2016

UMP Consumer-Directed Health Plan

Certificate of Coverage

Self-insured by the State of Washington
Effective January 1, 2016

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HCA 54-549 (10/15)

Directory

Customer Service	**1-888-849-3681** (TTY 711)	Monday–Friday 7 a.m. to 5 p.m. Pacific Time
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 Time
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 21267 Seattle, WA 98111-3267	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
HealthEquity Health Savings Account trustee	**www.healthequity.com/pebb** Or link from **www.hca.wa.gov/ump**	1-877-873-8823 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 Monday–Friday 8 a.m. to 5 p.m. Pacific Time
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 Time

To obtain this booklet in another format (such as Braille or audio), call 1-888-849-3681.
TTY users may call this number through the Washington Relay service by dialing 711.

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 27–40). 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 181.

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.

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 through 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.

Table of Contents

About the UMP Consumer-Directed Health Plan ---------- **7**

Online Services 7

What Is UMP CDHP? 8

How Does a Health Savings Account Work? 8

Finding a Health Care Provider ---------- **10**

How to Find a Preferred Provider 10

Services Received Outside the U.S. 10

Why Choose a Preferred Provider? 13

When You Don't Have Access to a Preferred Provider: Network Waiver *15*

Covered Provider Types 17

What Is a Primary Care Provider? *17*

Comparing Payments to Preferred, Participating, and Out-of-Network Providers 18

What You Pay for Medical Services ---------- **20**

Your Deductible 20

What Is Coinsurance? 22

How Do I Pay My Claims? 22

Your Out-of-Pocket Limit 23

Your Health Savings Account 25

If You Qualified for the SmartHealth Wellness Incentive *26*

Summary of Benefits ---------- **27**

Deductibles and Limits 28

How Much Will I Pay? 29

Benefits: What the Plan Covers ---------- **41**

Guidelines for Coverage 41

Health Technology Assessment (HTA) Program 42

List of Benefits 42

Acupuncture *42*

Ambulance *43*

Applied Behavior Analysis (ABA) Therapy *44*

Autism Treatment *44*

Bariatric Surgery *45*

Breast Health Screening Tests *45*

Chemical Dependency Treatment *46*

Chiropractic Physician Services (Spinal and Extremity Manipulations) *75*

Dental Services *48*
Diabetes Care Supplies *50*
Diabetes Control Program *51*
Diabetes Education *51*
Diabetes Prevention Program *51*
Diagnostic Tests, Laboratory, and X-Rays *52*
Dialysis *53*
Durable Medical Equipment, Supplies, and Prostheses *53*
Emergency Room *56*
End-of-Life Counseling *56*
Family Planning Services *56*
Foot Care, Maintenance *59*
Genetic Services *59*
Hearing Care (Related to Diseases and Disorders of the Ear) *59*
Hearing Exams and Hearing Aids *59*
Home Health Care *61*
Hospice Care (Inpatient, Outpatient, and Respite Care) *61*
Hospital Services *62*
Knee Arthroplasty, Total *63*
Mammograms *64*
Massage Therapy *65*
Mastectomy and Breast Reconstruction *65*
Mental Health Treatment *66*
Naturopathic Physician Services *66*
Nutrition Counseling and Therapy *67*
Obstetric and Newborn Care *67*
Office Visits *70*
Orthognathic Surgery *70*
Physical, Occupational, Speech, and Neurodevelopmental Therapy *71*
Prescription Drugs *82*
Preventive Care (including Covered Immunizations) *72*
Second Opinions *74*
Skilled Nursing Facility *74*
Spinal and Extremity Manipulations *75*
Spinal Injections *75*
Surgery *75*
Telemedicine Services *76*
Temporomandibular Joint (TMJ) Treatment *76*
Tobacco Cessation Services *77*
Transgender Health *79*
Transplants *79*
Urgent Care *80*

Vision Care (Related to Diseases and Disorders of the Eye) *80*
Vision Exams (Routine) *80*
Vision Hardware (Eyeglasses and Contact Lenses) *81*
Your Prescription Drug Benefit ---------- 82
What Drugs Are Covered? The *UMP Preferred Drug List* 82
Who Decides Which Drugs Are Preferred? *83*
How Much Will I Pay for Prescription Drugs? 83
Where to Purchase Your Prescription Drugs 85
Limits on Your Prescription Drug Coverage 88
Programs Limiting Drug Coverage *89*
Can the Pharmacist Substitute One Drug for Another? *91*
Travel Overrides for Prescription Drugs *93*
Refill Too Soon *93*
What Can I Do If Coverage Is Denied? 93
Guidelines for Drugs Covered 94
Exceptions Covered *94*
Products Covered Under the Preventive Care Benefit *96*
Some Injectable Drugs Are Covered Only Under the Prescription Drug Benefit *96*
Compounded Prescription Drugs *97*
Guidelines for Drugs Not Covered 97
Exceptions Covered *98*
Prescription Drug Contacts 98
Limits on Plan Coverage ---------- 100
Preauthorizing Medical Services 100
Your Preauthorization Role *100*
Where Can I Find the List of Services Requiring Preauthorization or Notification? *101*
Notification for Facility Admissions *101*
What Is the Difference Between Preauthorization and Notification? *102*
How Long Does the Plan Have to Make a Decision? *102*
General Information From Customer Service Is Not a Guarantee That a Service Is Covered 103
Case Management 103
What the Plan Doesn't Cover ---------- 105
Expenses Not Covered, Exclusions, and Limitations 105
If You Have Other Medical Coverage ---------- 112
When UMP CDHP Pays First (Primary) 112
What Is Coordination of Benefits? 112
Whom Do I Inform If I Have Other Coverage? 113

Who Pays First? 114
How Does UMP CDHP Coordinate Benefits When It Pays Second? 116
How Much Will I Pay When UMP CDHP Pays Second? *116*
How Are Diabetes Care Supplies Covered When UMP CDHP Pays Second? *118*
How Does Coordination of Benefits Work With Prescription Drugs? 119
Who Can Have Both UMP CDHP and Medicare? 120
Does UMP Coordinate With Occupational Injury or Illness (Workers' Compensation) Claims? 121
Billing & Payment: Filing a Claim ----------122
Submitting a Claim for Medical Services 122
Submitting a Claim for Prescription Drugs 125
False Claims or Statements 126
What You Need to Know as a Plan Member ----------127
Your Rights and Responsibilities 127
Information Available to You 129
Confidentiality of Your Health Information 130
Release of Information 130
Complaint and Appeal Procedures----------131
What Is a Complaint or Grievance? 131
How to File a Complaint or Grievance *132*
What Is an Appeal? 132
The Appeals Process 132
Internal Review *132*
External Review *138*
Complaints About Quality of Care 139
Appeals Related to Eligibility 140
When Another Party Is Responsible for Injury or Illness ----------141
What Do I Need to Do? 141
What Are My and the Plan's Legal Rights and Responsibilities? 141
Services Covered by Other Insurance 143
Motor Vehicle Coverage 144
Fees and Expenses 144
Future Medical Expenses 144
Eligibility and Enrollment for Active Employees----------145
Notice 145
Who Can Enroll in UMP CDHP With an HSA? 145

Eligibility 146
Eligible Employees *146*
Eligible Dependents *146*
Enrollment 148
How to Enroll *149*
When Medical Enrollment Begins *150*
Annual Open Enrollment *151*
Special Open Enrollment *151*
National Medical Support Notice (NMSN) or Court Order *156*
Medicare Entitlement *157*
When Medical Enrollment Ends *157*
Options for Continuing PEBB Medical Coverage 159
Family and Medical Leave Act of 1993 159
Payment of Premium During a Labor Dispute 160
Conversion of Coverage 160
Appeals of Determinations of PEBB Eligibility 160
Relationship to Law and Regulations 161
Eligibility and Enrollment for Retirees and Surviving Dependents ---- 162
Eligibility 162
Eligible Dependents *163*
Enrollment 165
Deferring Enrollment in PEBB Retiree Coverage *165*
How to Enroll *166*
When Medical Coverage Begins *167*
Enrollment Following Deferral *168*
Annual Open Enrollment *169*
Special Open Enrollment *169*
Medicare Entitlement 172
Medicare Part A and Medicare Part B *172*
Medicare Part D *172*
When Medical Coverage Ends 173
Options for Continuing PEBB Medical Coverage 174
Conversion of Coverage 175
Appeals of Determinations of PEBB Eligibility 175
Relationship to Law and Regulations 175
Customer Service 176
General Provisions ---------- 177
Definitions ---------- 181

About the UMP Consumer-Directed Health Plan

The UMP Consumer-Directed Health Plan (UMP CDHP) 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 in partnership with HealthEquity and Washington State Rx Services.

UMP CDHP is a high-deductible health plan that meets the requirements of Section 223 (c) (2) of the Internal Revenue Code. The health care coverage described in this *Certificate of Coverage* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

UMP CDHP 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 CDHP 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.

See "How Does a Health Savings Account Work?" below for online features available through HealthEquity.

What Is UMP CDHP?

UMP CDHP is a health plan that covers the same services as UMP Classic, including free preventive care (see pages 72–74). For a lower premium, you have a higher deductible for covered services other than those covered as preventive. However, you have only one combined deductible and your out-of-pocket limit includes your deductible and prescription drug costs, in addition to medical services.

A major feature of UMP CDHP is a Health Savings Account (HSA), which allows you to save money for qualified medical expenses. Unlike a flexible spending account (FSA), you don't have to spend all the money in your account each year; it rolls over into the next year. And if you use your HSA funds only to cover qualified medical expenses, you will realize tax savings.

How Does a Health Savings Account Work?

ALERT! If you enroll in a consumer-directed health plan with a Health Savings Account (HSA), you may not also have a flexible spending account (FSA). If you have both an HSA and an FSA, you may be subject to tax penalties.

The subscriber is the owner of the Health Savings Account (HSA). He or she gets the tax advantages associated with an HSA and pays any taxes or penalties that result if the HSA

does not comply with IRS rules. Within certain limits, you can contribute funds to the HSA. Money from the HSA can be used tax free on qualified medical expenses of the subscriber and his or her IRS dependents (able to be claimed as a tax dependent). See page 25 for details of how this works with UMP CDHP.

The trustee (manager) of your Health Savings Account, HealthEquity, features a member portal at **www.healthequity.com/pebb** through which you can:

- Check your Health Savings Account balance.
- View and pay a provider's claim that's already been processed by UMP CDHP.
- Make deposits directly from your bank account using electronic funds transfer.
- Manage your investments (for accounts with more than $2,000).
- Check your transaction history.
- Access forms to reimburse yourself for expenses you paid out of pocket.
- Research healthcare costs (based on national data).
- View and print monthly account statements.
- Access tutorials and demos on how to use your account.

Finding a Health Care Provider

How to Find a Preferred Provider

UMP CDHP 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 7).

To find a network pharmacy, see pages 85–87.

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 192–194).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by U.S. standards.
- 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, call the BlueCard Worldwide Service Center (see "Contact BlueCard Worldwide on page 10) 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 10). 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 122). 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 122). 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" above.

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 10 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.

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 87 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 deductible.
- You pay nothing for covered preventive care services and immunizations when you see a preferred provider. See "Preventive Care" on pages 72–74 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 on page 14).
- You still have to meet your deductible before the plan begins to pay. Any amount you pay above the allowed amount does not count toward your deductible or 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 181–182). 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 183).

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 CDHP members. These providers are designated in the online provider directory with $$.

Comparing Your Cost

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 18 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 183): 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.
- **Out-of-pocket limit:** Once you meet your out-of-pocket limit (see pages 23–25), 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 187) 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 within 30 miles of your residence to a preferred provider able to provide medically necessary services.

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 101 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 131 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.

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 any applicable deductible and coinsurance. 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 deductible or out-of-pocket limit. See the list of covered provider types at **www.hca.wa.gov/ump**. See page 44 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)	Adult Medicine
Doctor of Osteopathic Medicine (D.O.)	Family Practice
Naturopathic Physician (N.D.)	General Practice
Nurse Practitioner	Internal Medicine
Physician Assistant	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 CDHP is your primary insurance. For these examples, assume you have paid your deductible and haven't reached your 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 deductible or 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 Deductible

ALERT! Prescription drug costs do count toward your deductible. You pay the entire cost of your drugs, even those covered by the plan, until you have met your entire deductible. See "Products Covered Under the Preventive Care Benefit" on page 96 for exceptions.

A deductible is a fixed dollar amount you pay each calendar year before the plan begins paying most benefits. For this plan, the deductible for a single person on an account is $1,400; for more than one person on an account, $2,800; see "How Does the Deductible Work With More Than One Person?" on page 21. You pay your providers until you meet your deductible for the year, then the plan begins to pay benefits for your care. See below for services that are exempt from the deductible.

What Doesn't Count Toward My Deductible?

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

- Services you pay for that aren't covered by the plan (see pages 105–111 for some examples).
- Services that are exempt from the 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 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 deductible.
- Out-of-network provider charges that exceed the allowed amount (see table on page 18), including non-network pharmacies.

TIP: You can spend from your HSA for noncovered services as long as they are qualified medical expenses (see definition on page 202).

Which Services Are Exempt From the Deductible?

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

- Preventive care and immunizations as described on pages 72–74.
- Routine vision care: exams, glasses, and contacts (pages 80–81).
- Select contraceptive supplies and services (pages 56–58).
- Certain products available from network pharmacies (page 96).
- Diabetes Control Program (page 51) and Diabetes Prevention Program (page 51).
- Tobacco cessation services (page 77).

TIP: All services **not** listed above are subject to the deductible. This means that you must pay the first $1,400 or $2,800 of covered services before the plan begins to pay.

How Does the Deductible Work With More Than One Person?

- **If you cover only yourself,** your deductible is $1,400; you must pay this amount for covered services not exempt from the deductible (including covered drugs) before the plan begins to pay for your care.
- **If you cover yourself and at least one other person,** your deductible is $2,800. You must meet this amount of covered services for all covered persons combined before the plan pays for any services, including drugs (other than those exempt from the deductible).

ALERT! If you receive services with a benefit limit (such as spinal or extremity manipulation, massage therapy, or physical therapy) before meeting your 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 deductible, that visit will count toward the maximum of 16 visits per calendar year. See definition of "Limited Benefit" on page 190 for more information. **Note:** If a dependent has other primary coverage, visits paid by the primary plan also count toward UMP CDHP 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 deductible, you pay the following percentages for most medical services:

- **For preferred providers:** 15% of the allowed amount.
- **For participating providers:** 40% of the allowed amount; see table on page 18 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 183.

See pages 82–99 for how much you pay for prescription drugs.

How Do I Pay My Claims?

To ensure you pay the correct amount, it's best to pay after claims are processed by the plan. Your provider should bill the plan first. When the plan processes a claim, it applies any network provider discount, checks the benefits for the service, and confirms if you've met your deductible in order to calculate what you owe on the claim. Both you and your provider will receive an Explanation of Benefits (EOB) that provides the detail on what the plan pays and what amount, if any, is the member's responsibility. Your provider should then bill you the same amount that is shown in the "member responsibility" column on the EOB.

How to Use the Funds in Your Health Savings Account (HSA) to Pay

After a claim is processed, you may log into your HealthEquity health savings account (HSA) to view your claims. You may pay for qualified medical expenses (see definition on page 202) by:

- Using your HealthEquity debit card at the time of service.
- Logging in to your HSA and designating payment to be sent by HealthEquity directly to the provider. **Note:** You can make a partial payment using this method.
- Logging in to your HSA and paying yourself back for a medical expense you paid using non-HSA funds. For example, if you paid cash at the pharmacy for qualified purchases, you can reimburse yourself from your HSA.

Your Out-of-Pocket Limit

How Does It Work?

The out-of-pocket limit is the most you pay during a calendar year for covered services from preferred providers. After you meet your 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, 2016, or your first day of enrollment, whichever is later; and December 31, 2016, or your last day of enrollment, whichever is first.

How Much Is the Out-of-Pocket Limit?

Number of persons covered on the account	Out-of-pocket limit per calendar year
One person covered	$4,200
Two or more persons covered	$8,400 *An individual cannot exceed $6,850 in covered out-of-pocket expenses annually.*

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

What counts toward the out-of-pocket limit?	▪ Your coinsurance paid to preferred and participating providers (see page 18). ▪ Your deductible. ▪ Your out-of-pocket costs for covered prescription drugs and products.
What doesn't count toward the out-of-pocket limit? *See "Exceptions: Out-of-Network Provider Services That Count" on page 25.*	1. Amounts paid by the plan, including services covered in full (preventive). 2. Non-network pharmacy charges that exceed the allowed amount (see page 182). 3. Balance billed amounts (see definition of balance billing below). For exceptions, see "Exceptions: Out-of-Network Provider Services That Count" on page 25. 4. Services not covered by the plan; for examples, see pages 105–111. 5. 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 out-of-pocket limit. 6. 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 190 for more benefits with this type of limit.
What will I pay for after reaching my out-of-pocket limit?	You will still be responsible for paying numbers 2–6 above after you meet your out-of-pocket limit.

Balance billing is a provider billing you for the difference between the provider's charge and the allowed amount (see definition beginning on page 181). 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 18.

You Still Pay For Out-of-Network Provider Services

Services by out-of-network providers are not paid at 100% (see "Exceptions: Out-of-Network Provider Services That Count" below). Even after you meet your out-of-pocket limit, you will still pay 40% coinsurance for out-of-network provider services and the provider may still balance bill you (see definition on page 24). Balance billed amounts do not count toward your out-of-pocket limit.

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 out-of-pocket limit. In addition, the plan will pay 100% of billed charges for these services after you meet your out-of-pocket limit.

- Ambulance (see page 43).
- Dialysis (see page 53).
- Ocularists (creation and fitting of prosthetic eyes).

ALERT! Services by out-of-network providers are not paid at 100%; even after you reach your out-of-pocket limit, you will still pay 40% coinsurance and the provider may balance bill you (see definition on page 183).

Your Health Savings Account (HSA)

PEBB will deposit $700.08 for one person, and $1,400.04 for more than one person on an account, deposited in equal amounts over the calendar year. Employer contributions are made only during those months you are enrolled in UMP CDHP. You may also make deposits to your account. See page 28 for this year's contribution limits. Subscribers age 55 and older can contribute an additional $1,000 per year. The PEBB contributions count toward the limit, as does the SmartHealth incentive (see below).

You can use your HSA to pay for member cost-sharing and other qualified medical expenses as described in Internal Revenue Code 223(d) (2), including those not normally covered by the plan. You can use HSA funds to pay for expenses for your spouse or tax dependents, even if they are not covered by UMP CDHP. The federal Internal Revenue

Service determines which services are eligible for reimbursement through an HSA, and who can pay for services using HSA funds. For a list of items and services that you can pay for with your HSA funds, see **www.healthequity.com/pebb** or call 1-877-873-8823.

FOR MORE INFORMATION: See the HealthEquity website at **www.healthequity.com/pebb** or call 1-877-873-8823 for details on how to use your Health Savings Account.

If You Qualified for the SmartHealth Wellness Incentive

If you earned the 2016 SmartHealth $125 wellness incentive, it will be deposited in your HSA. This counts toward your maximum annual contribution; you may need to adjust your payroll contributions to ensure you don't exceed your maximum allowed contribution for the year.

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 192–194).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 181–206.

This Certificate of Coverage applies ***only*** *to dates of service between the day your coverage begins (but no earlier than January 1, 2016) and the day your coverage ends (no later than December 31, 2016).*

ALERT! If a dependent has coverage under another health plan, see pages 112–121.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Deductible	▪ $1,400 for one person on the account ▪ $2,800 for two or more persons on an account (family) ▪ If you qualified for the 2016 SmartHealth wellness incentive, PEBB will deposit $125 into your Health Savings Account.	▪ This deductible applies to all services, including prescription drugs, unless specifically stated the services are not subject to the deductible. ▪ For a family account, you must meet the entire $2,800 deductible. ▪ You pay toward this deductible before the plan pays for covered services. ▪ You don't have to pay the deductible for some services. ▪ Not all services count toward this deductible.	20–22
Out-of-pocket limit	▪ $4,200 for one person on the account ▪ $8,400 for two or more persons on an account (family)	▪ Your deductible and prescription drug costs count toward this limit. ▪ Not all services count toward this limit. ▪ No individual within a family can exceed $6,850 of covered out-of-pocket expenses.	23–25
Health Savings Account (HSA) *If the subscriber is age 55 or older, may contribute up to an additional $1,000.*	▪ Maximum annual contribution: ▪ Account with one person $3,350 ▪ Account with two or more persons: $6,750	▪ You may pay for any qualified medical expenses (see definition on page 202) from your HSA, including: ▪ Services that apply to your deductible. ▪ Services that are not covered by the plan, but are still qualified medical expenses	25

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
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 deductible. See the Summary of Benefits table on pages 31–40 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
Standard Subject to the deductible; see pages 20–22.	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 183). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. Indicated by $$ in the provider directory on **regence.com**.
Preventive Preventive services are not subject to the deductible (you don't have to pay your deductible before the plan pays).	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.

Type of Service	How Much You Pay
Inpatient Subject to the deductible; see pages 20–22. ▪ Facility charges and professional services (such as physicians and lab tests) are usually billed separately. See a specific benefit—for example, diagnostic tests—for how these related services are covered. ▪ 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 100 for a description of how this works. ♦ **Notification:** Your provider must notify the plan upon admission to a facility; see page 101 for a description of how this works.	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 18). ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. Indicated by $$ in the provider directory on **regence.com**. Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of "Inpatient Stay" on page 190. **A facility, such as a hospital, may be referred to as a "provider."*
Special Subject to the deductible; see page 20.	These services have unique payment rules, which are described in the "How much will I pay?" column on pages 31–40.

What else do I need to know?

- Some services aren't covered; see pages 105–111 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 13.
- 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 41–81 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 100 for how this works); see page 101 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 current list at **www.hca.wa.gov/ump** or call 1-888-849-3681.
- Services that aren't covered (exclusions; see pages 105–111).

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 29–30 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.	43, 105, 110	Covered only for a medical emergency (see definition on page 191).
Applied Behavior Analysis (ABA) Therapy	Standard	44	Specific preauthorization requirements; see page 44. Only specified providers are covered; see page 44.

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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Chemical Dependency Treatment			
Inpatient Services	Inpatient	46, 109	See page 46 for preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	46, 109	See page 46 for services that may require preauthorization.* May be subject to review for medical necessity.
Chiropractic Physician Services		75	See "Spinal and Extremity Manipulations" on page 38.
Contraceptive Services for Women	Preventive or Standard	56–58, 72	See page 57 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. No preferred dentists; providers may balance bill (see definition on page 183)	48, 106	See "Dental Services" on page 48 for limitations on covered 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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Diabetes Care Supplies	**Special:** Paid under the prescription drug benefit; see pages at right.	50, 118	See "How Are Diabetes Care Supplies Covered When UMP CDHP Pays Second?" on page 118 if another plan pays first.
Diabetes Control Program: NOT ME	Preventive	51	Only the NOT ME program is covered.
Diabetes Prevention Program: NOT ME	Preventive	51	Only the NOT ME program is covered.
Diagnostic Tests, Laboratory, and X-Rays	Standard	52, 69, 105, 108, 110	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses	Standard	53–55, 80, 86, 106, 109, 185	May require preauthorization.* Some breast pumps are covered as preventive; see "Services Covered as Preventive" on page 68.
Emergency Room (ER)	Standard	56, 191	Services determined not to be due to a medical emergency (page 191) are not covered in an emergency room setting.

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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
End-of-Life Counseling	▪ If received as part of hospice: Paid at 100% after meeting your deductible. ▪ If received outside of hospice services: Standard.	56	Total of 30 visits, all services combined.
Family Planning Services	Standard *Some contraceptive services are covered as preventive; see page 57.*	56–58, 107	Not covered: ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids	**Special:** Plan pays up to $800.	59	Limited to $800 plan payment per three calendar years.
Hearing Exams, Routine	Standard	59, 72	Newborn hearing screening is covered as preventive.
Home Health Care	Standard	61, 76, 107, 184, 189, 191	See page 61 for what is covered. Specific services are not covered; see exclusion 24 on page 107. Maintenance care (page 191) and custodial care (page 184) 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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Hospice Care (Includes respite care)	**Special:** Paid at 100% after meeting deductible.	61, 189, 204	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.
Hospital Services			
Inpatient Services	Inpatient	62, 67–70, 107	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	62	Some services require preauthorization.*
Immunizations (Vaccines)	Preventive (usually)	73, 107, 194	Covered under CDC recommendations; see page 73. Not covered for travel or employment.

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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mammograms (Diagnostic)	Standard	64	Must be billed as diagnostic by the provider.
Mammograms (Screening) *See "Breast Health Screening Tests" on page 45 for additional services covered.*	Preventive	45, 64	**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 64 for details. For women under age 40 and not at increased risk, see page 64. *See "Breast Health Screening Tests" on page 45 for additional services covered.*
Massage Therapy	Standard	65, 108	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Standard	53, 65	All inpatient services require plan notification.*

****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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Mental Health Treatment			
Inpatient Services	Inpatient	66, 109	See page 66 about preauthorization of inpatient services. Plan notification is required at the time of admission.*
Outpatient Services	Standard	66, 108, 109	See page 66 for services that require plan notification.*
Naturopathic Physician Services	Standard	17, 66, 97, 106	Herbs, vitamins, and other supplements are not covered. See "Exceptions Covered" on page 94 for exceptions.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) *Some breast pumps are covered as preventive; see* page 68.	67–70, 110	For non-routine services for a newborn, you may pay an additional deductible or separate coinsurance; see page 69. See page 68 for coverage of circumcision for males, which is not a preventive service.
Office Visits	Standard	70, 108	See pages 72–74 for routine exams covered as preventive.

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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard Inpatient services are usually charged separately from facility charges.	71, 108, 191	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription Drugs	15% after deductible is met.	82–99	See exclusions on pages 105–111, and other limits on pages 88–91.
Preventive Care Includes vaccines, routine exams, some screening tests	Preventive	64, 68, 72–74, 96, 200	Only certain services are covered as preventive; see pages 72–74. See page 68 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient *Some services may be billed separately (such as physical therapy).*	74, 108, 110, 204	Maintenance care (page 191) and custodial care (page 184) are not covered.
Spinal and Extremity Manipulations	Standard	75, 108	Limited to 10 visits 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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Surgery		49, 62, 65, 70, 75, 79, 107, 110, 182, 196, 202	Bariatric surgery: page 45. Transgender surgery: page 79.
Inpatient Services	Inpatient		Some services require preauthorization and/or plan notification.*
Outpatient Services	Standard		Some services require preauthorization.*
Telemedicine Services	Standard	76	
Tobacco Cessation Services	Preventive	77	See page 77 for coverage of drugs and nicotine replacement supplies. See page 78 for tobacco cessation services for members ages 17 and under.
Transgender Services	Standard	79	Some services require preauthorization and/or plan notification. See page 79 for covered services.
Urgent Care	Standard	80	
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	80, 105, 107, 108	

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 100–102 *for how this works.*

Benefit/Service	How much will I pay? (See pages 29–30 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Vision Exams, Routine	Preventive	80, 107, 108	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 deductible.	81	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 deductible. **Eyeglasses:** You pay $0 for one set of standard or deluxe frames and lenses per year. **Contact lenses:** You pay 15% of billed charges.	72–74	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 81 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits	Preventive	72–74	See pages 72–74.

****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 100–102 *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 192–194).

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, 2016) and the date your coverage ends (but no later than December 31, 2016); and
- Listed as covered; and
- Consistent with the plan's coverage policies and preauthorization requirements; and
- Medically necessary (see definition on pages 192–194).

Limits and exclusions may apply to plan benefits. See both the benefit description and "What the Plan Doesn't Cover" starting on page 105. Some services require preauthorization and/or plan notification prior to receiving treatment; see page 101 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.***

Health Technology Assessment (HTA) Program

ALERT! HTA Program decisions are usually implemented by UMP at the beginning of the next calendar year after the HTA Program decision is issued. If UMP implements an HTA Program 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 Health Technology Assessment (HTA) Program, which includes the work of 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 HTA Program at **www.hca.wa.gov/hta**.

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

ALERT! HTA Program 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 190.

Ambulance

TIP: You pay 20% for ambulance services, which must be medically necessary (see definition on pages 192–194). Out-of-network providers may balance bill you (see page 183 for how this works). For these services, balance billed amounts will count toward your 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 191).
- 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 191).
- Air or water ambulance is medically necessary (see definition on pages 192–194).
- 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 18 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 deductible or 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 71 under the "Physical, Speech, Occupational, or Neurodevelopmental Therapy" benefit; mental health coverage is found under "Mental Health Treatment" on page 66. 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.

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. You must use providers and facilities in the plan network.

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, the 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.

Breast Health Screening Tests

See also "Mammograms" on page 64 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 64.

See ***For women under age 40*** on page 64 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)

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 100 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 183).

Services are considered "inpatient" when you are admitted to a facility. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 191).

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 192–194.

Chiropractic Physician Services

See "Spinal and Extremity Manipulations" on page 75.

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. The plan pays 80% of the allowed amount, and the provider may balance bill you (see page 183).

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 94. 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 29–30. 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 183). ***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 CDHP during the entire course of treatment. The plan does not cover treatment after UMP coverage ends.

Example: You have an accident on March 12, 2016, resulting in injuries that are covered by the plan. Your treatment plan must be finalized no later than April 11, 2016. All related treatment must be completed by December 31, 2017 (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 CDHP.

Oral Surgery

TIP: See page 76 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 CDHP 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 CDHP is the primary payer (see definition on page 201) for a dependent, claims for diabetes care supplies may be paid differently. See page 118 for more information.

Diabetic supplies listed below are covered under your plan's prescription drug benefit (15% of the cost after you meet your deductible). To be covered, you must get a written prescription for these medications and supplies.

You avoid having to submit your own claims when you purchase these diabetic supplies from a Washington State Rx Services network pharmacy. To find a network pharmacy, check the Washington State Rx Services online pharmacy locator at **www.hca.wa.gov/ump** or call 1-888-361-1611.

The following diabetes care supplies are covered under the prescription drug benefit as described on pages 82–99:

- Glucometers
- Test strips
- Insulin syringes
- Lancets

Select nonpreferred diabetes care supplies may be available through preauthorization (see page 89).

Glucose monitors must be preauthorized and are covered only under the medical benefit (see page 191).

See page 55 for coverage of insulin pumps and related supplies.

Diabetes Control Program

TIP: The NOT ME Diabetes Control Program is exempt from the deductible and is free for UMP CDHP members ages 18 and older.

For members ages 18 and older with a diagnosis of diabetes (except Medicare enrollees), the plan covers 100% for the NOT ME Diabetes Control Program administered by the Diabetes Prevention and Control Alliance (DPCA). If you qualify for the NOT ME Diabetes Control Program, representatives may contact you to enroll in a series of quarterly consultations with a DCPA-contracted pharmacist trained to help you reduce the risk of complications by tracking and controlling blood sugar, cholesterol levels, blood pressure, and weight. Tests ordered by the DCPA-contracted pharmacists are also covered at 100% by the plan. The DCPA-contracted pharmacist may also offer advice on medications. All consultations are by appointment and private. Contact the NOT ME Diabetes Control Program at 1-800-650-2885.

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 67.

Diabetes Prevention Program

TIP: The NOT ME Diabetes Prevention Program is exempt from the deductible and is free for UMP CDHP members ages 18 and older.

For members ages 18 and older (except Medicare enrollees), the plan covers 100% for the NOT ME Diabetes Prevention Program (DPP) administered by the Diabetes Prevention and Control Alliance. NOT ME offers screening to determine if you meet program criteria that indicate you may be at high risk for or have prediabetes

If you meet the NOT ME program's screening criteria, you will be encouraged to participate in the program at no cost to you. NOT ME's DPP consists of 16 one-hour classes designed to reduce your risk of progressing from prediabetes to diabetes. NOT ME has proven effective in slowing or stopping the progression to diabetes.

The PEBB Program will schedule NOT ME screening events at sites around the state. You may also qualify for NOT ME classes if a blood sugar test ordered by your provider in the previous 12 months is in the prediabetes range. Contact the NOT ME Diabetes Prevention Program at 1-800-237-4942.

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 192–194. 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** 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 72 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 deductible and coinsurance), even if billed as preventive.
- Skin allergy testing.

FOR MORE INFORMATION: See page 64 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 183) will count toward your 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**, 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 101 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 65.)
- Breast pumps for pregnant and nursing women (see page 68).

- 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" below).
- Insulin pumps and related pump supplies (see "Insulin Pumps and Related Pump Supplies" on page 55).
- 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**. 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 the *Provider Search* link; you must enter a ZIP Code upon entering the site.

Gives you the following options to fill in:

- Name (if you have one, optional)
- Location (will default to the ZIP you entered before if you don't enter something here)
- Specialty:

Under "Specialty," begin typing "durable medical"; will display a drop down list. Select "Durable Medical Equipment & Supplies Supplier" from the list.

- Click "Search"

On the left side, under "Refine Your Results":

- Under "Network," click "More Networks," then select Uniform Medical Plan.

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 191), see "Urgent Care" on page 80 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.

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, the provider's network status, payment rules, and services provided.

If your emergency room visit is not the result of a medical emergency (see definition on page 191), the plan may not pay for emergency services.

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 183).

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 deductible. Outside of hospice, these services are paid as a medical benefit (see page 191), subject to the 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 your deductible 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 191).

Education and counseling related to contraception are covered as preventive (see page 72).

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 122–126). 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 58).

Contraceptive Drugs

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

Hormonal contraceptives 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 deductible and coinsurance as described on page 83.

Generally, only generic drugs are covered as preventive, which are indicated on the *UMP Preferred Drug List* posted on **www.hca.wa.gov/ump**, 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 89). Otherwise, they are covered subject to the deductible and coinsurance.

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 15% coinsurance.

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 89 for how to request an exception.

Barrier Devices

Barrier devices requiring a prescription or fitting: This includes intrauterine devices (IUDs), diaphragms, and cervical caps (see coverage of female condoms on page 58). All barrier devices 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. At time of publication, the only over-the-counter contraceptives that meet these requirements are the FC Female Condom and the Reality Female Condom. If additional products are later registered with and approved by the FDA, UMP CDHP will cover them as preventive.

For the plan to cover FDA-registered over-the-counter contraceptives, you must present a prescription from a covered provider type (see page 17) 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

Sterilization procedures, such as tubal ligation or vasectomy, are covered. However, only sterilization procedures for women are covered as preventive; male procedures are covered under the medical benefit (page 191).

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. Maintenance foot care provided outside approved medical criteria is not medically necessary, and is not covered. See page 54 for coverage of orthotics for the prevention of diabetes complications.

Genetic Services

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

Hearing Exams (Routine)

ALERT! The plan pays for a hearing exam performed as part of a newborn screening as preventive (not subject to the deductible and paid at 100% for preferred providers).

One routine hearing exam is covered per calendar year and is subject to the deductible. When you see a preferred provider, these services are paid at 85% 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

Hearing aids and related items are subject to the deductible.

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.

Hearing Aids and Your Deductible

If you purchase a hearing aid before you meet your deductible:

- You may pay the entire cost of the hearing aid and related items (as long as they are qualified medical expenses; see page 202) out of your HSA. However, only up to the $800 limit will apply toward your deductible and out-of-pocket limit.
- You or the provider must submit a claim to UMP CDHP, even if you are paying the entire cost out of pocket. The plan must have a claim to count the amount paid (up to the $800 limit) toward your deductible and out-of-pocket limit.
- Even if you pay the entire cost of the hearing aid, you have used your hearing aid benefit for the next three years. The plan will not cover another hearing aid for you for three years. Call 1-888-849-3681 to ask when your benefit will renew.

Home Health Care

ALERT! See exclusion 24 on page 107 for services not covered by the plan.

UMP CDHP 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 56).

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)

Services received from preferred providers are covered at 100% of the allowed amount after you meet your deductible. The plan covers hospice care for terminally ill enrollees for up to six months. See page 56 for coverage of end-of-life counseling.

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 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 100–102 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 192–194). Some services require preauthorization; see page 101 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 100). The plan pays these services according to the network status of the providers (including the hospital), unless your condition is a medical emergency (see page 191). All covered professional services are paid based on the allowed amount.

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. Some services require preauthorization; see page 101 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 183). For examples of how much you pay, see "Comparing Payments to Preferred, Participating, and Out-of-Network Providers" on page 18.

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**, at **regence.com**, or call Customer Service at 1-888-849-3681.

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.

Mammograms

ALERT! See "Breast Health Screenings" on page 45 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 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 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 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 45 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 deductible, those visits count toward the 16-visit limit. See the definition of "Limited Benefit" on page 190. 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**, at **regence.com**, or call Customer Service at 1-888-849-3681.

Mastectomy and Breast Reconstruction

ALERT! See page 79 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 17) 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.

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 100 for details. Contact UMP Customer Service at 1-888-849-3681 about preauthorization requirements. See the bullets above for services that require plan notification.

The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 191). All covered professional services are paid based on the allowed amount.

Outpatient

ALERT! See page 44 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 above for services requiring plan notification.

Naturopathic Physician Services

Naturopaths may recommend services that the plan doesn't cover; all services must be medically necessary (see definition on pages 192–194) to be covered. You will pay all costs for noncovered services.

The plan does not cover herbal, homeopathic, or other dietary supplements (including vitamins and minerals, except as described on page 94), even if prescribed by a covered provider type.

Nutrition Counseling and Therapy

TIP: See "Diabetic Education" on page 51 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 51), "Diabetes Control Program" (page 51) and "Diabetes Prevention Program" (page 51).

Obstetric and Newborn Care

Services for pregnancy and its complications are covered. See "Covered Provider Types" on page 17 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 68.

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

- Any remaining deductible for the mother.
- Coinsurance for facility charges and professional services for the mother while hospitalized.
- The deductible for the newborn; however, if only preventive care services (see pages 72–74) are billed for the newborn, you will not pay the newborn's deductible or coinsurance when you see a preferred provider.

For non-routine hospitalization of the newborn, you will also pay coinsurance for facility and professional services for the newborn.

Circumcision is covered as a medical benefit for males only (subject to the deductible and coinsurance). As this is not a preventive service, you will pay the newborn's deductible and coinsurance for this service.

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 69 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 191) 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 192–194).
- 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 medical 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 deductible or coinsurance when you see a preferred provider):

- Screening for gestational diabetes during pregnancy.
- Purchase or rental of manual and electric breast pumps for pregnant and nursing women, plus supplies at the time of 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 96.

See pages 72–74 for more prenatal, newborn, and well-baby services that are covered as preventive. See page 94 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 must 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.

How Does the Deductible Work When You Add a Dependent?

When Only One Person Is Enrolled in UMP CDHP

If you are the only member enrolled in UMP CDHP and a new member enrolls under your account during the plan year:

- You will have to satisfy an additional $1,400 deductible when the new member enrolls.
- You must meet the entire deductible ($2,800) even if the new member enrolls later in the year.

Even if you have already met your $1,400 deductible before the new member enrolls, you will need to meet the additional $1,400 deductible before UMP CDHP begins paying for services.

Once a new member enrolls, PEBB will contribute to your HSA on his or her behalf. These contributions are equal monthly amounts, up to a maximum of $700 per year for those enrolled in UMP CDHP for the entire 12 months.

When More Than One Person Is Enrolled in UMP CDHP

For two or more members enrolled in UMP CDHP:

- The maximum deductible is $2,800.
- The maximum PEBB contribution to your HSA is $1,400.

ALERT! You may be eligible to change plans when a newly eligible member enrolls. See page 151 or page 169 for details.

Office Visits

The plan pays for office visits for covered conditions under the medical benefit (see page 191). Preventive care visits to preferred providers as described under "Preventive Care" beginning on page 72 are covered in full and are not subject to the deductible.

Orthognathic Surgery

Orthognathic surgery (see definition on page 196) 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 76 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 17), 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 190).

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 190).

For the purposes of this benefit, developmental delay (see definition on page 185) 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 82.

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 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 may be covered under the medical benefit and subject to the deductible and coinsurance.

You don't have to meet your 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 181–182), 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 15 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 73 for examples).
- Certain radiology and lab tests such as screening mammograms (see page 64).
- Screening procedures such as colonoscopy; see page 52 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 73.
- 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 94 for coverage. See page 48 for coverage of fluoride varnish.
- Certain screening tests performed during pregnancy; see pages 67–70 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 56–58, "Mammograms" on page 64, and "Obstetric and Newborn Care" on page 67.

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 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 191).

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 the deductible. Immunizations given by the providers listed under "Where Can I Get Immunizations?" on page 74 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 194); check the UMP website 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

The plan covers second opinions under the medical benefit (subject to the deductible and coinsurance).

Skilled Nursing Facility

Services must be preauthorized by the plan before you are admitted to a skilled nursing facility; see page 100. In addition, the facility must notify the plan within 24 hours of your admission; see page 101.

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 CDHP 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 192–194).

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

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 deductible also count toward your 10-visit limit (see "Limited Benefit" on page 190).

Spinal Injections

Some spinal injections must be preauthorized by the plan (see page 100 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 67 on page 110 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 18 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 100. In addition, your provider must notify the plan (see page 101) when you receive certain services, including admission as an inpatient. See the list of services that require preauthorization at **www.hca.wa.gov/ump**. Call Customer Service at 1-888-849-3681 if you have questions.

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 telemedicine for audio and video communication between the distant site physician, patient, and consulting practitioner under the medical benefit (see page 191). The originating site (where the patient is) must be a rural health professional shortage area as defined by the Centers for Medicaid & Medicare Services (CMS).

The following are not covered by the plan:

- Email or facsimile transmissions between doctor and patient.
- "Store and forward" technology (transmission of medical information reviewed at a later time by physician or practitioner at distant site).
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.

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 85–87 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 Limitation column) are not subject to the 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 Limitation column.

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 deductible and 15% coinsurance. To request full coverage of non-preventive nicotine replacement therapy for a medical reason, see "How to Request an Exception" on page 78

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 Limitation 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 deductible and 15% 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 29–30).when you see a preferred provider.

Phone or online counseling is covered only through the *Quit for Life* program described below. UMP CDHP 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 89 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 CDHP 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 CDHP 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 Limitation 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/pebb** 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 CDHP member receives an organ from a live donor, UMP CDHP 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 56 for care during a medical emergency (definition on page 191).

If you need immediate care or when your usual provider is closed, and your situation is not a medical emergency (see definition on page 191), you may use Urgent Care facilities to receive care at a lower cost than an emergency room. These services are paid at the Standard rate as described in the table on pages 29–30, according to the provider's network status.

See Find a Provider at **www.hca.wa.gov/ump** 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 53–55). These services are subject to the 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)

The plan covers one routine eye exam for each enrollee per calendar year, which is exempt from the 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 29).

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).

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 deductible. This $150 limit is renewed on January 1 of even years (2014, 2016, 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)" on page 80 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 122 for instructions.

Children Ages 18 and Under

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

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

- **Eyeglasses:** The plan pays 100% of billed charges 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 billed charges, 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 CDHP as your secondary coverage, any charges paid by your primary plan will also count against your UMP CDHP vision hardware limit.

Your Prescription Drug Benefit

See page 98 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 CDHP. 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**. 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.
- If the drug must be preauthorized (see "Preauthorizing Drugs" on page 89).
- If the drug must be purchased from the plan's specialty pharmacy (see page 90).

- If there are any limits on a drug's coverage (see pages 88–91 under "Limits on Your Prescription Drug Coverage").
- If there are less expensive alternatives.

The *UMP Preferred Drug List* is updated online at least monthly. You can look up your prescription drugs online at **www.hca.wa.gov/ump** 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 nonpreferred. 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 CDHP 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 coverage level (preferred or nonpreferred).

How Much Will I Pay for Prescription Drugs?

Until you meet your deductible (see page 20), you will pay the entire cost of your prescription drugs. Once you have met your deductible for the year, you pay 15% of the drug's cost for covered prescription drugs. You can get up to a 90-day supply for most drugs (except for specialty drugs; see page 90). For drugs covered as preventive (see page 96), you don't pay the deductible or coinsurance when you use a network pharmacy.

If a prescription drug isn't covered by the plan, it does not count toward either your deductible or your out-of-pocket limit.

Note: You may use your Health Savings Account (HSA) to pay for many drugs not covered by the plan; see "Your Health Savings Account" on page 25 for more information.

ALERT! When you use network pharmacies, retail or mail-order, you pay based on the drug's allowed amount, a discounted price negotiated for the plan. If you use a non-network pharmacy of any type, the pharmacy may charge more than the allowed amount; you will have to pay this amount, which doesn't count toward your deductible or out-of-pocket limit and is not payable by the plan. **NOTE:** Prescriptions ordered through foreign mail-order pharmacies are not covered, even if you send in a claim.

If a Dependent Has Other Medical Coverage

If a dependent has primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on pages 88–91 will apply when UMP CDHP pays secondary to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 125 for how to submit a prescription drug claim.

Using Network Pharmacies When UMP CDHP Is Secondary

If a dependent has 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 CDHP Is Secondary

If a dependent's primary plan uses PPS, 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 the primary plan uses a different mail-order pharmacy, the member must use the primary plan's mail order, then submit a paper claim for payment by UMP CDHP; see "Submitting a Claim for Prescription Drugs" beginning on page 125 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 182) will count toward your deductible or out-of-pocket limit.

Retail 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. To see if your pharmacy is in the network, check the online pharmacy locator at **www.hca.wa.gov/ump** or call 1-888-361-1611.

When you get your prescriptions at a network pharmacy, the pharmacy sends the claim to the plan for you, and you pay only what you owe. Before meeting your deductible, this will be the allowed amount for a covered drug. After you have met your deductible, you will pay 15% of a covered drug's allowed amount. **Note:** You will pay the entire cost for any drug not covered by the plan, which will not apply toward either your deductible or your out-of-pocket limit.

Mail-Order Pharmacy

ALERT! PPS cannot ship outside of the United States. See "Travel Overrides for Prescription Drugs" on page 93 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.

Refills can be ordered through your online pharmacy account at **www.hca.wa.gov/ump**, 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 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 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.

Faxing Prescriptions to the Network Mail-Order Pharmacy

Fax number for PPS (providers only): 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.

Remember, ***only*** a provider can fax in a prescription. Not following these instructions may cause a delay in filling your prescription.

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 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 125).
- You don't get the plan discount.
- You'll pay the difference between the allowed amount (see page 182) and what the pharmacy charges, and it won't count toward your deductible or out-of-pocket limit.
- 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 90).

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 125.

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 125. 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 for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- A nonprescription alternative (see definition on page 195), including an over-the-counter alternative (see definition on page 197) 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 82).
- The Washington State Health Technology Clinical Committee (see page 42) 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.

Programs Limiting Drug Coverage

The limits and restrictions described from "Limits on Your Prescription Drug Coverage" on page 88 through "Refill Too Soon" on page 93 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, 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**. Some 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 Customer Service at 1-888-849-3681 for more information.

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 93 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**, or by calling Washington State Rx Services.

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 52 on page 109.

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.

Step Therapy

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,** 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 188), 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*** 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** 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 applicable cost-share for the nonpreferred brand-name drug.

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 for the nonpreferred brand-name drug.

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 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, 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, or if a network pharmacy tells you that coverage is denied, quantities are limited, or the prescription is otherwise

not covered in full, you have the right to submit an appeal. (See instructions for appealing on pages 134–137.)

If your provider thinks that you need the medication immediately, he or she may request an expedited review. This means that the decision whether to cover the medication will be made within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense. You will receive a written notice from Washington State Rx Services of the decision. We will reimburse you only if Washington State Rx Services approves coverage of the drug.

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 82) and has been placed on the *UMP Preferred Drug List*.
- 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 195), 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 50 for more information).
- Select contraceptive devices and drugs (see pages 56–58).
- Low-dose aspirin for pregnant women; see page 69 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 204) as supported by clinical evidence;
- In most relevant peer-reviewed medical literature (defined on page 198), 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 CDHP 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 72–74, 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 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 56–58 for details. See "Tobacco Cessation Services" on page 77 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 and cure 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 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:

- 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 195), except for the drugs specified under "Guidelines for Drugs Covered" on page 94. **Note:** Prescription drugs with a nonprescription alternative (see definition on page 195), 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 89 for details.
- Drug costs covered by other insurance including Medicare Part B (see page 119 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 (see page 86) *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 90)	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

Prescription Drug Contacts

Submit paper claims Find claim forms at **www.hca.wa.gov/ump** See instructions on pages 125–126	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
Online services • Find a network 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, whether subject to TIP.	**www.hca.wa.gov/ump**

Limits on Plan Coverage

Preauthorizing Medical Services

ALERT! This section does not apply to prescription drugs. See page 89 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 192–194).*** If you receive a service listed as an exclusion in the "What the Plan Doesn't Cover" section on pages 105–111, 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 44) and bariatric surgery (page 45)—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 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 105–111).

ALERT! For how to appeal denial of a preauthorization request before receiving services see pages 132–137.

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**. Type "preauthorize" in the Search box and click. From the list that comes up, select "Medical 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** 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**. 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**, 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 out-of-pocket limit (see pages 23–25). 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 CDHP 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. 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.
6. Computed Tomographic Colonography for routine colorectal cancer screening.
7. Corneal Refractive Therapy (CRT), also called Orthokeratology.
8. 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.
9. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.

10. Custodial care (see definition on page 184).
11. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 48–50.
12. 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 98 for exceptions that are covered by the plan).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see exceptions on page 94).
13. Dietary programs.
14. Drugs or medicines not covered by the plan as described in the "Your Prescription Drug Benefit" section, pages 82–99.
15. Drugs or medicines obtained through foreign (non-United States) mail-order pharmacies.
16. Educational programs, except as described under:
    - "Diabetes Control Program" on page 51.
    - "Diabetes Education" on page 51.
    - "Diabetes Prevention Program" on page 51.
    - "Tobacco Cessation Services" on page 77.
17. Email consultations or e-visits.
18. 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
19. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.

20. Experimental or investigational services, supplies, or drugs.
21. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
22. Foot care not related to a medical condition: Cutting of toenails; treatment for diagnosed corns and calluses; or any other maintenance-related foot care.
23. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome.
24. Home health care, except as described on page 61. 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 61 or not specifically listed as covered in this *Certificate of Coverage*.
25. 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 192–194).
    - Personal or convenience items.
26. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
27. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
28. Implantable drug delivery systems (infusion pumps or IDDS) for chronic non-cancer pain.
29. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
30. Incarceration: Services and supplies provided while confined in a prison or jail.
31. 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.
32. Late fees, finance charges, or collections charges.

33. Learning disabilities treatment after diagnosis, except as covered under the following benefits:
    - "Applied Behavior Analysis (ABA) Therapy" on page 44.
    - "Physical, Occupational, Speech, and Neurodevelopmental Therapy" on page 71; or
    - When part of treating a mental health disorder as described on page 66.
34. Magnetic Resonance Imaging—Upright MRIs (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
35. Maintenance care (see definition on page 191).
36. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 75.
37. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental, or personality disorder.
38. Massage therapy services when the massage therapist is not a preferred provider.
39. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage.
40. Missed appointment charges.
41. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 17).
42. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
43. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications, except as specified on page 54.
44. Out-of-network provider charges that are above the allowed amount.
45. Over-the-counter contraceptive supplies intended for use by males.
46. Postage and handling related to medical services and supplies.
47. Prescription drug charges over the allowed amount, regardless of where purchased.
48. 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.
49. 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.

50. Recreation therapy.
51. Replacement of lost, stolen, or damaged durable medical equipment.
52. Replacement of medications that are any of the following:
    - Confiscated or seized by Customs or other authorities
    - Contaminated
    - Damaged
    - Lost or stolen
    - Ruined
53. 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.
54. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).
55. 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.
56. Separate charges for records or reports.
57. Service animals: Any expenses related to a service animal.
58. 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 121 for more about how this works.
59. Services delivered by providers delivering services outside the scope of their licenses.
60. 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.
61. Services performed during a noncovered service.

62. 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.
63. Services, supplies, or drugs related to occupational injury or illness (see definition on page 196).
64. 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.
65. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.
66. Spinal cord stimulator for chronic neuropathic pain.
67. Spinal injections, therapeutic (except as described under "Spinal Injections" on page 75) of the following types:
    - Medial branch nerve block
    - Intradiscal
    - Facet neurotomy
68. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
69. Telephone consultations, except as described under "Telemedicine Services" on page 76.
70. TENS (Transcutaneous Electrical Nerve Stimulation) Units.
71. Travel, transportation, and lodging expenses, other than ambulance services covered by the plan as described on page 43.
72. Ultrasounds during pregnancy, except as described on page 69.
73. 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 51), "Nutrition Counseling and Therapy" (see page 67), or "Preventive Care" on page 72.
    - **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..

74. 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

When UMP CDHP Pays First (Primary)

If you have UMP CDHP as your primary payer (see definition on page 201), UMP CDHP pays the normal benefit as described elsewhere in this book. If you have other secondary coverage and have questions about how that plan coordinates benefits, you should contact that plan. If you are unsure about which plan is primary, contact UMP Customer Service at 1-888-849-3681.

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

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

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

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 114 through page 116 determine which plan pays first ("primary payer") and which pays second ("secondary payer"). See pages 116–118 for a description of how UMP CDHP 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** • Select *Forms* under *Fast Find* to download form to mail or fax in	Go to **www.hca.wa.gov/ump** • Select *Forms* under *Fast Find* to download form to mail or fax in Or submit through your pharmacy account at **www.hca.wa.gov/ump**
Fax	1-877-357-3418	503-412-4058
Mail	Regence BlueShield Attn: UMP Claims PO Box 91015 MS BU385 Seattle, WA 98111-9115	Washington State Rx Services PO Box 40168 Portland, OR 97240-0168

Each person claiming payment for benefits under UMP CDHP 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 CDHP 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 you 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 CDHP 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.

How Does UMP CDHP Coordinate Benefits When It Pays Second?

UMP CDHP uses a type of coordination of benefits called **nonduplication of benefits** (see examples on page 117). When UMP CDHP 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 CDHP 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 CDHP plan. The nonduplication of benefits type of coordination is not designed to pay your covered expenses in full.

How Much Will I Pay When UMP CDHP Pays Second?

When you see providers preferred under UMP CDHP (see definition on page 13), you will owe only the balance of the UMP CDHP allowed amount after your primary plan and UMP CDHP 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 18 for examples.

Examples

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

	Preferred Provider Charge	UMP CDHP Allowed Amount	UMP CDHP Normal Benefit	Other Plan Pays	UMP CDHP Pays	You Pay Your Provider
UMP CDHP Is Primary, Other Plan Is Secondary						
EXAMPLE 1: When UMP CDHP pays first (or is the only plan)	$200	$100	$85 (85% of $100)	N/A	$85	$15
UMP CDHP Is Secondary, Other Plan Is Primary						
EXAMPLE 2: The other plan pays less than the normal UMP CDHP benefit	$200	$100	$85	$80	$5	$15
EXAMPLE 3: The other plan pays as much (or more than) the normal UMP CDHP 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 CDHP 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 122–126 for how to submit claims.

How Are Diabetes Care Supplies Covered When UMP CDHP Pays Second?

When UMP CDHP Is Secondary to a Plan Other Than Medicare

UMP CDHP covers diabetes care supplies only 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 CDHP. 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 125–126 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 125–126 for instructions.

Note: Nonduplication of benefits applies to these claims (see "How Does UMP CDHP Coordinate Benefits When It Pays Second?" on page 116), which means that UMP CDHP may pay nothing after your primary plan pays.

See also "Diabetes Care Supplies" on page 50 for more about this benefit.

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

When UMP CDHP Is Secondary to Medicare

ALERT! When Medicare pays after UMP CDHP, your provider must bill Medicare after UMP pays; UMP does not bill Medicare.

If Medicare is primary and UMP CDHP is secondary, Medicare pays for some diabetes care supplies under the Part B medical benefit. As a result, UMP CDHP pays these claims under the durable medical benefit (not the prescription drug benefit) according to standard coordination of benefits rules (not nonduplication of benefits). See "What Happens When Medicare Pays First and UMP CDHP Pays Second?" on page 120 for more about when Medicare is primary to UMP CDHP.

How Does Coordination of Benefits Work With Prescription Drugs?

Some of the limits and restrictions to prescription drug coverage listed on pages 88–91 will apply when UMP CDHP pays second ("secondary payer") to another plan. See "Submitting a Claim for Prescription Drugs" beginning on page 125 for how to submit your prescription drug claim.

Note: If UMP CDHP pays second ("secondary payer") to another plan other than Medicare, nonduplication of benefits applies (see "How Does UMP CDHP Coordinate Benefits When It Pays Second?" on page 116). This means that UMP CDHP may pay nothing after your primary plan pays.

Using Network Pharmacies When UMP CDHP 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 CDHP Is Secondary

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 CDHP. See "Submitting a Claim for Prescription Drugs" beginning on page 125 for how to do this.

Who Can Have Both UMP CDHP and Medicare?

You can be enrolled in both UMP CDHP and Medicare only if:

- You are not the subscriber; and
- The subscriber is an employee enrolled in UMP CDHP and you are their dependent or spouse.

Since the subscriber must be an employee, UMP CDHP is usually primary to Medicare. This means that UMP CDHP pays first, then Medicare pays second. In this case, UMP CDHP pays its normal benefit as described elsewhere in this book.

ALERT! When UMP CDHP pays first and Medicare pays second, you or your provider must submit a claim to Medicare after UMP CDHP pays (see pages 122–124). UMP CDHP does not bill Medicare.

What Happens When UMP CDHP Pays First and Medicare Pays Second?

Make sure that your provider agrees to bill both UMP CDHP and Medicare. The provider should submit claims to UMP CDHP first, then to Medicare after UMP CDHP has paid its share. Medicare doesn't usually accept claims from members; if a provider doesn't bill Medicare you may not receive reimbursement from Medicare. The provider would need to bill Medicare after UMP CDHP has processed the claim.

ALERT! UMP does not bill Medicare or in any way coordinate benefits with Medicare when Medicare is the secondary payer.

What Happens When Medicare Pays First and UMP CDHP Pays Second?

In a few cases, Medicare may be primary and UMP CDHP secondary. Examples are dependents who are domestic partners with Medicare primary due to age, or a dependent enrolled in Medicare due to disability (such as but not limited to end stage renal disease).

In such cases, standard coordination of benefits (not nonduplication of benefits) applies to UMP CDHP payments. If you have questions about how your claims will be paid, call Customer Service at 1-888-849-3681.

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

UMP CDHP does not pay claims for services, drugs, or items related to occupational injury or illness (see definition on page 196). 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 CDHP 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 claims as being not medically necessary, or beyond benefit limits, UMP CDHP will not cover future 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 CDHP will provide benefits related to the occupational injury or illness.

Billing & Payment: Filing a Claim

Submitting a Claim for Medical Services

When UMP CDHP 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 CDHP. 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 CDHP is secondary. (**See also:** Medicare retirees, see "Who Can Have Both UMP CDHP and Medicare?" on page 120). Dependents with other coverage, see pages 112–121.)

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** 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** 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 CDHP 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 21267
Seattle, WA 98111-3267

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 117 for how this works when you have other coverage that pays first.

For important information about submitting claims for services outside of the United States, see "Services Received Outside the U.S." on page 10. 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 112–121 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 156—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 96 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 CDHP 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 122). 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** 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 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; see page 83.
- 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 93).

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 CDHP 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 117.
- 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.
- 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 also determined to be medically necessary as described in this *Certificate of Coverage*, subject to the maximums, limits, exclusions, deductibles, and coinsurance.
  - 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.
- 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 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 41–81).
- Benefit exclusions, reductions, and maximums or limits (pages 105–111).
- Clear explanation of complaint and appeal procedures (pages 131–140).
- Preventive health care benefits that are covered (pages 72–74, page 96).
- Definition of terms (pages 181–206).
- Process for preauthorization, notification, or review (page 89 and pages 100–102).
- Policies regarding drug coverage and how the plan adds and removes drugs from the *UMP Preferred Drug List* (pages 83 and 94).

You can get the following information at **www.hca.wa.gov/ump** or by calling Customer Service:

- Directory of preferred providers, including both primary care providers and specialists.
- The Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms (UGT).
- Preferred Drug List.
- Claims history and deductible status.
- Information on the plan's care management programs.
- When the plan may retroactively deny coverage for preauthorized care.
- Notice of privacy practices (includes plan policy for protecting the confidentiality of health information; see "Confidentiality of Your Health Information" on page 130).
- 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.
- How you can be involved in decisions about benefits.
- 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.
- Documents and other materials referred to in the PEBB Program's open enrollment materials or this *Certificate of Coverage*.

You may also call Customer Service for an annual accounting of all payments made by the plan that have been counted against any 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 at **regence.com**.

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 CDHP. 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 134.

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 137).

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 140.

The Appeals Process

Internal Review

ALERT! If your appeal is for an urgent or life-threatening condition, see "Expedited Appeals" on page 136.

You, your treating provider, or an authorized representative (see "How to Designate an Authorized Representative" on page 133) 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**

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 137). 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 133), 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

There are two parts to the expedited appeals process: first-level appeal and independent review. 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. 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)

Expedited Appeals for Prescription Drugs

If your provider thinks that you need a medication immediately, he or she may request an expedited review. This means that 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 deductible if applicable). If Washington State Rx 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

Where to Send Complaints or Appeals

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 133) when we need an extension to the 30-day timeline, to get medical records or a second opinion.
- 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 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.
- 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 133) 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 CDHP 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 complete the internal review process as described on pages 132–137 (first- and second-level appeal, or expedited appeal) before pursuing litigation against UMP or the Health Care Authority. Following the internal review, you may pursue litigation after an independent review decision or instead of requesting an independent review. See "Independent Review" on page 138 for deadlines and how to submit a request.

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/pebb**.
- 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 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

Notice

This consumer-directed health plan (CDHP) is a qualified high-deductible health plan compatible with a Health Savings Account (HSA) under federal law. In addition to enrolling in a qualified high-deductible health plan, you must meet the eligibility requirements below to contribute funds to an HSA. If you enroll in UMP CDHP and are not eligible to have an HSA, you may be liable for tax penalties. UMP does not provide tax advice If you have questions about whether you are eligible to have an HSA, call HealthEquity at 1-877-873-8823, or consult with a financial or tax advisor.

Who Can Enroll in UMP CDHP With an HSA?

NOTE: The following rules apply to the PEBB subscriber, who is the person directly enrolled in the plan (UMP CDHP) and is an employee or retiree of the sponsoring agency, or other self-pay subscriber (for example, COBRA or LWOP). Some rules are different for spouses and dependents.

To enroll in UMP CDHP, you must enroll in an HSA. IRS rules state that to be eligible to enroll in an HSA, you must:

- Have a qualified, high-deductible health plan (also called a consumer-directed health plan).
- Have no other health coverage, with certain exceptions allowed by the IRS (for example, dental, vision, long-term care, and disability coverage are allowed).
- Not be enrolled in Medicare.*
- Not be enrolled in a flexible spending account (FSA). If you're currently enrolled in an FSA and want to enroll in UMP CDHP for 2015, you must spend all of your FSA dollars by December 31, 2014. These provisions also apply if your spouse has a "general purpose" FSA, even if you are not covering your spouse on your CDHP.
- Not be able to be claimed as a tax dependent on someone else's tax return.

- Not have received disqualifying services from Veterans' Administration benefits (including prescription drugs) or the Indian Health Service in the three months before your CDHP enrollment begins, or have TRICARE coverage.
- Have a "limited purpose" VEBA account (if you or your spouse has a VEBA health reimbursement account).

**An enrolled spouse or dependent of an employee may be enrolled in Medicare as their secondary plan. PEBB rules require subscribers and dependents enrolled in PEBB retiree insurance coverage to enroll in Medicare if eligible.If you or your dependent do not enroll in Medicare Part B when first eligible, you or your dependent may have to pay a premium penalty to enroll in Part B later.*

In addition, PEBB will not allow non-Medicare retiree or COBRA subscribers who have a family member enrolled in Medicare to select the CDHP/HSA. If you are a non-Medicare retiree or COBRA subscriber with a Medicare dependent enrolled on your account, you must:

- Choose a medical plan that is not a CDHP and keep your Medicare dependent enrolled in PEBB coverage. Your annual deductible and annual out-of-pocket limit will restart with your new plan.

  OR

- Disenroll that dependent from your PEBB coverage to enroll in a CDHP. Your disenrolled family member will not qualify for COBRA or other continuation coverage options through the PEBB Program.

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 140 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 employing agency 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. Registered domestic partner, defined to include the following:
    a. Effective January 1, 2010, a state-registered domestic partner; or
    b. A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the employee in a PEBB health plan or life insurance.
3. Children. Children are eligible up to the last day of the month in which their 26 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 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 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 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 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 verify the disability and dependency of children with disabilities periodically, but no more frequently than annually after the two-year period following the child's 26 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 a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
      - The parent maintains continuous enrollment in a PEBB medical plan;
      - 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 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 insurance. 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 employee may waive enrollment in a PEBB medical plan if he or she is enrolled in other employer-based group medical insurance, TRICARE, or Medicare. If an employee waives enrollment in a PEBB medical plan, 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 151.
- **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 151–153.

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 151) or during a special open enrollment (see "Special Open Enrollment" beginning on page 151). 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 are required to 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. 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 159;
- 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 will begin the first day of the month following the day the employee became eligible. If the employee becomes eligible on the first working day of the month, coverage will begin 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 date 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, medical plan coverage 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, medical coverage 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 beginning 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 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. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the appropriate 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 69.

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 to get 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 or an employee's dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility for the employer contribution toward employer-based group health insurance;
4. 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;
5. 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);

6. 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;
7. Employee or an employee's dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a CHIP;
8. 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;
9. 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);
10. 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 CDHP, 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 CDHP 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 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 or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for their employer contribution toward employer-based group medical insurance;
4. Employee or an employee's dependent has a change in enrollment under another employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;
5. 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;
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 CHIP, or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP;
8. 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.

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 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 or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for their employer contribution toward employer-based group health insurance;
4. 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;
5. 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;
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 an employee's dependent loses eligibility for coverage under Medicaid or a CHIP; or
8. 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 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

TIP: 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 a PEBB medical plan. The employee can again enroll in a PEBB medical plan during a special open enrollment or annual open enrollment. However, the employee must remain enrolled in PEBB dental, basic life and basic long-term disability insurance coverage.

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 Enrollment 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 for PEBB insurance coverage.
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 canceled due to lack of payment, the enrollee's eligibility to participate in PEBB medical coverage will end.

An enrollee who needs help getting 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 four possible continuation coverage options for PEBB health plan enrollees:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) Coverage
4. PEBB retiree insurance coverage

The first three 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 in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative in specific situations.

The fourth option above is only available to retiring employees and surviving dependents who meet eligibility and procedural requirements.

All four 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 a full premium was paid.

If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full 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 coverage to an individual conversion plan offered through Regence BlueShield to UMP CDHP 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. The 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 PEBB medical 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

FOR MORE INFORMATION: See the "Notice" section on page 145 for details on who may enroll in UMP CDHP.

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 140 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 140 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 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 appropriate 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 165.

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. Registered domestic partner, defined to include the following:
    a. Effective January 1, 2010, a state-registered domestic partner; or
    b. A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the subscriber in a PEBB health plan or life insurance.
3. Children. Children are eligible up to the last day of the month in which their 26 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 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 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 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 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 verify the disability and dependency of children with disabilities periodically, but no more frequently than annually after the two-year period following the child's 26 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 a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
      - The parent maintains continuous enrollment in a PEBB medical plan;
      - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
      - The subscriber continues enrollment in 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 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 of coverage ends. If a retiree defers enrollment in a PEBB medical plan, they also defer enrollment for all eligible dependents. Retiring employees and surviving dependents that do not enroll in a PEBB medical 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 medical 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 of coverage.
- Beginning January 1, 2001, retirees may defer enrollment in a PEBB medical 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 medical 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 medical 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 medical plan within the PEBB Program's required enrollment time limits. **Exception:** A retiree may defer enrollment in a PEBB medical 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 medical 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 of the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers; or
- The date of the employee's death; or
- The last day the surviving dependent was covered under a health plan through the emergency service worker's employer or COBRA through the emergency service employee's employer.

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 section below) or during a special open enrollment (see Special Open Enrollment section below). 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 the dependent no longer meets the eligibility criteria described under "Eligible Dependents" on pages 163–164 of this booklet. Consequences for not submitting the notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue medical plan coverage under one of the continuation coverage options described on page 174 of this booklet;

- The subscriber may be billed for services received 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 69.

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 of coverage ending, medical coverage begins on the first day of the month following the loss of employer-paid coverage, r COBRA coverage, or continuation of 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, medical 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, medical 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 CDHP 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 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 appropriate forms, information on premiums, and available medical plans.

Annual Open Enrollment

Subscribers may make a change to their enrollment during the PEBB 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 170 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. The 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 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 or the subscriber's dependent has a change in employment status that affects the subscriber's or the subscriber's dependent's eligibility for the employer contribution toward employer-based group health insurance;
4. 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;
5. 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 registered domestic partner is not an eligible dependent);
6. 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;
7. Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP;
8. 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;
9. 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);

10. 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 eight 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 may 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 a 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 or a subscriber's dependent has a change in employment status that affects the subscriber's or the subscriber's dependent's eligibility for their employer contribution toward employer-based group health insurance;

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 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.

PEBB rules do not require you to enroll in Medicare's prescription drug coverage, Medicare Part D. You cannot have both UMP CDHP and Medicare Part D. If you drop your UMP CDHP 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 CDHP 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 CDHP. 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 CDHP 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 174 of this *Certificate of Coverage*, 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 ends for the subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or a subscriber requests to cancel his or her medical coverage before the end of the 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 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" below 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," 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 CDHP for services you receive, the plan will deny all claims.

Options for Continuing PEBB Medical Coverage

Subscribers and their dependents covered by this medical 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 of Coverage Election Notice* booklet for specific details.
2. PEBB Extension of 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 Extension of Coverage is an alternative for PEBB enrollees who are not eligible for COBRA.

The third option above is only available to surviving dependents who meet eligibility requirements. Contact PEBB Customer Service at 1-800-200-1004 or refer to the *Continuation of Coverage Election Notice* booklet for details.

Conversion of Coverage

Enrollees have the right to switch from PEBB group coverage to an individual conversion plan offered by Regence BlueShield to UMP CDHP members when they are no longer able to continue PEBB group coverage, 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 coverage 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. The 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 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 PEBB medical plan by following the appeal provisions of the plan, except for 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/pebb**. 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 CDHP.

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 134–137 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 133 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 181). 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 18.

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 112–121.

Cost Share

Cost share means the amount you pay for a service, supply, or drug. This may be a deductible (pages 20–22), coinsurance (page 22), 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

The deductible is a dollar amount you must pay each calendar year for health care expenses before the plan starts paying for services. For one person on an account, the annual deductible is $1,400; if there is more than one person, the deductible is $2,800 and applies to all persons collectively. Only expenses covered by the plan count toward your

deductible. For example, if you receive LASIK surgery (see exclusion 21 on page 107), the plan does not apply this payment to your deductible. Some services are exempt from this deductible (see the "Summary of Benefits" on pages 27–40). See pages 20–22 for details on how the deductible works.

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 146–148 and pages 163–164).

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 18 on page 106 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."

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 92) 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, or drug that the plan has classified as investigational. 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, or drug to determine if it is 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 as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use 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 204) or, if not, then in a majority of relevant peer-reviewed medical literature (see definition on page 198); or by the United States Secretary of Health and Human Services.

- The scientific evidence must permit conclusions concerning the effect of the service, supply, 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, or drug must improve net health outcome.
- The scientific evidence must show that the service, supply, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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 136 for that process.

Explanation of Benefits (EOB)

An **Explanation of Benefits** (EOB) is a detailed account of each 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 181–182 for more details.

Formulary

See "What Drugs are Covered? The *UMP Preferred Drug List*" on page 82.

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 91 for how this works.)

Grievance

A **grievance** is also called a complaint; see page 131 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, UMP CDHP, 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.

Health Savings Account (HSA)

A **Health Savings Account** (HSA) is a tax-advantaged spending and savings account that can be used to pay for qualified medical expenses. IRS rules govern who can have an HSA and how the funds can be spent. The HSA is funded by pre-tax contributions from you, your employer, or both. See page 28 for the current year's contribution limits. You can save up to the limit even if your health plan deductible is lower. The rates are subject to change every year, adjusted for inflation.

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 184).
- Is operated as a school.
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

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 138).

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 192–194) or preauthorization of services (see page 100).

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 deductible (see pages 20–22) 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 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 deductible and coinsurance. See pages 20–26 for a description of how this works.

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 interventions, 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 (see page 42); these decisions may be referenced at **www.hca.wa.gov/hta**. 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.

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 CDHP members at the contracted rate (allowed amount). See pages 85–87 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** 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 105–111 and "Guidelines for Drugs Not Covered" on page 97 for details.

Nonduplication of Benefits

Nonduplication of benefits is how UMP CDHP coordinates benefits when UMP CDHP is your secondary coverage (see definition on page 203). When another plan (other than Medicare) is primary (pays first), that plan pays their normal benefit. UMP CDHP then pays up to the amount we would have paid if UMP CDHP had been the primary plan. If the primary plan pays as much or more than the normal UMP CDHP benefit, UMP CDHP pays nothing. UMP CDHP does not pay the rest of the allowed amount.

Example *(this is an example only, and may not apply to your specific situation).*

The calculations below assume that you have met any applicable deductible(s).

Plan	Allowed amount	Plan's normal benefit	Paid by plan
Plan A (primary)	$100	$85 (assumes Plan A pays 85% of the allowed amount)	$85
UMP CDHP (secondary)	$100	$85	$0
		You pay:	$15

Non-Network Pharmacy

A **non-network pharmacy** does not contract with Washington State Rx Services. See page 87 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 nonpreferred in the *UMP Preferred Drug List* (see page 82).

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

The **out-of-pocket limit** is the maximum total amount you pay to your providers for covered services and prescription drugs during a calendar year. The limit is $4,200 for one person on an account, or $8,400 if there is more than one person on an account. However, no individual may exceed $6,850 in covered out-of-pocket expenses annually. Once you have reached this limit, the plan pays 100% of the allowed amount for covered services from preferred providers for the rest of the calendar year. See pages 23–25 for what does and doesn't count toward this limit. **Note:** Your deductible (see page 20) does count toward this limit.

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 $$. 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 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 that reviews and determines how prescription drugs are covered (see page 83).

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 UMP Consumer-Directed Health Plan (UMP CDHP) with a Health Savings Account, a self-funded PPO plan offered by the PEBB Program. In the eligibility sections (pages 145–176), "plan" refers to any PEBB-sponsored plan. In the "If You Have Other Medical Coverage" section on pages 112–121, "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 CDHP 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 100 for how this works. A list of medical services that require preauthorization is available at **www.hca.wa.gov/ump** or by calling UMP Customer Service at 1-888-849-3681. See page 89 for information on drugs that must be preauthorized.

Preferred Drug

A **preferred drug** is a prescription drug that is designated as preferred on the *UMP Preferred Drug List*.

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, 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 88–91).

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 83 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.

Preventive Care

In this *Certificate of Coverage*, **preventive care** means only those services designated with an A or B rating by the United States Preventive Services Task Force (USPSTF), or immunizations as described on page 73, when received from a covered provider type. See pages 29–30 for how the plan pays for these services.

Primary Care Provider

A **primary care provider** is a physician (see "Physician Services" on page 199), nurse practitioner, or physician assistant who provides, coordinates, or helps a patient access a

range of health care services. See page 17 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.

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 181–182). Preferred providers for UMP CDHP members in 2016 consist of Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers in the BlueCard® program designated as preferred providers.

Qualified Medical Expense

A **qualified medical expense** is a cost payable through a Health Savings Account, without paying income tax or tax penalties. IRS publication 502 lists the specific types of services and supplies that qualify. You may also access a list at **www.healthequity.com/pebb**.

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 73).

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 112 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 2016 to eligible non-Medicare subscribers who met eligibility requirements. More details on eligibility and program requirements are at **www.hca.wa.gov/pebb.**

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 90 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 202), 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 92).

Tobacco Cessation Services

Tobacco cessation services are provided for the purpose of quitting tobacco use, usually cigarette smoking. UMP CDHP members under age 18 who use tobacco may participate in the online Smokefree Teen program. See page 77 for more information.

UMP Consumer-Directed Health Plan (UMP CDHP)

The **UMP Consumer-Directed Health Plan (UMP CDHP)** is a self-insured health plan offered through the Public Employees Benefits Board (PEBB) Program and managed by the Health Care Authority. It features a tax-advantaged Health Savings Account.