of the filled prescription.
- **Quantity limits:** You cannot get more than the stated quantity limit under an emergency fill. If you have a current filled prescription for a medication (or its therapeutic equivalent) and it was filled to the quantity limit, you cannot get an emergency fill until you have used 84% or more of the filled prescription.

Quantity Limits

Certain drugs have a quantity limit per prescription (how much or how many you get). If you need more than is covered under a quantity limit, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611.

If the plan denies your request or your provider or pharmacist does not get preauthorization, we will cover the drug only up to the quantity limit amount. You will pay for any extra amount.

Specialty Drugs

ALERT! Ardon Health, the plan's network specialty pharmacy, is unable to ship outside the United States. See "Travel Overrides for Prescription Drugs" on page 91 if you will be traveling.

"Specialty" drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special handling (including a few products, such as intrauterine devices [IUDs]). Specialty drugs are subject to special rules. You can find out if a drug is a specialty drug by checking the *UMP Preferred Drug List* at **www.hca.wa.gov/ump/find-drugs**, or by calling Washington State Rx Services. Specialty drugs are covered under the cost-share tier listed on the *UMP Preferred Drug List*.

You may receive ***up to*** a 30-day supply for specialty medications per prescription or refill. Specialty drugs are covered only when purchased through the plan's network specialty drug pharmacy. Select specialty medications that have been determined to have a high discontinuation rate or short duration of use may be limited to a 15-day supply. Order your specialty medications from Ardon by calling 1-855-425-4085 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time, Saturday 8 a.m. to 12 p.m. PT).

Specialty drugs require preauthorization. A Patient Care Coordinator will contact your provider to review the coverage criteria and authorize the prescription if the criteria are met. The Patient Care Coordinator will work with you to schedule a delivery time for the medication. If you are unable to be present for the delivery, the specialty pharmacy will deliver your medications anywhere you choose, such as to your workplace or to a neighbor, but not out of the country. Specialty

medications often require special handling and storage. Note that the plan is not responsible for replacement of lost, stolen, or damaged prescription drugs or products; see exclusion 53 on page 105.

If your provider will be administering a medication, you can have it shipped to the provider's office. However, once the drug is received at the provider's office, the provider takes responsibility for the drug.

Prescription Cost-Limit for Specialty Drugs

ALERT! The prescription cost-limit is the ***most*** you'll pay for an individual prescription; however, you may pay less based on normal coinsurance—see the table on page 79.

See "How Does the Prescription Cost-Limit Work?" on page 80 for details about the prescription cost-limit. This limit applies to individual prescriptions only; see "Your Prescription Drug Out-of-Pocket Limit" on page 78 for the annual limit to your prescription drug costs.

Specialty drugs are usually limited to no more than a 30-day supply. The prescription cost-limit for a 30-day (or under) supply corresponds to the "The Most You'll Pay" column in the table on page 79.

However, some specialty medications are available only in packages with more than a 30-day supply. In such cases, the prescription cost-limit shown in the table on page 79 will be calculated by multiplying the standard 30-day prescription cost-limit amount as follows:

- A 31- to 60-day supply, multiply the standard prescription cost-limit by 2.
- A 61-day and greater supply, multiply the standard prescription cost-limit by 3.

Example: If your specialty drug is Tier 3 and you receive a 45-day supply, the most you'll pay (prescription cost-limit) is $300 (standard 30-day limit $150 x 2=$300).

Step Therapy

ALERT! If a Step 2 or Step 3 drug is approved for coverage by Washington State Rx Services, you will pay the applicable cost-share of that drug according to its tier in the *UMP Preferred Drug List*.

When a drug is part of the step therapy program, you have to try certain drugs (Step 1) before the prescribed Step 2 drug will be covered. When a prescription for a step therapy drug is submitted "out of order," meaning you haven't first tried the Step 1 drug before submitting a prescription for a Step 2 drug, your prescription will not be covered. When this happens, your provider will need to prescribe the Step 1 drug for you.

If you or your provider feels that you need the Step 2 prescription filled as originally written, your pharmacist or prescribing provider can call Washington State Rx Services at 1-888-361-1611 and request coverage. You will have to pay the entire cost of the drug if you have not tried the Step 1 drug and coverage hasn't been authorized before you get the Step 2 drug.

To find out if step therapy applies to your drug, check the *UMP Preferred Drug List* at **www.hca.wa.gov/ump/find-drugs**, or call Washington State Rx Services at 1-888-361-1611.

Note: Only network pharmacies will check to see if step therapy applies to your prescription drug. If you get a step therapy drug at a non-network pharmacy, the drug may not be covered.

Can the Pharmacist Substitute One Drug for Another?

ALERT! New generic drugs are released throughout the year. If you want to take advantage of the cost-savings that generics provide, ask your provider to allow substitution on your prescriptions, even if a generic drug isn't available. That way, when one becomes available, the pharmacist can automatically refill with the generic.

Generic Substitution Under Washington State Law

When a brand-name drug has a generic equivalent (see definition on page 179), pharmacists in Washington State must substitute the generic equivalent drug for the brand-name drug. Your provider may write the prescription "dispense as written" if he or she wants you to get only the brand-name drug, or you can tell the pharmacist you want the brand-name drug. However, you will usually pay more for drugs that have a generic equivalent.

Therapeutic Interchange Program (TIP)

The Washington State Therapeutic Interchange Program (TIP) allows a pharmacist to substitute a "therapeutic alternative" drug for a ***nonpreferred brand-name drug*** (Tier 3) in certain cases. Therapeutic alternatives are drugs that are chemically different from your prescribed drug but provide the same therapeutic benefit.

You can find out if your drug is affected by TIP by checking the *UMP Preferred Drug List* at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611. Not all nonpreferred drugs are affected by TIP.

The pharmacist will substitute the preferred drug when your prescribing provider has "endorsed" the Washington Preferred Drug List, and:

- You are filling your prescription in Washington State or through PPS.
- Your prescribing provider allows substitution on your prescription.

If you do not want your drug to be changed, simply ask the pharmacist to fill the prescription as written.

Regardless of whether you or your prescriber ask the pharmacist to "dispense as written," if you get the nonpreferred drug, you will pay the higher Tier 3 coinsurance.

How Does TIP Work at the Network Mail-Order Pharmacy?

The pharmacy will contact your provider to request authorization for the substitution. If approved by the provider, you will receive the alternative preferred drug along with a letter of explanation. If the pharmacy cannot get an authorization from your provider within 48 hours, the prescription will be filled as written, and you will be charged the Tier 3 coinsurance.

Travel Overrides for Prescription Drugs

You may request a travel override to get an additional supply of medications for extended business or vacation travel. All of the conditions listed below apply.

- You may request no more than two travel overrides per calendar year, including all travel within or outside the United States:
  - **Within the United States,** you may request up to a 90-day supply per prescription, or as allowed under that prescription.
  - **Outside the United States,** you may request up to a 6-month supply per prescription, or as allowed under that prescription.
- Travel overrides will be granted only while you are covered by the plan. If your eligibility is ending, the plan does not cover drugs past the time when your enrollment in the plan ends.
- You will pay applicable charges (deductible and coinsurance) for each extra supply received.

To request a travel override, call Washington State Rx Services at 1-888-361-1611.

Refill Too Soon

The plan will not cover a refill until 84% of the prior prescription should be used up. Claims for therapeutic equivalents of the previously prescribed drug will also be denied. This also applies if your prescription is destroyed, lost, or stolen. For example, if you get a 90-day supply and you try to refill this prescription before 76 days have passed, coverage will be denied.

What Can I Do If Coverage Is Denied?

TIP: If your prescription claims are denied by the pharmacy due to plan eligibility issues or termination of coverage, contact:

- **Employees**—Your employer's personnel, payroll, or benefits office.
- **All other members**—PEBB Benefits Services at 1-800-200-1004.

If a network pharmacy (including a mail-order or specialty pharmacy) tells you that preauthorization is required, coverage is denied, or quantities are limited, your pharmacist or prescribing physician may contact Washington State Rx Services at 1-888-361-1611 to request a coverage review.

If Washington State Rx Services denies the coverage request, you have the right to submit an appeal. (See instructions for appealing on pages 137–140.)

If your provider thinks that you need the medication immediately, he or she may request an expedited review by submitting all clinically relevant information to the plan by phone or fax. An expedited appeal replaces the first and second level appeals. Washington State Rx Services will

decide regarding coverage of the drug within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense.

Guidelines for Drugs Covered

To be covered, a prescription drug must meet all of the following criteria:

- Has been reviewed by one of the following: the Washington State Pharmacy & Therapeutics (P&T) Committee or a P&T Committee of a Washington State Rx Services partner (see list on page 75) and has been placed on the *UMP Preferred Drug List*.
- Be medically necessary (see definition on pages 182–184).
- Can be legally obtained in the United States only with a written prescription.
- Is approved by the Food and Drug Administration (FDA).
- Does ***not*** have a nonprescription alternative (see definition on page 185), including an over-the-counter alternative with similar safety, efficacy, and ingredients. (See "Exceptions Covered" below.)
- Is not classified as a vitamin (except as listed below), mineral, dietary supplement, homeopathic drug, or medical food.

ALERT! Only select generic prenatal vitamins and generic fluoride supplements are covered; the plan does not cover brand-name prenatal vitamins and fluoride supplements.

Exceptions Covered

The plan covers the following prescription drugs as **exceptions** to the above rules:

- Activated vitamin D for patients on renal dialysis or with parathyroidism.
- Select generic fluoride supplements for prevention of dental caries for children ages 6 months to 18 years.
- Select generic prescription prenatal vitamins without docosahexaenoic acid (DHA) for women of childbearing age.

Your pharmacy benefit also includes the following nonprescription drugs and supplies:

- Insulin and diabetic supplies such as blood glucometers, test strips, lancets, and insulin syringes used in the treatment of diabetes. (See "Diabetes Care Supplies" on page 43 for more information).
- Select contraceptive devices and drugs (see pages 49–50).
- Low-dose aspirin for pregnant women; see page 63 for coverage details.

- Select generic over-the-counter prenatal vitamins without DHA for women of childbearing age.
- Other over-the-counter products that are specifically noted in the *UMP Preferred Drug List* as covered by the plan.

ALERT! The plan does not cover prenatal vitamins, prescription or over-the-counter, that contain DHA (docosahexaenoic acid). DHA is a dietary supplement, and dietary supplements are not covered by the plan (excluded).

Coverage Guidelines for Exceptions

To be covered, the above-listed prescription and nonprescription drugs and supplies must:

- Be prescribed by a provider prescribing within his/her scope of practice (is licensed to prescribe).
- Be dispensed from a licensed pharmacy employing licensed registered pharmacists.
- Meet plan coverage criteria.

The plan covers FDA-approved drugs used for off-label indications (that is, prescribed for a use other than its FDA-approved label) only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 193) as supported by clinical evidence;
- In most relevant peer-reviewed medical literature (defined on page 187), if not recognized in a standard reference compendium; or
- By the federal Secretary of Health and Human Services.

The plan may require that you try standard treatment(s) before it will cover off-label use of a drug.

The plan will not cover any drug when the FDA has determined its use to be unsafe.

ALERT! Drugs newly approved by the FDA must be reviewed by a Pharmacy & Therapeutics Committee before UMP Classic will cover the drug. If you are prescribed a new drug, call Washington State Rx Services to ask about coverage.

Products Covered Under the Preventive Care Benefit

ALERT! For products covered as preventive—even if normally covered over-the-counter without a prescription—you must have a prescription and purchase through the pharmacy counter at a network pharmacy to receive 100% reimbursement. You may not receive full reimbursement for claims from register receipts and non-network pharmacies.

Some products are covered under the preventive care benefit, if recommended by the U.S. Preventive Services Task Force (USPSTF) as described on pages 65–67, and must conform to coverage guidelines stated above. The brand and type of products covered are limited; call 1-888-361-1611 for more information on which ones are covered. You pay nothing if your provider writes you a prescription and you purchase these products from the pharmacy counter at a network pharmacy. If you purchase over-the-counter and send in a paper claim, you may pay part of the cost.

Some contraceptive drugs and supplies are covered as preventive; see "Family Planning Services" on pages 49–50 for details. See "Tobacco Cessation Services" on page 70 for products covered as preventive for tobacco cessation.

Some Injectable Drugs Are Covered Only Under the Prescription Drug Benefit

ALERT! If a claim for one of these drugs is submitted as medical, it will be denied.

Certain drug classes, including but not limited to those listed below, are covered only under the prescription drug benefit and not the medical benefit:

- Growth hormones
- Self-administered drugs for multiple sclerosis
- Self-administered drugs for rheumatoid arthritis
- Drugs to treat hepatitis C

A drug may be approved for use for another condition, but is still available only through the prescription drug benefit. Call 1-888-361-1611 if you have questions.

Compounded Prescription Drugs

Compounded prescription drugs are the result of combining, mixing, or altering of ingredients by a pharmacist in response to a physician's prescription to create a new drug tailored to the specialized medical needs of an individual patient. Traditional compounding typically occurs when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug

is not appropriate for a patient's medical needs. Compounded prescription drugs are covered under Tier 3. Compounded drugs costing more than $150 require preauthorization. Claims for compounded drugs require additional information submitted on the claim form; this information is available from the compounding pharmacy.

Guidelines for Drugs Not Covered

Drugs not covered under the plan include but are not limited to:

- Drugs that are not medically necessary (see definition on pages 182–184).
- Experimental or investigational drugs.
- Dietary supplements, vitamins, minerals, herbal supplements, and medical foods.
- Homeopathic drugs, including FDA-approved prescription products.
- Dental preparations, such as rinses and pastes.
- Over-the-counter drugs or prescription drugs that have a nonprescription alternative (see definition on page 185), except for the drugs specified under "Guidelines for Drugs Covered" on page 92. **Note:** Prescription drugs with a nonprescription alternative (see definition on page 185), including an over-the-counter alternative having similar safety, efficacy, and ingredients are not covered.
- Drugs under a Risk Evaluation and Mitigation Strategies (REMS) program required by the Food and Drug Administration (FDA) when prescribed outside REMS guidelines; see page 87 for details.
- Drug costs covered by other insurance including Medicare Part B (see page 123 regarding coordination of benefits with Medicare Part B, and page 113 in this booklet for coordination with other plans).

The plan also does not cover drugs to treat conditions that are not covered under the medical benefit. These include, but aren't limited to, drugs for:

- Cosmetic purposes
- Infertility
- Obesity (or weight loss)
- Sexual dysfunction

ALERT! Drugs classified as proton pump inhibitors (commonly called PPIs) have over-the-counter alternatives and are not covered under the plan for persons age 18 and over. The plan does cover PPIs for persons under age 18 when prescribed, because the available over-the-counter alternatives are not approved for persons under age 18.

Exceptions Covered

The plan covers the following prescription products as exceptions to the above rules:

- Limited products for the treatment of congenital metabolic disorders such as phenylketonuria (PKU) detected by newborn screening when specialized formulas are medically necessary; and
- Elemental formulas for Eosinophilic Gastrointestinal Disorders (EGIDs).

Prescription Drug Contacts

Washington State Rx Services	1-888-361-1611 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday
Network Mail-Order Pharmacy	
Faxing prescriptions *Note: Only a provider can fax a prescription.*	
• PPS (Postal Prescription Services)	1-800-552-6694 Fax 1-800-723-9023 (providers only)
Mailing a prescription order Postal Prescription Services PO Box 2718 Portland OR 97208-2718	***Contact PPS for how to place a mail order***
Specialty Pharmacy (Ardon Health) (see page 88)	1-855-425-4085 Fax 1-855-425-4096 (providers only)
To request preauthorization for prescription drugs (providers)	1-888-361-1611 Fax 1-800-207-8235
Submit paper claims Find claim forms at **www.hca.wa.gov/ump/forms-and-publications** See instructions on pages 127–128	Washington State Rx Services Attn: Pharmacy Claims PO Box 40168 Portland, OR 97240-0168 Fax 1-800-207-8235
Send appeals/complaints for prescription drugs	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168 Fax 1-866-923-0412

Prescription Drug Contacts

Online services • Find a network pharmacy • Find a Choice90 pharmacy • Find a network vaccination pharmacy • Refill mail-order prescriptions • Get estimates of drug costs at retail versus mail order • Review the *UMP Preferred Drug List* tier levels, covered or not, quantity limits, preauthorization coverage criteria, whether subject to TIP.	**www.hca.wa.gov/ump/ump-classic/prescription-drugs**

Limits on Plan Coverage

Preauthorizing Medical Services

ALERT! This section does not apply to prescription drugs. See page 87 for how to request preauthorization of covered drugs under the prescription drug benefit.

Some medical services and supplies require preauthorization by Uniform Medical Plan to determine whether the service or supply meets the plan's medical necessity criteria in order to be covered. ***The fact that a service or supply is prescribed or furnished by a provider does not, by itself, make it a medically necessary covered service; see definition on pages 182–184).*** If you receive a service listed as an exclusion in the "What the Plan Doesn't Cover" section on pages 102–107, you are responsible for paying all associated charges.

A change after the plan has approved a preauthorization request—such as but not limited to a change of provider, or different/additional services—requires a new preauthorization request be submitted to and approved by the plan.

Your Preauthorization Role

ALERT! Some services—including but not limited to Applied Behavior Analysis Therapy (page 38) and bariatric surgery (page 39)—must be preauthorized before services are received to be covered.

- A preferred or participating provider may be required to request preauthorization before performing services.
- Out-of-network providers are not required to obtain preauthorization in advance of some services.

Because your provider has the clinical details and technical billing information needed for the preauthorization request, it is to your benefit that they submit a preauthorization request on your behalf.

You may request that an out-of-network provider preauthorize services on your behalf to determine medical necessity prior to the services being rendered.

Call UMP Customer Service at 1-888-849-3681 to ask if a service requires preauthorization and how to submit a request.

You may be liable for all charges if you receive services that are determined to be not medically necessary, experimental or investigational, or not covered under this plan (see "What the Plan Doesn't Cover" section on pages 102–107).

ALERT! For how to appeal denial of a preauthorization request before receiving services see pages 135–140.

Where Can I Find the List of Services Requiring Preauthorization or Notification?

For a list of services and treatments requiring preauthorization or plan notification:

- Visit the UMP website at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization**.
- Call UMP Customer Service at 1-888-849-3681.
- Request a printed list by calling UMP Customer Service at 1-888-849-3681.

ALERT! The Uniform Medical Plan preauthorization list is updated throughout the year. You may view the current list of services that require preauthorization at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization** or call Customer Service at 1-888-849-3681 to determine if services require preauthorization or notification. The fact that a service doesn't require preauthorization or notification does not guarantee coverage.

Notification for Facility Admissions

Your provider must notify the plan upon your admission to a facility for services requiring notification as listed at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization** (click the notification link), or call UMP Customer Service at 1-888-849-3681. Facility admissions for which the plan is not notified may not be covered. Notification is usually done by the facility at the time you are admitted. Notification is not the same as preauthorization; many services require both.

What Is the Difference Between Preauthorization and Notification?

ALERT! Many services, including but not limited to inpatient services, require both preauthorization and notification. Call 1-888-849-3681 or talk to your provider if you have questions about services needing preauthorization or notification by the plan.

"Preauthorization" is when your provider sends a request for coverage of a service on the Uniform Medical Plan preauthorization list at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization**, and the plan sends either an approval or denial of coverage. If services that require preauthorization are not approved before being provided, coverage may be denied. The plan does not preauthorize services that are not on the Uniform Medical Plan preauthorization list. Preauthorization is usually requested by the provider performing the services. "Notification" means that your provider must contact the plan to let us know when you receive services. Notification is usually done by the facility at the time you are admitted.

ALERT! If the plan denies coverage for a service requiring preauthorization and you receive those services anyway, you (the patient) are responsible for the provider's entire billed charge.

How Long Does the Plan Have to Make a Decision?

You will be notified in writing within 15 calendar days of the plan's receipt of the preauthorization request whether the request has been approved, denied, or if more information is needed to make a determination.

If additional information is requested:

- You are allowed up to 45 calendar days of the date on the letter to submit the information requested.
- You will be notified in writing of the determination within 15 calendar days of either the plan's receipt of the additional information or the end of the 45-day period if no additional information is received.

If you or your physician believes that waiting for a determination under the standard time frame could place your life, health, or ability to regain maximum function in serious jeopardy, your physician should notify the plan by phone or fax as a shorter time limit may apply.

General Information From Customer Service Is Not a Guarantee That a Service Is Covered

For services not requiring preauthorization, you may call 1-888-849-3681 to ask if a particular service is generally covered by the plan, and for an estimate of how much you will pay.

Until a claim is submitted, we cannot guarantee that your service will be covered or give an exact amount you will pay out of pocket. This is because when a provider bills for a service, the plan pays for it based on procedure codes developed by independent organizations (not affiliated with the plan). Each code describes a particular service in some detail, and there are many codes for similar-sounding services. Your provider, not the plan, determines which of these codes is used on the submitted claim. If you receive covered services from a preferred provider, you will generally pay 15% of the allowed amount per code billed until you reach your medical out-of-pocket limit (see pages 21–23). Once you reach that limit, the plan pays 100% of the allowed amount for covered services from preferred providers.

Case Management

Case Management for Complex Health Care Needs

Case management is a free service offered by the plan to help enrollees with serious, complex, or difficult health care needs coordinate their care. You work with a nurse case manager who assists you in finding health care providers and services appropriate for your treatment. When preauthorization is requested for a condition that may benefit from case management services or the plan receives a claim for services indicating complex health needs, you will be contacted by case management staff to discuss your options.

This free service helps you:

- Ensure you get the most out of your UMP Classic benefits.
- Find preferred providers, facilities, and other resources to assist in the coordination of your medical care.
- Keep your health care costs down (for example, negotiating rates when no preferred providers are available).

You, your family, or any provider or facility (such as a hospital) involved in your treatment may call 1-866-543-5765 to request evaluation and consideration of case management services.

Alternative Benefits

Alternative benefits means benefits for services or supplies that are not otherwise covered as specified in this *Certificate of Coverage*, but for which the plan may approve coverage after case management evaluation and analysis. The plan may cover alternative benefits through case management if the plan determines that alternative benefits are medically necessary and will result in overall reduced covered costs and improved quality of care. Before coverage of alternative benefits and before the processing of claims for alternative benefits, the plan, you or your legal representative and, if required by the plan, your physician or other provider must enter into a written agreement to the specific terms and conditions for payment. Alternative benefits are approved on a case-specific basis only. Approval of an alternative benefit applies to only the services and member as specified in the written agreement; the rest of this *Certificate of Coverage* remains in force.

Case Management as a Condition of Coverage

An HCA or plan medical director may review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, the plan may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care if you do not already have one, and designating a single hospital and pharmacy to provide covered services or medications. The plan may deny payment for any services and providers or facilities not included in your required case management plan, except medically necessary emergency services.

What the Plan Doesn't Cover

Expenses Not Covered, Exclusions, and Limitations

TIP: If you have any questions about services not covered by the plan, call Customer Service at 1-888-849-3681. You may pay all costs associated with a noncovered service.

This plan covers only the services and conditions specifically identified in this *Certificate of Coverage*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list. These examples are called exclusions, meaning these services are **not** covered, ***even if the services are medically necessary.***

1. Air ambulance, if ground ambulance would serve the same purpose.
2. Arthroscopic knee surgery (lavage and debridement of the knee) for the diagnosis of osteoarthritis.
3. Bariatric surgery for members under age 18.
4. Cardiac Artery Calcium Scoring.
5. Carotid Intima Media Thickness testing.
6. Complications arising directly from services that would not be covered by the plan during the current plan year. The plan will, however, cover complications arising directly from services that a PEBB plan paid for you in the past.
7. Computed Tomographic Colonography (CTC) (also called a virtual colonoscopy) for routine colorectal cancer screening.
8. Corneal Refractive Therapy (CRT), also called Orthokeratology.
9. Cosmetic services or supplies, including drugs and pharmaceuticals. However, the plan does cover:
   - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
   - Reconstructive surgery of a congenital anomaly, such as cleft lip or palate, to improve or restore function.
10. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
11. Custodial care (see definition on page 176).
12. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 42–43.

13. Dietary or food supplements, including but not limited to:
    - Herbal supplements, dietary supplements, medical foods, and homeopathic drugs.
    - Infant or adult dietary formulas (see "Exceptions Covered" on page 95 for exceptions that are covered by the plan).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see exceptions on page 92).
14. Dietary programs.
15. Drugs or medicines not covered by the plan as described in the "Your Prescription Drug Benefit" section, pages 75–97.
16. Drugs or medicines obtained through foreign (non-United States) mail-order pharmacies.
17. Educational programs, except as described under:

    - "Diabetes Education" on page 44.
    - "Diabetes Prevention Program" on page 44.
    - "Tobacco Cessation Services" on page 70.
18. Email consultations or e-visits.19. ENS (Electrical Neural Stimulation), which includes Transcutaneous Electrical Nerve Stimulation (TENS) Units.
20. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems
    - Arch supports
    - Communication aids
    - Elevators
    - Exercise equipment
    - Massage devices
    - Overbed tables
    - Sanitary supplies
    - Telephone alert systems
    - Vision aids
    - Whirlpools, portable whirlpool pumps, or sauna baths

21 Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.

22. Experimental or investigational services, supplies, or drugs.
23. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
24. Foot care not related to a medical condition: Cutting of toenails; treatment for diagnosed corns and calluses; or any other maintenance-related foot care.
25. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome.

26. Home health care, except as described on page 52. The plan does not cover the following services:
    - Private duty or continuous care in the member's home.
    - Housekeeping or meal services.
    - Care in any nursing home or convalescent facility.
    - Care provided by or for a member of the patient's family.
    - Any other services provided in the home that do not meet the definition of skilled home health care as described on page 52 or not specifically listed as covered in this *Certificate of Coverage*.
27. Hospital inpatient charges for non-essential services or features such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Reserved beds.
    - Services and devices that are not medically necessary (see definition of "Medically Necessary Services, Supplies, Drugs, or Interventions" on pages 182–184).
    - Personal or convenience items.
28. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
29. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
30. Implantable drug delivery systems (infusion pumps or IDDS) for chronic non-cancer pain.
31. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
32. Incarceration: Services and supplies provided while confined in a prison or jail.
33. Infertility or fertility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing, treatment, complications resulting from such treatment (for example, selective fetal reduction), or visits for infertility.
34. Late fees, finance charges, or collections charges.
35. Learning disabilities treatment after diagnosis, except as covered under the following benefits:
    - "Applied Behavior Analysis (ABA) Therapy" on page 38.
    - "Physical, Occupational, Speech, and Neurodevelopmental Therapy" on page 64; or
    - When part of treating a mental health disorder as described on page 60.
36. Magnetic Resonance Imaging—Upright MRIs (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
37. Maintenance care (see definition on page 181).
38. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 68.
39. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental, or personality disorder.
40. Massage therapy services when the massage therapist is not a preferred provider.

41. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see page 122).
42. Missed appointment charges.
43. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 15).
44. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
45. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications, except as specified on page 47.
46. Out-of-network provider charges that are above the allowed amount.
47. Over-the-counter contraceptive supplies intended for use by males.
48. Postage and handling related to medical services and supplies.
49. Prescription drug charges over the allowed amount, regardless of where purchased.
50. Prescription drugs that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
51. Provider administrative fees—Any charges for completing forms, copying records, or finance charges, except for records requested by the plan to perform retrospective (postpayment) review.
52. Recreation therapy.
53. Replacement of lost, stolen, or damaged durable medical equipment.
54. Replacement of medications that are any of the following:
    - Confiscated or seized by Customs or other authorities
    - Contaminated
    - Damaged
    - Lost or stolen
    - Ruined
55. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient treatment. Examples include, but are not limited to, schools, wilderness programs, and behavioral programs.
56. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).
57. Riot, rebellion, and illegal acts: Services and supplies for treatment of an illness, injury, or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion, or sustained by a member arising directly from an act deemed illegal by a court of law.
58. Separate charges for records or reports.
59. Service animals: Any expenses related to a service animal.
60. Services covered by other insurance, including but not limited to motor vehicle, homeowner's, renter's, commercial premises, personal injury protection (PIP), medical payments (Med-Pay), automobile no-fault, general no-fault, underinsured or uninsured motorist coverage. See page 114 for more about how this works.

61. Services delivered by providers delivering services outside the scope of their licenses.
62. Services or supplies:
    - That are not medically necessary for the diagnosis and treatment of injury or illness or restoration of physiological functions, and are not covered as preventive care. This applies even if services are prescribed, recommended, or approved by your provider.
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member or any household member.
    - Provided by a resident physician or intern acting in that capacity.
    - That are solely for comfort.
    - For which you are not obligated to pay.
63. Services performed during a noncovered service.
64. Services performed primarily to ensure the success of a noncovered service, including but not limited to a hiatal hernia repair done to ensure the success of a noncovered Laparoscopic Adjustable Gastric Banding surgery.
65. Services, supplies, or drugs related to occupational injury or illness (see definition on page 185).
66. Services, supplies, or items that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
67. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.
68. Spinal cord stimulator for chronic neuropathic pain.
69. Spinal injections, therapeutic (except as described under "Spinal Injections" on page 68) of the following types:
    - Medial branch nerve block
    - Intradiscal
    - Facet neurotomy
70. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
71. Telephone or virtual consultations or appointments, except as described under "Telemedicine Services" on page 69.
72. Travel, transportation, and lodging expenses, except as specified for ambulance services covered by the plan (see page 37), or approved travel and lodging expenses related to the Center of Excellence (COE) Program for knee and hip joint replacement surgery (see pages 54-58).
73. Ultrasounds during pregnancy, except as described on page 63.

74. Weight control, weight loss, and obesity treatment:
    - **Non-surgical:** Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise or diet programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider, except as covered under "Diabetes Prevention Program" (see page 44), "Nutrition Counseling and Therapy" (see page 61), or "Preventive Care" on page 65.
    - **Surgical:** Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies, except when approved by preauthorization review.
75. Workers' compensation: When a claim for workers' compensation is accepted as being caused by a work-related injury or illness, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation.

If you have questions about whether a certain service or supply is covered, call Customer Service at 1-888-849-3681.

If You Have Other Medical Coverage

FOR MEDICARE RETIREES: Different rules apply to members who have Medicare as their primary payer; see pages 116–124 for how UMP Classic works with Medicare.

Coordination of Benefits

What Is Coordination of Benefits?

Coordination of benefits (COB) happens when you have health coverage through two or more groups (such as your employer and your spouse's employer), and these two group health plans both pay a portion of your health care claims. The rules beginning under "Who Pays First?" on page 109 through "What Happens With Federal and Military Plans?" on page 111 determine which plan pays first ("primary payer") and which pays second ("secondary payer"). See page 111 for a description of how UMP Classic coordinates benefits when it is secondary.

Uniform Medical Plan processes claims differently depending on if it is the plan that pays first ("primary payer") or the plan that pays second ("secondary payer"). The differences are described in the next several pages.

TIP: If you have other health coverage, it is important that you let all of your providers know, including the pharmacies where you get your prescription drugs.

Whom Do I Inform If I Have Other Coverage?

If you or your dependents have other insurance, you must let Regence BlueShield and Washington State Rx Services know so claims are paid correctly. To do this, you must complete and submit a separate form for medical services and prescription drugs; see the table below.

	Medical Services	Prescription Drugs
Phone	Call 1-888-849-3681 (TTY 711) to request the form	1-888-361-1611

Online	Visit **regence.com** • Log in to your online account • In the Search box, type Coordination of Benefits • On the list that comes up, choose "UMP Multiple Coverage Inquiry–Coordination of Benefits" • You may fill out and submit online, or print out and mail or fax in Or go to **www.hca.wa.gov/ump/forms-and-publications**, search for "coordination of benefits," and choose the Medical form.	Go to **www.hca.wa.gov/ump/forms-and-publications**, search for "coordination of benefits," and choose the Prescription Drug form. Or submit through your pharmacy account at **www.hca.wa.gov/ump/find-drugs**
Fax	1-877-357-3418	503-412-4058
Mail	Regence BlueShield Attn: UMP Claims PO Box 1106 Lewiston, ID 83501-1106	Washington State Rx Services PO Box 40168 Portland, OR 97240-0168

Each person claiming payment for benefits under UMP Classic is required to give Regence and Washington State Rx Services any facts needed to apply these coordination of benefits rules and determine the correct benefits payable. If your coverage under other plans changes, please call Customer Service right away.

Who Pays First?

When UMP Classic coordinates benefits with other plans, the following rules determine which plan pays first. These rules apply in order, so the first rule below that applies to your situation will determine which plan is your primary coverage (subsequent rules do not apply).

FOR MORE INFORMATION: If you cannot determine which plan pays first ("primary payer"), call Customer Service at 1-888-849-3681.

The Following Plan Pays First

1. Any plan that does not coordinate benefits.
2. The plan that covers the patient as a subscriber, not a dependent.
3. The plan that covers the patient (or their spouse or domestic partner) as an active employee pays before a plan that covers the patient as a retired employee.
4. The plan that has covered the patient (or their spouse or domestic partner) as a subscriber the longest, if there are two plans and numbers 1–3 in the list above do not determine which plan pays first.

5. The plan that covers the patient (or their spouse or domestic partner) as an active employee if the other coverage is Medicare.
6. A plan covering the patient as an employee, subscriber, retiree, or the dependent of such a patient will pay before a COBRA or a state right of continuation plan.

For Dependent Children

- If a dependent child has coverage through his or her employment, the child's coverage pays before the parent's.
- This plan is usually primary over Medicaid programs that cover children.

Dependent children of married parents

The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August 21). This is called the "birthday rule." This rule looks only at the month and day, not the year. If both parents have the same birthday, the plan that covered either parent longer is primary.

Exception for newborn children: Under Washington State law, the mother's health plan must provide newborns with coverage that is no less than the mother's coverage for the first 21 days of life. Therefore, the mother's plan pays first for covered charges during the first 21 days of life, unless there is other primary coverage.

Dependent children of legally separated or divorced parents

When there is no court order that specifies which parent is responsible for providing health insurance coverage, the following standard coordination of benefits rules determine which plan pays first:

1. The plan of the custodial parent.
2. The plan of the custodial parent's spouse, if the custodial parent has remarried.
3. The plan of the non-custodial parent.
4. The plan of the non-custodial parent's spouse, if the non-custodial parent has remarried.

The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

The ***birthday rule*** is used to determine which parent's plan pays first if:

- The court order states that both parents are responsible for the child's/children's health coverage and expenses.
- The court orders joint custody without specifying that one parent is responsible for the child's/children's health coverage and expenses.

If the court order states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health coverage or health care expenses, the plan of the parent assuming financial responsibility is the primary payer.

In some cases, a court order determines payment for health care expenses and ***standard coordination of benefits rules may not apply***. In these cases, you must promptly provide UMP

Classic with copies of legal documents needed to decide which plan pays first and which plan pays second.

If a dependent child is covered under more than one plan through persons who are not the child's parent or stepparent (for example, a grandparent or other guardian), use the birthday rule to determine which plan pays first ("primary payer").

If none of the preceding rules determines who pays first, then each plan covers half of the allowed expenses.

What Happens With Federal and Military Plans?

UMP Classic usually pays first ("primary payer") over certain federal or military programs for veterans.

How Does UMP Classic Pay When It Pays First?

When UMP Classic is the primary payer (pays first), UMP Classic pays its normal benefit (as described in this *Certificate of Coverage*). You may need to send UMP Classic's Explanation of Benefits and a copy of your provider's bill to your secondary payer to receive payment. Check with that plan for more information.

What Happens When UMP Classic Is Supposed to Pay First, But Another Plan Actually Paid First?

If another plan pays first on claims where UMP Classic should have paid first:

- UMP Classic may pay the other plan the amount UMP Classic should have paid.
- Amounts paid by UMP Classic to the other plan are considered benefits paid by UMP Classic.

How Does UMP Classic Coordinate Benefits When It Pays Second?

UMP Classic uses a type of coordination of benefits called **nonduplication of benefits** (see examples on page 112), except for Medicare retirees (see page 117). When UMP Classic pays second ("secondary payer") to another group plan that covers you, we will pay only an amount needed to bring the total benefit up to the amount UMP Classic would have paid if you did not have another plan. The intent of this type of coordination of benefits is to maintain the level of benefits available through the UMP Classic plan. The nonduplication of benefits type of coordination is not designed to pay your covered expenses in full.

When UMP Classic pays second ("secondary payer") it coordinates with these types of plans:

1. Group, blanket or franchise health or disability insurance policies, health care service contractor and health maintenance organization group agreements issued by insurers, health care service contractors, and health maintenance organizations.

2. Labor management trusteed plans, labor organization plans, employer plans, or employee benefit organization plans.
3. Governmental programs including, but not limited to, Medicare and Medicaid.

FOR MEDICARE RETIREES: For more detail on how Medicare and UMP Classic interact when Medicare pays first and UMP Classic pays second, see pages 116–124.

How Much Will I Pay When UMP Classic Pays Second?

When you see providers preferred under UMP Classic (see definition on page 189), you will owe only the balance of the UMP Classic allowed amount after your primary plan and UMP Classic pay benefits for covered services. Your cost will usually be higher if you see out-of-network providers; see "Comparing Payments to Preferred, Participating, and Out-of-Network Providers" on page 16 for examples.

Examples

The examples in the table below assume that you have met your medical deductible.

	Preferred Provider Charge	UMP Classic Allowed Amount	UMP Classic Normal Benefit	Other Plan Pays	UMP Classic Pays	You Pay Your Provider
UMP Classic Is Primary, Other Plan Is Secondary						
EXAMPLE 1: When UMP Classic pays first (or is the only plan)	$200	$100	$85 (85% of $100)	N/A	$85	$15
UMP Classic Is Secondary, Other Plan Is Primary						
EXAMPLE 2: The other plan pays less than the normal UMP Classic benefit	$200	$100	$85	$80	$5	$15
EXAMPLE 3: The other plan pays as much (or more than) the normal UMP Classic benefit	$200	$100	$85	$85	$0	$15

Please contact UMP Customer Service at 1-888-849-3681 for help with any questions when you or a family member is covered by more than one plan.

Submit Secondary Claims Promptly

All health plans have deadlines for filing a claim, called a "timely filing" requirement. The timely filing deadline for UMP Classic is 12 months from the date of service. If a claim is not submitted within a plan's timely filing deadline, the plan can deny it. If your primary plan delays payment on a claim, the claim should be submitted to Uniform Medical Plan within the timely filing deadline to prevent denial of the claim. Promptly notifying your providers of any change to your coverage will help avoid errors and delays in processing of claims. See pages 125–129 for how to submit claims.

How Are Diabetes Care Supplies Covered When Another Plan Pays First?

FOR MEDICARE RETIREES: If your primary coverage is under Medicare, see page 120.

UMP Classic covers diabetes care supplies under the prescription drug benefit.

- If you get your supplies from a pharmacy, ask if the pharmacy can bill both your primary plan and UMP Classic. If your pharmacy does, you don't need to do anything further. If not, you will need to send a claim to Washington State Rx Services for secondary payment; see pages 127–128 for instructions.
- If you get your supplies from a diabetic care supplier, the primary plan may process the claim as medical. In this case, you will need to send your Explanation of Benefits and a claim form to Washington State Rx Services for secondary payment; see pages 125–127 for instructions.

Note: Nonduplication of benefits applies to these claims (see page 112), which means that UMP Classic may pay nothing after your primary plan pays.

See also "Diabetes Care Supplies" on page 43 for more about this benefit.

ALERT! A secondary claim for diabetes care supplies submitted to Regence BlueShield will be denied; the claim must be submitted to Washington State Rx Services.

How Does Coordination of Benefits Work With Prescription Drugs?

Some of the limits and restrictions to prescription drug coverage listed on pages 86–90 will apply when UMP Classic pays second ("secondary payer") to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 127 for how to submit your prescription drug claim.

Note: If UMP Classic pays second ("secondary payer") to another plan other than Medicare, nonduplication of benefits applies (see page 112). This means that UMP Classic may pay nothing after your primary plan pays.

ALERT! If UMP Classic pays second ("secondary payer"), you must still pay your prescription drug deductible before UMP Classic covers Tier 2 and Tier 3 drugs.

Using Network Pharmacies When UMP Classic Is Your Secondary Coverage

If you have primary coverage through another plan that covers prescription drugs, show both plan cards to the pharmacy and make sure they know which plan pays first and which plan pays second. It is important that the pharmacy bills the plans in the correct order, or claims may be denied or paid incorrectly.

Using Mail-Order Pharmacies When UMP Classic Is Secondary

FOR MEDICARE RETIREES: See the Tip on page 123 on using PPS when Medicare is your primary coverage.

If your primary plan also uses PPS as the plan's network mail-order pharmacy, PPS can process payments for both plans and charge only what's left. Make sure that PPS has the information for both plans and knows which plan is primary.

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP Classic. See "Submitting a Claim for Prescription Drugs" beginning on page 127 for how to do this.

Does UMP Coordinate With Occupational Injury or Illness (Workers' Compensation) Claims?

No. UMP Classic does not pay claims for services, drugs, or items related to occupational injury or illness (see definition on page 185). You must file a workers' compensation claim with your workers' compensation carrier (for example, in Washington State you would file a claim with the Washington State Department of Labor & Industries). If your claim for workers' compensation is denied as not being related to an occupational injury or illness, UMP Classic will pay for covered services.

However, if your workers' compensation claim is approved, UMP will not cover future services related to the occupational injury or illness while that case is open. Even if your workers' compensation case denies specific services or treatments as being not medically necessary, or beyond benefit limits, UMP Classic will not cover services for that injury or illness unless or until the workers' compensation case is closed. You may be required to provide written proof of claim denial or case closure before UMP Classic will provide benefits related to the occupational injury or illness.

For Retirees Enrolled in Medicare and UMP Classic

FOR MEDICARE RETIREES: When you see this format throughout this *Certificate of Coverage*, it gives specific tips for Medicare retirees.

Am I a Medicare Retiree?

You are considered a Medicare retiree if ***all*** of the following apply:

- Enrolled in Public Employees Benefits Board (PEBB) retiree coverage; and
- Age 65 or older (or younger and eligible for Medicare due to medical disability); and
- Enrolled in both Medicare Part A (hospital) and Part B (medical).

ALERT! If you are the subscriber (see definition on page 193) and are an employee, see "What Happens When UMP Classic Pays First and Medicare Pays Second?" on page 117 for coverage when UMP Classic pays before Medicare. This also applies to retired dependents enrolled in UMP Classic under an employee's account.

If you aren't a Medicare retiree as defined above, UMP Classic pays first and Medicare pays second. You or your provider must bill Medicare after UMP pays; see how to submit a claim beginning on page 125.

How Do UMP Classic and Medicare Work Together?

Because Medicare pays first ("primary payer"), there are a few rules that are different for Medicare retirees. This section tells you about these rules, including:

- How UMP Classic and Medicare work together.
- What UMP Classic covers that Medicare doesn't cover.
- What your choices for providers are.
- How billing works.
- How your prescription drug coverage works.
- Where to go for more information.

Retirees are required to enroll in Medicare Part A and Part B when they become entitled to it to be eligible for PEBB coverage under UMP Classic. You may not enroll in a Medicare Part D drug plan and be covered by UMP Classic. Your monthly premiums will be lower because Medicare pays part of your medical costs. Be sure to tell Medicare you are enrolled in UMP Classic so that they send us your claims after Medicare processes them.

If you are retired but not yet eligible to enroll in Medicare Part A and Part B, this section does not apply to you. If you think you might be eligible for Medicare and need information on how to sign up, see the "Medicare Entitlement" section on page 154.

Note: Medicare accepts claims **directly** from enrollees only under certain circumstances.

What Happens When UMP Classic Pays First and Medicare Pays Second?

If UMP Classic is your primary coverage (pays first) and Medicare is secondary (pays second), make sure that you tell Medicare about your UMP Classic coverage and that your provider agrees to bill Medicare as secondary to get the maximum benefit from both plans. Medicare generally accepts claims only from providers, so you may not be able to send a claim to Medicare for secondary payment. The provider would need to bill Medicare after UMP Classic has processed the claim.

ALERT! UMP does not bill Medicare or in any way coordinate benefits with Medicare when Medicare is the secondary payer.

Coordination of Benefits When Medicare Pays First and UMP Classic Pays Second

UMP Classic and Medicare are two separate health plans that work together to pay for covered services and supplies. Here's how coordination of benefits works:

- Your providers bill Medicare. Medicare pays your claims first. After Medicare processes the claim, Medicare sends the claim to UMP Classic.
- UMP Classic pays your claims second. For most covered services, UMP Classic pays the rest of the Medicare allowed amount and you owe nothing.

For the first services you receive each calendar year, you have to meet the UMP Classic medical deductible ($250 per person) before UMP Classic starts paying benefits. If you incur more covered services during the same calendar year, you may be reimbursed for at least some of your UMP Classic deductible. That reimbursement will come from the COB savings reserve. This is the part of the UMP Classic benefit saved because Medicare pays part of your claims. **Note:** Claims apply to the UMP Classic medical deductible in the order they are processed, not necessarily in the order services were received by the member.

Paying the UMP Classic and Medicare Deductibles

If you meet the $250 UMP Classic deductible, you do not pay both the Medicare Part B and the UMP Classic deductible. The $147 Part B deductible is a part of the same total calendar year expenses processed by UMP Classic. Here is an example:

Medicare Benefit Calculation	
Medicare allowed amount:	$600
Medicare deductible (**Note:** This example uses the 2016 deductible):	$166
Subtract deductible from allowed amount: $600—$147=	$434
Medicare pays 80% of this amount (.80 x $453)=	$347.20
Balance remaining after Medicare pays: $600—$362.40=	$252.80
UMP Classic Benefit Calculation	
Plan allowed amount	$600
UMP Classic deductible	$250
Subtract deductible from allowed amount: $600—$250=	$350
Normal UMP Classic benefit (85% of this amount) (.85 x $350) =	$297.50
Since the UMP Classic benefit available (dollar amount) is greater than the balance, UMP pays the balance remaining after Medicare pays:	$252.80
The difference between the normal UMP Classic benefit and the amount UMP paid is: ***This amount is considered "COB savings" (see page 122).***	$44.70

Note: This is an example only and may not apply to your specific situation.

Example of Coordination of Benefits When Medicare Pays First and UMP Classic Pays Second

Here's an example to show how the coordination of benefits (COB) process works, after you have met your UMP Classic medical deductible and Medicare deductible (see example above). This example assumes you received care from a preferred provider in Washington State, or a provider who accepts Medicare (has not "opted out" of Medicare) anywhere in the U.S.

Provider's charge	**$300**	
Medicare Benefit Calculation		
Medicare allowed amount	$100	
Medicare pays	$80	(80% of $100)
Remaining amount	$20	
UMP Classic Benefit Calculation		
Plan allowed amount	$100	
UMP Classic normal benefit	$85	(85% of $100)
UMP Classic pays	$20	
You pay	***$0***	
COB savings accrued	$65	$85 – $20 =$65

The $65 of the normal UMP Classic benefit not paid on this claim is tracked as part of your COB savings reserve. That excess benefit can be used to reimburse you directly for your UMP Classic medical deductible met earlier in the same year, or used to pay more on a service covered by UMP Classic, but not covered by Medicare. See "Why Did I Get a "COB Savings" Check From UMP Classic?" on page 122.

In this example, you owe nothing because the provider accepts Medicare. You may still have to pay coinsurance and deductible amounts when you have not fully met your Medicare deductibles, or when Medicare does not cover a service.

If UMP Classic covers a service or supply not covered by Medicare, then the benefit will be the normal UMP Classic benefit plus any COB savings you may have accrued in the same calendar year, up to allowed amount for the claim. If a provider does not bill Medicare for services covered by Medicare, UMP Classic may not cover services. Medicare accepts claims from enrollees only under certain circumstances, and UMP Classic processes claims for services covered by Medicare only after Medicare has processed them. (See "What Does UMP Classic Cover That Medicare Doesn't?" on page 120 for exceptions.) Ask your provider if he or she bills Medicare.

Payment for Diabetes Care Supplies When Medicare Pays First

Medicare pays claims for some diabetes care supplies under the Part B medical benefit; as a result, UMP Classic pays the claim under the durable medical equipment benefit, not the prescription drug benefit. This means you will have to meet your medical deductible before UMP Classic begins to pay on diabetes care supplies claims, then UMP Classic pays its share based on medical benefit coinsurance (85% of the allowed amount for providers that accept Medicare).

See also "Diabetes Care Supplies" on page 43 for more about this benefit.

What Does UMP Classic Cover That Medicare Doesn't?

ALERT! Services listed below are covered based on whether the provider is preferred or out-of-network and the specific benefit. You will pay more if you use out-of-network providers for these services.

UMP Classic covers some services that Medicare doesn't cover at all. For these services, it doesn't matter if the provider accepts Medicare, because Medicare doesn't cover the service. You will receive the highest level of benefit if you choose a preferred provider.

For the services listed below, the secondary benefit paid by UMP Classic is the only benefit (plus any COB savings accrued earlier in the year). Out-of-network providers may balance bill you; see definition on page 175.

Services not covered by Medicare Part A or Part B include but are not limited to:

- Acupuncture (see page 37).
- Hearing aids.
- Hearing exams for the purpose of getting a hearing aid (see page 51).
- Massage therapy (a massage therapist ***must*** be a preferred provider).
- Medical coverage outside the country; Medicare doesn't cover services outside of the U.S. (see pages 9–11 for details).
- Naturopathic medicine (see page 61).
- Prescription drugs (see "Use Network Pharmacies That Bill Medicare Part B Directly" on page 123 for exceptions).
- Routine vision exams and hardware (see page 73). (Medicare covers medical vision exams and vision hardware following cataract surgery.)
- Wigs for cancer patients (see page 46).

If you see a preferred provider, he or she will submit the claim for you. For out-of-network providers, check if the provider will submit the claim. If not, you will need to send a claim to UMP Classic. See "Billing & Payment: Filing a Claim" starting on page 125.

UMP Classic Covers More Than Medicare for Certain Services

UMP Classic covers some services after the Medicare benefit ends. These services include:

- Chemical dependency services (Medicare covers some substance abuse services under mental health).
- Inpatient hospital services.
- Mental health, both outpatient and inpatient services.
- Preventive care: Medicare covers some preventive services; see pages 65–67 for what UMP Classic covers.
- Skilled nursing facility services (see page 67 for what UMP Classic covers).

You may receive higher UMP Classic benefits if you see preferred providers for these services. Call Customer Service at 1-888-849-3681 for more information.

ALERT! Preferred providers do not necessarily accept Medicare—you should ***always*** ask.

Should I See a Preferred Provider?

To find preferred providers outside the U.S., see pages 9–11

Type of Service	Higher Benefits When You See a Preferred Provider?	Important Information
Services covered by Medicare	No	You should see a provider who accepts Medicare. See "When a Provider Doesn't Accept Medicare: Opt-Out Providers" on page 122 for more about why this is important.
Services covered by UMP Classic but not by Medicare (**Exception:** See information on massage therapy below.)	Yes	See "What Does UMP Classic Cover That Medicare Doesn't?" starting on page 120 to see which services apply. Use the Provider Search at **www.hca.wa.gov/ump**, at **regence.com**, or call 1-888-849-3681 to find a preferred provider.
Massage therapy	Yes	UMP Classic pays for massage therapy services only when the provider is preferred.
Prescription drugs	Yes	You must also choose pharmacies that participate in and can bill Medicare Part B directly because Medicare Part B covers a few drugs. See "Use Network Pharmacies That Bill Medicare Part B Directly" on page 123 for more information.

When a Provider Doesn't Accept Medicare: Opt-Out Providers

When services are covered by Medicare, you must see providers who accept Medicare to get the services covered by Medicare and UMP Classic. If your provider has chosen to "opt out" of participating in Medicare, UMP Classic will not cover services by that provider, even if the provider is in the Regence or Blue Card network (preferred) for UMP Classic members (see pages 9–11). Providers that "opt out" of Medicare are supposed to have you sign a "private contract" before providing services, but you are responsible for all costs even if you did not sign a contract.

When Do I Pay? How Billing Works

Most of the time, you pay only ***after*** both Medicare and UMP Classic have processed your claim. Here's how it typically works:

1. Your provider bills Medicare.
2. Medicare processes the claim, and sends you an Explanation of Medicare Benefits (EOMB). The EOMB tells you how much Medicare paid on your claim.
3. Medicare then sends the claim to UMP Classic for processing. You do not need to submit a claim form or other paperwork to UMP Classic.
4. UMP Classic processes the claim and sends you an Explanation of Benefits (EOB). The EOB tells you how much UMP Classic paid, plus how much you owe the provider.
5. You receive a bill from your provider for any remaining amount due. To confirm that the provider has credited your account with both Medicare and UMP Classic payments:
   - Note the allowed amount on the Medicare EOMB.
   - Subtract both Medicare's and UMP Classic's payments from that amount; this should match the bill from your provider.
6. You pay your provider the amount due, if any. After you've met both your Medicare and UMP Classic deductibles, you won't pay anything for most claims.

If you haven't received any paperwork on a health care service within three months, call your provider's billing office and ask if they've sent the claim. Neither Medicare nor UMP Classic can process a claim they haven't received. While you are welcome to call UMP Classic and ask, if we haven't received the claim, we won't have any record of the service.

Why Did I Get a "COB Savings" Check From UMP Classic?

At the beginning of the year, you must first satisfy your Medicare and UMP Classic deductibles. Once you have satisfied these deductibles in full and receive more health care services during the year, UMP Classic (your secondary plan) usually pays less than its normal benefit. The difference between what UMP Classic pays as the secondary plan and what UMP Classic would have paid had it been the first payer ("primary payer"), is your Coordination of Benefits savings, or "COB savings."

UMP Classic keeps track of how much you've paid out of pocket during the year. If your Medicare coverage generates COB savings for UMP Classic, we may send you a "COB savings check" to pay you back for the out-of-pocket expenses you paid to providers earlier in the year for covered services. UMP Classic does not reimburse you for more than you paid out of pocket. See "How Do UMP Classic and Medicare Work Together?" starting on page 116 for examples.

How UMP Classic Prescription Drug Coverage Works With Medicare

FOR MORE INFORMATION: See "Your Prescription Drug Benefit" on pages 75–97 for complete information about your prescription drug coverage.

Use Network Pharmacies That Bill Medicare Part B Directly

ALERT! UMP's network mail-order pharmacy, PPS, cannot bill Medicare for you when Medicare is your primary coverage. You must submit a claim to Washington State Rx Services after Medicare has paid its share (see "Submitting a Claim for Prescription Drugs" beginning on page 127).

We recommend that you choose a network pharmacy that can bill Medicare Part B directly to get the most from your prescription drug coverage. Medicare Part B does cover a few drugs and supplies for specific purposes; these drugs and supplies are identified on the *UMP Preferred Drug List*. **Note:** Medicare Part B quantity restrictions may apply.

Medicare accepts claims only from pharmacies, not from individuals. If Medicare covers a drug or supply and the pharmacy doesn't send the claim to Medicare first for payment, UMP Classic will reject the claim. To find a network retail pharmacy, see the pharmacy locator at **www.hca.wa.gov/ump** or call Washington State Rx Services at 1-888-361-1611.

Drugs or supplies covered under Medicare Part B are paid as medical. When paying secondary to Medicare Part B, UMP Classic also pays under the medical benefit. Therefore, these charges are subject to the medical deductible.

Can I Have UMP Classic and Medicare Part D?

No, you can't enroll in both UMP Classic and a Medicare Part D prescription drug plan. UMP Classic provides your prescription drug coverage and you may not have both. Medicare will notify the PEBB Program if you enroll in a Part D plan while enrolled in UMP Classic. You could lose your eligibility for PEBB coverage if you do this. If you think you want a Part D prescription drug plan, you must change your medical plan from UMP Classic to Medicare Supplement Plan F. See "Medicare Part D" on page 167 for more information. Contact PEBB Benefits Services at 1-800-200-1004 to ask when and how you can change your PEBB medical plan.

Where Do I Go for More Information?

If you have questions about…	Contact…
• What Medicare covers • Your Medicare deductibles and coinsurance amounts • Medicare premiums • Whether your claim has been processed by Medicare	Medicare 1-800-MEDICARE (1-800-633-4227) **www.medicare.gov** **www.MyMedicare.gov**
• What UMP Classic covers • Your UMP Classic copays, coinsurance, and deductible amounts	UMP Customer Service 1-888-849-3681 **www.hca.wa.gov/ump**
• Your claim after it has been processed by Medicare	UMP Customer Service 1-888-849-3681 Log in at **regence.com**
• Prescription drugs	Washington State Rx Services 1-888-361-1611
• UMP Classic premiums • Address changes • Adding or removing dependents on your account • Changing your PEBB medical coverage	PEBB Benefits Services 1-800-200-1004 **www.hca.wa.gov/public-employee-benefits**
• Whether your claim has been submitted to Medicare • If the Patient Responsibility dollar amount on your UMP Classic Explanation of Benefits doesn't match your doctor's bill	Your doctor's billing office

Billing & Payment: Filing a Claim

FOR MEDICARE RETIREES: Be sure to read "For Retirees Enrolled in Medicare" starting on page 116.

Submitting a Claim for Medical Services

When UMP Classic is your primary insurance and your provider is preferred, you don't need to submit claims; the provider will do it for you. If you have a question about whether your provider's office has submitted a claim, log in to your account at **regence.com** or call Customer Service at 1-888-849-3681.

TIP: In the following section, Uniform Medical Plan refers to the administrative functions for submitting claims for UMP Classic. Medical claims are handled by Regence BlueShield, and claims involving prescription drugs are handled by Washington State Rx Services.

When Do I Need to Submit a Claim?

You may need to submit a claim to Uniform Medical Plan for payment if:

- You receive services from an out-of-network provider.

You have other insurance that pays first and UMP Classic is secondary. (**See also:** Medicare retirees, pages 116–124; all other members with other coverage, pages 108–115.)

Out-of-network providers may submit a claim on your behalf; ask the provider.

How Do I Submit a Claim?

TIP: If you purchase contact lenses or eyeglasses from an out-of-network provider that doesn't bill your plan, you will need to submit a claim for reimbursement. You can download the *Vision Claim Form* at **www.hca.wa.gov/ump/forms-and-publications** or call Customer Service for a copy.

To submit a claim yourself, you'll need to obtain and mail the following documents:

1. The *Medical Claim Form*—You can find the form online at **www.hca.wa.gov/ump/forms-and-publications** or you may request a form by calling Customer Service at 1-888-849-3681.
2. An itemized bill from your provider that describes the services you received and the charges.

The following information must appear on the provider's itemized bill for the plan to consider the claim for payment:

- Patient's name and plan ID number, including the alpha prefix (three letters before ID number).
- Description of the injury or illness.
- Date and type of service.
- Provider's name, address, and phone number.
- For ambulance claims, please also include where the patient was picked up and where he or she was taken.

3. If UMP Classic is secondary, you must include a copy of your primary plan's Explanation of Benefits, which lists the services covered and how much the other plan paid. You should wait until the primary plan has paid to submit a secondary claim to Uniform Medical Plan, unless the primary plan's processing of the claim is delayed. Claims not submitted to Uniform Medical Plan within 12 months of the date of service will not be paid.

If we have to request additional information, the processing of your claim may be delayed.

Reimbursement for services received from an out-of-network provider may be sent to the provider or to you in the form of a check listing both you and the provider as payees.

Be sure to make copies of your documents for your records.

Mail both the claim form and the provider's claim document (or bill) to:

Regence BlueShield
PO Box 1106
Lewiston, ID 83501-1106

Call Customer Service at 1-888-849-3681 if you have a question about the processing of your claim.

Important Information About Submitting Claims

ALERT! You or your provider must submit claims within 12 months of the date you received health care services; this is called the "timely filing" deadline. The plan will not pay claims submitted more than 12 months after the date of service. See "Submit Secondary Claims Promptly" on page 113 for how this works when you have other coverage that pays first.

For information about submitting claims for services outside of the United States, see instructions at **www.hca.wa.gov/ump**, or call UMP Customer Service at 1-888-849-3681. You may have to pay services upfront and submit a claim for reimbursement.

If you or a family member has other health care coverage, see "If You Have Other Medical Coverage" on pages 108–115 for information on how the plan coordinates benefits with other plans.

Claims Reimbursement

Most of the time, the plan will pay preferred providers directly. For claims submitted by you or an out-of-network provider, the plan will determine whether to pay you, the provider, or both you and the provider. For a child covered by a legal qualified medical child support order (QMCSO)—see page 154—the plan may pay the custodial parent or legal guardian of the child.

Claims Determinations

You will be notified of action taken on a claim within 30 days of the plan receiving it. This 30-day period may be extended by 15 days when action cannot be taken on the claim due to:

- Circumstances beyond the plan's control. Notification will include an explanation why an extension is necessary and when the plan expects to take action on the claim.
- Lack of information. The plan will notify you within the 30-day period that an extension is necessary, with a description of the information needed as well as why it is needed.

If the plan is asking you for additional information, you will be allowed at least 45 days to provide it. If the plan doesn't receive the information requested within the time allowed, the claim will be denied.

Submitting a Claim for Prescription Drugs

ALERT! See "Products Covered Under the Preventive Care Benefit" on page 94 for coverage of products such as contraceptive drugs, tobacco cessation drugs, nicotine replacement, or over-the-counter products covered as preventive.

You may need to submit your own prescription drug claim to Washington State Rx Services for reimbursement if you:

- Purchase drugs at a non-network pharmacy.
- Fail to show your ID card at a network pharmacy.
- Get a prescription from a mail-order or internet pharmacy other than PPS, the plan's network mail-order pharmacy.
- Have other prescription coverage that pays first and UMP Classic is secondary.

TIP: If you get a vaccine from an out-of-network provider, make sure that you submit your claim to Regence BlueShield as a medical claim (see page 125). Member-submitted vaccine claims sent to Washington State Rx Services will be denied.

Prescription drug claim forms are available online at **www.hca.wa.gov/ump/forms-and-publications** or by calling Washington State Rx Services at 1-888-361-1611. Send the completed claim form, along with your pharmacy receipt(s), to:

Washington State Rx Services
Attn: Pharmacy Claims
PO Box 40168
Portland, OR 97240-0168
Fax 1-800-207-8235

It's a good idea to keep copies of all your paperwork for your records.

TIP: Foreign claims for prescription drugs must be translated into English with specific services, charges, drugs and dosage documented, and you must tell us the currency exchange rate. The plan does not pay for this documentation or translation.

When you submit a prescription drug claim to Washington State Rx Services, the plan pays the claim based on the following rules, no matter where you purchased the drug:

- The plan pays based on the allowed amount. If the pharmacy charges you more than the allowed amount, you will pay your usual coinsurance (and prescription drug deductible if applicable), plus the difference between what the plan paid and the pharmacy's charge.
- The plan pays all prescription drug claims, including non-network, based on coinsurance (as shown in the table on page 79).
- If your claim exceeds the quantity limit allowed by the plan or the maximum days' supply, the plan will pay only for the amount of the drug up to the quantity limit or maximum days' supply.
- If you receive a refill before 84% of the last supply you received should have been taken, the plan will not pay for it. This is called a "refill too soon" (see page 91).

You must submit prescription drug claims within 12 months of purchase. Claims for prescription drugs submitted more than 12 months after purchase will not be paid.

ALERT! If you do not show your plan ID card when purchasing a prescription at a Washington State Rx Services' network pharmacy, you will have to pay the full cash price and submit a *Prescription Drug Claim Form*. You won't receive the plan discount.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any document for your plan coverage.

The plan may recover any payments or overpayments made as a result of a false claim or false statement by withholding future claim payments, by suing you, or by other means. False claims may also be crimes.

If you represent yourself as being enrolled in this plan when you are not, the plan will deny all claims.

What You Need to Know as a Plan Member

Your Rights and Responsibilities

To ensure UMP Classic offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must know your rights and responsibilities.

As a plan member, you have the right to:

- Be treated with respect.
- Be informed by your providers about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Ask your provider to submit secondary claims to Medicare; see page 113.
- On request, receive information from the plan about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - Technologies and treatments currently under review by the Health Technology Clinical Committee (HTCC).
  - Services and treatments that have completed HTCC review and how that affects coverage by Uniform Medical Plan.
  - How the plan reimburses providers.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - The plan and preferred providers.
  - Your covered expenses, exclusions, reductions, and maximums or limits.
- Keep your medical records and personal information confidential as described in *Notice of Privacy Practices,* available online at **www.hca.wa.gov/ump**.
- Get a second opinion about your provider's care recommendations.
- Make decisions with your providers about your health care.
- Make recommendations about member rights and responsibilities.
- Have a translator's assistance, if required, when calling the plan.
- Complain about or appeal plan services or decisions, or the care you receive.
- Receive:
  - All covered services and supplies determined to be medically necessary as described in this *Certificate of Coverage*, subject to the maximums, limits, exclusions, deductibles, coinsurance, and copayments.
  - Courteous, prompt answers from the plan.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from the plan about any request to refund an overpayment.

As a plan member, you have the responsibility to:

- Understand your plan benefits, including what's covered, preauthorization and notification requirements, and other information described in this *Certificate of Coverage*.
- Understand how to contact the plan for additional information and assistance about any covered benefit or information described in this *Certificate of Coverage*.
- Contact the plan as soon as possible if you do not understand what is covered, if you have any questions, or if you need information.
- Confirm your provider's network status before *every* visit.
- Understand how Uniform Medical Plan coverage coordinates with other insurance coverage you may have, including Medicare.
- Enroll in Medicare Part A and Part B as soon as you are entitled, if you are retired. You must notify the PEBB program.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with the plan or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, and deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to the plan any outside sources of health care coverage or payment.
- Return your completed Multiple Coverage Inquiry questionnaire you receive from the plan in a timely manner to prevent delay in claims payment.
- Use preferred providers when available.

Information Available to You

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. You can find the following information in this *Certificate of Coverage*:

- List of covered expenses (pages 36–74).
- Benefit exclusions, reductions, and maximums or limits (pages 102–107).
- Clear explanation of complaint and appeal procedures (pages 134–142).
- Preventive health care benefits that are covered (pages 65–67, page 94).
- Definition of terms (pages 173–194).
- Process for preauthorization, notification, or review (page 87 and pages 98–100).
- Policies regarding drug coverage and how the plan adds and removes drugs from the *UMP Preferred Drug List* (pages 76 and 92).

You can find the following at **www.hca.wa.gov/ump**, or by calling UMP Customer Service at 1-888-849-3681:

- Online directory of preferred providers, including both primary care providers and specialists.
- The Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms (UGT).
- Notice of privacy practices (includes plan policy for protecting the confidentiality of health information; see "Confidentiality of Your Health Information" on page 133).
- Clinical coverage criteria applicable to health care services and supplies that require preauthorization.
- When the plan may retroactively deny coverage for preauthorized medical services.
- Information on the plan's care management programs.
- Procedures to follow for consulting with providers.
- General reimbursement or payment arrangements between the plan and preferred providers.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Accreditation information, including measures used to report the plan's performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.

The following are available through your medical online account at **regence.com** or by calling UMP Customer Service at 1-888-849-3681:

- Medical claims history and medical deductible status.
- Online directory of preferred providers, including both primary care providers and specialists.

The following are available at **www.hca.wa.gov/ump** or by calling Washington State Rx Services at 1-888-361-1611:

- The *UMP Preferred Drug List*.
- Prescription drug claims history and prescription drug deductible status (through your online prescription drug account).
- Clinical coverage criteria applicable to prescription drugs that require preauthorization.

You may also call 1-888-849-3681 for an annual accounting of all payments made by the plan that have been counted against medical payment limits, day limits, visit limits, or other limits on your coverage. The plan will provide a written summary of payments within 30 calendar days of your request. Some of this information is also available through your online account at **regence.com**.

You may call Washington State Rx Services at 1-888-361-1611 with questions about coverage of and limitations on prescription drugs.

The plan does not prevent or discourage providers from telling you about the care you require, including various treatment options and whether the provider thinks that care is consistent with the plan's coverage criteria. You may, at any time, get health care outside of plan coverage for any reason; however, you must pay for those services and supplies. In addition, the plan does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of Your Health Information

The plan follows our *Notice of Privacy Practices,* available online at **www.hca.wa.gov/ump** or by calling Customer Service. The plan will release member health information only as described in that notice or as required or permitted by law or court order.

Release of Information

The plan or Washington State Health Care Authority may require you to give information when needed to determine eligibility, administer benefits, or process claims. This could include medical and other records. The plan could deny coverage if you don't provide the information when requested.

Complaint and Appeal Procedures

TIP: In the following section, Uniform Medical Plan refers to the administrative functions for appeals for UMP Classic. Medical appeals are handled by Regence BlueShield, and appeals involving prescription drugs are handled by Washington State Rx Services. See below for contact information.

For more information: If you have any questions about appeals or complaints, you may contact us at:

Medical Services

1-888-849-3681
Uniform Medical Plan
PO Box 2998
Tacoma, WA 98401-2998

Prescription Drugs

1-888-361-1611
Washington State Rx Services
Attn: Appeals
PO Box 40168
Portland, OR 97240-0168

ALERT! Appeals procedures may change during the year if required by federal or Washington State law.

What Is a Complaint or Grievance?

A complaint (also known as a grievance) is an oral or written complaint submitted by or on behalf of a member regarding:

- Dissatisfaction with medical care.
- Waiting time for medical services.
- Provider or staff attitude or demeanor.
- Dissatisfaction with service provided by the health plan.

Note: If your issue is regarding denial of payment or nonprovision of medical services, it is an appeal; see "How to File an Appeal" on page 137.

How to File a Complaint or Grievance

For all complaints or grievances, we recommend calling Customer Service first. Many issues can be resolved with a phone call. If an initial phone call does not resolve your grievance, you may submit your complaint or grievance:

- Over the phone: If you want a written response, you must request one.
- In writing: By mail, fax, or email (see contact information on page 139).

You will receive notice of the action on your written request, complaint, or grievance within 30 calendar days of our receiving it. We will notify you if we need more time to respond.

What Is an Appeal?

An appeal is an oral or written request sent by you or your authorized representative to Regence BlueShield or Washington State Rx Services to reconsider a previous decision about:

- Claims payment, processing, or reimbursement for health care services or supplies.
- A decision to deny, modify, reduce, or terminate payment, coverage, certification, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.
- A retroactive decision to deny coverage based on eligibility; see "Appeals Related to Eligibility" on page 142.

The Appeals Process

Internal Review

ALERT! If your appeal is for an urgent or life-threatening condition, see "Expedited Appeals" on page 138.

You, your treating provider, or an authorized representative (see "How to Designate an Authorized Representative" on page 136) may request an appeal for you. There are three parts to the appeals process: first-level appeal, second-level appeal, and independent review.

If your request involves a decision to change, reduce, or terminate coverage for services, supplies, or prescription drugs already being covered, the plan must continue coverage for these services during your appeal. However, if the plan or the Health Care Authority upholds the decision to change, reduce, or terminate coverage, you will be responsible for any payments made by the plan during that period. If you request payment for denied claims or approval of services, supplies, or prescription drugs not yet covered by the plan, we do not have to cover the services, supplies, or prescription drugs while the appeal is under consideration.

The plan will consult with a health care professional on appeals where the plan's decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. In this case, the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved.

You may send written comments, documents, and any other information when you request an appeal. You may also request copies of documents the plan has that are relevant to your appeal, which the plan will provide at no cost. Our review will consider any information you or your provider submits to us.

How to Designate an Authorized Representative

TIP: Because of privacy laws, the plan usually cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or the plan has received written authorization to release personal health information to the other person. To authorize someone to receive your protected health information, request an *Authorization to Disclose Protected Health Information* form (see next page). This form must be returned to the address on the form before the plan can share information. However, you don't need to send a form for someone else to initiate an appeal on your behalf, but without a completed *Authorization to Disclose Protected Health Information* the plan will communicate only with the patient (or subscriber for a minor) and their treating provider regarding the appeal.

In most cases, Uniform Medical Plan must have written authorization to communicate with anyone but the member (patient). However, a parent or legal guardian may act as a representative for a member under age 13 without written authorization, except for issues involving contraceptive use. For members age 13 to 17, a parent or legal guardian may usually act as a representative, except for certain specially protected types of information, for which the plan must receive written authorization as described below.

You may choose to authorize a representative to:

- Talk to Uniform Medical Plan about claims or services.
- Share your protected health information.
- Communicate with the plan on your behalf regarding an appeal in process.

To authorize release of protected health information, you must complete an *Authorization to Disclose Protected Health Information* form, available by:

Medical Appeals	Prescription Drug Appeals
Calling Customer Service at 1-888-849-3681 or through your **regence.com** account.	Calling Washington State Rx Services at 1-888-361-1611, or downloading the form at **www.hca.wa.gov/ump/forms-and-publications**

Send the form to the address on the form. Uniform Medical Plan cannot share information until we receive the completed form.

On the form, you must specify:

- What information may be disclosed;
- The purpose of the disclosure (for example, receiving an outcome of an appeal); and
- Who is designated to receive or release the information.

How to File an Appeal

You can send an appeal **by telephone, mail, fax, or email** (see contact information on page 139). The plan will send confirmation upon receipt of your appeal. You will also receive notice of the action on your appeal within 30 calendar days. We will ask your permission if we need more time to respond.

Information to Provide With an Appeal

Your appeal will be handled more quickly if you provide all the necessary information when you file it. Please include the following information when requesting an appeal:

- The subscriber's full name (the name of the employee or retiree covered by the plan).
- The patient's full name (the name of the employee, retiree, or family member covered by the plan).
- The subscriber's ID number (starting with a "W" on your ID card).
- The name(s) of any providers involved in the issue you are appealing.
- The dates when services were provided.
- Your mailing address.
- Your daytime phone number(s).
- A statement of what the issue is and what you are asking for.
- A copy of the Explanation of Benefits, if applicable.
- Medical records from your provider, if applicable. For cases in which the denial of coverage is based on medical necessity or other clinical reasons, your provider should supply clinically relevant information such as medical records or any other relevant information along with your appeal. Because of the time limits on deciding appeals, getting this information in advance will help us make the most accurate decision on your case.

First-Level Appeals

You may request a first-level appeal orally or in writing, no more than 180 days after you receive notice of the action leading to the appeal. Although you may request an appeal by phone or in person, putting your appeal in writing will help us make more informed decisions. If you don't request an appeal within this time period, your appeal will not be reviewed and you will not be able to continue further appeals (second-level and independent review).

First-level appeals for medical services are handled by Regence BlueShield and first-level appeals for prescription drugs are handled by Washington State Rx Services. Employees from Regence BlueShield and Washington State Rx Services handling the appeals will not have been involved in the initial decision you are appealing. Claim processing disputes will be reviewed by administrative staff. Appeals that involve issues requiring medical judgment about covering, authorizing, or providing health care will be evaluated by the staff of health care professionals at Regence BlueShield or Washington State Rx Services.

ALERT! Deadlines for submitting an appeal are based on the first date you are notified of how a claim processed, usually when the plan sends you an Explanation of Benefits (including services that applied to the deductible or were denied). The plan does not waive deadlines based on untimely billing by your provider.

Second-Level Appeals

If you disagree with the decisions made on your first-level appeal, you may request a second-level appeal. Second-level appeals must be submitted no more than 180 days after the date of the letter responding to your first-level appeal. If you don't request an appeal within this time period, your appeal will not be reviewed and you will not be able to continue further appeals (independent review).

Second-level appeals for medical services are reviewed by Regence BlueShield employees, and second-level appeals for prescription drugs are handled by Washington State Rx Services. Employees from Regence BlueShield and Washington State Rx Services handling the appeals will not have been involved in, or subordinate to anyone involved in, the first-level decision. You, or your authorized representative (see page 136), will be given a reasonable opportunity to provide written testimony for the Regence BlueShield panel or Washington State Rx Services to consider.

Expedited Appeals

Expedited Appeals for Medical Service Claims Involving Urgent Care

If the plan denies coverage for services and your provider determines that taking the usual time allowed could seriously affect your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the disputed care or treatment, ask your provider to request an expedited appeal. An expedited appeal replaces the first- and second-level appeals. Regence BlueShield will decide on your expedited appeal within 72 hours of the request. Your provider must submit all clinically relevant information to the plan by phone or fax at:

Phone: 1-888-849-3681 **Fax: 1-877-663-7526 (providers only)**

If you disagree with the expedited appeal decision, your provider may request an urgent expedited independent review.

Expedited Appeals for Prescription Drugs

If your provider thinks that you need a medication immediately, he or she may request an expedited review by submitting all clinically relevant information to the plan by phone or fax at the phone number listed below. An expedited appeal replaces the first- and second-level appeals. Washington State Rx Services will decide regarding coverage of the drug within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense. If Washington State Rx Services' decision is to cover the drug, Washington State Rx will reimburse you up to the allowed amount minus the member cost-share (coinsurance and prescription drug deductible if applicable). If Washington State Rx Services decides not to cover the drug (denies the appeal), you are responsible for the full cost of the drug.

Phone: 1-888-361-1611 **Fax: 1-866-923-0412 (providers only)**

Where to Send Complaints or Appeals

ALERT! If you are appealing services related to the Center of Excellence (COE) Program for knee and hip joint replacement surgery, including the plan's denial of your participation in the Program, see page 58 for where to send your appeal. Do not send it to Regence. You cannot appeal to the plan a decision by your physician that you are not medically appropriate for the Program

We recommend calling first with a complaint or appeal about prescription drugs, since many problems can be resolved quickly over the phone.

	Medical Services Regence	Prescription Drugs Washington State Rx Services
Phone	1-888-849-3681 (TTY 711) Monday through Friday, 7 a.m. to 5 p.m. Pacific Time	1-888-361-1611 Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Time
Mail	Uniform Medical Plan PO Box 2998 Tacoma, WA 98401-2998	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168
Email	Secure email through your account at **regence.com**	
Fax	1-877-663-7526	1-866-923-0412

Time Limits for the Plan to Decide Appeals

ALERT! The plan will comply with shorter time limits than those below when required by Washington State law.

The time limits below apply to both first- and second-level appeals, and are calculated from when the plan receives the appeal.

- The plan will decide on your appeal within 14 days of receipt but may take up to 30 days unless a different time limit applies as explained below. We will request written permission from you or your authorized representative (see page 136) when we need an extension to the 30-day timeline, to get medical records or a second opinion.

The time limits below apply to expedited appeals:

- When your provider determines a delay could seriously jeopardize your life, health, or ability to regain maximum function, or that delay would cause severe pain that could not be adequately managed without the care or treatment you are appealing, we will decide as soon as possible but always within 72 hours. We will notify you (or your authorized representative) of our decision verbally within 72 hours, and will mail a written notification within 72 hours of the decision.
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 business days. If a shorter time limit applies under other provisions of this *Certificate of Coverage*, the shorter time limit applies.

External Review

Independent Review

You may request an external or independent review when the denial is based on the plan's decision to:

- Deny;
- Modify;
- Reduce; or
- Terminate coverage of or payment for a health care service.

If you have gone through both a first- and second-level appeal (or expedited appeal) and your appeal was based on one of the issues listed above, you may request an external or independent review in the following situations:

- If the plan has exceeded the timelines for response to your appeal without good cause and without reaching a decision.
- If you are dissatisfied with the decision of your second-level appeal (or expedited appeal).
- If the plan has failed to strictly adhere to the requirements of the appeals process.

You must request an independent review no more than 180 days after the date of the letter responding to your second-level appeal. Only the member or an authorized representative (see page 136) can request an independent review.

TIP: An Independent Review Organization (IRO) will conduct the external review. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not related to the plan, Regence BlueShield, Washington State Rx Services, or the Health Care Authority. An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the plan's decision is consistent with state law and the *UMP Classic Certificate of Coverage*. The plan will pay the IRO's charges.

Requesting an Independent Review

To request an independent review, contact the plan at:

	For Medical Services	For Prescription Drugs
Mail	Uniform Medical Plan PO Box 2998 Tacoma, WA 98401-2998	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168
Phone	1-888-849-3681 (TTY 711)	1-888-361-1611
Fax	1-877-663-7526	1-866-923-0412

The plan—Regence BlueShield for medical services, and Washington State Rx Services for prescription drugs—will send the relevant information and correspondence to the Independent Review Organization.

Additional Legal Options

You are required to have exercised the opportunity to seek IRO review (see page 140) of the plan's decision before you are authorized to bring a cause of action in court against the plan or the Health Care Authority. The IRO decision is binding on both the plan and you except to the extent that other remedies are available under state or federal law. If you prevail at the IRO level, the plan must provide benefits (including by making payment on the claim) following the IRO's decision without delay, regardless of whether the plan intends to seek judicial review of the IRO's decision and unless and until there is a judicial decision otherwise.

Complaints About Quality of Care

For complaints or concerns about the quality of care you received from:

Preferred Providers Only	Any Provider (Preferred or Out-of-Network
UMP Customer Service: 1-888-849-3681	Washington State Department of Health: 360-236-4700
Secure email through your **regence.com** account	**Email: HSQAComplaintIntake@doh.wa.gov** Website: **www.doh.wa.gov/AboutUs/DepartmentofHealth/Fileacomplaint**

Appeals Related to Eligibility

Appeals related to eligibility and enrollment are handled by the Public Employees Benefits Board (PEBB) Program and governed by Washington Administrative Code (WAC) chapter 182-16. Information on how to file an appeal is available:

- On the PEBB website at **www.hca.wa.gov/public-employee-benefits**.
- By contacting the PEBB Appeals Manager at 1-800-351-6827 or **pebappeals@hca.wa.gov.**

When Another Party Is Responsible for Injury or Illness

What Do I Need to Do?

You may receive a letter from the plan asking if your injury or illness was the result of an accident, or might be someone else's responsibility. To ensure timely payment of claims, it is important that you respond as directed in the letter, even if the answer is no. If you don't, coverage may be denied. You may call Customer Service at 1-888-849-3681 if you have questions.

What Are My and the Plan's Legal Rights and Responsibilities?

Coverage under the plan is not provided for medical, dental, or vision expenses you incur for treatment of an injury or illness if the costs associated with the injury or illness may be covered by another first party insurance or may be recoverable from any of the following:

- A third party; or
- Any other source, including no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no-fault coverage, commercial premises no-fault medical coverage, sports policies including excess or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage; or
- Services or supplies for work-related injury or illness, even when the service or supply is not a covered workers' compensation benefit under the workers' compensation plan.

ALERT! You must respond to any communication sent to you about other sources of benefits, or claims may be denied. See "What Do I Need to Do?" above.

However, after expiration or exhaustion of the above no fault benefits, if you also have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced by the plan pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, you agree that the plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This includes any arbitration award, judgment, settlement, disputed claim settlement, underinsured or uninsured motorist payment or any other recovery related to the injury or illness for which benefits under the plan have been provided.

- The plan may choose to recover expenses through subrogation to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. The plan is authorized, but not obligated, to recover any benefits to the extent that they were paid under the plan directly from any party liable to you, upon mailing of a written notice to the potential payer, to you or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration, award, or judgment; or other characterization of the recovery by the claimant or any third party or the recovery source. The plan is entitled to reimbursement from the first dollars received from any recovery to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This applies regardless of whether:
  - The third party or third party's insurer admits liability;
  - The health care expenses are itemized or expressly excluded in the recovery; or
  - The recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the plan.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the plan's rights (including an assignment of rights to pursue your claim if you fail to pursue your claim of recovery from the third party or other source). If you are asked to sign a trust/reimbursement agreement or other document to reimburse the plan from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits. If you or your agent or attorney fail to comply during the course of the case, we may request refunds from the providers or offset future benefits.
- You must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the plan, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the plan of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - The filing of a lawsuit;
  - The making of a claim against any third party;
  - Scheduling of settlement negotiations in accordance with the plan (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the injury or illness that gives rise to the plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to your benefit that in any manner relates to the injury or illness giving rise to the plan's right of reimbursement or subrogation, until the plan's right is satisfied or released.
- In the event you or your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any illness or injury may be recovered through legal action to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained.
- Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, the plan is not waiving any right to reimbursement or subrogation.

Services Covered by Other Insurance

The plan does not cover services that are covered by other insurance, including but not limited to no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no fault coverage, commercial premises no fault medical coverage, sports policies including excess, underinsured or uninsured motorist coverage or similar contract or insurance. You are responsible for any cost-sharing required under the other coverage as allowed by state law. Once you have exhausted benefits (for example, reached the maximum medical expenses amount of the other insurance policy[ies], or services are no longer injury-related), the plan will cover services according to this *Certificate of Coverage*.

Motor Vehicle Coverage

If you are involved in a motor vehicle accident, whether as a driver, passenger, pedestrian, or other capacity, you may have rights under multiple motor vehicle insurance no fault coverages and also against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining a recovery. We shall pay a proportional share of such attorney's fees and costs incurred by you at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to the plan to less than the full amount of benefits paid by the plan.

Future Medical Expenses

Benefits for otherwise covered services may be excluded, as follows:

- When you have received a recovery from another source relating to an illness or injury for services for which we normally would provide benefits. The amount of any exclusions under this provision, however, will not exceed the amount of your recovery.
- Until the total amount excluded under this subrogation provision equals the third-party recovery.

Eligibility and Enrollment for Active Employees

Eligibility

Eligible Employees

In these sections, we may refer to employees as "subscribers" or "enrollees." The employee's employing agency will inform the employee whether or not he or she is eligible for benefits upon employment and whenever the employee's eligibility status changes. The communication will include information about the employee's right to appeal eligibility and enrollment decisions. Information about an employee's right to an appeal can be found on page 142 of this *Certificate of Coverage*.

Eligible Dependents

To enroll in a health plan, a dependent must be eligible and the employee must follow the procedural requirements for enrolling the dependent. The PEBB Program verifies the eligibility of all dependents and requires employees to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Lawful spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in Washington State statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection (i) of this section. Children are defined as the subscriber's:
    a. Children as defined in state statutes that establish the parent-child relationship;
    b. Biological children, where parental rights have not been terminated;
    c. Stepchildren The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends on the same date the subscriber's legal relationship with the spouse or state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
    d. Legally adopted children;
    e. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    f. Children of the subscriber's state-registered domestic partner;
    g. Children specified in a court order or divorce decree;

h. Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program; and

i. Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26.
   - The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
   - The subscriber must notify the PEBB Program in writing when his or her dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that a child age 26 or older no longer qualifies under this subsection.
   - A child with a developmental disability or physical handicap who becomes self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support.
   - A child with a developmental disability or physical handicap age 26 and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support.
   - The PEBB Program will periodically certify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday.

ALERT! Don't forget to notify your employer of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents of the subscriber.

   a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:
      - The parent maintains continuous enrollment in PEBB medical;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in PEBB insurance coverage; and
      - The parent is not covered by any other group medical plan.

   b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

TIP: When you retire, be sure to enroll in PEBB retiree coverage within 60 days of your retirement date or the date that your employer-paid coverage, COBRA coverage, or continuation of coverage ends. Retirees may defer medical coverage if they have other employment that provides employer-based group medical. If you do not enroll or formally defer PEBB coverage within 60 days of retirement or the date that your employer-paid coverage, COBRA coverage, or continuation coverage ends, you will not be able to return to PEBB coverage later.

An employee or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents working for employers that participate in PEBB coverage may be enrolled as a dependent under only one parent.

An eligible employee may waive enrollment in PEBB medical if he or she is enrolled in employer-based group medical, TRICARE, or Medicare. If an employee waives enrollment in PEBB medical, the employee cannot enroll eligible dependents.

How to Enroll

ALERT! Subscribers may change health plans at the following times:

- **During annual open enrollment:** Subscribers may change health plans during the annual open enrollment; see page 150.
- **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs; see pages 150–152.

Employees must submit an *Employee Enrollment/Change* form to their employing agency. The form must be received by the employing agency no later than 31 days after the date the employee becomes eligible. To enroll an eligible dependent, the employee must include the dependent's enrollment information on the form and provide the required document(s) as evidence of the dependent's eligibility. The dependent will not be enrolled if his or her eligibility is not verified. If the employee does not return the *Employee Enrollment/Change* form in time to meet the procedural requirements, the employee will be enrolled in the Uniform Medical Plan Classic, and any eligible dependents cannot be enrolled until the next open enrollment.

An employee or his or her dependents may enroll during the annual open enrollment (see "Annual Open Enrollment" on page 150) or during a special open enrollment (see "Special Open Enrollment" beginning on page 150). The employee must provide evidence of the event that created the special open enrollment.

ALERT! Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

Employees must notify their employing agency to remove dependents no later than 60 days from the last day of the month when dependents no longer meet the eligibility criteria described under "Eligible Dependents" on page 146. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described on page 156;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

TIP: Keeping your address and other personal information up-to-date helps ensure that you receive important notices about your benefits. If your address or name changes:

- Employees should notify their personnel, payroll, or benefits office as soon as possible.
- Retirees (and other self-pay enrollees) should contact PEBB Customer Service at 1-800-200-1004.

When Medical Enrollment Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, medical plan enrollment begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

For an employee or an employee's eligible dependent enrolled during the PEBB Program's annual open enrollment, medical coverage will begin on January 1 of the following year.

For an employee or an employee's eligible dependent enrolled during a special open enrollment, medical coverage will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a developmental

disability or physical handicap, PEBB medical will begin on the first day of the month following eligibility certification.

Annual Open Enrollment

Employees may make a change to their enrollment during the PEBB Program's annual open enrollment as follows:

- Enroll in or waive their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change medical plan choice.

The employee must submit the required enrollment/change form to his or her employing agency. The form must be received no later than the last day of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

TIP: You may be eligible to change medical plans if you move during the calendar year. See the list of special open enrollment events below for details.

Special Open Enrollment

Employees may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both. The special open enrollment may allow an employee to:

- Enroll in or change his or her health plan;
- Waive his or her health plan enrollment; or
- Enroll or remove eligible dependents.

To make an enrollment change, the employee must submit the required form(s) to his or her employing agency. Form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program or employing agency will require the employee to prove eligibility or provide evidence of the event that created the special open enrollment.

ALERT! See "Adding a New Dependent to Your Coverage" on page 63.

Exception: If an employee wants to enroll a newborn or child whom the employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the employee should notify his or her employer by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Employees should contact their personnel, payroll, or benefits office for the required forms.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us. Also, if an employee transfers from one employing agency to another during the year, the enrollee cannot change medical plans, except as outlined in this Enrollment section beginning on page 148.

When can an employee change his or her health plan?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
   a. Marriage or registering a domestic partnership;
   b. Birth, adoption or when the employee assumes a legal obligation for total or partial support in anticipation of adoption;
   c. A child becomes eligible as an extended dependent through legal custody or legal guardianship; or
   d. A child becomes eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects his or her eligibility for the employer contribution toward employer-based group health plan;
4, Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan;
5. Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee moves and the employee's current health plan is not available in the new location the employee must select a new health plan;
6. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former registered domestic partner is not an eligible dependent);
7. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or the employee's dependent loses eligibility for coverage under Medicaid or CHIP;
8. Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state children's health insurance program (CHIP);
9. Employee or an employee's dependent becomes entitled to coverage under Medicare, or the employee or an employee's dependent loses eligibility for coverage under Medicare, or enrolls in or cancels enrollment in a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or an employee's dependent's entitlement to Medicare, the employee must select a new health plan;

10. Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Employee or an employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change his or her health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
    b. Transplant within the last 12 months; or
    c. Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for this continuity of care); or
    d. Recent major surgery still within the postoperative period of up to 8 weeks; or
    e. Third trimester of pregnancy.

Note: If an enrollee's provider or health care facility discontinues participation with UMP Classic, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Program determines that a continuity of care issue exists. UMP Classic cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can an employee waive his or her medical plan coverage, or enroll after waiving coverage?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a state-domestic partnership;
    b. Birth, adoption or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption;
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
    d. A child becoming eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects his or her eligibility for the employer contribution toward employer-based group medical insurance;
4, Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group medical;
5. Employee or an employee's dependent has a change in enrollment under an employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;
6. Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

7. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state CHIP, or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Employee or an employee's eligible dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.
10. Employee or employee's dependent becomes eligible and enrolls in TRICARE, or loses eligibility for TRICARE;
11. Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

When can an employee enroll or remove eligible dependents?

To enroll a dependent, the employee must include the dependent's enrollment information and provide any required document(s) as evidence of the dependent's eligibility. The dependent will not be enrolled if his or her eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a state domestic partnership;
    b. Birth, adoption or when an employee has assumed a legal obligation for total or partial support in anticipation of adoption;
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
    d. A child becoming eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects his or her eligibility for the employer contribution toward employer-based group health insurance;
4, Employee's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group medical;
5. Employee or an employee's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
6. Employee 's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
7. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or a CHIP; or

9. Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

National Medical Support Notice (NMSN)

When an NMSN requires an employee to provide health plan coverage for a dependent child the following provisions apply:

1. The employee may enroll his or her dependent child and request changes to his or her health plan coverage as described under subsection three of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB Program.
2. If the employee fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according to subsection three of this section upon request of:
   a. The child's other parent; or
   b. Child support enforcement program.
3. Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
   a. The dependent will be enrolled under the employee's health plan coverage as directed by the NMSN;
   b. An employee who has waived PEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;
   c. The employee's selected health plan will be changed if directed by the NMSN;
   d. If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.
4. Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the employee's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.
5. The employee may be eligible to make changes to his or her health plan enrollment and salary reduction elections during a special open enrollment related to the NMSN.

Medicare Entitlement

FOR MEDICARE RETIREES: Retirees, permanently disabled employees, and eligible dependents must enroll in Medicare Part A and Part B if entitled.

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

For employees and their enrolled spouses age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees age 65 and older may choose to reject his or her PEBB medical plan and choose Medicare as their

primary insurer. If an employee does so, the employee cannot enroll in PEBB medical. The employee can again enroll in PEBB medical during a special open enrollment or annual open enrollment.

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment. If Medicare entitlement is due to disability, the enrollee must contact Medicare about deferral of premiums. Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan becomes secondary.

Medicare guidelines direct that state-registered domestic partners who are age 65 or older must have Medicare as their primary insurer.

When Medical Coverage Ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. On the last day of the month when any individual ceases to be eligible.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.

Premium payments are not prorated if an enrollee dies or asks to cancel his or her medical plan before the end of the month.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums. If the enrollee's insurance coverage is terminated due to lack of payment, the enrollee's eligibility to participate in PEBB medical coverage will end.

An enrollee who needs the required forms for an enrollment or benefit change may contact the employing agency.

TIP: When your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended and he or she bills the plan for services you receive, the plan will deny all claims.

Options for Continuing PEBB Medical Coverage

Employees and their dependents covered by this health plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are continuation coverage options for PEBB health plan enrollees:

1. COBRA
2. PEBB Continuation Coverage
3. PEBB retiree insurance coverage

The first two options temporarily extend group insurance coverage in some cases when the employee or dependent's PEBB medical plan coverage ends. COBRA coverage is governed by eligibility and administrative requirements under federal law and regulation. PEBB Continuation Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA.

PEBB retiree insurance coverage (option 3) is available only to retiring employees and surviving dependents who meet eligibility and procedural requirements.

All options are administered by the PEBB Program. Refer to the *PEBB Continuation of Coverage Election Notice* booklet or the *PEBB Retiree Enrollment Guide* for specific details or call PEBB Customer Service at 1-800-200-1004.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The employee's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. The employee's employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. If the employee's contribution toward premiums is more than 60 days delinquent, insurance coverage will end as of the last day of the month for which the monthly premium was paid.

If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the monthly premium set by the HCA, with no contribution from the

employer while on approved leave. For additional information on continuation of coverage, see the section titled "Options for Continuing PEBB Medical Coverage."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to Uniform Medical Plan or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical to an individual conversion plan offered by Regence BlueShield to UMP Classic members when they are no longer able to continue the PEBB group medical plan, and are not eligible for Medicare or another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call Customer Service at 1-888-849-3681.

Appeals of Determinations of PEBB Eligibility

Any employee of a state agency and his or her dependent may appeal a decision by the employing state agency about PEBB eligibility or enrollment to the employing agency.

Any employee of an employer group or his or her dependent may appeal a decision made by an employer group regarding PEBB eligibility or enrollment to the employer group.

Any enrollee may appeal a decision made by the PEBB Program regarding eligibility, enrollment, or premium payments to the PEBB appeals committee.

Any enrollee may appeal a decision regarding administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment determinations.

Relationship to Law and Regulations

Any provision of this *Certificate of Coverage* that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Eligibility and Enrollment for Retirees and Surviving Dependents

Eligibility

In these sections, we may refer to retirees and surviving dependents as "subscribers" or "enrollees."

The Public Employee's Benefits Board (PEBB) Program will determine if an employee is eligible to enroll in retiree insurance coverage upon receipt of a completed *Retiree Coverage Election/Change* form. If the employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the employee of his or her right to an appeal. Information about appealing a decision made by the PEBB Program can be found on page 142 of this *Certificate of Coverage*.

The PEBB Program will determine if a dependent is eligible to continue enrollment in insurance coverage as a surviving dependent when it receives a completed *Retiree Coverage Election/Change* form. If the dependent does not have substantive eligibility or does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the dependent of his or her right to an appeal. Information about appealing a decision made by the PEBB Program can be found on page 142 of this *Certificate of Coverage*.

Retirees, surviving dependents, and their enrolled dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B. This is a condition of their enrollment in PEBB retiree insurance coverage. Enrollees must provide a copy of their Medicare card or Social Security letter with Medicare Parts A and B dates to the PEBB Program as proof of enrollment in Medicare. If an enrollee is not entitled to either Medicare Part A or Part B on his or her 65th birthday, the enrollee must provide the PEBB Program with a copy of the required documentation from the Social Security Administration. The only exception to this rule is for employees who retired before July 1, 1991.

Eligible Dependents

To be enrolled in a medical plan, a dependent must be eligible and the subscriber must follow the procedural requirements described in the "Enrollment" section beginning on page 160.

The PEBB Program verifies the eligibility of all dependents and requires documents from subscribers that prove a dependent's eligibility.

The following are eligible as dependents:

1. Lawful spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection (i) of this section. Children are defined as the subscriber's:
   a. Children as defined in state statutes that establish the parent-child relationship;
   b. Biological children, where parental rights have not been terminated;
   c. Stepchildren The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends on the same date the subscriber's legal relationship with the spouse or state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
   d. Legally adopted children;
   e. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
   f. Children of the subscriber's state-registered domestic partner;
   g. Children specified in a court order or divorce decree;
   h. Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program; and
   i. Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26.
      - The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
      - The subscriber must notify the PEBB Program in writing when his or her dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that a child age 26 or older no longer qualifies under this subsection.
      - A child with a developmental disability or physical handicap who becomes self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support.
      - A child with a developmental disability or physical handicap age 26 and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support.
      - The PEBB Program will periodically certify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday.

ALERT! Notify the PEBB Program at 1-800-200-1004 as soon as possible of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents of the subscriber.
   a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:
      - The parent maintains continuous enrollment in PEBB medical;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in PEBB insurance coverage; and
      - The parent is not covered by any other group medical plan.
   b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

Deferring Enrollment in PEBB Retiree Coverage

Retiring employees and surviving dependents (except for survivors of emergency service personnel killed in the line of duty) who want to defer enrollment must submit a *Retiree Coverage Election/Change* form to the PEBB Program. The forms must be received by the PEBB Program no later than 60 days after the employer paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. If a retiree defers enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents. Retiring employees and surviving dependents that do not enroll in a PEBB health plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, retirees may defer enrollment in a PEBB health plan if they are enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under COBRA coverage or continuation coverage.
- Beginning January 1, 2001, retirees may defer enrollment in a PEBB health plan if they are enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, retirees may defer enrollment in a PEBB health plan if they are enrolled in Medicare Parts A and B and a Medicaid program that includes payment of medical and hospital benefits.
- Beginning January 1, 2014, retirees who are not eligible for Part A and Part B of Medicare may defer enrollment in a PEBB health plan if they are enrolled in coverage through a health care exchange developed under the Affordable Care Act.

To defer enrollment, the retiree or surviving dependent must submit a PEBB *Retiree Coverage Election/Change* form to the PEBB Program indicating his or her desire to defer enrolling in a PEBB health plan within the PEBB Program's required enrollment time limits. **Exception:** A retiree may defer enrollment in a PEBB health plan during the period of time he or she is enrolled as a dependent in a medical plan sponsored by PEBB, a Washington state school district, or a Washington state education service district, including such coverage under COBRA or continuation coverage. He or she does not need to submit a *Retiree Coverage Election/Change* form.

If a retiree or surviving dependent defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for PEBB dental.

Enrollees can enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers.

Note: PEBB retiree health plan enrollment is deferred if a retiree becomes newly eligible for PEBB benefits as a new employee and enrolls in a PEBB health plan.

How to Enroll

Retirees and surviving dependents must submit a *Retiree Coverage Election/Change* form to enroll in PEBB retiree insurance coverage. The form must be received no later than 60 days after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

Surviving dependents of emergency service personnel killed in the line of duty must submit a *Retiree Coverage Election/Change* form to PEBB. The completed form must be received no later than 180 days after:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that he or she is determined to be an eligible survivor; or
- The date of the emergency service worker's death; or
- The last day the surviving dependent was covered under COBRA coverage from the emergency service worker's employer.

A retiree or surviving dependent who requests to voluntarily terminate his or her PEBB retiree insurance coverage must do so in writing to the PEBB Program. If a retiree or surviving dependent(s) cancels his or her PEBB retiree insurance coverage, he or she is not eligible to enroll at a later date unless enrollment was deferred.

To enroll a dependent the subscriber must include the dependent's enrollment information and provide any required document(s) as evidence of the dependent's eligibility. The PEBB Program will not enroll or reenroll dependents if the PEBB Program is unable to verify a dependent's eligibility.

A subscriber may enroll his or her dependents during the PEBB annual open enrollment (see "Annual Open Enrollment" on page 163) or during a special open enrollment (see "Special Open Enrollment" on page 163). The subscriber must provide evidence of the event that created the special open enrollment.

Subscribers are required to remove dependents no later than 60 days from the last day of the month when dependents no longer meet the eligibility criteria described under "Eligible Dependents" on pages 158–160 . Consequences for not submitting the notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described on page 168 ;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;

- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

When Medical Coverage Begins

ALERT! See "Adding a New Dependent to Your Coverage" on page 63.

For eligible employees and their dependents enrolling in PEBB retiree insurance coverage within 60 days of the employee's employer-paid coverage, COBRA coverage, or continuation coverage ending, PEBB retiree insurance begins the first day of the month following the loss of employer-paid coverage, COBRA coverage, or continuation coverage. For a retiree who deferred enrollment and is enrolling in PEBB retiree insurance no later than 60 days following a loss of other coverage, medical coverage will begin the first day of the month following the loss of other coverage.

For an eligible surviving dependent, medical coverage will be continued without a gap subject to payment of premium.

For a retiree's or surviving dependent's dependent enrolled during the PEBB annual open enrollment, medical coverage will begin on January 1 of the following year.

For a retiree's or surviving dependent's dependent enrolled during a special open enrollment, medical coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exceptions:

- If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the event occurs.
- If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a disability, health plan coverage will begin on the first day of the month following eligibility certification.

TIP: Retirees should notify PEBB Customer Service at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP Classic benefits and helps us serve you better.

Enrollment Following Deferral

Retirees or surviving dependents who defer enrollment may enroll in a PEBB medical plan during the annual open enrollment or no later than 60 days after the date their enrollment in employer-

based group medical insurance or such coverage under COBRA coverage or continuation coverage ends as long as they were continuously enrolled in such coverage.

Retirees or surviving dependents who defer enrollment while enrolled in a federal retiree medical plan as a retiree or dependent will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends, as long as they were continuously enrolled in a medical plan.

Retirees or surviving dependents who defer enrollment while enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage may enroll in a PEBB medical plan during the PEBB annual open enrollment period or no later than 60 days after their Medicaid coverage ends or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D.

Retirees or surviving dependents who defer enrollment while enrolled in coverage through a health care exchange developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB annual open enrollment period or no later than 60 days after exchange coverage ends by submitting the required forms and evidence of continuous enrollment in exchange coverage to the PEBB Program.

Retirees or surviving dependents who defer enrollment may enroll in a PEBB medical plan if he or she receives formal notice that the HCA has determined it is more cost-effective to enroll in PEBB medical than a medical assistance program.

To enroll in a PEBB medical plan, the retiree or surviving dependent must send a *Retiree Coverage Election/Change* form and evidence of continuous enrollment to the PEBB Program.

Retirees and surviving dependents should contact the PEBB Program to obtain the required forms, information on premiums, and available medical plans.

Annual Open Enrollment

Subscribers may make a change to their enrollment during the PEBB Program's annual open enrollment as follows:

- Enroll in or defer his or her enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change medical plan choice.

Special Open Enrollment

TIP: You may be eligible to change medical plans if you move during the calendar year. See "When may a subscriber change his or her health plan?" on page 164 for a list of special open enrollment events.

Subscribers may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must correspond to and be consistent with the event that creates the special open enrollment for the subscriber or the subscriber's dependent.

Exception: A retiree or surviving dependent may cancel a dependent's enrollment at any time.

Retirees or surviving dependents who have deferred their PEBB retiree insurance coverage may only enroll as described in the "Enrollment Following Deferral" section.

To make an enrollment change, the subscriber must submit the required form(s) to the PEBB Program. Forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program will require the subscriber to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

When may a subscriber change his or her health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
    a. Marriage or registering a state domestic partnership,
    b. Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
    d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward employer-based group health plan;
4. Subscriber's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan;
5. Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan;
6. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
7. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or a CHIP;

8. Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state children's health insurance program (CHIP);
9. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare, or enrolls in or cancels enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare the subscriber must select a new health plan;
10. Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Subscriber or a subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent for a specific condition or ongoing course of treatment. The subscriber may not change his or her health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
    b. Transplant within the last 12 months; or
    c. Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for continuity of care); or
    d. Recent major surgery still within the postoperative period of up to 8 weeks; or
    e. Third trimester of pregnancy.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can a subscriber enroll or remove eligible dependents?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
    a. Marriage or registering for a state domestic partnership;
    b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship;
    d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

3. Subscriber's dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan;
4. Subscriber or a subscriber's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
5. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
6. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent. (A former spouse or former state-registered domestic partner is not an eligible dependent.);
7. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or a CHIP;
8. Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

Medicare Entitlement

Medicare Part A and Medicare Part B

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration Office to ask about Medicare enrollment. Unless retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee who retired before July 1, 1991 and is enrolled in PEBB coverage, the enrollee must enroll and maintain enrollment in Medicare Part A and Medicare Part B. Medicare will become the primary insurance coverage, in most cases, and the PEBB retiree medical plan will become the secondary insurance coverage.

FOR MEDICARE RETIREES: PEBB rules do not require you to enroll in Medicare's prescription drug coverage, Medicare Part D. You cannot have both UMP Classic and Medicare Part D. If you drop your UMP Classic coverage and sign up for Medicare Part D, you will need to select a Medicare supplement plan offered through PEBB. If you do not sign up with a PEBB Medicare supplement plan, you cannot keep your PEBB coverage.

Medicare Part D

PEBB has determined that UMP Classic has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, you cannot enroll in Medicare Part D and remain in UMP Classic. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in the PEBB-sponsored Medicare supplement plan.

FOR MEDICARE RETIREES: PEBB includes an "annual notice of creditable prescription drug coverage" in the fall *For Your Benefit* newsletter sent to each subscriber. If sometime in the future you or your covered family member(s) decide to drop your UMP Classic coverage, you may contact the PEBB Program to request a certificate of creditable coverage. If you do not show that you had creditable coverage, you may have to pay higher Medicare premiums.

When Medical Coverage Ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. On the last day of the month when any individual ceases to be eligible.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.
3. For an enrollee who declines the opportunity or is ineligible to continue enrollment under one of the options described in the "Options for Continuing PEBB Medical Coverage" on page 168 , coverage ends for the enrollee on the last day of the month in which he or she ceases to be eligible.
4. If the subscriber stops paying monthly premiums, coverage will be terminated for the subscriber and enrolled dependents retroactive to the last day of the month for which the monthly premium was paid. A full month's premium is charged for each calendar month of coverage. Premium payments are not prorated during any month, if an enrollee dies or a subscriber requests to cancel his or her medical coverage before the end of a month.

The enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address. The enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes no later than 60 days after the event, such as divorce, termination of a state-registered domestic partnership, death, or when a dependent no longer meets the eligibility criteria described under "Eligible Dependents."

Failure to report changes can result in loss of premiums and loss of the subscriber and his or her dependent's right to continue coverage under one of the continuation coverage options described in the "Options For Continuing PEBB Medical Coverage" on page 168 of this *Certificate of Coverage*. To obtain forms subscribers can contact PEBB Customer Service at 1-800-200-1004.

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care" (page 61) is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends and the enrollee is not immediately covered by other health care coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from a skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the time limits explained in the following sections.

TIP: If your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended and he or she bills UMP Classic for services you receive, the plan will deny all claims.

Options for Continuing PEBB Medical Coverage

Subscribers and their dependents covered by this health plan may be eligible to continue enrollment if they lose eligibility and are eligible under one of the following options for continuing coverage:

1. COBRA gives enrollees the right to continue group coverage for 18 to 36 months. Refer to the *Continuation Coverage Election Notice* booklet for specific details.
2. PEBB Continuation Coverage allows for continued retiree coverage of dependents of a deceased subscriber.
3. PEBB retiree insurance coverage.

The first two options above temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical coverage. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Continuation Coverage is an alternative for PEBB enrollees who are not eligible for COBRA.

The third option above is available only to surviving dependents who meet eligibility requirements. Contact PEBB Customer Service at 1-800-200-1004 or refer to the *Continuation Coverage Election Notice* booklet for details.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by Regence BlueShield to UMP Classic members when they are no longer able to continue the PEBB group medical plan, and are not eligible for Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion plan differ from those of the enrollee's current group plan. To obtain detailed information on conversion options under this medical plan, call Customer Service at 1-888-849-3681.

Appeals of Determinations of PEBB Eligibility

Any enrollee may appeal a decision made by the PEBB Program regarding eligibility, enrollment, or premium payments to the PEBB appeals committee.

Any enrollee may appeal a decision regarding the administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment determinations.

Relationship to Law and Regulations

Any provision of this *Certificate of Coverage* that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Customer Service

If you have questions about your PEBB retiree eligibility and benefit information, please contact the PEBB Program at 1-800-200-1004 or go to **www.hca.wa.gov/public-employee-benefits**. For questions about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or go to **www.medicare.gov**.

General Provisions

Relationship to Blue Cross and Blue Shield Association

The Washington State Health Care Authority (HCA) on behalf of itself and you expressly acknowledges its understanding that the agreement constitutes an agreement solely between the HCA and Regence BlueShield, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans (the association), permitting Regence BlueShield to use the Blue Cross and Blue Shield service marks in the state of Washington, for those counties designated in the service area, and that Regence BlueShield is not contracting as the agent of the association. The HCA on behalf of itself and you further acknowledges and agrees that it has not entered into this agreement based upon representations by an person or entity other than Regence BlueShield and that no person or entity other than Regence BlueShield will be held accountable or liable to HCA or you for any of Regence BlueShield's obligations to the HCA or you created under this agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield other than those obligations created under other provisions of the agreement.

Out-of-Area Services

Regence BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Regence's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Regence and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Regence's service area, you will obtain care from health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from out-of-network providers. Regence's payment practices in both instances are described below.

BlueCard Program

Under the BlueCard Program, when you access covered services within the geographic area served by a Host Blue, Regence will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever you access covered services outside Regence's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Regence.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Regence by the Host Blue.

Out-of-Network Providers Outside Regence's Service Area

- **Member Liability Calculation.** When covered services are provided outside of Regence's Service Area by out-of-network providers, the amount you pay for such services will generally be based on either the Host Blue's out-of-network provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.
- **Exceptions.** In certain situations, Regence may use other payment bases, such as billed covered charges, the payment Regence would make if the health care services had been obtained within Regence's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Regence will pay for services rendered by out-of-network providers. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.

Right to Receive and Release Needed Information

Regence may need certain facts about your health care coverage or services provided in order to process your claims correctly. Regence may get these facts from or give them to other organizations

or persons without your consent. You must give Regence any facts necessary for processing of claims to get benefits under UMP Classic.

Right of Recovery

Uniform Medical Plan has the right to a refund of incorrect payments. Uniform Medical Plan may recover excess payment from any:

- Person that received an excess payment.
- Person on whose behalf an excess payment was made.
- Other issuers of payment.
- Other plans involved.

Limitations on Liability

In all cases, you have the exclusive right to choose a health care provider. Since neither the Uniform Medical Plan (the plan) nor Regence BlueShield provides any health care services, neither can be held liable for any claim or damages connected with injuries you may suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the plan and Regence BlueShield. Neither Regence BlueShield nor the plan is responsible for the quality of health care you receive, except as provided by law.

In addition, Regence BlueShield will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the plan by reason of epidemic, disaster or other cause or condition beyond Regence BlueShield's control.

Governing Law and Discretionary Language

The Uniform Medical Plan (the plan) will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Washington State Health Care Authority delegates discretion to Regence BlueShield for the purposes of paying benefits under this coverage only if it is determined that you are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when you seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. Regence BlueShield is not the plan administrator, but does provide claims administration under the plan, and the court will determine the level of discretion that it will accord determinations.

No Waiver

The failure or refusal of either party to demand strict performance of the plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the plan will be considered waived unless such waiver is reduced to writing and signed by one of the Washington State Health Care Authority's authorized officers.

Definitions

Allowed Amount, Medical Services

ALERT! In the following definition, the term "network provider" is the same as "preferred provider" elsewhere in this document, and the term "non-network provider" is the same as "out-of-network provider."

Allowed amount is the most the plan pays for a specific covered service or supply. The allowed amount is determined as follows:

- **For network providers** that are within the Regence service area, the preferred provider organization contract with Regence BlueShield is the relevant contract that determines the allowed amount.
- **For network providers** that are outside the Regence Service Area, the contract with another Blue Cross or Blue Shield organization in the BlueCard® program for its "Preferred Provider Organization ('PPO') network" is the relevant contract that determines the allowed amount.
- **For non-network providers** (providers not contracted with Regence BlueShield) within the Regence service area, the amount Regence has determined to be reasonable charges for covered services and supplies.

The allowed amount may be based upon the billed charges for some services, as determined by Regence or as otherwise required by law. Where, although it does not qualify as a network provider hereunder, one of these providers has a contract with Regence, the provider will accept the allowed amount as payment in full.

- **For non-network providers** (providers not contracted with BlueCard) accessed through the BlueCard Program, the allowed amount is the lower of the provider's billed charges and the amount that the other Blue plan identifies as the amount on which it would base a payment to that provider.

Under the BlueCard Program, when you access covered services within the geographic area served by a Host Blue, Regence will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever you access covered services outside Regence's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Regence.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of

settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Charges in excess of the allowed amount are not reimbursable. For questions regarding the basis for determination of the allowed amount, please call Customer Service at 1-888-849-3681 (TTY 711).

Allowed Amount, Prescription Drugs

The **allowed amount for prescription** drugs is based on Washington State Rx Services' contractually agreed reimbursement, unless other contractual arrangements or terms apply. All covered prescription drug claims are paid based on this allowed amount.

Ambulatory Surgery Center (ASC)

An **ambulatory surgery center** (ASC) is a health care facility that specializes in providing surgery, pain management, and certain diagnostic services in an outpatient setting. ASC-qualified procedures are typically more complex than those done in a doctor's office but not so complex as to require an overnight stay. Procedures commonly performed in these centers include colonoscopies, endoscopies, cataract surgery, orthopedic, and ENT (ear, nose, and throat) procedures. An ASC may also be known as an outpatient surgery center or same-day surgery center.

Appeal

See pages 137–140 for an explanation of appeals and how the process works.

Authorized Representative

An **authorized representative** is someone you have designated in writing to communicate with the plan on your behalf. See page 136 for how this works.

Balance Billing

Balance billing is a provider billing you for the difference between the provider's charge and the allowed amount (see definition beginning on page 173). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Preferred and participating providers may not balance bill you for covered services above the allowed amount. See an example of how this works on page 16.

Brand-Name Drug

A **brand-name drug** is a drug sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

A **calendar year** is January 1 through December 31.

Chemical Dependency

Chemical dependency is an illness characterized by a physiological or psychological dependency on a controlled substance or alcohol.

Clinical Review

Clinical review is when a plan clinical professional reviews medical records related to inpatient treatment in order to determine if inpatient treatment is medically necessary.

Coinsurance

Coinsurance is the percentage of the allowed amount you must pay the provider on claims for which the plan pays less than 100% of the allowed amount. This includes most medical services and prescription drugs.

Complications of Pregnancy

Complications of pregnancy are conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. For example, morning sickness or a non-emergency caesarean section aren't complications of pregnancy.

Coordination of Benefits

For members covered by more than one health plan, **coordination of benefits** is the method the plan uses to determine which plan pays first, which pays second, and the amount paid by each plan. Please see description and examples in "If You Have Other Medical Coverage" on pages 108–115.

Copayment

Copayment (or copay) is a set dollar amount you pay when receiving specific services, treatments, or supplies, such as inpatient hospitalization or emergency room visits.

Cost Share

Cost share means the amount you pay for a service, supply, or drug. This may be a deductible (page 18), coinsurance (page 20), copay (page 20), or amounts not covered by the plan.

Custodial Care

Custodial care is care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered.

Deductible

See the definitions of "Medical Deductible" and "Prescription Drug Deductible."

Dependent

A **dependent** is a spouse, state-registered domestic partner, child, or other eligible family member covered by the plan under the subscriber's account (see "Eligible Dependents" on pages 146–147 and pages 158–160).

Developmental Delay

Developmental delay is a significant lag in reaching developmental milestones as expected during infancy and early childhood. The cause may be present at birth or acquired after birth from a disease or disorder of the body, an injury, a disorder of the mind or emotions, or harmful effects of the surrounding environment. Only a physician or other provider can diagnose a developmental delay.

Domestic Partner

For the purposes of this *Certificate of Coverage*, a **domestic partner** is defined as:

- A state-registered domestic partner (effective January 1, 2010); **or**
- A person who qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and has been continuously enrolled under the subscriber in a PEBB health plan or life insurance.

Durable Medical Equipment

Durable medical equipment is:

- Designed for prolonged use.
- For a specific therapeutic or clinical purpose, or to assist in the treatment of an injury or illness.
- Medically necessary (meeting all plan medical necessity criteria).
- Primarily and customarily used only for a medical purpose.

See exclusion 20 on page 103 for examples of durable medical equipment that are not covered.

Efficacy

Efficacy is the extent to which a specific intervention, procedure, or service produces the desired effect under ideal conditions (in a controlled environment under lab circumstances).

Emergency

See "Medical Emergency."

Emergency Fill

Emergency fill is a process where the plan covers a limited quantity of a medication on an emergency basis while the plan processes your drug preauthorization request.

Endorsing Prescriber

An **endorsing prescriber** is a provider who has endorsed the Washington Preferred Drug List and has agreed to allow "therapeutic interchange" (see page 90) of a preferred drug for a nonpreferred one in the same drug class.

Enrollee

An **enrollee** is an employee, retiree, former employee, or dependent enrolled in this plan (see also "Member," "Subscriber," and "Dependent").

Experimental or Investigational

Experimental or investigational means a service, supply, intervention, or drug that the plan has classified as experimental or investigational and therefore, is not covered, even if the service, supply, intervention, or drug is considered medically necessary. The plan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the service, supply, intervention, or drug to determine if it is experimental or investigational. A service, supply, or drug not meeting all of the following criteria is, in the plan's judgment, investigational:

- If a medication or device, the health intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use(s) and

is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia (see definition on page 193) or, if not, then in a majority of relevant peer-reviewed medical literature (see definition on page 187); or by the United States Secretary of Health and Human Services.

- The scientific evidence must permit conclusions concerning the effect of the service, supply, intervention, or drug on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.
- The service, supply, intervention, or drug must improve net health outcome.
- The scientific evidence must show that the service, supply, intervention, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.
- The service, supply, intervention, or drug is provided by a provider that has demonstrated medical proficiency in the provision of the service, supply, or drug. The service, supply, intervention, or drug is recognized by the medical community in the service area in which they are received.
- The service, supply, intervention, or drug is not considered to be experimental or investigational by U.S. standards.

When the plan receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 20 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Customer Service at 1-888-849-3681 (TTY 711). You may have the right to an expedited appeal; see page 138 for that process.

Explanation of Benefits (EOB)

An **Explanation of Benefits** (EOB) is a detailed account of each medical claim processed by the plan, which is sent to you to notify you of claim payment or denial. You can also get this online on your account at **regence.com**, or call Customer Service to request a copy of an EOB (you will need to provide identifying information).

Family

Family is defined as all eligible family members (subscriber and dependents) who are enrolled on a single account.

Fee Schedule

A **fee schedule** is a list of the plan's maximum payment amounts for specific services or supplies. Preferred providers have agreed to accept these fees as payment in full for services to enrollees. See "Allowed Amount, Medical Services" on pages 173–174 for more details.

Formulary

See "What Drugs are Covered? The *UMP Preferred Drug List*" on page 75.

Generic Drug

A **generic drug** is a drug with the same active ingredient(s), but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent. A generic drug is therapeutically equivalent to the brand-name drug, which means it works like the brand-name drug in dosage, strength, performance, and use. All generic drugs sold in the United States must be reviewed and approved by the U.S. Food and Drug Administration, and meet the same quality and safety standards as brand-name drugs.

Generic Equivalent

A **generic equivalent** is a generic drug that has the same active ingredients as its brand-name counterpart. For a generic drug to be considered "equivalent," it has to be approved by the FDA as being interchangeable with that brand-name drug. Under Washington State law, the pharmacist is required to dispense a generic equivalent in place of a brand-name drug, unless your provider objects. (See "Can the Pharmacist Substitute One Drug for Another?" on page 90 for how this works.)

Grievance

A **grievance** is also called a complaint; see page 134 for details on how these are handled.

Health Care Authority (HCA)

The **Health Care Authority** is the Washington State agency that administers the Uniform Medical Plan (UMP Classic, the UMP Consumer-Directed Health Plan, and the UMP Plus Plans: UMP Plus–UW Medicine Accountable Care Network and UMP Plus–Puget Sound High Value Network) in addition to the following health care programs: Prescription Drug Program, Public Employees Benefits Board (PEBB) Program, and Apple Health, formerly called Medicaid.

Health Intervention

Health intervention is a medication, service, or supply provided to prevent, diagnose, detect, treat, or palliate the following: disease, illness, injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A health intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

High-Cost Generic Drugs

High-cost generic drugs are generic drugs (see "Generic Drug" above) that the plan covers under Tier 2 (see table on page 79).

Home Health Agency

A **home health agency** is an agency or organization that:

- Provides a program of home health care;
- Practices within the scope of its license as a provider of home health services; and
- Is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a preferred provider.

Hospice

Hospice is services provided by a state-licensed hospice program in the home or in a hospice facility to terminally ill patients. Services include pain relief care and support services that address the needs of terminally ill patients and their families without intent to cure.

Hospital

A **hospital** is an institution accredited under the Hospital Accreditation Program of the Joint Commission and licensed by the state where it's located. Any exception to this must be approved by the plan.

The term hospital ***does not*** include a convalescent nursing home or institution (or a part of one) that:

- Furnishes primarily domiciliary or custodial care (see definition on page 176).
- Is operated as a school.
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Inpatient Copay

The **inpatient copay** is what you pay for inpatient services at a preferred facility—hospital, skilled nursing, mental health, chemical dependency: $200 per day for facility charges. Employees and retirees not enrolled in Medicare pay up to $600 maximum per person per calendar year; retirees enrolled in Medicare pay up to a $600 maximum per admission up to the medical out-of-pocket limit. The inpatient copay does not count toward your medical deductible, but does count toward the medical out-of-pocket limit.

Note: Professional charges, such as for physicians or lab work, may be billed separately and are not included in this copay.

Inpatient Stay

Inpatient stay: From when you are admitted to a hospital or other medical facility, until you are discharged from that facility.

IRO

Independent Review Organization (see page 140).

Limited Benefit

TIP: This definition applies only to those benefits in which it is used in this *Certificate of Coverage*. Other benefits have additional limits related to medical necessity (see pages 182–184) or preauthorization of services (see page 98).

A **limited benefit** is a benefit that is limited to a certain number of visits or a maximum dollar amount. The limit applies to these benefits even if the provider prescribes additional visits and even if the visits are medically necessary. The plan does not make exceptions to benefit limits.

For benefits limited to a certain number of visits, any visits that are applied to your medical deductible (see pages 18–20) also count against your annual visit or dollar limit. In addition, visits that are paid by another health plan that is primary apply to the plan limit. For example, if your primary plan applies your first six massage therapy sessions to your medical deductible, you may receive coverage for 10 more sessions in that calendar year, for a total of 16 visits (the visit maximum for massage therapy). **Note:** These limits apply *per enrollee*.

Services are counted against a limited benefit according to the type of service, not the provider type. When a provider practicing within the scope of his/her license provides services coded under a limited benefit (for example, spinal manipulation or physical therapy), those services will be counted against the benefit regardless of the provider type. In addition, if more than one type of limited benefit service is provided during a single visit, the services will count against all of the limited benefits. For example, if both manipulation and physical therapy codes are billed for a visit, that visit will count against both the spinal and extremity manipulation and physical therapy benefits.

Maintenance Care

Maintenance care is a health intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed.

Maintenance care may apply to a number of different services, including but not limited to physical therapy, speech therapy, neurodevelopmental therapy, home health care, and skilled nursing care.

Medical

Medical generally refers to all plan benefits and services other than those covered under preventive care and prescription drug benefits (except as the term is used in the eligibility sections of this *Certificate of Coverage*).

Medical Benefit

Medical benefit refers to services subject to the medical deductible, and copayment or coinsurance. See pages 18–23 for a description of how this works.

Medical Deductible

The **medical deductible** is a dollar amount you must pay each calendar year for health care expenses before the plan starts paying for services. You pay the first $250 per person in medical expenses to your providers ($750 maximum if you have a family of three or more on one account). Only expenses covered by the plan count toward your deductible. For example, if you receive LASIK surgery (see exclusion 23 on page 103), the plan does not apply this payment to your medical deductible. Some services are exempt from this deductible (see the "Summary of Benefits" on pages 24–35). See pages 18–20 for details on how the medical deductible works.

The medical and prescription drug deductibles are separate: Medical services do **not** count toward your prescription drug deductible. Prescription drug purchases do **not** count toward your medical deductible. See "Prescription Drug Deductible" starting on page 77.

Medical Emergency

A **medical emergency** means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the person's health, or with respect to a pregnant female, her health or the health of her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary Services, Supplies, Drugs, or Interventions

ALERT! The provider or patient must provide documentation demonstrating medical necessity when requested by the plan, or services may be denied as not medically necessary. Some services that are medically necessary may not be covered by the plan. All benefits or services that are medically necessary are subject to the coverage limitations, exclusions, and provisions of the plan. It is important to review this *Certificate of Coverage* or verify coverage with Customer Service at 1-888-849-3681 (TTY 711) before receiving services.

Medically Necessary or **Medical Necessity** means health care services, drugs, supplies, or interventions that a treating licensed health care provider recommends and all of the following conditions are met:

1. The purpose of the service, supply, intervention, or drug is to treat or diagnose a medical condition.
2. It is the appropriate level of service, supply, or intervention, or drug dose considering the potential benefits and harm to the patient.
3. The level of service, supply, intervention, or drug dose is known to be effective in improving health outcomes.

4. The level of service, supply, intervention, or drug recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary.

The plan may require proof that services, interventions, supplies, or drugs (including court-ordered care) are medically necessary. No benefits will be provided if the proof isn't received or isn't acceptable, or if the service, supply, drug, or drug dose is not medically necessary. Claims processing may be delayed if proof of medical necessity is required but not provided by the health service provider.

The plan uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and intervention not yet in widespread use for the medical condition and patient indications being considered. State law requires that Uniform Medical Plan determine whether a service or intervention is covered based on decisions made by the Health Technology Clinical Committee (HTCC) (see page 36); these decisions may be referenced at **www.hca.wa.gov/about-hca/health-technology-assessment**. If the HTCC determines that a health technology will be covered only under certain conditions, the plan is required by law to use the HTCC coverage criteria when evaluating whether the technology is medically necessary. For other services, interventions, or supplies the plan first uses scientific evidence, then professional standards, then expert opinion to determine effectiveness. "Effective" means that the drug, drug dose, intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. The scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determining medical necessity. If no scientific evidence is available, professional United States (U.S.) standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that the plan should deny coverage of interventions in the absence of conclusive scientific evidence. Interventions can meet the plan's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, drug, or intervention is considered "cost effective" if the benefits and harms relative to the costs represent an economically efficient use of resources for the patients with this condition. The plan applies this criterion based on the characteristics of the individual patient. Cost-effective does not necessarily mean the lowest price.

Preventive services not covered by the plan's preventive care benefit will still be covered under the medical benefit if medically necessary.

A "health intervention" is an item or service delivered or undertaken primarily to treat (that is prevent, diagnose, detect, treat, or palliate) a medical condition (such as a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity" the plan does not consider a health intervention separately from the medical condition and patient indications it is applied to.

"Treating provider" means a licensed health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

Interventions for which clinical trials have not been conducted because of epidemiological reasons (that is, rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

Medical Out-of-Pocket Limit

See "Out-of-Pocket Limit, Medical" on page 186.

Member

A **member** is an employee, retiree, former employee, or dependent enrolled in the plan (see also "Enrollee").

Network

Network is the facilities, providers, and suppliers your health plan contracts with to provide health care services.

Network Pharmacy

A network pharmacy contracts with Washington State Rx Services to provide prescription drug coverage to UMP Classic members at the contracted rate (allowed amount). See pages 83–84 for details of the advantages of using network pharmacies.

Network Vaccination Pharmacy

A **network vaccination pharmacy** is a pharmacy that contracts with Washington State Rx Services to give immunizations to plan enrollees at the network rate. You can find out which pharmacies are contracted at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611.

Noncovered Services

Noncovered services refers to any service that is not covered by the plan. Some services may be medically necessary, yet still are not covered. See "What the Plan Doesn't Cover" on pages 102–107 and "Guidelines for Drugs Not Covered" on page 95 for details.

Nonduplication of Benefits

Nonduplication of benefits is how UMP Classic coordinates benefits when UMP Classic is your secondary coverage (see definition on page 192). When another plan (other than Medicare) is primary (pays first), that plan pays their normal benefit. UMP Classic then pays up to the amount we would have paid if UMP Classic had been the primary plan. If the primary plan pays as much or more than the normal UMP Classic benefit, UMP Classic pays nothing. UMP Classic does not pay the rest of the allowed amount. See examples on page 112.

Non-Network Pharmacy

A **non-network pharmacy** does not contract with Washington State Rx Services. See page 84 for what happens if you use a non-network pharmacy to purchase covered prescription drugs.

Nonpreferred Drug

A **nonpreferred drug** is a prescription drug designated as Tier 3 (nonpreferred) in the *UMP Preferred Drug List* (see page 75).

Nonprescription Alternative

A **nonprescription alternative** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you can buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Nonprescription Drug

A **nonprescription drug** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you can buy without a prescription.

Normal Benefit

The plan's **normal benefit** is the dollar amount of the benefit the plan would normally pay if no other health plan had the primary responsibility to pay the claim.

Occupational Injury or Illness

An **occupational injury or illness** is one resulting from work for pay or profit.

Open Enrollment

Open enrollment is a period defined by the HCA when you have the opportunity to change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Orthognathic Surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure, growth, sleep apnea, or TMJ disorders; or to correct orthodontic problems that cannot be easily treated with braces.

Out-of-Network Provider(s)

An **out-of-network provider** is a health care provider that is:

- In the Regence Service Area, but is not contracted as part of Regence BlueShield's preferred provider organization network; or
- Outside the Regence Service Area, but is not contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Out-of-Pocket Limit, Medical

The **medical out-of-pocket limit** is the most you pay during a calendar year before the plan pays 100% of the allowed amount. This limit doesn't include your premium, balance-billed charges, or services the plan doesn't cover; also see page 23 for other costs that do not count toward this limit. For more information on how this works, see page 21 under "Your Medical Out-of-Pocket Limit."

Out-of-Pocket Limit, Prescription Drugs

The **prescription drug out-of-pocket limit** is the maximum you pay for covered prescription drugs and products during a calendar year. Once the $2,000 limit per enrolled member is met, the plan pays 100% of the allowed amount for covered prescription drugs and products for that member. See page 79 for a list of services that don't count toward this limit and that you pay even after you have met it.

Over-the-Counter Alternative

An **over-the-counter alternative** drug is a drug that you can buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Over-the-Counter Drugs

Over-the-counter drugs are medications you can get without a prescription.

Over-the-Counter Equivalent

An **over-the-counter equivalent** is a drug you can buy without a prescription that has identical active ingredients and strengths as a prescription drug or product in a comparable dosage form.

P&T Committee

See "**Pharmacy & Therapeutics Committee.**"

Participating Provider

A **participating provider** is contracted but is in another network. Participating providers are designated in the **regence.com** provider directory with a bar icon. The plan pays these providers at the out-of-network rate (most covered services are paid at 60%), but the provider may not balance bill you. Coinsurance paid to a participating provider applies to the medical out-of-pocket limit. Covered preventive services from participating providers will be paid by the plan at 100% of the allowed amount. Covered mental health or substance abuse services from participating providers will be considered in-network.

PEBB

The **Public Employees Benefits Board** is a group of representatives, appointed by the governor, that approves insurance benefit plans for employees and establishes eligibility criteria for participation in insurance benefit plans.

PEBB Plan

A **PEBB plan** is one of several health benefit plans, including the Uniform Medical Plan (UMP Classic, the UMP Consumer-Directed Health Plan, and the UMP Plus Plans: UMP Plus–UW Medicine Accountable Care Network and UMP Plus–Puget Sound High Value Network), offered through the Public Employees Benefits Board (PEBB) Program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive benefits package.

PEBB Program

The **PEBB Program** is the Washington State Health Care Authority program that administers PEBB benefit eligibility and enrollment.

Peer-Reviewed Medical Literature

Peer-reviewed medical literature is scientific studies printed in journals or other publications in which original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related websites or in-house publications of pharmaceutical manufacturers.

Pharmacy & Therapeutics (P&T) Committee

Pharmacy & Therapeutics Committee: A group of providers and other health care professionals who review prescription drugs and make recommendations on the preferred status of prescription drugs on the Preferred Drug List (see page 76).

Physician Services

Physician services are health care services provided or coordinated by a licensed medical physician:

- Medical Doctor (M.D)
- Doctor of Osteopathic Medicine (D.O.)
- Naturopathic physician (N.D.)

Plan

Plan as referred to in this document means the Uniform Medical Plan Classic (UMP Classic), a self-funded PPO plan offered by the PEBB Program. In the eligibility sections (pages 146–169), "plan" refers to any PEBB-sponsored plan. In the "If You Have Other Medical Coverage" section on pages 108–115, "plan" may mean any health insurance coverage.

PPO

A **Preferred Provider Organization (PPO)** is a health plan that has a network of providers who have agreed to provide services for the plan's enrollees at discounted rates. Enrollees may self-refer to most specialists. UMP Classic is a PPO.

Preauthorization

Preauthorization is approval by the plan for coverage of specific services, supplies, or drugs before they are provided to the member. Preauthorization is not a guarantee of coverage. If you or your provider do not receive preauthorization for certain medical services or drugs, the claim may be denied. See "Preauthorizing Medical Services" on page 98 for how this works. A list of medical services that require preauthorization is available at **www.hca.wa.gov/ump/ump-classic/services-requiring-preauthorization** or by calling UMP Customer Service at 1-888-849-3681. See page 87 for information on prescription drugs that must be preauthorized.

Preferred Drug

A **preferred drug** is a prescription drug that is listed on the *UMP Preferred Drug List* and covered under the Value Tier, Tier 1, or Tier 2.

Preferred Drug List

The ***UMP Preferred Drug List*** is a list available online that specifies how prescription drugs are covered by the plan. By using this list, you can find out if a drug is covered, how much you'll pay, if the drug must be ordered through the plan's specialty drug pharmacy, and whether the drug has any limitations (such as needing preauthorization or quantity limits; see pages 86–90).

Drugs are designated by "tiers": Value Tier are cost-effective drugs for treatment of certain chronic conditions; Tier 1 are primarily generic drugs; Tier 2 are preferred brand-name drugs and some high-cost generic drugs; and Tier 3 are nonpreferred brand-name drugs.

"NC" designates a drug not covered under the prescription drug benefit; however, some drugs—such as IV drugs that require administration by a physician—may be covered under the medical

benefit. Call Washington State Rx Services at 1-888-361-1611 for more information about drugs listed as NC.

The *UMP Preferred Drug List* is based on the Washington Preferred Drug List and recommendations by one of the Pharmacy & Therapeutics Committees that partner with Washington State Rx Services (see "Who Decides Which Drugs Are Preferred?" on page 76 for more information).

If your drug is not listed, call Washington State Rx Services at 1-888-361-1611.

Preferred Provider(s)

A **preferred provider** is a provider:

- In the Regence Service Area and contracted as part of Regence BlueShield's preferred provider organization network; or
- Outside the Regence Service Area and contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Prenatal

Prenatal means during pregnancy.

Prescription Cost-Limit

The **prescription cost-limit** is the most you pay for a generic or preferred prescription drug at a network pharmacy; see page 80 for how this works. See "Your Prescription Drug Out-of-Pocket Limit" on page 78 for annual limits to covered prescription drug costs.

Prescription Drug Deductible

The **prescription drug deductible** is a dollar amount you must pay each calendar year for Tier 2 and Tier 3 prescription drugs before the plan starts paying benefits for these drugs. You pay the first $100 per individual in prescription drug charges ($300 maximum if you have a family of three or more on one account). Only expenses for Tier 2 and Tier 3 drugs covered by the plan count toward your deductible. For example, if you receive a prescription for a drug for cosmetic purposes (see exclusion 9 on page 102), the plan does not apply this payment to your deductible.

See "Your Prescription Drug Out-of-Pocket Limit" on page 78 for annual limits to your cost for prescription drugs.

The prescription drug and medical deductibles are separate: Prescription drug purchases do **not** count toward your medical deductible. Medical services do **not** count toward your prescription drug deductible. See "Your Deductibles" on page 18.

Note: What you pay (coinsurance) for Value Tier and Tier 1 drugs does not count toward your prescription drug deductible.

Prescription Drug Out-of-Pocket Limit

See "Your Prescription Drug Out-of-Pocket Limit" on page 78.

Preventive Care

In this *Certificate of Coverage*, **preventive care** means those services described by the Public Health Services Act, Section 2713:

- Services with an A or B rating by the United States Preventive Services Task Force (USPSTF).
- Evidence-informed preventive care screenings and immunizations for infants, children, and adolescents that are supported by the Health Resources and Services Administration (HRSA).
- Evidence-informed preventive care and screenings for women as described in HRSA Guidelines in accordance with 45 CFR 147.131 (a).

Primary Care Provider

A **primary care provider** is a physician (see "Physician Services" on page 188), nurse practitioner, or physician assistant who provides, coordinates, or helps a patient access a range of health care services. See page 16 for a list of specialties that may be a primary care provider.

Primary Payer

The **primary payer** is the insurance plan that processes the claim first when a member has more than one group insurance plan covering the services and the plans must coordinate benefits.

Professional Services

Professional services means non-facility medical services performed by professional providers such as (but not limited to) medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

Proof of continuous coverage refers to the Certificate of Creditable Coverage (not this document) provided to the member by the member's health plan; or a letter from the member's employer on the employer's letterhead stating the time period the member and his or her dependent(s) were covered by the employer's health insurance.

Provider

A **provider** is an individual medical professional (such as a doctor or nurse), hospital, skilled nursing facility, pharmacy, program, equipment and supply vendor, or other facility, organization, or entity that provides care or bills for health care services or products.

Provider Network(s)

A **provider network** is a network of providers who are contracted to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates (see "Allowed Amount, Medical Services" on pages 173–174). Preferred providers for UMP Classic members in 2017 consist of Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers in the BlueCard® program designated as preferred providers.

Quantity Limit

A **quantity limit** is a limit on how much of a particular drug you can get for a specific time period (days' supply).

Reconstructive Surgery

Reconstructive surgery is surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Regence Service Area

The **Regence Service Area** means the Washington counties of Clallam, Columbia, Cowlitz, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Yakima, Wahkiakum, Walla Walla, Whatcom, and any other areas designated by Regence. Please check the website **regence.com** for up-to-date information.

Residential Treatment Facility

A **Residential Treatment Facility** is a licensed facility that operates 24 hours a day to provide health care to patients receiving services related to chemical dependency or mental health treatment. Patients receiving residential treatment do not need the high level of security and treatment offered though an inpatient facility or unit.

Respite Care

Respite care is continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Routine

Routine services are those provided as preventive, not as a result of an injury or illness. In the case of immunizations, routine refers to immunizations included on the Centers for Disease Control and Prevention (CDC) schedules (see page 66).

Scientific Evidence

Scientific evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Scope of Practice

Scope of Practice refers to the services a provider may perform and bill for, based on the provider's professional license as issued by local authorities. For example, some provider types may prescribe prescription drugs, and some may not.

Screening

Screening refers to services performed to prevent or detect illness in the absence of disease or symptoms.

Secondary Coverage

When you are covered by more than one health plan, you have **secondary coverage** that may pay a part or the rest of a provider's bill after your primary payer has paid. See "If You Have Other Medical Coverage" starting on page 108 for more information on how this plan coordinates benefits.

Skilled Nursing Care

Skilled nursing care is services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled Nursing Facility

A **skilled nursing facility** is an institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

SmartHealth

SmartHealth is a wellness program offered by the PEBB Program. SmartHealth offers a $125 wellness incentive in 2017 to eligible non-Medicare subscribers who met eligibility requirements. More details on eligibility and program requirements are at **www.hca.wa.gov/public-employee-benefits.**

Specialty Drugs

Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy (including a few products, such as intrauterine devices [IUDs]). Specialty drugs are identified on the *UMP Preferred Drug List*. See page 88 for information on how specialty drug prescriptions are handled.

Standard Reference Compendium

Standard reference compendium refers to any of these sources:

- *The American Hospital Formulary Service Drug Information*
- *The American Medical Association Drug Evaluation*
- *The United States Pharmacopoeia Drug Information*
- Other authoritative compendia as identified from time to time by the U.S. Secretary of Health and Human Services

Subscriber

A **subscriber** is the individual or family member who is the primary certificate holder and plan member.

Substance Abuse Treatment Facility

A **substance abuse treatment facility** is an institution, or part of an institution, that specifically treats alcoholism or drug addiction and meets all of these criteria:

- Is licensed by the state.
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs.
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing.
- Performs the services under full-time supervision of a physician or registered nurse.
- Certified by the Washington State Division of Behavioral Health and Recovery (DBHR), or for facilities outside of the Regence Service Area (see page 191), contracted with the local BlueCard network.

Therapeutic Alternative

A **therapeutic alternative** is a drug that isn't chemically identical to a nonpreferred drug, but has similar effects when given in therapeutically equivalent doses.

Therapeutic Equivalent

A **therapeutic equivalent** is a drug that is chemically identical to a nonpreferred drug and is expected to have the same efficacy and toxicity when given in the same doses.

Therapeutic Interchange

Therapeutic interchange is substitution of a nonpreferred drug by a pharmacist with a preferred drug that is a therapeutic alternative or equivalent, with the endorsing provider's permission (see page 90).

Tier

Tier is a term that tells you how much you will have to pay for a covered prescription drug. UMP Classic's prescription drug benefit categorizes covered medications into four tiers. See page 79 for details on the prescription drug tiers.

Tobacco Cessation Services

Tobacco cessation services are provided for the purpose of quitting tobacco use, usually cigarette smoking. UMP Classic members under age 18 who use tobacco may participate in the online Smokefree Teen program. See page 70 for more information.

Uniform Medical Plan Classic (UMP Classic)

Uniform Medical Plan Classic (UMP Classic) is a self-insured health plan offered through the Public Employees Benefits Board (PEBB) Program and managed by the Health Care Authority.

Value Tier

Value Tier refers to cost-effective drugs that are used to treat certain chronic conditions; see table on page 79 for details. For a list of Value Tier drugs, go to **www.hca.wa.gov/ump.ump-classic/prescription-drugs**, or call 1-888-361-1611.