Uniform Medical Plan

2025 UMP Classic Medicare with Part D (PDP) (PEBB)

Certificate of Coverage

Self-insured by the State of Washington · Effective January 1, 2025

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

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Directory

Directory: medical services

Contact type and description	Contact information
UMP Customer Service **Contact UMP Customer Service for questions about your medical benefits, including information on behavioral health support services, the expert second opinion program, your care management benefit, and more.**	**Call:** 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Chat now:** Sign in to your Regence account at ump.regence.com/ump/signin to chat now Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Email:** Send secure email via your Regence account at ump.regence.com/ump/signin **Visit:** UMP website at ump.regence.com/pebb If you are outside the U.S. and you have questions about your benefits and coverage, you can use email, chat now, or Skype to contact UMP Customer Service. You may request to have a customer service representative contact you at a scheduled time during normal business hours. If you are outside the U.S. and need to find a local provider, make an appointment, or be hospitalized, call Blue Cross Blue Shield Global® Core at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, 7 days a week. You can also use the online provider search tool on the Blue Cross Blue Shield Global Core website at bcbsglobalcore.com.
Network provider directory	**Call:** 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Chat now:** Sign in to your Regence account at ump.regence.com/ump/signin to chat now Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Provider search:** ump.regence.com/go/pebb/UMP-Classic
Medical appeals and grievances (aka complaints)	**Call:** 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Chat now:** Sign in to your Regence account at ump.regence.com/ump/signin to chat now Monday–Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Fax:** 1-877-663-7526

	Online: Sign in to your secure Regence account at ump.regence.com/ump/signin. Go to Appeals to appeal online. **Email:** UMPmemberappeals@regence.com **Mail:** UMP Appeals and Grievances Regence BlueShield PO Box 1106 Lewiston, ID 83501-1106
Preauthorization **For providers submitting medical service preauthorization requests**	**Call:** 1-888-849-3682 (TRS: 711) Monday–Friday: 7 a.m. to 5 p.m. (Pacific) **Fax:** 1-844-679-7763 **Visit:** availity.com
Access to medical claims	**Visit:** Sign in to your Regence account at ump.regence.com/ump/signin
Claims **For members submitting medical service claims**	**Fax:** 1-877-357-3418 **Mail:** Regence BlueShield Attn: UMP Claims PO Box 1106 Lewiston, ID 83501-1106
Coordination of benefits **Contact UMP if you or your dependents have other insurance to make sure your claims are processed correctly. You may fax or mail the "Multiple Coverage Inquiry" form to UMP.**	**Call:** 1-888-849-3681 (TRS: 711) to request a form **Visit:** UMP commonly used forms available online webpage at ump.regence.com/pebb/forms/common-forms and under medical forms choose the "Multiple Coverage Inquiry" form **Fax:** 1-877-357-3418 **Mail:** Regence BlueShield Attn: UMP Claims PO Box 1106 Lewiston, ID 83501-1106
Medicare	**Call:** 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) 24 hours, 7 days a week **Visit:** medicare.gov or MyMedicare.gov
Eligibility, enrollment, and address changes	Call the PEBB Program: 1-800-200-1004 (TRS: 711) Monday–Friday: 8 a.m. to 4:30 p.m. (Pacific) **Visit:** hca.wa.gov/erb
Medical policies that affect coverage or care **Including preauthorization, Health Technology Clinical Committee (HTCC) information, clinical policies, and drugs covered under medical benefits**	**Visit:** Policies that affect your care webpage at ump.regence.com/pebb/benefits/policies

Directory: vision services

Contact type and description	Contact information
UMP vision benefits Get an overview of your vision benefit	**Visit:** UMP Vison benefits webpage at ump.regence.com/pebb/benefits/vision
Vision Service Plan (VSP) Member Services	**Call:** 1-844-299-3041 Monday – Saturday: 6 a.m. to 5 p.m. (Pacific). If you are outside of the U.S. dial the exit code of your country, which is typically 00, and then 1-916-635-7373. **Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY):** 1-800-428-4833 If you are outside of the U.S. dial the exit code of your country, which is typically 00, and then 1-916-851-1375. **Visit:** VSP website at vsp.com **Mail:** Vision Service Plan PO Box 997100 Sacramento, CA 95899-7100
VSP provider directory	**Provider search:** Create an account on the VSP website at vsp.com and log in to find a Choice Network provider. If you don't have an account, you can visit the VSP website at vsp.com/eye-doctor, use the Advanced search, and select "Choice" for the "Doctor network" to find a provider. **Call:** 1-844-299-3041 Monday – Saturday: 6 a.m. to 5 p.m. (Pacific) **Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY):** 1-800-428-4833
VSP appeals	**Call:** 1-844-299-3041 to submit an expedited appeal (will be processed within 24 hours) Monday – Saturday: 6 a.m. to 5 p.m. (Pacific) **Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY):** 1-800-428-4833 **Mail:** To appeal in writing with VSP, including expedited appeals: Vision Service Plan Attn: Appeals Department PO Box 2350 Rancho Cordova, CA 95741
VSP complaints	**Call:** 1-844-299-3041 Monday – Saturday: 6 a.m. to 5 p.m. (Pacific)

	Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY): 1-800-428-4833 **Visit:** VSP website at vsp.com/contact-us/grievance and complete the online form. **Mail:** Vision Service Plan Attention: Complaint and Grievance Unit PO Box 997100 Sacramento, CA 95899-7100
VSP Claims	**Call:** 1-844-299-3041 to request a VSP Member Reimbursement Form. Monday – Saturday: 6 a.m. to 5 p.m. (Pacific) **Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY):** 1-800-428-4833 to request a VSP Member Reimbursement Form. If you are outside of the U.S. and you need to submit a claim form for services received outside the U.S. dial the exit code of your country, which is typically 00, and then 1-916-851-1375. **Visit:** VSP website at vsp.com/claims/submit-oon-claim and select "Start new claim" to submit an out-of-network claim online **Mail:** Vision Service Plan Attention: Claims Services PO Box 495918 Cincinnati, OH 45249-5918

Table of Contents

Part One: Medical services

Online services

See the Directory pages at the beginning of this booklet for links and contact information.

Register for a Regence account and get personalized information such as:

- Access the certificate of coverage (this booklet) and the summary of benefits and coverage (SBC) for your plan, as well as the Glossary of Health Coverage and Medical Terms.
- Chat with customer service using the chat now feature.
- Download the Regence mobile application.
- Find providers in your plan's network.
- View or order your UMP member ID card.
- View your Explanations of Benefits (EOBs).
- View letters UMP sent you.

Visit the UMP website to:

- Access information on BlueCard® or Blue Cross Blue Shield Global® Core.
- Access resources and programs.
- Access the certificates of coverage (this booklet) and the summaries of benefits and coverage (SBCs) for all plans.
- Access UMP medical policies.
- Access wellness tools.
- Download or print documents and forms.
- Find providers in any plan network.
- Get cost estimates for treatment of common medical conditions.
- Learn about submitting medical claims.
- Review complaints and appeals procedures.

Visit the Policies that affect your care webpage to:

- View Regence medical policies.

Visit the UMP vision benefits webpage to:

- Find a link to the Vision Service Plan (VSP) website.
- Find information on your vision benefit.

How to use this certificate of coverage

For general topics, check the table of contents.

For an overview of the most common benefits, see the "Summary of benefits" section. The summary also shows:

- How much you will pay.
- The page numbers where you may learn more about a benefit.

To look up unfamiliar terms, see the "Definitions" section.

About UMP Classic Medicare with Part D (PDP)

Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) plan is a self-insured Preferred Provider Organization (PPO) health plan with Medicare Part D prescription drug coverage. This plan is offered through the Washington State Health Care Authority's (HCA's) Public Employees Benefits Board (PEBB) Program. The medical plan is administered by Regence BlueShield. Moda Health administers the Part D prescription drug benefits for ArrayRx. Medical benefit changes may require approval by the PEB Board. Prescription drug changes are governed by Centers for Medicare & Medicaid Services (CMS). Approval takes place when benefits are procured for the next calendar year.

This plan is available only to members who are no longer enrolled in active group coverage (retirees, survivors, PEBB COBRA, retired employees of a former employer group, and their eligible dependents) through the PEBB and SEBB Program, and who are enrolled in Medicare parts A and B. See the "Eligibility and enrollment" section for more information.

This plan is designed to keep you and your enrolled dependents healthy and provide benefits in case of injury or illness. Review this document carefully so you may get the most from your health care benefits.

Accumulators

Insurance accumulators may transfer when a subscriber changes their enrollment from one UMP plan to another UMP plan mid-year during a special open enrollment (SOE).

When a subscriber enrolled in active PEBB or SEBB Program UMP plan retires and changes their own enrollment to a PEBB UMP plan (meaning the subscriber continues to be the subscriber on the new PEBB UMP Plan during an SOE, the amounts already accrued toward deductibles, out-of-pocket limits, and benefit limits (see definition of "Limited benefit") will transfer to the new UMP plan. These accumulators will also transfer for any member on the subscriber's account who changes UMP plans with the subscriber.

When a subscriber enrolled in a retiree PEBB Program UMP plan changes their enrollment to an active PEBB Program UMP plan (meaning the subscriber continues to be the subscriber on the new PEBB Program UMP Plan) during an SOE, the amounts already accrued toward the medical deductible and the out-of-pocket limit and benefit limits (see definition of "Limited benefit") for themselves and their enrolled dependents will transfer to the new PEBB UMP plan.

When a subscriber enrolled in a retiree PEBB Program UMP plan changes their enrollment to an active SEBB Program UMP plan (meaning the subscriber continues to be the subscriber on the new SEBB Program UMP Plan) during an SOE, the amounts already accrued toward the medical deductibles and the out-of-pocket limits for themselves and their enrolled dependents will transfer to the new SEBB UMP plan.

If you have questions, contact UMP Customer Service.

Finding a health care provider

ALERT: When providers do not accept Medicare

When services are covered by Medicare, you must see providers who accept Medicare for the services to be covered by Medicare and UMP Classic Medicare with Part D plan. If your provider is not contracted with Medicare or has chosen to "opt out" of participating in Medicare, this plan will not cover services by that provider, even if the provider is in the Regence or Blue Card network (preferred).

As a UMP member, you may see preferred, participating, or out-of-network providers. The amount you pay for services depends on the network status of the provider. Seeing providers who accept Medicare and Regence preferred providers will save you money.

Visit the UMP provider search to find UMP providers. You can search for preferred or participating providers by signing in to your Regence account and selecting Find a Doctor. See the Directory pages at the beginning of this booklet for links and contact information.

If you use Find a Doctor by searching as a guest, you will only see preferred providers. You can confirm a provider's network status before your visit by using the provider search or contacting UMP Customer Service.

Preferred providers are in the Preferred Provider Organization (PPO) network that applies to this plan.

> **ALERT!** Some providers are preferred at one practice location but not another (example: urgent care clinics). Contact UMP Customer Service if you have any questions about the network status of a provider at a specific location.

- You pay 15 percent of the allowed amount after you meet your medical deductible. The plan pays 85 percent of the allowed amount.
- You pay $0 for covered preventive care services, including covered immunizations. The plan pays 100 percent of the allowed amount.
- The provider cannot bill you for charges above the allowed amount.
- If you see a provider who accepts Medicare, you will not have to file a claim.
- When you receive nonemergency services at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider. For nonemergency services performed at one of these facilities outside of Washington State, you still pay the network rate, but in some states, an out-of-network provider may be allowed to ask you to waive some of your balance billing protections.
- When you receive covered ground or air ambulance services in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider.

ALERT! Some services and supplies are not covered by the plan (see the "What the plan does not cover" section) or have benefit limits. If you receive services or supplies that are not covered by the plan or you exceed your benefit limit, you will pay for those services or supplies, even if you see preferred providers. Contact UMP Customer Service to find out if a service or supply is covered.

Participating providers contract with Regence BlueShield or another BlueCard® network as a participating provider.

- You pay 40 percent of the allowed amount after you meet your medical deductible. The plan pays most covered services at 60 percent of the allowed amount.

- You pay $0 for covered preventive care services, including covered immunizations. The plan pays 100 percent of the allowed amount.
- The provider cannot bill you for charges above the allowed amount.
- If you see a provider who accepts Medicare, you will not have to file a claim.

Out-of-network providers are not contracted with Regence BlueShield or another BlueCard® network.

- You pay 40 percent of the allowed amount after you meet your medical deductible. The plan pays most covered services at 60 percent of the allowed amount.

  Note: The provider may bill you for charges above the allowed amount, which is known as balance billing. You pay all charges billed to you above the allowed amount. Any balance billed amounts do not apply to your out-of-pocket limit.

  At an out-of-network facility, when you receive emergency services you pay the network cost-sharing amount regardless of the network status of the provider or facility, and cannot be balance billed.
- You pay 40 percent of the allowed amount for covered preventive care services, including covered preventive immunizations. You will pay all charges above the allowed amount (balance billing). The plan pays 60 percent of the allowed amount.
- You pay $0 for flu shots and COVID-19 vaccines.
- The plan pays 100 percent of the allowed amount for covered preventive childhood immunizations.
- The 40 percent coinsurance you pay to out-of-network providers will **not** apply to your medical out-of-pocket limit.
- Any amount you pay above the allowed amount does **not** apply to your medical deductible or medical out-of-pocket limit.
- You may have to pay all charges at the time of service and then fill-out and send a claim form to the plan for reimbursement.
- The provider may choose not to request preauthorization for services that require it. As a result, the plan may delay or deny payment.

Note: The plan may send payment for covered out-of-network services to you or the provider.

How to find a preferred provider

As a UMP member, you have access to Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers worldwide through the Blue Cross Blue Shield Global® Core program (see the "Services received outside the United States" section). This means your health coverage is with you wherever you are. Your access to care includes many 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 UMP provider search.
- Contact UMP Customer Service.
- Sign in to your Regence account, where you have access to more information about providers, as well as other tools.
- Use the Regence mobile application to find providers in your network.

- Call Blue Cross Blue Shield Global® Core Service Center at 1-800-810-2583 or call collect at 1-804-673-1177 to find providers outside the U.S. You can also use the online provider search tool on the Blue Cross Blue Shield Global Core website at **bcbsglobalcore.com**.

See the Directory pages at the beginning of this booklet for links and contact information.

Covered and noncovered provider types

Covered provider types

The plan pays the allowed amount for covered services only when performed by covered provider types within the scope of their license(s). When a facility charges facility fees, the plan pays the allowed amount if they are covered services and are within the scope of the facility's license. All preferred and participating providers are covered provider types.

See the list of covered provider types at the UMP website at
ump.regence.com/pebb/benefits/providers/covered-providers

Noncovered provider types

If you see a provider who is not a covered provider type, such as a Licensed Athletic Trainer, the plan will not pay for any of the services received, and you will pay for all charges. As with all noncovered services, any payments you make to a noncovered provider type will not apply to your medical deductible or medical out-of-pocket limit. If you have questions about noncovered providers contact UMP Customer Service.

Primary care providers

A **primary care provider (PCP)** is a physician, nurse practitioner, or physician assistant who provides, coordinates, and helps you access a range of health care services, such as covered immunizations. A PCP may also help coordinate care for you when you need to see specialists.

You are not required to choose a PCP. However, a PCP may help prevent and treat health care conditions early, promoting your health and well-being. Patients who have a PCP have better health outcomes and a better care experience. To be designated as a PCP, a provider must be one of the provider types and practice under one of the specialties listed below.

Provider type:

- Doctor of Osteopathic Medicine (D.O.)
- Medical Doctor (M.D.)
- Naturopathic Physician (N.D.)
- Nurse Practitioner (A.R.N.P.)
- Physician Assistant (P.A.)

Specialties:

- Adult Medicine
- Family Practice
- General Practice
- Geriatrics
- Internal Medicine
- Obstetrics and gynecology (OB/GYN)
- Pediatrics (for members under age 18)
- Preventive Medicine

When you do not have access to a preferred provider: network waiver

An approved network waiver allows the plan to pay for covered services provided by an out-of-network provider at the network rate. You may request a network waiver **only** when you do not have access to a

preferred provider able to provide covered medically necessary services within 30 miles of your residence. **A service or supply prescribed, ordered, recommended, approved, or given by a provider does not make it a medically necessary covered service or supply**.

When and how to request a network waiver

Before your visit

When services require preauthorization, you may request a network waiver before services are provided. Visit the UMP Policies that affect your care webpage for the list of services requiring preauthorization (see Directory for link). Your network waiver request should be included with the preauthorization request. See the "Information needed to submit a network waiver request" section below to learn what to include in your request.

When the plan approves the network waiver **before** you receive medical services from an out-of-network provider:

- You pay your cost-share for medical services the plan has approved through this waiver as though the provider is preferred.
- You pay $0 for covered preventive services, including covered immunizations. The plan pays 100 percent of the allowed amount.

After your visit

When you receive any service, except those that require preauthorization, you may request a network waiver **after** the claims have been processed.

Network waiver requests not approved in advance are considered an appeal and must be submitted within 180 days of receiving an Explanation of Benefits. See the "Complaint and appeal procedures" section for information about your appeal rights.

Information needed to submit a network waiver request

You should include all the following information in your request:

- A letter of explanation from you or your provider stating the need to see the out-of-network provider.
- Details of the research conducted by you or your provider to locate a preferred provider (e.g., dates network status was checked, names and phone numbers of preferred providers that were researched and may have been contacted before receiving services from the out-of-network provider).

More information needed for preauthorization requests

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

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

See the "Preauthorizing medical services" section for more information about requesting medical services preauthorization from the plan.

Where to send your network waiver request

UMP Member Appeals
Regence BlueShield
PO Box 1106
Lewiston, ID 83501-1106

If you have questions about the network waiver process, contact UMP Customer Service.

> **ALERT!** If a network waiver is approved, you must still pay your cost-share for most medical services. Services provided under an approved network waiver are subject to your medical deductible and out-of-pocket limit. Network waivers for ongoing services will require periodic review.

Out-of-area services

Regence BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access health care services outside of the geographic area Regence BlueShield services, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Regence BlueShield's service Area, you may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred provider are paid at the preferred provider level and will not bill you for balances beyond any deductible, copayment and/or coinsurance for covered services. Providers that contract with the Host Blue as a participating provider are paid at the participating provider level and will not bill you for balances beyond any deductible, copayment and/or coinsurance for covered services. Some providers (out of network providers) don't contract with the Host Blue. The section below explains how the Plan pays these different kinds of providers.

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 doing what was agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its preferred or participating providers.

When covered services are received outside the 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 considers 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 considering 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 of claims, as noted above. However, such adjustments will not affect the price Regence BlueShield uses for your claim because they will not be applied after a claim has already been 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.

Value-Based Programs

If covered services are received under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Regence through average pricing or fee schedule adjustments.

For the purpose of this section, the following definitions apply.

Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

A Care Coordination Fee is a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Inter-Plan Programs: Federal or state taxes, surcharges, or fees

Federal law or state law may require a surcharge, tax or other fee that applies to self-insured accounts. If applicable, any such surcharge, tax or other fee will be included as part of the claim fee passed on to the claimant.

Out-of-network providers outside Regence’s service area

Member liability

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. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.

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, 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.

Services received outside the United States Blue Cross Blue Shield Global® Core

ALERT! Claims for services received outside the U.S. may take longer to process. UMP Customer Service is available to assist members with the Global® Core claim process.

If you are outside the U.S., you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered health services. Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the U.S. in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the U.S., you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical services (including locating a doctor or hospital) outside the U.S., you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary. Covered services received from providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore you may be billed for balances beyond any deductible, copayment and/or coinsurance for covered services.

Inpatient services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay upfront for covered inpatient services, except for your medical deductible, coinsurance, and copays. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of services, you must submit a claim to receive reimbursement for covered health care services.

Outpatient services

Physicians, urgent care centers, and other outpatient providers located outside the U.S. will typically require you to pay in full at the time of services. You must submit a claim to obtain reimbursement for covered health care services.

Submitting a Blue Cross Blue Shield Global® Core claim

When you pay for covered health care services outside the BlueCard® service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center, or online at the Blue Cross Blue Shield Global Core® website at **bcbsglobalcore.com**. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

When services received outside the U.S. are covered

The plan covers the same benefits as described in this COC if the services received outside the U.S.:

- Are appropriate for the condition being treated;
- Are covered by the plan;

- Are medically necessary;
- Are not considered to be experimental or investigational by U.S. standards; and
- Have met all medical policy criteria.

Important tips for receiving care outside the U.S.

- Always carry your UMP member ID card.
- If you need emergency medical care, go to the nearest hospital.
- If you need urgent medical care, contact the Blue Cross Blue Shield Global® Core Service Center for help finding a network provider.
- If you are admitted to the hospital, call the Blue Cross Blue Shield Global® Core Service Center to notify the plan of your admission.

Blue Cross Blue Shield Global® Core contact and online information

Contact Blue Cross Blue Shield Global® Core to learn about services received outside the U.S., find a provider outside the U.S., or submit a claim for medical care provided outside the U.S.

- Call the Blue Cross Blue Shield Global® Core Service Center at 1-800-810-BLUE (2583), or call collect 1-804-673-1177 (available 24 hours a day, 7 days a week).
- To use the online provider search tool, register and sign in on the Blue Cross Blue Shield Global® Core website at **bcbsglobalcore.com**.
- Visit the Blue Cross Blue Shield Global® Core website on the Blue Cross Blue Shield Global® Core website at **bcbsglobalcore.com**. After you create an account, you may find Blue Cross Blue Shield Global® Core information, get an international claim form, and submit claims electronically.

Finding a preferred provider outside the U.S.

Under Blue Cross Blue Shield Global® Core, you have access to network providers outside the U.S., including hospital care (inpatient and outpatient) and professional provider services at network rates.

To find a contracted provider outside the U.S., register and sign in on the Blue Cross Blue Shield Global® Core website at **bcbsglobalcore.com** or call the Blue Cross Blue Shield Global® Core Service Center: 1-800-810-BLUE (2583) or collect at 1-804-673-1177.

What you pay for medical services

Deductibles

A deductible is a fixed dollar amount you pay each calendar year before the plan begins paying for covered services. Your medical deductible amount is $250 per member, with a maximum of $750 per family. When you first get services, you pay the first $250 in charges. After you pay that first $250, the plan begins to pay for covered services. This applies to each covered member, up to the $750 maximum.

Your medical deductible applies to all covered services unless otherwise stated in this COC. See below for services that are not subject to your medical deductible. Services apply to your UMP medical deductible in the order claims are received, not necessarily in the order the member receives the services.

ALERT! If you receive services with a benefit limit (such as nutritional counseling) before meeting your medical deductible, those visits still apply to the benefit limit. For example, if you pay out of pocket for a nutritional counseling visit because you have not met your medical deductible, that visit will apply to the maximum of 12 visits per lifetime. See definition of "Limited benefit" for more information.

SmartHealth wellness incentive

Members enrolled in this plan are not eligible to participate in, or earn, the SmartHealth wellness incentive.

If a subscriber was enrolled in a non-Medicare PEBB or SEBB medical plan and earned the $125 SmartHealth wellness incentive in 2024, the deductible will be reduced in January 2025.

More details on eligibility and program requirements are on HCA's SmartHealth webpage at **hca.wa.gov/pebb-smarthealth**.

What does not count toward your medical deductible

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

- Charges for services that exceed the benefit limit.
- Charges that exceed the maximum dollar limit.
- Out-of-network provider charges above the allowed amount (see the "Sample payments to different provider network status" section).
- Prescription drugs covered under Medicare Part D.
- Services that are not subject to your medical deductible, even if you had out-of-pocket costs. For example, covered preventive care services received from an out-of-network provider.
- Services you pay for that are not covered by the plan (see the "What the plan does not cover" section).
- Your emergency room copay.
- Your inpatient hospital copay.
- Your chiropractor copay.
- Your acupuncture copay.
- Your massage therapy copay.

Services not subject to your medical deductible

The plan pays the allowed amount for the services listed below, subject to cost-share, even if you have not met your medical deductible. When you see a preferred or participating provider, you do not have to meet your medical deductible before the plan pays for these services:

- Covered contraceptive supplies and services (see the "Family planning services" benefit).
- Covered preventive care services, including covered immunizations.
- Prescription drugs covered under Medicare Part D.
- Routine hearing exams.
- Hearing aids.

- Routine vision care: exams, glasses, and contacts.
- Second opinions required by the plan.
- Covered screening mammograms and medically necessary diagnostic and supplemental breast exams"(see the "Mammogram and Digital Breast Tomosynthesis (DBT)" benefit).

How your medical deductible works with dependents

If your family has three or fewer members enrolled, your medical deductible amount is $250 per member, with a maximum of $750. Once a member pays their $250 deductible, the plan begins paying for covered services for that member. Because the plan is now paying for this member's covered services, they are no longer contributing toward your family deductible. Once your family deductible has been met, the plan begins paying for covered services.

If your family has four or more members enrolled, each member has a medical deductible of $250. The maximum amount a family pays toward the medical deductible is $750 Once a member pays their $250 deductible, the plan begins paying for covered services for that member. Because the plan is now paying for this member's covered services, they are no longer contributing toward your family deductible. Once your family deductible has been met, the plan begins paying for covered services for all enrolled family members, even if some have not met their own deductible.

If the subscriber earned the SmartHealth wellness incentive for the 2025 plan year before enrolling in this plan, the subscriber's medical deductible is reduced. See the "If you earned the SmartHealth wellness incentive" section above to learn more.

Note: Only services that are covered and are subject to your medical deductible count toward the deductible. See page 19 for a list of services that do not count toward your medical deductible.

Coinsurance

> **TIP:** Allowed amount is the most the plan pays for a specific covered service or supply. Out-of-network providers may charge more than this amount, and you are responsible for paying the difference between the billed amount and the allowed amount. This is called balance billing.

Coinsurance is the percentage of the allowed amount you pay for most medical services when the plan pays less than 100 percent. After you meet your medical deductible, you pay the percentages described below for most covered medical services.

- **For preferred providers:** You pay 15 percent of the allowed amount. The plan pays most covered services at 85 percent of the allowed amount.
- **For participating providers:** You pay 40 percent of the allowed amount. The plan pays most covered services at 60 percent of the allowed amount.
- **For out-of-network providers:** You pay 40 percent of the allowed amount, and the provider may balance bill you. The plan pays most covered services at 60 percent of the allowed amount.

Professional charges, such as for physician services while you are in the hospital or lab work, may be billed separately.

Note: When you receive nonemergency services at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider. For nonemergency services performed at one of these facilities outside of Washington State, you still pay

the network rate, but in some states, an out-of-network provider may be allowed to ask you to waive some of your balance billing protections.

When you receive emergency services at an out-of-network facility you pay the network rate regardless of the network status of the provider or facility and cannot be balance billed.

When you receive covered ground or air ambulance services in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider.

Copay

A copay is a set dollar amount you pay when you receive treatments, supplies, or services including, but not limited to:

- Emergency room copay: $75 per visit. See the "Emergency room" benefit for details.
- Facility charges for services received while an inpatient at a hospital, or mental health, skilled nursing, or substance use disorder facility: $200 per day (see "Inpatient copay" below).
- Covered chiropractic, acupuncture, and massage services when you see a preferred provider will have a $15 copay per visit. The copay for these services will apply toward the annual out-of-pocket maximums. See the "Spinal and extremity manipulations" benefit, "Acupuncture" benefit, and "Massage therapy" benefit for more details.

Inpatient copay

You pay $200 per day up to a maximum of $600 per enrolled member per admission for inpatient services at a preferred facility, such as a hospital, or mental health, skilled nursing, or substance use disorder facility.

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

Note: Professional charges, such as lab work or provider services, while you are in the hospital may be billed separately and are not included in this copay.

When you pay

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

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

Note: A provider may ask you to pay your deductible and copay at the time of service. You may check your EOB to ensure the amount you paid was correct.

Medical out-of-pocket limit

The medical out-of-pocket limit is the most you pay during a calendar year for covered services from preferred providers. After you meet your medical out-of-pocket limit for the year, the plan pays for covered services by preferred providers at 100 percent of the allowed amount. The plan will not pay more than the allowed amount. **Expenses are counted from January 1, 2025, or your first day of enrollment (whichever is later) through December 31, 2025, or your last day of enrollment (whichever is earlier).**

Your medical out-of-pocket limit is $2,500 per member and $5,000 per family.

What counts toward this limit

- Inpatient and emergency room copays
- Coinsurance paid to preferred and participating providers
- Coinsurance paid to out-of-network providers for emergency room services, air ambulance, and nonemergency services furnished during a visit or stay at a preferred and participating hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center.
- Your medical deductible paid to preferred and participating providers
- Chiropractic, acupuncture, and massage therapy visit copays to preferred providers

What does not count toward this limit

A. Amounts paid by the plan, including services covered in full

B. Costs you pay under the Medicare Part D prescription drug benefit including your prescription drug deductible and copay.

C. Amounts paid by Medicare

D. Your monthly premiums

E. Your coinsurance paid to out-of-network providers and your coinsurance and copayments paid to non-network pharmacies (except those listed above in "What counts toward this limit")

F. Balance billed amounts

G. Amounts paid for services the plan does not cover (see the "What the plan does not cover" section)

H. Amounts that are more than the maximum dollar amount paid by the plan. Any amount you pay over the allowed amount does not count toward the medical out-of-pocket limit

I. Amounts paid for services over a benefit limit. For example, the benefit limit for acupuncture is 24 visits. If you have more than 24 acupuncture visits in one year, you will pay in full for those visits, and what you pay will not count toward this limit

What you pay after reaching this limit

After you meet your out-of-pocket limit for the year, you pay:

- $0 of the allowed amount for covered medical services from preferred providers.
- C through H (above) in the "What does not count toward this limit" section.
- 40% of the allowed amount for covered medical services for participating providers.
- 40% of the allowed amount for covered medical services for out-of-network providers. You may be balance billed.

Summary of services and payments

ALERT! Even if a provider orders a test or prescribes a treatment, the plan may not cover it. Review this COC or contact UMP Customer Service if you have questions about benefits or limitations.

On the next several pages, you will find a summary of types of services and what you will pay for them. For a complete understanding of how a benefit works, read the pages listed in the "For more information" column.

All services must be medically necessary to be covered. **If you see an unfamiliar term, see the alphabetical list of definitions in the "Definitions" section.**

This COC applies only to dates of service between the day your coverage begins (no earlier than January 1, 2025) and the day your coverage ends (no later than December 31, 2025).

Deductibles and limits

Deductibles and limits	Dollar amounts	What else you need to know	For more information, see page(s)
Medical deductible	$250 per member (maximum of $750 for a family of three or more)	You must meet your medical deductible before the plan pays for covered medical services. Not all services count toward your deductible.	18–20
Medical out-of-pocket limit	$2,500 per member ($5,000 for family)	Your medical deductible, coinsurance, and copays for covered services paid to preferred and participating providers count toward this limit. Once you meet your medical out-of-pocket limit, covered services paid to preferred providers only are paid at 100% of the allowed amount.	21–22
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

Types of services

The table in this section describes how much you and the plan will pay for covered services. Unless otherwise noted, all payments are based on the allowed amount, and services are subject to your medical deductible. See the "What you pay for medical services" section for more information about your deductible.

Type of service	How much you pay for covered services	How much the plan pays for covered services
Standard	How much you pay (your coinsurance) depends on the provider's network status: • **Preferred providers:** You pay 15%of the allowed amount. The provider cannot balance bill you.	• **Preferred providers:** The plan pays 85% of the allowed amount.

Type of service	How much you pay for covered services	How much the plan pays for covered services
	• **Participating providers:** You pay 40% of the allowed amount. The provider cannot balance bill you. • **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.	• **Participating providers:** The plan pays 60% of the allowed amount. • **Out-of-network providers:** The plan pays 60% of the allowed amount.
Preventive	Covered preventive services are not subject to your medical deductible. How much you pay (your coinsurance) depends on the provider's network status: • **Preferred providers:** You pay $0. The provider cannot balance bill you. • **Participating providers:** You pay $0. The provider cannot balance bill you. • **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.	• **Preferred providers:** The plan pays 100% of the allowed amount. • **Participating providers:** The plan pays 100% of the allowed amount. • **Out-of-network providers:** The plan pays 60% of the allowed amount.
Inpatient	Most inpatient services require both preauthorization (see page 66) and notice (your provider must notify the plan as soon as possible after you are admitted to a facility, but not later than 24 hours after you are admitted; see page 67). You pay the $200-per-day copay up to $600 maximum per admission up to the annual medical out-of-pocket limit at a preferred facility • **Note:** The inpatient copay counts toward your medical out-of-pocket limit. Services are considered inpatient only when you are admitted to a facility. See definition of "Inpatient stay." When you are admitted to a facility, you pay your deductible and: • **Preferred facilities:** You pay the inpatient copay. • **Participating facilities:** You pay 40% of the allowed amount. The facility cannot balance bill you. • **Out-of-network facilities:** You pay 40% of the allowed amount. The facility may balance bill you.	The plan pays 100% of the allowed amount after you pay your deductible and copay at preferred facilities. The plan pays for professional services such as provider consultations or lab tests, based on the provider's network status: • **Preferred providers:** The plan pays 85% of the allowed amount. **Note:** For behavioral health professional services, the plan pays 100% of the allowed amount. • **Participating providers:** The plan pays 60% of the allowed amount. • **Out-of-network providers:** The plan pays 60% of the allowed amount.

Type of service	How much you pay for covered services	How much the plan pays for covered services
	• Fees for professional services, such as, but not limited to, provider consultations or lab tests. How much you pay for professional services depends on the provider's network status: • **Preferred providers:** You pay [15% of the allowed amount. The provider cannot balance bill you. • **Participating providers:** You pay 40% of the allowed amount. The provider cannot balance bill you. • **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.	
Outpatient	If you receive services at a facility that offers inpatient services (like a hospital), but you are not admitted, the services are covered as outpatient. See the specific benefit (e.g., emergency room or diagnostic tests) for how much you pay. You may be billed separately for facility fees in addition to provider fees. • **Preferred providers:** You pay 15%of the allowed amount. The provider cannot balance bill you. • **Participating providers:** You pay 40% of the allowed amount. The provider cannot balance bill you. • **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.	• **Preferred providers:** The plan pays 85% of the allowed amount. • **Participating providers:** The plan pays 60% of the allowed amount. • **Out-of-network providers:** The plan pays 60% of the allowed amount.

Type of service	How much you pay for covered services	How much the plan pays for covered services
Facility	You may be charged facility fees in addition to provider fees when accessing clinics, ambulatory surgery centers, and other facilities. A facility may be referred to as a "provider" on the Explanations of Benefits or other documents. How much you pay depends on the provider's network status: • **Preferred facility:** You pay 15% of the allowed amount; the provider cannot balance bill you. • **Participating facility:** You pay 40% of the allowed amount; the provider cannot balance bill you. • **Out-of-network facility:** You pay 40% of the allowed amount; the provider may balance bill you.	• **Preferred facility:** The plan pays 85% of the allowed amount. • **Participating facility:** The plan pays 60% of the allowed amount. • **Out-of-network facility:** The plan pays 60% of the allowed amount.
Special	These services have unique payment rules, which are described in the "How much you will pay" column in the Summary of benefits table located in the "Summary of benefits" section.	

What else you need to know

- Some services are not covered (see the "What the plan does not cover" section).
- There is no waiting period for preexisting conditions.
- You will save money by seeing preferred providers (see the "Finding a health care provider" section).
- You must be enrolled in this plan for the plan to pay for medically necessary covered services.

Benefits: what the plan covers

Guidelines for coverage

ALERT! A service or supply prescribed, ordered, recommended, approved, or given by a provider does not make it a medically necessary covered service or supply.

This plan will cover a service or supply if it meets all of the following conditions. The service or supply must:

- Be listed as covered; and
- Be medically necessary; and
- Be received by a member on a day between the date coverage begins (but no sooner than January 1, 2025) and the date coverage ends (but no later than December 31, 2025); and

- Have been determined to be a covered benefit by the Health Technology Clinical Committee (HTCC), if reviewed by the HTCC, and, if determined to be covered with conditions, meet the conditions of coverage established by the HTCC; and
- Meet the plan's coverage policies and preauthorization requirements.

Limits and exclusions may apply to plan benefits. See both the benefit description and the "What the plan does not cover" section.

Some services require preauthorization and/or notice before you receive treatment. Visit the UMP Policies that affect your care webpage for a list of these services, or contact UMP Customer Service to ask if a certain service is covered, requires preauthorization, or requires notice. See Directory for link and contact information.

The following sections describe the benefits provided by this plan. Be sure to read them carefully for important information that may 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 contacting UMP Customer Service.

UMP is a self-insured PPO health plan. UMP is offered through HCA's Public Employees Benefits Board (PEBB) Program. UMP is administered by Regence BlueShield. All services or other benefit changes may require approval by the PEB Board Approval takes place when benefits are procured for the next calendar year. Health Technology Clinical Committee (HTCC)

> **ALERT!** HTCC determinations may be implemented by the plan at any time during the calendar year, but are often implemented the January following the HTCC's decision. HTCC decisions are posted on the HCA website at **hca.wa.gov/hta**. Contact UMP Customer Service if you have questions about specific services that the HTCC has reviewed.

Created by chapter 70.14 of the Revised Code of Washington (RCW), the HTCC is a committee of 11 independent health care professionals that reviews selected health technologies (services) to determine appropriate coverage, if any, for the services. These may include medical or surgical devices and procedures, medical equipment, and diagnostic tests.

In public meetings, the HTCC considers public comments and scientific evidence regarding the safety, medical effectiveness, and cost-effectiveness of the services when making its determination.

How HTCC decisions affect UMP benefits

Under state law, the plan must comply with HTCC decisions, RCW 70.14.120 (1)(a), unless such determination conflicts with federal or state law. Services reviewed by the HTCC are either covered, covered with conditions, or not covered. The HTCC determines the conditions, if any, under which the service will be included as a covered benefit and, if covered, the criteria the plan must use to decide whether the service is medically necessary. Criteria established by the HTCC take precedence over Regence's medical policies. When the HTCC determines that a service is not covered, then the service is not covered by the plan. Some HTCC decisions include a requirement to follow FDA or Centers for Medicare and Medicaid Services (CMS) guidelines. You may review these guidelines on the FDA website at **fda.gov** or CMS website at **cms.gov**.

Where to find HTCC decisions

You may view the list of services that the HTCC has reviewed or currently has under review on the HCA website at **hca.wa.gov/hta**. The website includes:

- Evidence reports

- Instructions on providing public comments on pending reviews or re-reviews
- Public comments
- The decisions and criteria for coverage
- The public meeting schedule

You may also contact UMP Customer Service with questions about coverage of conditions for HTCC technologies.

Summary of benefits

ALERT! Not all covered services and limitations are listed in the table below. See the alphabetical list of all covered services in the "List of benefits" section

Read the pages listed in the "For information" column for detailed information about each benefit. Not all details are included in the table. Also read:

- Services for which your provider must notify the plan (see page 66)
- Services that are not covered (exclusions) (see the "What the plan does not cover" section)
- Services that require preauthorization (see the "Limits on plan coverage" section)

If you have questions about your benefits, benefit limitations, services that require preauthorization or notice, or services not covered by the plan, contact UMP Customer Service.

For a description of the types of services listed in the "How much you will pay" column in the table below, see the "Types of services" section. For definitions of the rates, see the definitions of "Inpatient rate," "Preventive rate," "Special rate," and "Standard rate."

Benefit/service	How much you will pay	For information, see page(s):
Ambulance	Special rate: • 20% of the allowed amount for any provider • Applies to your out-of-pocket limit	31, 68, 77
Applied Behavior Analysis (ABA) Therapy	Standard rate	31
Behavioral health	Mental health: • Inpatient rate • Outpatient/professional services: Standard rate Substance use disorder: • Inpatient rate • Outpatient/professional services: Standard rate	33, 73, 74
Breast health screening tests	See the "Mammogram and Digital Breast Tomosynthesis (DBT)" benefit	46

Benefit/service	How much you will pay	For information, see page(s):
Chiropractic physician services	Special rate: You pay a $15 copay per visit when you see a preferred provider.	See the "Spinal and extremity manipulations" benefit on page 54
Diagnostic tests, laboratory, and x-rays	Standard rate	37, 46, 68
Dialysis	Standard rate	39
Durable medical equipment (DME), supplies, and prostheses	Standard rate	38, 70, 73, 119
Emergency room (ER)	Special rate: ER services are paid at the network rate at preferred, participating and out-of- network hospitals. You pay 15% of the allowed amount plus an ER copay of $75. The $75 copay is waived if you are admitted. You may be billed separately for services such as: • Facility charges • Professional (physician) services • Lab tests, x-rays, and other imaging tests	40, 119
Hearing aids	Special rate: • No medical deductible • You pay $0 of the $3,000 benefit limit per ear every 3 years	42, 81
Home health care	Standard rate	43, 72, 122, 124
Hospice care	Special rate: • You pay $0 for medical services after meeting your medical deductible • You pay $0 for end-of-life counseling while in hospice after meeting your medical deductible	44, 122
Hospital services	Inpatient rate Outpatient/professional services: Standard rate	44, 48, 72
Mammograms	See the "Mammogram and Digital Breast Tomosynthesis (DBT)" benefit	46
Mental health	See the "Behavioral health" benefit	33, 73, 74
Naturopathic physician services	Standard rate	13, 47, 69
Obstetric and newborn care	Inpatient rate Outpatient/professional services: Standard rate	48, 74
Office visits	Standard rate	50, 73

Benefit/service	How much you will pay	For information, see page(s):
Preventive care and immunizations	Preventive care services: Preventive rate Covered preventive immunizations: Preventive rate	46, 49, 50, 130
Skilled nursing facility	Inpatient rate Some services may be billed separately, such as physical therapy	53, 72, 75, 133
Spinal and extremity manipulations	Special rate: You pay a $15 copay per visit when you see a preferred provider.	54
Substance use disorder	See the "Behavioral health" benefit	33
Surgery	Standard rate	44, 47, 50, 55, 55, 57, 72, 76, 116, 127, 131
Therapy: Habilitative and Rehabilitative	Inpatient rate Outpatient/professional services: Standard rate	56
Vision care exam (routine)	Preventive rate	61
Vision hardware (Lenses, frames, or contact lenses)	Special rate: • No medical deductible • Lenses and frames: You pay $0 of the allowed amount for one pair of covered standard lenses and frames once every two calendar years; **or** • Contact lenses: Plan pays up to $200 every two calendar years in lieu of lenses and frames. You pay a $30 fitting fee for contact lenses	61

Note: For services requiring preauthorization or plan notification, see the list of services on the UMP Policies that affect your care webpage or contact UMP Customer Service (see Directory for link and contact information). Many services require both preauthorization and plan notification. See the "Limits on plan coverage" section for how this works.

List of benefits

Acupuncture

The plan covers up to 24 visits for acupuncture treatment per calendar year (see definition of "Limited benefit"). You pay the special rate (a $15 copay) for acupuncture when you see a preferred provider. The copay will not apply toward your medical deductible, but the copay will apply to the out-of-pocket limit. All visits will apply to the 24-visit limit.

You may receive an office visit at the time of the acupuncture service (see the "Office visits" benefit for details). Not all acupuncture services are covered. See the "What the plan does not cover" section for more information.

Note: For participating providers and out-of-network providers, services are paid at the standard rate up to 24 visits per calendar year.

Ambulance

Ambulance services for personal or convenience purposes are not covered.

Ground ambulance

You pay 20 percent of the allowed amount for medically necessary ambulance services. You may not be balance billed for services provided in Washington State. 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.
- From one facility to the nearest other facility equipped to provide treatment for your condition.

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; or
- From a facility to home.

Air ambulance

You pay 20 percent of the allowed amount for medically necessary ambulance services regardless of network status. You may not be balance billed. Air professional ambulance services are covered only when all the following conditions are met:

- Ground ambulance is not appropriate
- The situation is a medical emergency
- Air ambulance is medically necessary
- Transport is to the nearest facility able to provide the care you need

> **ALERT!** The plan will not pay for air ambulance or other forms of air transport to move you to a facility closer to your home. If you travel outside the U.S., consider getting separate insurance that covers such air ambulance services.

Water ambulance

You pay 20 percent of the allowed amount for medically necessary ambulance services. Water professional ambulance services are covered only when all the following conditions are met:

- Ground ambulance is not appropriate
- The situation is a medical emergency
- Water ambulance is medically necessary
- Transport is to the nearest facility able to provide the care you need

Applied Behavior Analysis (ABA) Therapy

The plan covers Applied Behavior Analysis (ABA) Therapy only for a diagnosis of autism spectrum disorder. Providers of ABA Therapy services must be appropriately credentialed and qualified to prescribe or perform ABA Therapy services.

The plan must preauthorize ABA Therapy services for members age 18 or older before services are performed. No preauthorization is required for members under age 18. Like other preauthorized services, approved ABA preauthorization is specific to the provider who made the ABA preauthorization request. ABA Therapy hours preauthorized for one provider are not automatically transferable to another provider. A change in the provider requires a new ABA preauthorization. The initial assessment and ABA therapy treatment order or prescription do not require preauthorization for members of any age.

As for other covered services, you receive the highest-level benefit by using preferred providers. See the "Types of services" section for differences in your cost for preferred, participating, and out-of-network providers. To find a preferred provider, visit the UMP Provider search or contact UMP Customer Service.

You can also find more information on ABA Therapy by viewing the ABA policy on the UMP Policies that affect your care webpage. See the Directory pages at the beginning of this booklet for links and contact information.

Autism treatment

To determine how a service, supply, or intervention is covered, see that specific benefit. For example, Applied Behavior Analysis (ABA) Therapy is addressed on page 31; speech or occupational therapy is addressed on page 56 under the "Therapy: Habilitative and Rehabilitative" benefit; and mental health coverage is found under "Behavioral health" on page 33. If a specific benefit is subject to limits, such as number of visits, these limits do not apply when the services, supplies, or interventions are for an autism diagnosis.

Bariatric surgery

TIP: Contact UMP Customer Service to locate a provider.

For the plan to cover bariatric surgery, you must get preauthorization from the plan and follow all your chosen facility's bariatric surgery requirements. This includes working with a multidisciplinary bariatric surgery team and ensuring 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, members age 13 and older maybe eligible for covered bariatric procedures.

ALERT! If you are - considering bariatric surgery, contact UMP Customer Service.

Related care following bariatric surgery

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

UMP will cover medically necessary surgical follow-up care related to a covered bariatric procedure, such as care for complications and needed revisions. The follow-up surgery must be appropriate and essential to the long-term success of the initial bariatric surgery and must be preauthorized.

Members who had a bariatric procedure before coverage under a UMP plan and have complications or need medically necessary revision are not required to verify prior coverage or that they met the plan's medical policy criteria for the initial bariatric procedure. However, you must follow plan requirements for follow-up care, including requesting preauthorization.

Behavioral health

The plan covers behavioral health services including care for mental health and substance use disorder. You pay the inpatient rate when admitted to an inpatient facility, and the standard rate for all other care and services.

When you receive nonemergency services from an out-of-network provider at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center, you pay the network rate and cannot be balance billed for services performed in Washington State or without your informed consent in states that allow you to waive the federal balance billing protections. When you receive emergency services you pay the network cost-sharing amount regardless of the network status of the provider or facility and cannot be balance billed.

When you receive covered ground or air ambulance services in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider.

Mental health

The plan covers mental health services for members with neuropsychiatric and mental health conditions. Marriage or family counseling is not covered. The amount the plan pays depends on the provider's network status (see the "Finding a health care provider" section and page 24). See below for details about coverage for substance use disorder treatment.

Inpatient

> **ALERT!** Your provider must notify the plan as soon as possible after you are admitted to a facility, but not later than 24 hours after you are admitted when you receive inpatient services. If the plan is not notified of inpatient treatment, the plan may not cover the treatment. Inpatient treatment is subject to clinical review.

Services are considered inpatient when you are admitted to a facility. This may include either psychiatric inpatient hospitalization or care at a residential treatment facility. The plan must preauthorize non-emergency inpatient services. See the "Limits on plan coverage" section for details.

Your provider must notify the plan as soon as possible after you are admitted to a facility, but no later than 24 hours after you are admitted to a:

- Hospital
- Residential treatment facility

Contact UMP Customer Service about preauthorization requirements. Visit UMP Policies that affect your care webpage for a list of services that require plan notice. See Directory for link and contact information.

You pay an inpatient copay for facility charges at a preferred facility (see the "Copay" section). Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays the inpatient rate unless it is for emergency services. All covered professional services are paid based on the allowed amount.

Outpatient

> **ALERT:** See page 31 for preauthorization requirements related to Applied Behavior Analysis (ABA) Therapy services.

You pay the standard rate for outpatient mental health services. You pay based on the allowed amount and the network status of the provider. Most outpatient mental health services do not require preauthorization. Visit the UMP Policies that affect your care webpage for a list of services that require plan notice.

Your provider must notify the plan as soon as possible, but not later than 24 hours after the following services are initiated:

- Intensive Outpatient Therapy
- Partial Hospitalization Program (PHP)

Substance use disorder

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

To be covered, treatment programs must be licensed to provide treatment to persons requiring substance use disorder treatment. The amount the plan pays depends on the provider's network status (see the "Finding a health care provider" section and page 24). See above for details about coverage for mental health services. Contact UMP Customer Service about preauthorization requirements.

Inpatient

> **ALERT!** Your provider must notify the plan as soon as possible after you are admitted to a facility, but not later than 24 hours after you are admitted when you receive inpatient services for substance use disorder treatment. If the plan is not notified of inpatient treatment, the plan may not cover the treatment. Inpatient treatment is subject to clinical review.

You pay an inpatient copay for facility charges at a preferred facility (see the "Copay" section). Professional services (for example, doctors or lab tests) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless it is for emergency services.

Your provider must notify the plan when:

- You receive detoxification services
- You are admitted to a hospital
- You are admitted to a residential treatment facility

Outpatient

You pay the standard rate for outpatient substance use disorder treatment. You pay based on the allowed amount and the network status of the provider.

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

- Detoxification
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

Preauthorization for outpatient substance use disorder treatment is not required in most cases. The plan may require that your provider submit a treatment plan to determine medical necessity.

Behavioral health support resources

UMP provides behavioral health support resources to meet your needs.

Teledoc Health Mental Health

Teledoc Health Mental Health (formerly known as myStrength) is a self-guided health and resiliency online tool clinically proven to improve emotional health. This secure resource is available 24 hours a day, 7 days a week to members age 13 or older at no cost to you. Teledoc Health's interactive and activity-based tools are personalized to you and address conditions such as depression, anxiety, stress, substance use disorders, and chronic pain. Visit the Teledoc Health's Mental Health website at **Teladochealth.com/start/mental-health-digital**, click Register Now and use the Teledoc Health code WAPEBB to sign up and learn more or download the app in the Apple App Store or on Google Play.

Breast health screening tests

See also the "Mammogram and Digital Breast Tomosynthesis (DBT)."

Care management

Regence care management supports the unique needs of members with chronic, serious, or sudden illness or injury and prioritizes those needs by providing personalized services that enhance well-being.

Care management teams can help with:

- Advocating for members and their support systems and improving care through close collaboration with providers.
- Assisting members as they navigate the health care system, including helping members find preferred providers and facilities, and supporting members transitioning to different levels of care.
- Educating members about their care options, benefits, and coverage, as well as helping members make educated decisions regarding their health care.
- Supporting members with coordination of care needs.

We offer a single-nurse model dedicated to delivering personalized and holistic medical and behavioral health support to each member and their family. Once a member is engaged in the care management program, they may be assigned a case manager who is a licensed social worker or registered nurse. Regence case managers work closely with a member and their providers to help meet treatment plan goals and improve a member's overall health.

How to get started

Providers may refer members, and Regence also proactively reaches out to members most likely to benefit from care management support. Members can also self-refer by calling Regence at 1-866-543-5765 (TRS: 711) for information about care management services.

What's next

Once a member is identified for care management, the designated case manager calls the member. The Regence case manager will attempt at least three calls and will send a letter to the member. The member can respond to the letter if they wish to engage with a case manager. Providers are sent a letter or contacted by phone when their patient is enrolled in care management.

Care management newsletters

Newsletters are sent once per year with an option to opt into care management to all members with a new diagnosis of depression, anxiety, a painful condition, or adult/pediatric cancer.

Condition-specific newsletters are sent twice per year with an option to opt into care management to all members diagnosed with coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, or diabetes.

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.

Chiropractic physician services

See the "Spinal and extremity manipulations" benefit.

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 does not cover most dental services. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these are not covered. However, if you are enrolled in a dental plan, your dental plan may cover these services. Refer to your dental plan's COC, found on the HCA website at **hca.wa.gov/erb**, for more information.

What is covered by the plan

The plan covers oral surgery and other dental services under the medical benefit when they are considered medical. Oral surgery and dental services are considered medical if the condition being diagnosed and treated is either one which is not connected to the teeth and/or gums or is related to a disease or illness that affects the whole body. These medical services may be performed by a dentist or medical professional provider. You can find examples of these medical services in the Regence Medical Policy Administrative Guidelines to Determine Dental vs Medical Services by visiting the UMP Policies that affect your care webpage (see Directory for link). You pay 20 percent of the allowed amount for covered dental services unless otherwise stated, and the provider may balance bill you.

Note: UMP is not affiliated with the Uniform Dental Plan (UDP). If you are enrolled in UDP, contact UDP for information about services covered under your dental plan. Visit the HCA website at **hca.wa.gov/erb** and select "Contact" to find UDP contact information.

Fluoride treatment

Under certain circumstances, the plan may cover fluoride supplements (see the "Preventive care" benefit) at the preventive rate. The application of fluoride varnish may be covered for infants and children starting at the age when primary teeth come in (primary teeth eruption) in primary care practices for prevention of tooth decay (dental caries or cavities). Coverage of fluoride treatment depends on the network status of the medical provider as described in the "Finding a health care provider" section. Health care providers, such as your child's medical PCP, may apply fluoride varnish.

General anesthesia during a dental procedure

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

- It is provided by an anesthesiologist; and
- The charges are covered by the plan (see below).

Dental procedures
General anesthesia may be performed in a dental office for covered procedures and is paid at the standard rate. Dental procedures that are performed in a hospital or ambulatory surgery center are covered **only** when the member:

- Is under age 8 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 member 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 upon the initial assessment that treatment should start later or continue longer. Treatment must be completed by the end of the calendar year following the accident. The plan does not cover treatment after UMP coverage ends.

Example: You have an accident on March 12, 2025, resulting in injuries that are covered by the plan. Your treatment plan must be finalized no later than April 11, 2025. All related treatment must be completed by December 31, 2026 (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
- Extends past the end of your enrollment in the plan.

Diabetes care supplies

Medical

> **ALERT:** When Medicare is primary, UMP covers continuous glucose monitors, lancets, and test strips under your medical benefit.

Insulin pumps and pump supplies are covered as durable medical equipment (DME). See page 39 for coverage of insulin pumps and related supplies.

Diagnostic tests, laboratory, and x-rays

You pay the standard rate for covered diagnostic tests, laboratory tests, and x-rays when medically necessary. If there are alternative diagnostic approaches with different fees, the plan will cover the least expensive, evidence-based diagnostic method. Visit the UMP Policies that affect your care webpage or contact UMP Customer Service for a list of services requiring preauthorization (see Directory for link and contact information).

Covered services include:
- All prostate cancer screening (prostate-specific antigen [PSA testing]), which is subject to your medical deductible and coinsurance, even if billed as preventive.
- Colonoscopy performed to diagnose disease or illness. See the list on page 50 for coverage of preventive or screening colonoscopy.

- Diagnostic laboratory tests, x-rays, and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Skin allergy testing.

> **TIP:** See page 46 to learn how the plan covers mammograms.

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

Dialysis

You pay the standard rate for covered inpatient dialysis services. The plan pays based on the allowed amount and the network status of the provider. Other professional providers may bill separately from the facility.

Durable medical equipment (DME), supplies, and prostheses

> **TIP:** The plan pays for covered DME at the standard rate. To receive the highest benefit, you must get the equipment or supply from a preferred DME supplier or other preferred medical provider. To find preferred DME providers, see the "Finding a preferred DME supplier" section below.

You pay the standard rate for covered DME services and supplies if they are prescribed by a provider practicing within their scope of practice, medically necessary, and used to treat a covered condition, including, but not limited to:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required due to cataract surgery or to replace a missing portion of the eye).
- Automatic Positive Airway Pressure (APAP) devices and related supplies.
- Bi-level Positive Airway Pressure (BiPAP) devices and related supplies.
- Bone growth (osteogenic) stimulators.
- Breast prostheses and bras as required by mastectomy. See the "Mastectomy and breast reconstruction" benefit.
- Breast pumps for pregnant and nursing members (see "Services covered as preventive" on page 49).
- Casts, splints, crutches, trusses, and braces.
- Compression stockings.
- Continuous Positive Airway Pressure (CPAP) devices and related supplies.

- Diabetic shoes, only as prescribed for a diagnosis of diabetes. See the "Foot orthotics" section below.
- Elemental formulas for Eosinophilic Gastrointestinal Disorders (EGIDs).
- Insulin pumps and related pump supplies (see the "Insulin pumps and related pump supplies" section below).
- Ostomy supplies.
- Oxygen and its equipment, such as all types of concentrators and tanks for administration, are covered on a rental basis only.
- Penile prosthesis when other accepted treatment has been unsuccessful and impotence is:
  - Caused by a covered medical condition; or
  - A complication directly resulting from a covered surgery; or
  - A result of an injury to the genitalia or spinal cord.
- Rental or purchase (at the plan's discretion) of DME such as wheelchairs, hospital beds, and respiratory equipment. (The combined rental fees cannot exceed full purchase price.)
- Wig or hairpiece to replace hair loss due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100. Wigs and hairpieces for any other reason are not covered.

Some items require preauthorization. Find the list of supplies that require a preauthorization by visiting forms and publications at **hca.wa.gov/ump-forms-pubs** and search "durable medical equipment" or contact UMP Customer Service.

The plan limits coverage of DME to one item of a particular type of equipment and the accessories needed to operate the item. If you receive a higher-cost DME item when a less expensive, medically appropriate option is available, the plan will not pay for the more expensive item.

The plan also covers the repair or replacement of DME due to normal use or a change in the member's condition (including the growth of a child). You are responsible for the entire cost of any additional pieces of the same or similar DME you purchase or rent for personal convenience or mobility.

Note: The plan does not cover replacement of lost, stolen, expired, or damaged DME.

Foot orthotics

Items such as shoe inserts, foot orthotics, and other shoe modifications are covered only when both of these conditions are met:

- The member has been diagnosed with diabetes.
- Specialized (including customized) orthotics are prescribed to treat or reduce the risk of diabetes complications.

If you have questions about what services are covered, contact UMP Customer Service.

Insulin pumps and related pump supplies

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

Finding a preferred DME supplier

You may purchase DME through a medical supplier. To find a preferred DME supplier, visit the UMP Provider search (see Directory for link). You do not have to sign in to the Regence member site to search for a provider, but you will get more personalized results if you do. Click on the "All categories" link (found beneath "Doctors by name" and "Doctors by specialty"). Type "durable medical" into the search box; a drop-down list will appear. Select "Durable Medical Equipment & Supplies." You should now have a

list of network DME suppliers. Preferred providers are paid at the highest rate and are noted as a Category 1 provider in the UMP provider search. Different DME suppliers carry different types of supplies. You may need to contact to confirm that a supplier has what you need.

Commercial DME

You may purchase DME on Amazon by signing in to your Regence account and going to the Regence medical supplies webpage at **regence.com/member/medical-supplies/**. Select "Get started" in the Shop smart and save section. This will take you to the Amazon page where you will select and shop from one of the four categories for DME supplies:

- Post-mastectomy
- Illness and injury
- New parents
- Manage a condition

You pay 100 percent of the billed charge and submit a claim for reimbursement. To submit a claim, select "Start your claim" in the "How to get repaid" section on the Regence medical supplies webpage at **regence.com/member/medical-supplies/**. The plan will reimburse you 85percent of the allowed amount for covered DME supplies purchased through Amazon. To learn more contact UMP Customer Service.

Emergency room

> **TIP:** If you need immediate care but your situation is not a medical emergency, see the "Urgent care" benefit for how to get treatment at a lower cost than in an emergency room.

You pay a $75 copay and coinsurance for each emergency room visit, in addition to any amount owed toward your medical deductible. The plan covers facility charges for emergency room treatment when the treatment is for covered diagnoses and treatment of an injury.

Charges for professional services may be billed separately from facility (hospital or emergency room) charges. When you receive emergency services, you cannot be balance billed.

If your emergency room visit is determined to be a medical emergency, it will be paid at the network rate for preferred, participating, and out-of-network facilities. Separate professional services charges will also be paid at the network rate if your emergency room visit is determined to be a medical emergency.

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

End-of-life counseling

End-of-life counseling involves discussing and planning for your end-of-life care, including treatment options and advanced directives. 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 percent after you meet your medical deductible. Outside of hospice, these services are paid as a medical benefit, subject to your medical deductible and coinsurance. For more information on hospice care, see page 44.

Family planning services

If you receive care from a network provider, the plan will pay for the following covered services at the preventive rate:

- Voluntary and involuntary termination of pregnancy (abortion or miscarriage),
- Education and counseling related to contraception

If you receive care from an out-of-network provider, covered services are paid at the standard rate and the provider may balance bill you.

Barrier devices

All barrier devices requiring a fitting, insertion (includes IUD placement immediately after delivery), or removal are paid at the preventive rate when you see a preferred or participating provider. Barrier devices requiring a fitting include intrauterine devices (IUDs), diaphragms, and cervical caps.

Sterilization

When you see a preferred or participating provider, sterilization procedures, such as tubal ligation or vasectomy, are paid at the preventive rate and are not subject to your medical deductible.

Services and products not covered under the family planning benefit

The plan does not cover the following services and products as a family planning benefit:

- Prescription drugs
- Over-the-counter products
- Reversal of voluntary sterilization
- Treatment of fertility or infertility, including direct complications resulting from such treatment

Foot care, maintenance

Maintenance foot care includes services such as toenail trimming and corn or callous removal or trimming. These services are covered only for a diagnosis of diabetes and when provided by an approved provider type. The plan does not cover maintenance foot care provided outside the diagnosis of diabetes.

Gender affirming care

With a diagnosis of gender dysphoria, the following services are covered at the standard rate for outpatient services and at the inpatient rate for inpatient services:

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

This is not a complete list of medical and surgical treatments of gender dysphoria in transgender individuals. For more information on gender affirming care, visit the UMP Policies that affect your care webpage to find the clinical criteria for gender affirming care (see Directory for link). Some services associated with gender dysphoria may require preauthorization.

Genetic services

Covered genetic tests require preauthorization. With preauthorization, the plan covers medically necessary, evidence-based genetic testing services. Some genetics tests are not covered. For information about genetic services related to the fetus during pregnancy, see “Services for obstetric and newborn care” on page 48. Contact UMP Customer Service with any questions.

Headaches, chronic migraine or chronic tension type

The plan only covers the treatment of chronic migraine with OnabotulinumtoxinA (Botox) when both the following criteria are met:

- The condition has not responded to at least three prior pharmacological prophylaxis therapies from two different classes of prescription drugs; and
- The condition is appropriately managed for medication overuse.

Botox injections must be discontinued when:

- The condition has shown inadequate response to treatment (defined as less than 50 percent reduction in headache days per month after two treatment cycles); or
- The member has received a maximum of five treatment cycles.

The following treatments are **not** covered:

- Treatment of chronic tension-type headaches with Botox or acupuncture; and
- Treatment of chronic migraine or chronic tension-type headaches with massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (such as chiropractic services).

Hearing care (diseases and disorders of the ear)

The plan pays under the medical benefit for covered services for treatment of diseases and disorders of the ear or auditory canal not related to routine hearing loss. These services are not part of the "Hearing exam and hearing aids" benefit.

Hearing exam and hearing aids (instruments)

This benefit is not subject to your medical deductible and includes the services and supplies outlined below.

Hearing exam (routine)

> **ALERT!** The plan pays for a hearing exam performed as part of a newborn screening at the preventive rate.

You pay $0 for one routine hearing exam per calendar year when you see a preferred or participating provider. However, if you see an out-of-network provider, you pay 40 percent of the allowed amount and the provider may balance bill you.

Hearing aids

You pay $0 of the $3,000 benefit limit per ear every 3 calendar years for prescribed hearing aids. You are responsible for hearing aid charges exceeding the $3,000 benefit limit. See the definition of "Limited Benefit".

You pay the standard rate for the following hearing-related services:

- Ear mold(s)
- 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 rented hearing aid before actual purchase
- Repair of hearing aid equipment
- The initial assessment, fitting, adjustment, auditory training, and other ear molds as necessary to maintain an optimal fit for those who have obtained or intend to obtain a hearing aid

The following hearing-related items are **not** covered:

- Over-the-counter hearing aids that are not prescribed, except for initial assessment, fitting, adjustment, auditory training, and other ear molds as necessary to maintain an optimal fit.
- Charges incurred after your plan 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

The following ancillary equipment is **not** covered:

- Alerting devices
- Assistive listening devices for FM/DM systems, receivers and transmitters
- Assistive listening devices for microphone transmitters
- Assistive listening devices for TDD machines
- Assistive listening devices for telephones
- Assistive listening devices for televisions (including amplifiers and caption decoders)
- Assistive listening devices for use with cochlear implants
- Assistive listening devices, supplies, and accessories not otherwise specified
- Hearing aid batteries

Home health care

ALERT! See the "What the plan does not cover" section for services the plan does not cover.

In certain circumstances, the plan covers short-term, provider-directed, medically necessary home health services on an intermittent or part-time basis by a licensed home health, hospice, or home care agency, to help a member recover from an acute covered illness, injury, or hospital stay. Home Health care is provided through visits from specialized clinicians, performing specific tasks (rather than time-based shifts), on a short-term basis, until specified individual goals are met. These services must be part of a treatment plan written by your provider (such as your physician or advanced registered practitioner [ARNP]). The provider must certify that you are homebound. These short-term visits may include:

- Skilled nursing care, physical, occupational, or speech therapy
- 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

- Home care of wounds resulting from injury or surgery
- End-of-life counseling (see page 40)

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 COC for coverage rules and limitations. These limitations apply even if the services are provided in the home or by a home health provider. For information on substitution of private duty nursing as an alternative benefit in lieu of hospitalization or in lieu of admission to a skilled nursing facility, see page 45 (hospital services) or page 53 (skilled nursing facility). Contact UMP Customer Service if you have questions.

Hospice care

Hospice (inpatient, outpatient, and respite care) 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 members and their families without intent to cure.

Medical

Hospice services received from preferred and participating providers are covered at 100 percent of the allowed amount after you meet your medical deductible. The plan covers hospice care for terminally ill members for no more than six months. See page 40 for coverage of end-of-life counseling.

If you need hospice care, your provider will refer you to the program. For additional assistance, you may contact UMP Customer Service.

Respite care

Respite care is continuous care of more than four hours a day to give caretakers temporary relief from caring for a member who is homebound or in hospice. The plan covers these services at 100 percent of the allowed amount after you meet your medical deductible, up to 14 visits per the member's lifetime.

Death with Dignity

The Washington Death with Dignity Act allows terminally ill adults seeking to end their life to request lethal doses of prescription drugs. These terminally ill patients must be Washington residents who have less than six months to live. For more information about this Act, see chapter 70.245 RCW.

Care described under this Act includes services covered by UMP, subject to standard plan requirements.

If you have questions about medical services UMP covers, contact UMP Customer Service. If needed, UMP may assign a case manager to support you.

If your current provider is unable to meet your needs, or if you need assistance in finding a provider for these services, visit End of Life Washington's website at **endoflifewa.org**. End of Life Washington is a community resource available to support the public in finding available providers.

For more information about the Death with Dignity Act, visit:

- The Department of Health's website at **doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct**.
- The Washington State Hospital Association's website at **wsha.org/for-patients/end-of-life/**.

Hospital services

ALERT! Many services provided in a hospital setting require preauthorization, notice, or both. Failure to request or receive preauthorization, or to notify the plan, may result in complete denial of claims. See the "Limits on plan coverage" section for how preauthorization and notice 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. Some services require preauthorization. Visit the UMP Policies that affect your care webpage for the list of these services, or contact UMP Customer Service. See Directory for link and contact information.

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 cannot 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 is based on the benefit in effect when the stay began.

Inpatient

Services are considered "inpatient" when you are admitted as inpatient to a hospital. Your provider must notify the plan as soon as possible after you are admitted, but not later than 24 hours after you are admitted. You pay an inpatient copay at a preferred facility. See the "Copay" section for details. Professional services — such as lab tests, surgery, or other services — may be billed separate from the hospital. The plan pays these services according to the network status of the provider, unless your condition is a medical emergency (see the "Emergency room" benefit for more information). The plan pays for all covered professional services at the standard rate.

Private duty nursing furnished by a licensed home health agency may be substituted as an alternative to hospitalization only if:

- Inpatient hospitalization is medically necessary and would be covered by the plan;
- Private duty nursing is the most cost-effective setting (private duty nursing must be an equal or lesser cost compared to hospitalization); and
- The member's provider agrees that private duty nursing is medically appropriate and will adequately meet the member's needs.

Private duty nursing is shift-based, hourly nursing care at home for adults and children, typically with a chronic illness, injury, or disability.

Substitution of private duty nursing in lieu of inpatient hospitalization has the same requirements as the hospital benefit. For example, all deductibles and coinsurances apply.

Outpatient

Services are considered "outpatient" when you are not admitted to the hospital. Your cost depends on the services provided, such as lab tests, and the network status of the provider(s) involved in your care. You do not pay the inpatient copay for outpatient services. Some services require preauthorization. Visit the

UMP Policies that affect your care webpage for the list of these services, or contact UMP Customer Service. See Directory for link and contact information.

Not all providers at a network hospital are network providers

Some providers who work in a network hospital or other network facility, including, but not limited to, anesthesiologists and emergency room doctors, may not be network providers.

When you receive nonemergency services at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider. For nonemergency services performed at one of these facilities outside of Washington State, you still pay the network rate, but in some states, an out-of-network provider may be allowed to ask you to waive some of your balance billing protections.

Infusion drug site of care program

If Medicare does not cover the infusion drug, this plan will be primary payor for covered services. In this case, infusion drugs in the site of care program require preauthorization by the plan before services are performed, or services will not be covered. Approved sites of care include standalone infusion sites, doctor's offices, home infusion and some outpatient hospital facilities. Your provider must submit a preauthorization request for an unapproved site of care. See the "Limits on plan coverage" section for preauthorization instructions.

Contact UMP Customer Service for the drugs covered under the site of care program, more information, or help finding an approved site of care near you.

Knee arthroplasty, total

Covered services are paid at the standard rate. Computer navigated and unicompartmental knee arthroplasty for treatment of end-stage osteoarthritis and rheumatoid arthritis of the knee are covered only as follows:

- Total knee arthroplasty performed with 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.

Mammogram and Digital Breast Tomosynthesis (DBT)

Screening (preventive)

For members age 40 or older, with or without a clinical breast exam, the plan covers screening mammograms and Digital Breast Tomosynthesis (DBT) every year, and they are not subject to your medical deductible.

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

Note: Digital Breast Tomosynthesis (DBT) is only covered when you receive it along with a screening or a medically necessary diagnostic mammogram.

How much you will pay

For all members, services are covered at 100% of the allowed amount when they are screening or medically necessary diagnostic, and supplemental breast examinations.

Massage therapy

The plan covers up to 24 visits per calendar year for massage therapy (no more than 90 minutes per visit). See the definition of "Limited benefit." You pay the special rate (a $15 copay) for up to 24 massage therapy visits per calendar year for covered diagnoses when you see a preferred provider. The copay will not apply toward your medical deductible, but the copay will apply to the out-of-pocket limit. All visits will apply to the 24-visit limit.

You must have a prescription for massage therapy treatment from a covered provider type, such as a physician. The plan does not cover massage therapy when you see a participating or out-of-network provider.

> **ALERT!** The plan only covers preferred massage therapists. To find a preferred massage therapist, use the UMP Provider search or contact UMP Customer Service (see Directory for link and contact information).

Mastectomy and breast reconstruction

> **ALERT!** See page 41 for coverage of breast reconstruction or mastectomy services related to gender affirming care.

You pay the standard rate for a mastectomy as treatment for disease, illness, or injury, as well as:

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

Mental health

See the "Behavioral health" benefit.

Naturopathic physician services

While naturopaths are a covered provider type, naturopaths may recommend services that the plan does not cover. You will pay all costs for excluded and non-medically necessary services, even if your naturopathic physician recommends or prescribes them (see the "Medically necessary or medical necessity" definition for more information).

The plan does not cover herbal, homeopathic, or other dietary supplements (including vitamins and minerals), even if a covered provider type prescribes them.

Nurse line

UMP members have access to Advice24 registered nurses by phone 24 hours a day, 7 days a week or by secure chat from 8 a.m. to 8 p.m. (Pacific) at no cost to you. Nurses provide immediate symptom assessment, health information, and advice. They can help you decide if you need to go to the emergency room, see a doctor either virtually or in-person, or care for your symptoms at home. UMP members can call the nurse line at 1-877-375-2599 (TRS: 711) or by signing into your Regence account for live and secure nurse chat.

Nutrition counseling and therapy

TIP: See the "Diabetes education" benefit for how these services are covered for members with diabetes.

The plan covers up to 12 visits per lifetime for nutrition counseling and therapy services.

Obstetric and newborn care

Pregnancy program

As an expectant parent, the program helps you manage your health throughout pregnancy and offers access to a nurse line, pregnancy support, and education 24 hours a day, 7 days a week. It also includes a smartphone application to help you track milestones, identify symptoms, access education, and get one-click access to the nurse line. To enroll in the program, call 1-888-569-2229 (TRS: 711) or sign in to your Regence account (see Directory for link). This program is covered at no cost to you.

Services for obstetric and newborn care

See the "Covered and noncovered provider types" section for providers whose services are covered by the plan. Covered professional services include:

- Amniocentesis and related genetic counseling and testing during pregnancy.
- Care of complications associated with pregnancy, including pregnancies resulting from fertility or infertility treatment.
- Prenatal and postnatal care.
- Prenatal testing (as stated in Washington Administrative Code [WAC] 246-680-020).
- Vaginal or cesarean delivery.
- Placement of IUD including immediately after delivery.

Note: Early elective deliveries may not be covered. See "Deliveries before 39 weeks gestation" below.

For inpatient hospital charges related to a childbirth, you:

- Meet your medical deductible.
- Pay the inpatient copay.
- Pay the coinsurance for professional services while hospitalized.
- Meet your medical deductible for the newborn. However, if only covered preventive care services (see page 50) are billed for the newborn, you will not meet the newborn's medical deductible, pay the inpatient copay, or pay the coinsurance when you see a preferred provider.

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

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

Note: The Newborns' and Mother's Health Protection Act (NMHPA) requires a hospital length of stay in connection with childbirth for a mother or her newborn and may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

A newborn dependent of a covered gestational parent is covered by the plan 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 gestational parent's plan coverage for the first 21 days. Visit the HCA website at **hca.wa.gov/erb** for what you need to do for continued coverage.

If your obstetric care began while covered under another health plan, and your providers are not part of the UMP network, contact UMP Customer Service to discuss your options.

Deliveries before 39 weeks gestation

Vaginal or cesarean deliveries before 39 weeks of gestation are covered when the services are medically necessary. Examples include:

- A medical emergency affecting the member or baby.
- A medical condition of the member or baby for which a delivery is medically necessary.
- Labor begins naturally (without medical intervention) before the member 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 affecting the member or baby.
- Neither the member nor baby have a medical condition for which immediate delivery is medically necessary.

Talk to your provider about whether early delivery is for a medically necessary reason. For questions about this policy, contact UMP Customer Service.

Services covered as preventive

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

- HIV counseling and testing.
- Purchase of manual and electric breast pumps for pregnant and nursing members, plus supplies included with the initial purchase. Hospital-grade pumps are not covered.
- Screening for diabetes during pregnancy.

Lactation (breastfeeding) counseling

Lactation counseling is covered at the preventive rate during pregnancy and after birth to support breastfeeding when members receive services by a covered provider type.

Note: Donor human milk from an approved milk bank for inpatient use may be covered when medically necessary.

Ultrasounds during pregnancy

The following limits do not apply to high-risk pregnancies. For example, a multiple pregnancy is considered high risk. Contact UMP Customer Service to learn what is covered for high-risk pregnancies.

Routine ultrasounds during pregnancy are covered as follows:

- One in week 13 or earlier
- One during weeks 13-28

Adding a new dependent to your coverage

For information about how to enroll new dependents in your health plan, refer to the Employee Enrollment Guide or the Retiree Enrollment Guide on the HCA website at **hca.wa.gov/employee-retiree-benefits/forms-and-publications**. You can also refer to "Making changes" in the "Eligibility and Enrollment" section: and in the "Eligibility and enrollment for a retiree or survivor" sections of this certificate of coverage for more information.

Office visits

The plan pays for office visits for covered conditions under the medical benefit. Preventive care visits with preferred providers as described under the definition of "Preventive care" are covered in full and are not subject to your medical deductible.

Orthognathic and Telegnathic surgery

Orthognathic and telegnathic surgery must be preauthorized by the plan. Contact UMP Customer Service if you have questions. See page 56 for treatment of temporomandibular joint (TMJ) disorder.

Pain and joint management, interventional

Interventional pain management is a medical subspecialty that treats pain with invasive interventions like injections, spinal cord stimulations, and implantable drug delivery systems. The purpose of interventional pain management is to help members have less pain, so they can return to normal activities, when possible.

Preauthorization is required for interventional pain and joint management, such as:

- Epidural injections
- Facet blocks
- Pain pumps
- Radiofrequency ablations
- Sacroiliac joint injections

Preauthorization is not required for post-procedural pain management in an inpatient setting, including, but not limited to, treating acute pain due to trauma, acute post-thoracotomy pain, and acute postoperative pain.

Preventive care

> **ALERT!** This benefit covers **only** services that meet the requirements below. If you receive services during a preventive care visit that do not meet these requirements, or your provider bills your visit as medical treatment instead of a preventive service, the services are not covered as preventive. Instead, when medically necessary, they are covered under the standard rate.

Covered preventive care services are paid at the preventive rate. You do not have to meet your medical deductible before the plan pays the allowed amount for services covered under the preventive care benefit. When you see a preferred or participating provider for these services, you pay $0. If you see an out-of-network provider, you pay 40 percent of the allowed amount, and the provider may balance bill you. If you do not have access to a preferred or participating provider for preventive care services, see the

"When you do not have access to a preferred provider: network waiver" section for how to request a network waiver.

For a list of services covered as preventive, visit the HealthCare.gov website at **healthcare.gov/preventive-care-benefits**. This site also features links to specific preventive services covered for members based on age and other risk factors. The plan may not cover recommendations added during the calendar year as preventive until later years. For a list of immunizations covered as preventive, see the "Covered immunizations" section below.

Examples of services covered under the preventive care benefit include:

- Certain radiology and lab tests, such as screening mammograms (see page 47).
- Certain screening tests performed during pregnancy (see page 49 for more on prenatal care).
- Hearing tests as part of a newborn screening.
- Immunizations as specified under "Covered immunizations" on page 52.
- Intensive behavioral counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors.
- One-time screening by ultrasound for abdominal aortic aneurysm for men ages 65-75 who have ever smoked.
- Preventive vision acuity screening from birth through 18 years of age.
- Preventive visits such as well-baby care and annual physical exams.
- Routine screenings for adults.
- Screening for hepatitis B for adolescents and adults at high risk and those who are pregnant.
- Screening procedures, such as colonoscopy (see page 37 for coverage of colonoscopy performed to diagnose or treat disease or illness). If you have a screening and the provider diagnoses and treats a condition during the colonoscopy, services will be paid at the standard rate.

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 your medical deductible and coinsurance). For more information, see page 37.

> **ALERT!** Follow-up visits or tests as a result of your preventive care visit are not covered under the preventive care benefit. If the plan normally covers the test or visit and it is medically necessary, it is covered under the medical benefit.

Contact UMP Customer Service to ask if a medical service is covered as preventive.

The following specific services are covered as preventive:

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

For additional services covered as preventive, see the following benefits: "Family planning services," "Mammogram and Digital Breast Tomosynthesis (DBT)," and "Obstetric and newborn care."

Covered immunizations

You pay the standard rate for covered immunizations that are not considered preventive.

The plan covers immunizations listed on the Centers for Disease Control and Prevention (CDC) applicable immunization schedule (children, adolescents, adults) for U.S. residents. For a list of immunizations covered as preventive, visit the CDC website at **cdc.gov/vaccines/imz-schedules/index.html** or contact UMP Customer Service.

Some covered immunizations are classified as "may be recommended" by the CDC depending on medical condition or lifestyle. For those immunizations to be covered as preventive, you must meet the criteria specified on the CDC schedule.

Immunizations covered under the preventive rate are not subject to your medical deductible. Covered immunizations given by the providers listed under the "Where to get immunizations" section below are paid under the preventive care benefit. If you see an out-of-network provider for covered preventive immunizations, you pay 40 percent of the allowed amount and the provider may balance bill you. Flu shots and COVID-19 vaccines are paid at 100 percent regardless of the provider's network status.

> **TIP:** The plan covers flu shots and COVID-19 vaccines listed on the applicable CDC immunization schedule. For a list of immunizations covered as preventive, find a link to the CDC immunization schedules at the CDC website at **cdc.gov/imz-vaccines/schedules/index.html** or contact UMP Customer Service.

Where to get immunizations

You pay $0 for immunizations covered under the preventive care benefit when received from a:

- Preferred or participating provider
- Public health department

The plan does not cover immunizations for travel or employment, even when recommended by the CDC or required by travel regulations. **Exception:** COVID-19 vaccines are covered when required for employment.

> **TIP:** If you get a vaccine from an out-of-network provider, submit your claim to Regence BlueShield as a medical claim (see the "Billing and payment: submitting a claim" section).

Radiology

Preauthorization is required for all non-emergency diagnostic imaging. Providers should obtain preauthorization before scheduling or performing any elective outpatient imaging service. Examples of imaging tests that require a preauthorization are:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance angiography (MRA)

- Magnetic resonance imaging (MRI)
- Myocardial perfusion imaging (MPI)
- Nuclear cardiology:
  - Blood pool imaging
  - First pass ventriculography
  - Infarct imaging
  - Multiple-gated acquisition (MUGA) scan
- Positron emission tomography (PET and PET-CT)

Second opinions

This benefit covers:

- **Second opinions you choose to get.** The plan covers these under the medical benefit, once you meet your medical deductible and pay the coinsurance.
- **Second opinions required by the plan.** The plan covers these at 100 percent (you do not have to meet your medical deductible or pay the coinsurance). If you do not get a second opinion when required by the plan, coverage for services may be denied.
- **Expert second opinion program**. This program, provided by 2nd.MD, offers members the opportunity to consult virtually with specialists. It also provides for expert lead consultation and post-consultation follow-up support. To learn more visit the 2nd.MD website at **2nd.md/ump** or call 1-866-982-1434 (TRS: 711).

Skilled nursing facility

Skilled nursing facility services are paid at the inpatient rate. The plan must preauthorize services before you are admitted to a skilled nursing facility (see the "Limits on plan coverage" section). In addition, the facility must notify the plan within 24 hours of your admission (see page 67).

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. The plan 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.

The plan does not cover stays at a skilled nursing facility that are primarily convalescent or custodial in nature.

Private duty nursing furnished by a licensed home health agency may be substituted as an alternative to placement at a skilled nursing facility only if:

- Skilled nursing facility care is medically necessary, not primarily convalescent or custodial in nature, and would be covered by the plan;
- Private duty nursing is the most cost-effective setting (private duty nursing must be an equal or lesser cost compared to a nursing facility); and
- The member's provider agrees that private duty nursing is medically appropriate and will adequately meet the member's needs.

Private duty nursing is shift-based, hourly nursing care at home for adults and children, typically with a chronic illness, injury, or disability.

Substitution of private duty nursing in lieu of placement in a skilled nursing facility has the same requirements and limitations as the facility benefit. For example, all deductibles and coinsurances apply

and the benefit is limited to the equivalent of a maximum of 150 skilled nursing facility days per calendar year.

Skilled nursing care limits

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

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

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

Sleep therapy

Preauthorization is required for any facility-based diagnostic or titration study (free-standing or hospital), and for sleep treatment equipment and related supplies, such as:

- Initial treatment order and supplies (APAP, CPAP, BiPAP).
- In-lab sleep study (PSG, MSLT, MWT).
- Ongoing Treatment Order (APAP, CPAP, BiPAP).
- Titration study.

Exception

The following supplies do **not** require a preauthorization:

- Ongoing APAP supplies
- Ongoing BiPAP supplies
- Ongoing CPAP supplies

Locations where sleep therapy services are not covered

Sleep therapy services are not covered:

- In the emergency room
- At urgent-care facilities
- During inpatient hospitalization

Spinal and extremity manipulations

The plan covers up to 24 visits per calendar year for manipulations (adjustments) of the spine and extremities (arms and legs). See the definition of "Limited benefit."

You pay the special rate (a $15 copay) for up to 24 visits for spinal and extremity manipulations when you see a preferred provider. The copay will not apply toward your medical deductible, but the copay will apply to the out-of-pocket limit. All visits apply to the 24-visit limit.

You may receive an office visit (see the "Office visits" benefit for more details) and/or x-ray (see the "Diagnostic tests, laboratory, and x-rays" benefit for more details) at the time of your spinal and extremity manipulation service.

Note: For participating providers and out-of-network providers, services are paid at the standard rate up to 24 visits per calendar year.

Spinal injections

The plan must preauthorize some spinal injections (see the "Limits on plan coverage" section for how this works). The following therapeutic injections are covered for treatment of chronic pain:

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

Note: See page 76 for a list of spinal injections that are not covered by the plan.

Spinal injections not specified in this section may be covered subject to the plan's medical policy. Contact UMP Customer Service for more information.

Spinal surgery

The plan must preauthorize inpatient and outpatient spinal surgery

Substance use disorder

See the "Behavioral health" benefit.

Surgery

> **Note:** When you receive nonemergency services at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider. For nonemergency services performed at one of these facilities outside of Washington State, you still pay the network rate, but in some states, an out-of-network provider may be allowed to ask you to waive some of your balance billing protections.

You pay the standard rate for covered surgical services. The plan pays for covered surgical services according to the network status of the provider. The surgeon and other professional providers may bill separately from the facility.

Your provider must notify the plan when you are admitted for inpatient treatment and when you receive certain services. Some outpatient procedures require preauthorization. Find the list of services that require preauthorization on the UMP Policies that affect your care webpage. Contact UMP Customer Service if you have questions. See Directory for link and contact information.

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

The plan covers the following services as outpatient:

- Outpatient surgery at a hospital
- Short-stay obstetric (childbirth) services (released within 24 hours of admission)

- Surgery and procedures performed at an ambulatory surgery center

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

Temporomandibular joint (TMJ) disorder treatment

The plan covers diagnosis and medically necessary treatment of temporomandibular joint (TMJ) disorders, including surgery and non-surgical services. Treatment must follow the plan's medical policy and requires preauthorization. Treatment that is experimental or investigational, or primarily for cosmetic purposes, is not covered.

Therapy: Habilitative and Rehabilitative

Note: The total limit for therapies for inpatient habilitative and inpatient rehabilitative services is a combined limit of 60 days annually. The total limit for therapies for outpatient habilitative and outpatient rehabilitative services is a combined limit of 60 visits annually.

Habilitative (Neurodevelopmental) Services

The plan covers inpatient and outpatient habilitative (neurodevelopmental) services to assist a person to keep, learn, or improve skills and functioning for daily living. This could be related to issues such as:

- A congenital anomaly (such as cleft lip or palate.
- Conditions of developmental delay, including autism.

For the purposes of this benefit, developmental delay means a significant lag in achieving skills such as:

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

You must have a prescription for occupational, physical, and speech therapy services from a covered provider type (see the "Covered and noncovered provider types" section), such as a physician.

Inpatient habilitative services

Preauthorization is required for inpatient habilitative admissions. The plan covers therapy services when they are provided during inpatient habilitative admission, up to 60days combined per calendar year, counting all types of therapies listed here (see definition of "Limited benefit"). You must pay the inpatient copay and your coinsurance for inpatient services.

Outpatient habilitative services

The plan covers medically necessary outpatient occupational, physical, and speech therapy services up to 60visits combined per calendar year, counting all types of therapies listed here (see definition of "Limited benefit").

Rehabilitative Services

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

- An illness.
- An acute injury.

- Worsening or aggravation of a chronic injury.

You must have a prescription for occupational, physical, and speech therapy services from a covered provider type (see the "Covered and noncovered provider types" section, such as a physician.

Inpatient rehabilitation services
Preauthorization is required for inpatient rehabilitation admissions. The plan covers therapy services when they are provided during inpatient rehabilitation admission, up to 60 days combined per calendar year, counting all types of therapies listed here (see definition of "Limited benefit"). You must pay the inpatient copay and your coinsurance for inpatient services.

Outpatient rehabilitation services
The plan covers medically necessary outpatient neurodevelopmental, occupational, physical, and speech therapy services up to 60 visits combined per calendar year, counting all types of therapies listed here (see definition of "Limited benefit").

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 member receives an organ, eye, or tissue donation from a live donor, the plan pays the standard rate for 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 the "Emergency room" benefit for care during a medical emergency.

If you need immediate care or need care when your usual provider is closed, and your situation is not a medical emergency, you may use urgent care facilities to receive care at a lower cost than an emergency room. You do not pay the emergency room copay for urgent care services. These services are paid at the standard rate, according to the provider's network status. Visit the UMP Provider search to find preferred urgent care facilities (see Directory for link).

Virtual care

Telemedicine services

Telemedicine is the delivery of health care services through audio and visual technology, allowing real-time communication between the member at the originating site and a provider for the purpose of diagnosis, consultation, or treatment. Telemedicine includes audio-only telemedicine. Telemedicine does not include the use of fax or email.

"Store and forward technology" is a term used for the transfer of a member's medical information from one health care provider to another at a distant site, which results in medical diagnosis and management of the covered person. The purpose of telemedicine and store and forward technology is diagnosis, consultation, or treatment of the member. It does not include the use of fax or email.

If you see a network provider, telemedicine services are paid at the network rate. If you see an out-of-network provider, telemedicine services are paid at the out-of-network rate.

The plan covers store and forward technology and telemedicine from authorized originating sites under the medical benefit if:

- The plan provides coverage for the service when provided in person by the provider;

- The service is medically necessary;
- The service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards;
- The technology used to provide the service meets the standards required by state and federal laws governing the privacy and security of protected health information; and
- The service is recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act (PPACA) in effect on January 1, 2015.

If services are provided through store and forward technology, there must be an associated office visit between the covered person and the referring health care provider. The associated office visit may be in person or via telemedicine. For audio-only telemedicine, the member must have an established relationship with the provider.

The originating site (the member's physical location) for telemedicine services must be one of the following sites:

- Community mental health center
- Federally qualified health center
- Home or any location determined by the individual receiving the service
- Hospital
- Physician's or other health care provider's office
- Renal dialysis center (except independent renal dialysis center)
- Rural health clinic
- Skilled nursing facility

Any originating site, except home, may charge a facility fee for infrastructure and preparation of the member.

Telemedicine and store and forward technology are subject to all terms and conditions of the plan, including utilization review, preauthorization requirements, deductibles, and copay requirements. Services obtained from out-of-network providers will be reimbursed at the out-of-network rate.

The following are **not** covered by the plan:

- Email or fax transmissions between provider and member
- Home health monitoring
- Installation or maintenance of any telecommunication devices or systems
- Originating sites' professional fees
- Services that are not medically necessary
- Services that would not be covered if delivered in person
- Store and forward technology without an associated office visit between the covered member and the referring health care provider
- Telemedicine or store and forward services for services that are not recognized as essential health benefits under section 1302(b) of the PPACA in effect on January 1, 2015
- Telemedicine or store and forward services that cannot be safely and effectively provided through telemedicine or store and forward technology

- Telemedicine or store and forward services that use technology that does not meet state and federal requirements for privacy and security of protected health information
- Telemedicine visits originating from a location other than the specified originating sites

Doctor On Demand

Doctor On Demand is a virtual care service that gives you access to medical and behavioral health providers 24 hours a day, 7 days a week. It is a good option to consider when you need medical attention, but not emergency room or urgent care. Doctor On Demand providers are board-certified, U.S.-based providers who are specifically trained in video medicine. Members can connect in minutes with doctors face-to-face through a smartphone, tablet, or computer via the Regence website or Doctor On Demand smartphone application. To learn more, visit the Telemedicine (virtual care) webpage at **ump.regence.com/pebb/benefits/telemedicine**

Providers review a member's history and symptoms, perform a virtual exam, and recommend treatment, which may include prescription drugs and lab work. Doctor On Demand providers can treat most common health conditions, including, but not limited to:

- Asthma.
- Colds and allergies.
- Diabetes.
- Eczema and acne.
- Heartburn and indigestion.
- High blood pressure and high cholesterol.
- Migraines.
- Pink eye.
- Urinary Tract Infections (UTIs).

A Doctor On Demand virtual care appointment is paid at the standard rate and you will know exactly how much it will cost before you start your visit. Doctor On Demand providers are considered preferred providers.

Doctor On Demand does **not** include the use of audio-only telephone, fax, or email. For additional questions, contact UMP Customer Service.

Vision care (diseases and disorders of the eye)

You pay the standard rate under the medical benefit for treatment of diseases and disorders of the eye that are not part of a routine vision exam. 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 DME (see page 38). These services are paid at the standard rate.

Your routine vision benefits

Vision coverage is provided by UMP, in collaboration with Regence Choice Vision Plan administered by Vision Service Plan (VSP). Regence BlueShield administers benefits for the treatment of diseases and disorders of the eyes. VSP administers benefits for routine eye exams and hardware (prescription lenses, frames or prescription contact lenses) and provides claims administration for this plan.

When you have questions about treatment of diseases and disorders of the eyes contact UMP Customer Service. When you have questions about routine eye exams and hardware, call VSP Member Services at 1-844-299-3041 or Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY) 1-800-428-4833.

See the Directory at the beginning of the COC for vision services contact information.

Finding a routine vision provider

Get the most out of your UMP vision benefits and save money with a Choice Network provider. As a UMP member, you may search for a Choice Network provider for preventive (routine) vision services through the VSP website by logging in to your VSP account or by selecting "Find a doctor," and using the advanced search option to select "Choice" for "Doctor network." You can also search by signing in to your Regence account, selecting "Find care," and selecting "Vision." See the Directory pages at the beginning of this booklet for links and contact information. Members under age 19 do not have out-of-network provider benefits.

- **Choice Network provider:** When you choose to see a Choice Network provider for covered preventive vision care, you pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount. Select a Choice Network provider who participates in the Premier Edge Promise Program to receive the best value for lenses and frames or contact lenses. VSP providers who participate in the Premier Edge Promise Program provide access to special offers and savings.
- **Out-of-network provider:** For members age 19 or older, out-of-network providers will cost you more. See the table below for more information. Members under age 19 do not have out-of-network benefits.

ALERT! This benefit covers only services that meet the requirements below. If you receive services during a comprehensive routine eye exam and your provider bills your visit as a medical treatment instead of as a routine service, the services are not covered as routine. Instead, when medically necessary, they may be covered under your medical benefits. See the "Vision care (diseases and disorders of the eye)" benefit for more information.

How the plan pays

This section explains how the plan pays for covered services. The explanation includes information about maximum benefits, covered services, and payment. The below VSP coverage table applies to adults and dependents age 19 or older.

Benefit	Frequency	Your cost with a Choice Network provider	Your cost with an out-of-network provider
Professional comprehensive routine eye exams	One per calendar year.	You pay $0 of the allowed amount and the plan pays 100% of the allowed amount.	You pay 100% of billed charges. VSP will reimburse you up to $45 when you submit a claim for a covered exam.
Frames	One every two calendar years.	You pay $0 up to a $200 frame allowance: or You pay $0 up to an $110 frame allowance for Walmart®, Sam's Club®, or Costco® providers.	You pay 100% of billed charges. VSP will reimburse you up to $70 when you submit a claim for covered frames.

Benefit	Frequency	Your cost with a Choice Network provider	Your cost with an out-of-network provider
Lenses and enhancements	One set every two calendar years.	You pay $0 for the following covered lenses and the plan pays 100% of the allowed amount: • Single vision lenses • Lined bifocal lenses • Standard progressive lenses • Lined trifocal lenses • Lenticular lenses **Note:** Lens enhancement is not covered except for impact-resistant coating for dependent children age 19 or older.	You pay 100% of billed charges. VSP will reimburse you up to the following amounts when you submit a claim for covered lenses: • $30 single vision lenses • $50 lined bifocal lenses • $50 standard progressive lenses • $65 lined trifocal lenses • $100 lenticular lenses
Contacts	One set of contact lenses or disposable contact lenses up to the maximum allowance instead of frames and lenses every two calendar years.	You pay $30 copay for a contact lens evaluation and fitting exam. You pay $0 up to a $200 contact allowance for elective contact lenses. You pay $0 for necessary contact lenses. Note: You are still responsible for paying a $30 copay for the contact lens evaluation and fitting exam.	You pay 100% of billed charges. VSP will reimburse you up to the following amounts when you submit a claim for contact lenses: • $105 for elective contact lenses • $210 for necessary contact lenses

Vision exam

You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount when you see a Choice Network provider for one professional comprehensive routine eye examination with refraction or visual analysis per calendar year, including:

- Prescribing and ordering proper lenses;
- Verifying the accuracy of the finished lenses; and
- Progress or follow-up work as necessary.

When you see an out-of-network provider you pay 100 percent of the billed charges. VSP will reimburse you up to $45 when you submit a claim for covered services.

Vision hardware

Lenses for glasses

You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount once every two calendar years for one set of covered glass or plastic lenses:

- Single vision lenses
- Lined bifocal lenses

- Lined trifocal lenses
- Lenticular lenses
- Standard progressive lenses
- Lens enhancement covered for dependent children age 19 or older only:
  - Impact-resistant coating

When you see an out-of-network provider you pay 100 percent of the billed charges. When you submit a claim for covered lenses, VSP will reimburse you up to the following amounts:

- $30 single vision lenses
- $50 lined bifocal/standard progressive lenses
- $65 lined trifocal lenses
- $100 lenticular lenses

Frames

The plan covers one frame every two calendar years:

- When you see a Choice Network provider, the plan pays up to $200 You pay any amount over $200.
- When you see an out-of-network provider you pay 100 percent of the billed charges. VSP will reimburse you up to $70 when you submit a claim.
- When you see a VSP approved wholesale/retail vendor the plan pays up to the VSP approved wholesale/retail limit of $110. You pay any amount over $110. VSP approved wholesale/retail vendors include both community-based providers, as well as national retail chains. For a list of wholesale/retail vendors, contact VSP Member Services at 1-844-299-3041 or Deaf, DeafBlind, Late Deafened and Hard of Hearing members call (TTY) 1-800-428-4833.

Contact lenses

The plan covers elective contact lenses or necessary contact lenses in lieu of frames and lenses once every two calendar years.

- **Elective contact lenses** are contact lenses that are covered under the frame limit in lieu of coverage for eyeglasses.
- **Necessary contact lenses** are contact lenses that are prescribed by your provider for other than elective or cosmetic purposes. Necessary contact lenses are used to treat specific conditions for which contact lenses provide better visual correction.

When you see a Choice Network provider:

- The plan pays up to $200 for elective contacts. **You pay a $30 copay when you receive contact lens evaluation and fitting exam at the time of service.** You also pay any amount over $200.
- The plan pays 100 percent of the allowed amount for necessary contact lenses. **You pay a $30 copay when you receive contact lens evaluation and fitting exam at the time of service.**

When you see an out-of-network provider you pay 100 percent of the billed charges. When you submit a claim, VSP will reimburse you up to the following amounts:

- $105 for elective contacts including any fitting/evaluation services
- $210 for necessary contact lenses including any fitting/evaluation services

Low vision benefit

The plan covers low vision benefits when vision loss is sufficient enough to prevent reading and performing daily activities with standard corrective eyewear. If you fall within this category, you are entitled to professional services, as well as ophthalmic materials. These services and equipment are subject to the limitations stated below. Contact your Choice Network provider for more information.

You pay 25 percent of the allowed amount for covered supplemental aids. The plan pays 75 percent of the allowed amount for medically necessary supplemental aids provided by Choice Network providers and out-of-network providers. When you see an out-of-network provider for covered supplemental aids, you pay 100 percent of the billed charges. VSP will reimburse you up to 75 percent of the allowed amount when you submit a claim for covered aids.

The maximum low vision benefit available is $1,000 (excluding your coinsurance) every two calendar years for supplemental examinations (testing) and supplemental aids combined when provided by Choice Network providers and out-of-network providers. There is a benefit maximum of two supplemental examinations (testing) and all supplemental aids combined.

Supplemental examinations (testing)

You may receive up to two medically necessary supplemental tests (complete low vision analysis and diagnosis), including a comprehensive examination of visual functions, and the prescription of corrective eyewear or low vision aids when noted by the provider every two calendar years. When you see a Choice Network provider, you pay $0 and the plan pays 100 percent of the allowed amount. When you see an out-of-network provider you pay 100 percent of the billed charges. VSP will reimburse you up to $125 when you submit a claim for covered services.

Supplemental aids

The plan pays for covered supplemental aids every two calendar years, which may include:

- Optical and non-optical aids; and
- Training on how to use the aids.

Children (under age 19) who have Medicare as their primary coverage

This section explains how the plan pays for covered services for children under age 19.

Vision exam

You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount when you see a Choice Network provider for one professional comprehensive routine eye examination with refraction or visual analysis per calendar year, including:

- Prescribing and ordering proper lenses;
- Verifying the accuracy of the finished lenses; and
- Progress or follow-up work as necessary.

Vision hardware

Lenses for glasses

You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount when you see a Choice Network provider once every calendar year for one set of covered glass or plastic lenses.

Frames

You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount for one covered frame every calendar year when you see a Choice Network provider.

Contact lenses

- You pay $0 of the allowed amount and the plan pays 100 percent of the allowed amount for elective contact lenses or necessary contact lenses in lieu of frames and lenses once every calendar year when you see a Choice Network provider.
- You pay $0 and the plan pays 100 percent of the allowed amount for contact lens evaluation and fitting exam when you see a Choice Network provider.

Low vision benefit

ALERT! Out-of-network providers are not covered for any low vision services.

The plan covers low vision benefits when vision loss is sufficient enough to prevent reading and performing daily activities with standard corrective eyewear. If you fall within this category, you are entitled to professional services, as well as ophthalmic materials at no cost to you when the services are provided by a Choice Network provider. These services and equipment are subject to the limitations stated below. Contact your Choice Network provider for more information.

Supplemental examinations (testing)

You may receive up to two medically necessary supplemental tests (complete low vision analysis and diagnosis), including a comprehensive examination of visual functions, and the prescription of corrective eyewear or low vision aids when noted by the provider every two calendar years when you see a Choice Network provider.

Supplemental aids

The plan pays for covered supplemental aids every two calendar years, which may include:

- Optical and non-optical aids; and
- Training on how to use the aids.

Vision claims administration

This section explains how VSP administers claims.

How to submit a vision claim for reimbursement

When you visit a Choice Network provider, the doctor will submit the claim directly to VSP for payment.

If you are a member and are age 19 or older and you see an out-of-network provider, you pay 100 percent of the billed charges. You can submit the claim online or by mail. See the Directory pages at the beginning of this booklet for links and contact information.

When you submit a claim, attach an itemized receipt that includes the following information:

- Doctor’s name or office name;
- Name of patient;
- Date of service; and
- Each service received and the amount paid.

Timely submitting of claims

You have 12 months from the date of service to submit your claim. If you do not submit your claim within 12 months of the date of service, it will be denied.

If you disagree with how your claim was processed, you may file a complaint or an appeal.

Vision complaints and appeals

How to submit a vision complaint

Complaints can be submitted through a written or verbal request. See the Directory pages at the beginning of this booklet for links and contact information.

How to submit a vision appeal

You have the right to appeal if:

- You do not agree with VSP's decision about your health care.
- VSP will not approve or give you care you feel it should cover.
- VSP is stopping care you feel you still need.

VSP normally has 30 days to process your appeal. In some cases, you have a right to an expedited appeal. You can get an expedited appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard appeal. If you ask for an expedited appeal, VSP will decide whether your request is approved. If not approved, your appeal will be processed in 30 days. If any doctor asks VSP to give you an expedited appeal, or supports your request for an expedited appeal, it must be given to you.

If you want to file an appeal which will be processed within 30 days, do the following:
File the request in writing with VSP. See the Directory pages at the beginning of this booklet for contact information. Your appeal request will be processed within 30 days from the date your request is received.

If you want to file an expedited appeal, which will be processed within 24 hours, do the following:

- File an oral or written request for an expedited appeal. Specifically state that "I am requesting an expedited appeal," or "I believe that my health could be seriously harmed by waiting 30 days for a normal appeal."
- To file a request orally, contact VSP Member Services. VSP will document the oral request in writing.

See the Directory pages at the beginning of this booklet for contact information.

Help with your appeal:
If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. If you are covered by Medicare, you may contact the Medicare Rights Center toll free at 1-888-466-9050 (TRS: 711). You may also contact the National Institute on Aging at 1-800-222-2225 (TRS: 711) to request the phone number of your local Area Agency on Aging or Health Insurance Counseling and Assistance Program (HICAP).

Limits on plan coverage

If you receive a service that is not medically necessary, is experimental or investigational, is listed as an exclusion in the “What the plan does not cover” section, you are responsible for paying all associated charges.

Preauthorizing medical services

The plan must preauthorize some medical services and supplies to determine whether the service or supply meets the plan's medical necessity criteria 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**. Preauthorization is not a guarantee of coverage.

A change after the plan has approved a preauthorization request — including, but not limited to, a change of provider or different/additional services — requires your provider to submit a new preauthorization request and for the plan to approve it.

If your preauthorization is denied, your provider may request a peer-to-peer review where they can talk to a Regence BlueShield provider about your condition prior to submitting an appeal. For more information contact UMP customer service.

Your preauthorization role

> **ALERT!** Excluded, experimental, and investigational services do not require preauthorization because they are not covered by the plan. To confirm whether a service is covered, contact UMP Customer Service.

To be covered, some services, including, but not limited to, Applied Behavior Analysis (ABA) Therapy for members age 18 or older (see page 31) and bariatric surgery (see page 32), must be preauthorized before services are received. A preferred or participating provider may be required to request preauthorization before providing services. Contact UMP Customer Service to ask if a service requires preauthorization and how to submit a request.

An out-of-network provider is not obligated to obtain preauthorization for services that require a preauthorization because they do not have a contract with Regence. If an out-of-network provider does not obtain a required preauthorization in advance of the service, you will be responsible for all charges billed to you.

You are encouraged to request that an out-of-network provider preauthorize certain services on your behalf to determine medical necessity before the services are provided. They have the clinical details and technical billing information needed 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 the "What the plan does not cover" section).

> **ALERT!** See the "Complaint and appeal procedures" section for how to appeal denial of a preauthorization request before receiving services.

List of services and supplies requiring preauthorization or notice

For a list of services and supplies requiring preauthorization or notice:

- Visit the UMP Policies that affect your care webpage.

- Contact UMP Customer Service to request a printed list or ask questions.

See the Directory pages at the beginning of this booklet for links and contact information.

ALERT! The UMP preauthorization list is updated throughout the year. The fact that a service does not require preauthorization or notice does not guarantee coverage.

Notice for facility admissions

Your provider must notify the plan upon your admission to a facility for services requiring plan notice. You may find a list of services requiring plan notice by visiting the UMP Policies that affect your care webpage or contacting UMP Customer Service (see Directory for link and contact information). Facility admissions for which the plan is not notified may not be covered. Notice is usually done by the facility at the time you are admitted. Notice is not the same as preauthorization and many services require both.

What is the difference between preauthorization and notice?

ALERT! Many services, including, but not limited to, inpatient services, require both preauthorization and notice. Contact UMP Customer Service or talk to your provider if you have questions about services needing preauthorization or notice.

"Preauthorization" is when your provider sends a request for coverage of a service on the UMP preauthorization list. Preauthorization is usually requested by the provider performing the services. The plan sends either an approval or denial of coverage.

If the plan does not approve services that require preauthorization before services are received, the plan may deny coverage. The plan does not approve or deny preauthorization for services that are not on the UMP preauthorization list.

"Notice" means that your provider must contact the plan to let us know when you receive services. Notice is usually done by the facility when you are admitted.

ALERT! If the plan denies preauthorization and you receive those services anyway, you are responsible for the provider's entire billed charge.

How long the plan has to make a decision

The plan will respond to standard preauthorization requests submitted by contracted providers within 5 days of receipt for non-electronic requests and within 3 days of receipt for electronic requests. For expedited preauthorization requests, the plan will respond within 1 to 2 days of receipt. If additional information is required, the plan will notify the provider within the timelines described in this section. You will also be notified of the decision.

If your provider believes that waiting for a decision under the standard preauthorization timeframe could place your life, health, or ability to regain maximum function in serious danger, they can request an expedited preauthorization request.

General information from UMP Customer Service

For services not requiring preauthorization, you may contact UMP Customer Service to ask if a particular service is generally covered by the plan, and for an estimate of how much you will pay. **The plan does not approve or deny preauthorization for services that are not on the UMP preauthorization list.**

Until a claim is submitted and reviewed, the plan cannot guarantee that your service will be covered or give you 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. Each code describes a 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.

Alternative benefits

Alternative benefits mean benefits for services or supplies that are not otherwise covered as specified in this COC, but for which the plan may approve coverage after case management evaluation. The plan may cover alternative benefits through case management (see the "Care management" benefit) if the plan determines that alternative benefits are medically necessary and will result in overall reduced covered costs and improved quality of care.

Before alternative benefits are covered, the plan, you (or your legal representative), and, if required by the plan, your physician or other provider, must enter into a written agreement of the 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 listed in the written agreement. The rest of this COC remains in effect.

What the plan does not cover

> **TIP:** If you have any questions about services the plan does not cover, contact UMP Customer Service or ArrayRx Customer Service.

This plan covers only the services and conditions specifically identified in this COC. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. You may pay all costs associated with a noncovered service.

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. Activity Therapy. The following activity therapy services include, but are not limited to:
    - Aroma;
    - Creative arts;
    - Dance;
    - Equine or other animal-assisted;
    - Music;
    - Play;
    - Recreational or similar therapy; and

- Sensory movement groups.

2. Air ambulance, if ground ambulance would serve the same purpose
3. Ambulance (all types), to move you to a facility closer to your home or for purposes that are not medically necessary
4. Autologous blood and platelet-rich plasma injections
5. Bariatric surgery using intragastric balloons.
6. Bone growth stimulators for:
   - Nonunion of skull, vertebrae, or tumor related
   - Ultrasonic stimulator – delayed fractures and concurrent use with another noninvasive stimulator.
7. Bone morphogenetic protein-7 (rhBMP-7) for use in lumbar fusion
8. Bronchial thermoplasty for asthma
9. Carotid artery stenting of intracranial arteries
10. Carotid intima media thickness testing
11. Catheter ablation for non-reentrant supraventricular tachycardia
12. Cervical spinal fusion for Degenerative Disk Disease for neck pain without evidence of radiculopathy or myelopathy
13. Complications arising directly from services that would not be covered by the plan during the current plan year. The plan will cover complications arising directly from services that a PEBB or SEBB plan covered for you in the past.
14. Computed Tomographic Colonography (CTC), also called a virtual colonoscopy, for routine colorectal cancer screening
15. Corneal Refractive Therapy (CRT), also called Orthokeratology
16. Coronary or cardiac artery calcium scoring
17. Cosmetic services or supplies, including drugs and pharmaceuticals, unless part of the following care:
    - 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
18. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered
19. Custodial care (see definition on page 118)
20. Deep brain stimulation and transcranial direct current stimulation when used as nonpharmacological treatments for treatment-resistant depression
21. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services (see pages 36–37)
22. Dietary/food supplements, including, but not limited to:
    - Herbal supplements, dietary supplements, and homeopathic drugs
    - Infant or adult dietary formulas

- Medical foods (except when prescribed for inborn errors of metabolism)
- Minerals
- Prescription or over-the-counter vitamins

23. Dietary programs
24. Discography for patients with chronic low back pain and lumbar degenerative disc disease. This does not apply to patients with the following conditions:
    - Degenerative disease associated with significant deformity
    - Fracture, tumor, infection, and inflammatory disease
    - Functional neurologic deficits (motor weakness or Electromyography [EMG] findings of radiculopathy)
    - Isthmic spondylolysis
    - Primary neurogenic claudication associated with stenosis
    - Radiculopathy
    - Spondylolisthesis greater than Grade 1
25. Drugs or medicines not covered by the plan.
26. Educational programs,
27. Electrical Neural Stimulation (ENS), which includes Transcutaneous Electrical Nerve Stimulation (TENS) units, outside of medically supervised facility settings (e.g., in-home use).
28. Email consultations or e-visits, except as described under the telemedicine benefit.
29. 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
    - Residential accessibility modifications
    - Sanitary supplies
    - Telephone alert systems
    - Vision aids except when covered through VSP
    - Whirlpools, portable whirlpool pumps, or sauna baths
30. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals
31. Experimental or investigational services, supplies, or drugs (see page 120)
32. Extracorporeal shock wave therapy for musculoskeletal conditions
33. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery
34. Facet neurotomy for headache
35. Facet neurotomy for thoracic spine
36. Fecal microbiota transplantation for treatment of inflammatory bowel disease

37. Fees, Taxes, and Interest, except as required by law, the following fees taxes, and interest are not covered:
    - Charges for shipping and handling, postage, interest, or finance charges that the provider might bill;
    - Excise, sales, or other taxes;
    - Surcharges;
    - Tariffs;
    - Duties;
    - Assessments; or
    - Other similar charges whether made by federal, state, or local government or by another entity
38. Foot care not related to diabetes: Toenail cutting; diagnosed corns and calluses treatment; or any other maintenance-related foot care
39. Functional neuroimaging for primary degenerative dementia or mild cognitive impairment
40. Gene expression profile testing for multiple myeloma or colon cancer
41. Headaches:
    - Treatment of chronic tension-type headache with Botox or acupuncture
    - Treatment of chronic migraine or chronic tension-type headache with massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (e.g., chiropractic services)

    Note: For chronic migraines and tension-type headaches, see page 42
42. Hearing aid items:
    - Over-the-counter hearing aids that are not prescribed, except for initial assessment, fitting, adjustment, auditory training, and ear molds as necessary to maintain an optimal fit
    - Charges incurred after your plan 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

    The types of ancillary equipment not covered are:
    - Alerting devices
    - Assistive listening devices for FM/DM systems, receivers and transmitters
    - Assistive listening devices for microphone transmitters
    - Assistive listening devices for TDD machines
    - Assistive listening devices for telephones
    - Assistive listening devices for televisions (including amplifiers and caption decoders)
    - Assistive listening devices for use with cochlear implants
    - Assistive listening devices, supplies, and accessories not otherwise specified
43. Hip resurfacing

44. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome
45. Home health care, except as described on page 43. The plan does not cover the following services:
    - Housekeeping or meal services
    - Care in any nursing home or convalescent facility
    - Care provided by a family member
46. Hospital inpatient charges for non-essential services or features, such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis
    - Personal or convenience items
    - Reserved beds
    - Services and devices that are not medically necessary (see definition on page 125)
47. Hyaluronic acid treatment for treatment of knee or hip osteoarthritis
48. Hyperbaric oxygen therapy treatment for:
    - Chronic sensorineural hearing loss
    - Brain injury including traumatic (TBI) and chronic brain injury
    - Cerebral palsy
    - Migraine or cluster headaches
    - Multiple sclerosis
    - Non-healing venous, arterial, and pressure ulcers
    - Thermal burns
49. Imaging of the sinus for rhinosinusitis using x-ray or ultrasound
50. Immunizations, physical exams and associated services (laboratory or similar tests) for the purpose of travel or employment, even if recommended by the CDC
51. Implantable drug delivery systems (IDDS or infusion pumps) for chronic, non-cancer pain
52. Incarceration: Services and supplies provided while confined in a prison or jail
53. Infertility or fertility testing or treatment after initial diagnosis, including drugs, pharmaceuticals, artificial insemination, and any other type of testing, treatment, complications resulting from such treatment (e.g., selective fetal reduction), or visits for infertility
54. In Vitro Fertilization (IVF) and all related services and supplies, including all procedures involving selection of embryo for implantation
55. Knee arthroplasty: Multi-compartmental arthroplasty and partial knee arthroplasty (including bi-compartmental and bi-unicompartmental)
56. Knee arthroscopy for osteoarthritis of the knee
57. Late fees, finance charges, or collections charges
58. Learning disabilities treatment after diagnosis, except as covered under the following benefits:
    - "Applied Behavior Analysis (ABA) Therapy" on page 31;
    - "Therapy: Habilitative and Rehabilitative" on page 56;

- When part of treating a mental health disorder; or
- When part of treating a substance use disorder.

59. Lumbar artificial disc replacement.
60. Lumbar fusion for degenerative disc disease.
61. Lumbar radiculopathy/sciatica surgery: Minimally invasive procedures that do not include laminectomy, laminotomy, or foraminotomy, including, but not limited to, energy ablation techniques, Automated Percutaneous Lumbar Discectomy (APLD), percutaneous laser, nucleoplasty, etc.
62. Magnetic resonance imaging, (upright) (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
63. Maintenance care (see definition on page 124).
64. Manipulations of the spine or extremities, except as described under "Spinal and extremity manipulations" on page 54.
65. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental health, or substance use disorder.
66. Massage therapy services when the massage therapist is not a preferred provider.
67. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the member's primary coverage.
68. Microprocessor-controlled lower limb prostheses (MCP) for the feet and ankle
69. Migraine and tension-type headaches:
    - Treatment of chronic tension-type headache with Botox or acupuncture
    - Treatment of chronic migraine or chronic tension-type headache with massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (e.g., chiropractic services)

    Note: For chronic migraines and tension-type headaches, see page 42
70. Missed appointment charges.
71. Negative pressure wound therapy in patients with contraindications referred to by the FDA Safety Communication dated February 24, 2011
72. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 13)
73. Novocure (i.e., Optune) (tumor treating fields)
74. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye
75. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications, except as specified on page 39
76. Osteochondral allograft/autograft transplantation for joints other than the knee
77. Out-of-network provider charges that are above the allowed amount
78. Peripheral nerve ablation, using any technique, to treat limb pain for adults and children, including for knee, hip, foot, or shoulder due to osteoarthritis or other conditions
79. Pharmacogenetic testing for patients being treated with oral anticoagulants

80. Pharmacogenomics testing for depression, mood disorders, psychosis, anxiety, attention deficit hyperactivity disorder (ADHD), and substance use disorder

81. Positron Emission Tomography (PET) scans for routine surveillance of lymphoma

82. Printing costs for medical records

83. Private duty nursing or continuous care in the member's home, except as described on pages 45 and 53

84. Proton beam therapy for individuals age 21 or older for conditions other than:
    - Brain/spinal
    - Esophageal
    - Head/neck
    - Hepatocellular carcinoma
    - Ocular
    - Skull-based
    - Other primary cancers where all other treatment options are contraindicated

85. Provider administrative fees: Any charges for completing forms, copying records, or finance charges, except for records requested by the plan to perform retrospective (i.e., post-payment) review after review by a multidisciplinary tumor board

86. Repetitive transcranial magnetic stimulation for tinnitus

87. Replacement of lost, stolen, or damaged durable medical equipment (DME)

88. Residential treatment programs offered at facilities that do not meet the definition of Residential Treatment Facility (see definition of "Residential treatment facility")

89. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures)

90. 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

91. Routine ultrasounds during pregnancy, except one in week 13 or earlier, one during weeks 13-28, or high-risk pregnancies (see description on page 49)

92. Sacroiliac joint fusion: Minimally invasive and open sacroiliac joint fusion procedures in adults, age 18 or older, with chronic sacroiliac joint pain related to degenerative sacroiliitis and/or sacroiliac joint dysfunction.

93. Screening and monitoring tests for osteopenia/osteoporosis:
    - Once treatment for osteoporosis has begun, serial monitoring is not covered
    - Development of a fragility fracture alone is not a covered indication

94. Separate charges for records or reports

95. Service animals: Any expenses related to a service animal

96. Services covered by other insurance, including, but not limited to:
    - Automobile no-fault
    - Commercial premises
    - General no-fault
    - Homeowner's
    - Medical payments (Med-Pay)
    - Motor vehicle
    - Personal injury protection (PIP)
    - Renter's

- Underinsured or uninsured motorist

See page 94 for more about how this works.

97. Services delivered by providers or facilities delivering services outside the scope of their licenses
98. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage
    - For which you are not obligated to pay
    - Provided by a resident physician or intern acting in that capacity
    - Provided by someone in the member's family or household
    - 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.
    - That are solely for comfort
99. Services performed during a noncovered service
100. 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
101. Services supplemental to digital mammography. When performed supplementary to digital mammography for screening purposes for members with or without dense breasts, the following procedures are not covered:
    - Non-high-risk patients:
        - Automated Breast Ultrasound (ABUS)
        - Handheld Ultrasound (HHUS)
        - Magnetic Resonance Imaging (MRI)
    - High-risk patients:
        - Automated breast ultrasound (ABUS)
        - Handheld Ultrasound (HHUS)
        - Magnetic Resonance Imaging (MRI) less than 11 months after a prior screening
102. Services, supplies, or drugs related to occupational injury or illness (see page 92)
103. Services, supplies, or items that require preauthorization unless the request is:
    - Approved by the plan
    - Supported by medical justification from a clinician other than the member or the family of a member
104. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence
    - When treatment is primarily custodial
105. Sleep apnea diagnosis and treatment as indicated in referenced Medicare national and local coverage determinations
106. Sleep therapy services performed at the following locations are not covered:
    - Emergency room services

- Inpatient hospitalization
- Urgent-care facilities

107. Sound therapies for treatment of tinnitus, including, but not limited to:
    - Masking devices (sound maskers)
    - Altered auditory stimuli
    - Auditory attention training

108. Spinal cord stimulation for treatment of complex regional pain syndrome, or when any of the following are present:
    - Life expectancy less than one (1) year
    - Hemoglobin A1C (HbA1C) >10 (for PDN)
    - Body mass index (BMI) >45
    - Maximum daily morphine milligram equivalent (MME) ≥120
    - Concurrent, untreated, substance use disorder (including alcohol, prescription or illicit drugs) per American Society of Addiction Medicine (ASAM) guidelines
    - Active, substantial chronic pain in other regions that have required treatment in the past year
    - Related or pending worker's compensation claim (for FBSS and NSRBP)
    - Pending or existing litigation for the condition being treated with SCS

109. Spinal injections, therapeutic (except as described under "Spinal injections" on page 55) of the following types:
    - Facet injections
    - Intradiscal injections
    - Medial branch nerve block injections

110. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty

111. Stem cell therapies for musculoskeletal conditions

112. Stereotactic body radiation therapy for the treatment of primary tumor of the following cancer types:
    - Bone
    - Head and neck
    - Adrenal
    - Melanoma
    - Merkel cell
    - Breast
    - Ovarian
    - Cervical

113. Stereotactic radiation surgery for conditions other than central nervous system primary and metastatic tumors

114. Subscription, membership, and access-related fees. Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include but are not limited to:
    - Concierge fees;
    - Subscription fees
    - Membership fees
    - Retainer fees
    - VIP or priority access fees; and
    - Any other access-related fees
115. Surrogacy
116. Telephone or virtual consultations or appointments, except as described under "Telemedicine services" on page 57
117. Tinnitus specific therapies including, but not limited to:
    - Tinnitus retraining therapy (TRT)
    - Neuromonics tinnitus treatment (NTT)
    - Tinnitus activities treatment (TAT)
    - Tinnitus-masking counseling
118. Transcutaneous vagal nerve stimulation (does not include or apply to support of previous implanted VNS)
119. Transcutaneous vagal nerve stimulation for epilepsy or depression
120. Travel, transportation, and lodging expenses, except as specified for ambulance services covered by the plan (see page 31)
121. Treatment of varicose veins with Endovenous Laser Ablation (EVLA), Radiofrequency Ablation (RFA), Sclerotherapy, and Phlebectomy in patients with pregnancy, active infection, peripheral arterial disease, or deep vein thrombosis (DVT)
122. Upright magnetic resonance imaging (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading"
123. Vagal nerve stimulation (VNS) for treatment-resistant depression
124. Vagal nerve stimulation (VNS) for the treatment of depression (does not include or apply to support of previously implanted VNS)
125. Vision hardware replacements:
    - The plan does not cover the replacement of any lost, stolen or broken lenses and/or frames.
126. Vision, routine:
    - Certain contact lens expenses:
        - Artistically-painted or non-prescription contact lenses;
        - Contact lens modification, polishing or cleaning;
        - Refitting of contact lenses after the initial (90-day) fitting period;
        - Additional office visits associated with contact lens pathology; and
        - Contact lens insurance policies or service agreements.
    - Corrective vision treatment of an experimental or investigational nature

- The VSP benefits do not cover investigational or experimental treatments or procedures (health interventions), services, supplies, and accommodations provided in connection with health interventions.

◦ Lens enhancements: The VSP benefits do not cover lens enhancements, including, but not limited to:

- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch-resistant coating;*
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Premium and custom progressive multifocal lenses;
- Photochromic lenses;
- Tinted lenses, except Pink #1 and Pink #2;
- UV (ultraviolet) protected lenses;* and
- Impact-resistant coating.*

- Vision services and supplies:
  ◦ The plan does not cover services or supplies that are not medically necessary:

  - Plano lenses (less than a ± .50 diopter power).
  - Two pair of glasses instead of bifocals.
  - Services and/or materials not described as covered under this vision benefit.
  - Medical or surgical treatment of the eyes

127. Vitamin D screening and testing as part of routine screening

128. 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 relating to non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider, except as covered under "Bariatric surgery" (see page 32), "Nutrition counseling and therapy" (see page 48), or "Preventive care" (see page 50).

◦ 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.

129. Whole exome sequencing for:

◦ Uncomplicated autism spectrum disorder, developmental delay, mild to moderate global developmental delay.

◦ Other circumstances (e.g. environmental exposures, injury, infection) that reasonably explain the constellation of symptoms.

◦ Carrier testing for "at risk" relatives.

◦ Prenatal or pre-implantation testing.

130. Whole Genome Sequencing for:

◦ Carrier testing for "at risk" relatives.

◦ Prenatal or pre-implantation testing

131. Workers' compensation: When a claim for workers' compensation is accepted, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation

132. Transcranial Magnetic Stimulation (TMS) for treatment of:

- Obsessive-compulsive disorder (OCD)
- Generalized anxiety disorder (GAD)
- Posttraumatic stress disorder (PTSD)
- Smoking cessation
- Substance use disorder (SUD)

If you have questions about whether a certain service or supply is covered, contact UMP Customer Service.

Coordination of Benefits

Coordination of benefits (COB) happens when you have health coverage through two or more health plans, and these two health plans both pay a portion of your health care claims.

> **ALERT!** If Medicare pays for services that have benefit limits on the UMP plan, those services will apply to the UMP benefit limit.

How Medicare and UMP Classic Medicare work together

> **ALERT!** When services are covered by Medicare, you must see providers who accept Medicare for the services to be covered by Medicare and this plan.

Because Medicare pays first, a few rules apply to Medicare members. This section tells you about these rules, including:

- How this plan and Medicare work together.
- What this plan covers that Medicare does not cover.
- What your choices for providers are.
- How billing works.
- Where to go for more information.

To enroll in this plan, you and your eligible dependents who are eligible for Medicare are required to enroll in Medicare Part A and Part B. Be sure to tell Medicare you are enrolled in UMP so that they send us your claims after Medicare processes them.

When Medicare pays first, and this plan pays second

UMP and Medicare are two separate health plans that work together to pay for covered services and supplies. Here is how coordination of benefits works:

- Your providers bill Medicare. Medicare pays your claims first. After Medicare processes the claim, Medicare sends the claim to UMP.
- UMP pays your claims second. For most covered services, UMP pays the rest of the Medicare allowed amount and you owe $0.

Each calendar year, you must meet your UMP medical deductible before UMP starts paying benefits. If you receive more covered services during the same calendar year, you may be reimbursed for at least some of your UMP deductible. That reimbursement will come from the COB savings. This savings is the part of your UMP benefit saved because Medicare pays part of your claims. See the "Why you might get a COB savings check from UMP" section.

Note: Services apply to the UMP medical deductible in the order claims are received, not necessarily in the order the member receives the services.

Paying your UMP and Medicare deductibles

If you meet your UMP deductible, you do not pay both the Medicare Part B and your UMP deductible. Your Part B deductible is a part of the same total calendar year expenses processed by UMP An example is below. This example assumes you received care from a provider who accepts Medicare (has not "opted out" of Medicare) anywhere in the U.S.

Benefit calculation	Amount
Medicare allowed amount	$600
Medicare deductible	$183
Subtract Medicare deductible from allowed amount: $600 - $183 =	$417
Medicare pays 80% of this amount (0.80 x $417) =	$333.60
Balance remaining after Medicare pays: $600 - $333.60 =	$266.40
UMP allowed amount	$600
UMP deductible	$250
Subtract UMP deductible from allowed amount: $600 - $250 =	$350
Normal UMP benefit (85% of this amount) (0.85 x $350) =	**$297.50**
Since the UMP benefit available (dollar amount) is greater than the balance, UMP pays the balance remaining after Medicare pays:	$266.40
The difference between the normal UMP benefit and the amount UMP paid is: This amount is considered "COB savings" (see page 82).	**$31.10**

Note: This is an example only and may not apply to your specific situation.

Example of COB when Medicare pays first and UMP pays second

Below is an example to show how the COB process works after you have met your UMP medical deductible and Medicare deductible. This example assumes you received care from a provider who accepts Medicare (has not "opted out" of Medicare) anywhere in the U.S.

Benefit calculation	Amount
Provider's billed charge	$300
Medicare allowed amount	$100
Medicare pays	$80 (80% of $100)
Remaining amount	**$20**
UMP allowed amount	$100

Benefit calculation	Amount
UMP normal benefit	$85 (85% of $100)
UMP pays	$20
You pay	**$0**
COB savings accrued	$65 ($85 - $20 =$65)

The $65 of the normal UMP benefit not paid on this claim is tracked as part of your COB savings. That excess benefit may be used to reimburse you directly for your UMP medical deductible met earlier in the same year or used to pay more on a service covered by UMP but not covered by Medicare. See the "Why you might get a COB savings check from UMP" section.

In this example, you owe $0 because the provider accepts Medicare. You may still have to pay coinsurance and deductible amounts when you have not fully met your Medicare deductibles, or when Medicare does not cover a service.

If this plan covers a service or supply not covered by Medicare, then the benefit will be the normal UMP benefit plus any COB savings you may have accrued in the same calendar year, up to allowed amount for the claim.

If a provider does not bill Medicare for services covered by Medicare, this plan may not cover services. Medicare accepts claims from members only under certain circumstances, and UMP processes claims for services covered by Medicare only after Medicare has processed them. See the "What UMP covers that Medicare does not" section below for exceptions. Ask your provider if they bill Medicare.

Diabetes care supplies when Medicare pays first

Medicare pays claims for some diabetes care supplies under the Part B medical benefit. As a result, this plan pays the claim under the DME benefit, This means you will have to meet your medical deductible before this plan begins to pay on diabetes care supplies claims, then this plan pays its share based on medical benefit coinsurance (85 percent of the allowed amount for providers that accept Medicare).

See also the "Diabetes care supplies" benefit for more information.

What this plan covers that Medicare does not

> **ALERT:** Services listed below are paid at the standard rate. You will pay more if you use out-of-network providers for these services.

This plan covers some services that Medicare does not cover. For these services, it does not matter if the provider accepts Medicare, because Medicare does not cover the service. You will receive the highest level of benefit if you choose a preferred provider.

Services listed below are not covered by Medicare, but they are covered by this plan. Out-of-network providers may balance bill you.

Services not covered by Medicare Part A or Part B include, but are not limited to:

- Hearing aids.
- Hearing exams for getting a hearing aid.
- Massage therapy (a massage therapist must be a preferred provider).
- Naturopathic medicine.

- Routine vision exams and hardware. (Medicare covers medical vision exams and vision hardware following cataract surgery.)
- Services outside of the U.S. (see the "Services received outside the United States" section for details).
- Wigs for cancer patients (see page 39).

If you see a preferred provider, they will submit the claim for you. For out-of-network providers, check if the provider will submit the claim. If not, you will need to send a claim to UMP Classic Medicare "Billing and payment: submitting a claim" section.

When to see a preferred provider

ALERT: Preferred providers do not necessarily accept Medicare. You should always ask.

To find preferred providers outside the U.S., see page 18.

Type of service	Higher benefits with UMP preferred provider?	Important information
Services covered by Medicare	No	You should see a provider who accepts Medicare. See "When providers do not accept Medicare" on page 82 to learn why this is important.
Services covered by this plan but not by Medicare	Yes	See "What this plan covers that Medicare does not" starting on page 81 to see which services apply. Use the provider search on the UMP website (see Directory for link) or contact UMP Customer Service to find a preferred provider.
Massage therapy	Yes	The plan pays for massage therapy services only when the provider is preferred.

When providers do not accept Medicare

When services are covered by Medicare, you must see providers who accept Medicare for the services to be covered by Medicare and this plan. If your provider is not contracted with Medicare or has chosen to "opt out" of participating in Medicare, this plan will not cover services by that provider, even if the provider is in the Regence or Blue Card network (preferred). Providers that opt out of Medicare are supposed to have you sign a private contract before providing services, but you are responsible for all costs even if you did not sign a contract.

When you pay: How billing works

Most of the time, you pay only **after** both Medicare and UMP Classic Medicare have processed your claim. Here is how it typically works:

1. Your provider bills Medicare.

2. Medicare processes the claim and sends you a Medicare Summary Notice (MSN). An MSN may also be called an Explanation of Medicare Benefits (EOMB). The MSN tells you how much Medicare paid on your claim.
3. Medicare then sends the claim to UMP for processing. You do not need to submit a claim form or other paperwork to UMP.
4. UMP processes the claim and sends you an Explanation of Benefits (EOB). The EOB tells you how much UMP and Medicare paid, plus how much you owe the provider.
5. You receive a bill from your provider for any remaining amount due. To confirm that the provider has credited your account with both Medicare and UMP payments:
    - Note the allowed amount on the Medicare MSN.
    - Subtract both Medicare's and UMP's payments from that amount. This should match the bill from your provider.
6. You pay your provider the amount due, if any. After you've met both your Medicare and UMP deductibles, you will not pay anything for most claims.

If you have not received any paperwork on a health care service within three months, contact your provider's billing office and ask if they have sent the claim. Neither Medicare nor UMP may process a claim they have not received.

Why you might get a COB savings check from UMP

At the beginning of the year, you must first satisfy your Medicare and UMP deductibles to receive coordination of benefits (COB) savings. Once you have satisfied these deductibles in full and receive more health care services during the year, UMP usually pays less than its normal benefit when it is a secondary payer to Medicare. The difference between what this plan pays as the secondary plan and what this plan would have paid had it been the primary payer, is your COB savings.

UMP keeps track of how much you've paid out of pocket during the year. If your Medicare coverage generates COB savings, we may send you a "COB savings check" to pay you back for the out-of-pocket expenses you paid earlier in the year. UMP does not reimburse you for more than you paid out of pocket. See the "How UMP and Medicare work together" section for examples.

Drugs and supplies covered under the medical benefit

When prescription drugs or supplies covered under Medicare Part B, they are paid as medical benefit. When paying secondary to Medicare Part B, UMP also pays under the medical benefit. Therefore, these charges are subject to your medical deductible.

Note: Medicare Part B quantity restrictions may apply.

Medicare accepts claims only from providers, not from individuals. If Medicare covers a drug or supply and the provider does not send the claim to Medicare first for payment, UMP will deny the claim.

Where to go for more information

See the Directory at the beginning of this booklet for links and contact information.

Types of questions	Contact
Medicare premiums **What Medicare covers** **Whether your claim has been processed by Medicare**	Medicare

Types of questions	Contact
Your Medicare deductibles and coinsurance amounts	
What UMP Classic Medicare with Part D covers **Your UMP copays, coinsurance, and deductible amounts**	UMP Customer Service or visit the UMP website
Your claim after it has been processed by Medicare	UMP Customer Service or sign in to your Regence account
Adding or removing dependents from your account **Address changes** **Changing your PEBB medical coverage** **UMP Classic Medicare with Part D premiums**	PEBB Program
If the member responsibility dollar amount on your UMP Explanation of Benefits does not match your provider's bill **Whether your claim has been submitted to Medicare**	Your provider's billing office

Billing and payment: submitting a claim

Submitting a claim for medical services

When UMP is your primary insurance and your provider is preferred, or participating, you do not 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, sign in to your Regence account or contact UMP Customer Service (see Directory for links and contact information). See the "Submitting a Blue Cross Blue Shield Global® Core claim" section on page 17 for instructions on submitting a claim for services received outside of the United States.

> **TIP:** In the following section, Uniform Medical Plan (UMP) refers to the administrative functions for submitting claims to UMP. Regence BlueShield handles medical claims,

When you need to submit a claim

You may need to submit a claim to UMP for payment if:

- You receive services from an out-of-network provider.
- Medicare does not cover the service

Out-of-network providers may submit a claim on your behalf. Ask your provider.

How to submit a claim

To submit a claim yourself, you may sign in to your Regence account and go to the Submit claim webpage at regence.com/member/submit-claim/ or you may complete a medical claim form and mail the following documents:

- UMP (Regence) Medical Claim Form — You may find the form by visiting forms and publications at hca.wa.gov/ump-forms-pubs or you may request a form by contacting UMP Customer Service.

- 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:

- Member's name and member ID number, including the alpha prefix (three letters and the 'W' before member ID number)
- Procedure and diagnosis code(s) or description of the injury or illness
- Date and type of service
- Provider's name, address, phone number, and National Provider Identifier (NPI) or Tax ID number
- For ambulance claims, also include the ZIP code of where the member was picked up and where they were taken

If UMP 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 UMP, unless the primary plan's processing of the claim is delayed. Claims not submitted to UMP within 12 months of the date of service will not be paid.

If we must request additional information, the processing of your claim may be delayed.

Note: 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
Attn: UMP Claims
PO Box 1106
Lewiston, ID 83501-1106

Or you can fax documents to Regence at 1-877-357-3418.

The plan may send reimbursement for services received from an out-of-network provider to the provider or to you in the form of a check listing both you and the provider as payees. If you paid up front for services, proof of payment may be required. Contact UMP Customer Service if you have a question about the processing of your claim or for information on what is acceptable as proof of payment.

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 submitting" deadline. The plan will not pay claims submitted more than 12 months after the date of service. See "Submit secondary claims promptly" for how this works when you have other coverage that pays first.

For information about submitting claims for services outside of the U.S., contact UMP Customer Service. You may have to pay services upfront and submit a claim for reimbursement.
If you have other health care coverage, see the "If you have other medical coverage" section for information on how the plan coordinates benefits with other plans.

Services apply to your UMP medical deductible in the order claims are received, not necessarily in the order the member receives services.

Claims reimbursement

Most of the time, the plan will pay preferred or participating 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. For a child covered by a legal qualified medical child support order the plan may pay the child's custodial parent or legal guardian.

Claims determinations

The plan will notify you 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. Notice will include an explanation why an extension is needed and when the plan expects to act 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 and why it is needed.

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 the "Submitting a claim for medical services" section).

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 or any false claims on any document for your plan coverage.

The plan may recover any payments or overpayments made because 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.

If the plan asks you for more information, you will be allowed at least 45 days to provide it. If the plan does not receive the information requested within the time allowed, the plan will deny the claim.

Complaint and appeal procedures

ALERT! In the following section, UMP refers to the administrative functions for appeals for UMP. Regence BlueShield handles medical appeals. VSP handles appeals for routine vision benefits. See "Your routine vision benefits" for more information.

Appeals procedures may change during the year if required by federal or Washington State law.

What is a complaint (aka: grievance)?

A complaint is an oral statement or written document submitted by or on behalf of a member regarding:

- Dissatisfaction with medical care.
- Dissatisfaction with service provided by the health plan.
- Provider or staff attitude or demeanor.
- Waiting time for medical services.

Note: If your issue is regarding a denial, reduction, or termination of payment or nonprovision of medical services, it is an appeal.

How to submit a complaint (aka: grievance)

For all medical complaints, it's recommended that you first contact UMP Customer Service. Many issues may be resolved with a phone call. If an initial phone call does not resolve your complaint, you may submit your complaint:

- Over the phone: If you want a written response, you must request one.
- By mail, fax, or email (see the "Where to send complaints or appeals" section below).

You will receive notice of the action on your complaint or grievance within 30 calendar days of our receiving it. The plan will notify you if it needs more time to respond.

What is an appeal?

An appeal is an oral or written request submitted by you or your authorized representative to Regence BlueShield or ArrayRx to reconsider:

- 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 preauthorization.
- A retroactive decision to deny coverage based on eligibility (see the "Appeals related to eligibility" section below).
- Claims payment, processing, or reimbursement for health care services or supplies.

The appeals process

> **ALERT!** If your appeal is for an urgent or life-threatening condition, see the "Expedited appeals process" section below.

You or someone you authorize to represent you (see "How to designate an authorized representative" on page 97) may submit an appeal. There are three levels to the appeals process:

1. First-level appeal
2. Second-level appeal
3. External review (independent review)

Each of those parts are described in further detail below.

Coverage during each review

If your request involves a decision to change, reduce, or terminate coverage for services or supplies, the plan must continue to cover the disputed service until the outcome of the review. If the plan upholds the decision to change, reduce, or terminate coverage, you will be responsible for the cost of the services received during the review period. If you request payment for denied claims or approval of services or supplies not yet covered by the plan, the plan will not cover the services or supplies while the appeal is under consideration.

First-level and second-level appeal reviewers

Claim processing disputes will be reviewed by administrative staff. The plan will consult with a health care professional employed by Regence BlueShield on medical appeals when appeals involve issues requiring medical judgment about covering, authorizing, or providing health care. That includes decisions based on determinations that a treatment or other item is experimental, investigational, or not medically necessary. Your appeal will be reviewed by Regence BlueShield employees who have not been involved in, or subordinate to anyone involved in, reviewing the previous decisions.

How to submit an appeal

You or your authorized representative (including a relative, friend, advocate, attorney, or provider) may submit an appeal by using the methods described below in the "Where to send complaints or appeals" section. You may authorize a representative to submit an appeal on your behalf in writing or by contacting UMP Customer Service (medical appeals.

For each appeal request, you must appeal within 180 days of receiving the plan's decision. You may include written comments, documents, and any other information, such as medical records and letters from your provider, to support your appeal request. The plan will consider all information submitted when reviewing your 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 to you.

The plan will mail you a written response within 14 days of receiving your appeal request. If more time is needed to thoroughly research and review your appeal, the plan is allowed up to 30 days to respond. The plan will ask your permission if it needs more time to respond. You can access the UMP (Regence) Medical appeals and grievance form by visiting forms and publications at **hca.wa.gov/ump-forms-pubs**.

Information to provide with an appeal

You can submit information, documents, written comments, records, evidence, and testimony, including second opinions, with your appeal. When you provide all the necessary documentation, it allows the plan to review your appeal faster. Include the following when requesting an appeal:

- The member's full name (the name of the employee, retiree, or dependent covered by the plan)
- The member ID number (starting with a "W" on your UMP member ID card)
- The name(s) of any providers involved in the issue you are appealing
- Date(s) of service or incident
- Your mailing address
- Your daytime phone number(s)
- A statement describing the issue and your desired outcome
- A copy of the Explanation of Benefits, if applicable, or a list of the claim numbers you are appealing
- Medical records from your provider, if applicable. Your provider should supply clinically relevant information, such as medical records for services denied based on medical necessity or for other clinical

reasons. The plan must receive all relevant information with the appeal to make sure the most accurate decision is made.

First-level appeals

You or your authorized representative may submit a first-level appeal no more than 180 days after you receive the plan's decision. If you do not submit an appeal within this time, your appeal will not be reviewed, and you will not be able to continue further appeals (second-level and external review). You may authorize a representative to submit an appeal on your behalf in writing or by contacting UMP Customer Service (medical appeals).

Regence BlueShield manages first-level appeals for medical services, Employees from Regence BlueShield reviewing the appeals will not have been involved in the initial decision you are appealing. Administrative staff review claim processing disputes. A staff of health care professionals at Regence BlueShield evaluate appeals that involve issues requiring medical judgment about covering, authorizing, or providing health care.

ALERT! Deadlines for submitting an appeal are based on the first date you are notified of how a claim was processed, usually when you receive you an Explanation of Benefits (including services that applied to your 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 decision made on your first-level appeal, you or your authorized representative may submit a second-level appeal. You must submit second-level appeals no more than 180 days after you receive the letter responding to your first-level appeal. If you do not submit an appeal within this time, your appeal will not be reviewed, and you will not be able to continue further appeals (external review). You may authorize a representative to submit an appeal on your behalf in writing or by contacting UMP Customer Service (medical appeals).

Regence BlueShield manages second-level appeals for medical services.,. Employees from Regence BlueShield reviewing the appeals will not have been involved in, or subordinate to anyone involved in, reviewing the first-level appeal or initial decision. If new or additional evidence or rationale is considered in reviewing your appeal, the plan will provide you with this information free of charge, and you may respond before the final decision.

Expedited appeals process

Expedited appeals for medical services

You or your authorized representative may submit an expedited appeal within 180 days of receiving the previous decision if:

- You are currently receiving or prescribed treatment or benefits that would end because of the denial; or
- 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; or
- The issue is related to admission, availability of care, continued stay, or emergency health care services and you have not been discharged from the emergency room or transport service.

You may authorize a representative to submit an expedited appeal on your behalf in writing or by contacting UMP Customer Service.

An expedited appeal replaces both the first- and second-level appeals. Regence BlueShield will call you, or your authorized representative, with a decision on your expedited appeal within 72 hours of the request. Regence BlueShield will also mail a written response within 72 hours of the decision.

Your provider must submit all clinically relevant information to the plan by phone or fax at:

- **Phone:** 1-888-849-3681 (TRS: 711)
- **Fax:** 1-877-663-7526

If you disagree with the expedited appeal decision, your provider may request an expedited external review (see the "External review (independent review)" section below).

Time limits for the plan to decide appeals

> **ALERT!** The plan will comply with shorter time limits than those below when required by federal or Washington State law.

The time limits for both first- and second-level appeals are calculated from when the plan receives the appeal. The plan will decide your appeal within 14 days of receiving it but may take up to 30 days unless a different time limit applies as explained below. The plan will request written permission from you or your authorized representative if an extension to the 30-day time limit is needed to get medical records or a second opinion.

For expedited appeals, the plan will decide as soon as possible but always within 72 hours. The plan will notify you (or your authorized representative) of the decision verbally within 72 hours and will mail a written notice within 72 hours of the decision.

External review (independent review)

You or your authorized representative may submit a request for an external review by an independent review organization (IRO) if you have gone through both a first- and second-level appeal (or expedited appeal) and your appeal was based on the plan's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service.

You may also submit a request for an external review:

- If the plan has exceeded the timelines for response to your appeal without good cause and without reaching a decision; or
- If the plan has failed to adhere to the requirements of the appeals process.

You may submit a request for an expedited external review if you meet the requirements for the expedited process as described above. You may also request an expedited external review at the same time that you request an expedited appeal, called concurrent expedited review. When you request concurrent expedited review, you are not required to go through both a first- and second-level appeal.

An IRO will conduct the external review. An IRO is a group of medical and benefit experts certified by the Washington State Office of the Insurance Commissioner and not related to the plan, Regence BlueShield, or HCA. An external review provides unbiased, independent clinical and benefit expertise to determine whether the plan's decision is consistent with state law and the *2026 UMP Classic Medicare with Part D (PDP)*.

Requesting an external review

To request an external review, see the contact information listed in the "Where to send complaints or appeals" section below.

You or your authorized representative must submit a request for an external review no more than 180 days after you receive the letter responding to your second-level appeal (or expedited appeal). Only the member or an authorized representative may submit a request for an external review. You may authorize a representative to submit a request for an external review on your behalf in writing or by contacting UMP Customer Service (medical appeals).

The plan — Regence BlueShield for medical services — will send the IRO all of the relevant information and correspondence they considered in making the decision. You may send more information directly to the IRO. The IRO will notify you of their decision.

Additional legal options

You are required to exhaust the plan's appeals process before you may bring a cause of action in court against the plan or HCA. If an IRO reviews your appeal, their decision is binding on both the plan and you except to the extent that other remedies are available under state or federal law.

If the IRO overturns the plan's decision the plan will provide benefits (including making payment on the claim) according to the IRO's decision without delay, regardless of whether the plan intends to seek judicial review of the IRO's decision and unless and until there is a judicial decision otherwise.

Complaints about quality of care

For complaints or concerns about the quality of care you received from preferred and participating providers only, contact UMP Customer Service or send a secure email through your Regence account (see Directory for link and contact information).

For complaints or concerns about the quality of care you received from any provider:

- Call Washington State Department of Health at 360-236-4700 (TRS: 711) or 1-800-562-6900 (TRS: 711).
- Email the Department of Health at **HSQAComplaintIntake@doh.wa.gov**.
- Visit the Department of Health website at **doh.wa.gov/about-us/file-complaint**.

Appeals related to eligibility

Appeals related to eligibility and enrollment are handled by the PEBB Program and governed by chapter 182-16 WAC.

Information on how to file an appeal is available:

- On the HCA website at **hca.wa.gov/pebb-appeals**.
- By contacting the PEBB Appeals Unit at 1-800-351-6827 (TRS: 711).

Where to send complaints or appeals

ALERT! VSP handles appeals for routine vision benefits. See "Your routine vision benefits" for more information.

It is recommended that you call first with a complaint or appeal, since many problems may be resolved quickly over the phone. The Directory at the beginning of this booklet includes links and contact information to contact UMP (medical services) with a complaint or appeal.

When another party is responsible for injury or illness

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 make sure claims are paid in a timely manner, it is important that you respond as directed in the letter, even if the answer is no. If you do not, the plan may deny coverage. You may contact UMP Customer Service if you have questions.

Occupational injury or illness (workers' compensation) claims

When a claim for occupational injury or illness (workers' compensation) is accepted by your employer's workers' compensation carrier, UMP will not cover any services related to that injury or illness, even if the compensation carrier denies some services. You must file a workers' compensation claim with your workers' compensation carrier. If your claim for workers' compensation is denied because it is determined the injury or condition is not related to an occupational injury or illness, UMP will pay for covered services under the terms of this COC.

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;
- 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, and sports policies. This includes excess, underinsured, or uninsured motorist coverage, 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 the plan may deny claims.

However, after expiration or exhaustion of the above 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 provided or advanced by the plan pending the resolution of a claim to the right of recovery subject to all of the following conditions:

- 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 or advanced.

- The plan may choose to recover expenses directly from the third party (or third party's insurer) responsible for your injury or illness. This is called subrogation. The plan is authorized, but not obligated, to recover any expenses, to the extent that they were paid under the plan, directly from any party liable to you, upon mailing of a written notice to the potential payer, to you, or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award, or judgment, or other characterization of the recovery by you or any third party or the recovery source. The plan is entitled to reimbursement from the first dollar 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 will not do anything 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 with 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 (notice 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 provided or 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 or advanced solely to assist you. By paying such benefits, the plan is not waiving any right to reimbursement or subrogation.

Fees and expenses

You may incur attorney's fees and costs in connection with obtaining a recovery. We may pay a proportional share of such attorney's fees and costs you incur 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.

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, or 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 (e.g., 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 COC.

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.

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 equals the third-party recovery.

General provisions

UMP is administered by Regence BlueShield and ArrayRx under contract with HCA.

What you need to know: your rights and responsibilities

To make sure UMP offers access to 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:

- Ask your provider to submit secondary claims to Medicare, if applicable.
- Be informed by your providers about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Be treated with respect.
- Complain about or appeal plan services or decisions, or the care you receive.
- Get a second opinion about your provider's care recommendations.
- Have a translator's assistance, if required, when contacting the plan.

- Keep your medical records and personal information confidential as described in the UMP Notice of Privacy Practices, available online on the HCA website at **hca.wa.gov/ump-privacy**.
- Make decisions with your providers about your health care.
- Make recommendations about member rights and responsibilities.
- On request, receive information from the plan about:
  - How new technology is evaluated for inclusion as a covered service.
  - How the plan reimburses providers.
  - Preauthorization review requirements.
  - Providers you select and their qualifications.
  - Services and treatments that have completed HTCC review and how that affects coverage by UMP.
  - Technologies and treatments currently under review by the HTCC.
  - The plan and preferred providers.
- Your covered expenses, exclusions, reductions, and maximums or limits. Receive:
  - A written explanation from the plan about any request to refund an overpayment.
  - All covered services and supplies determined to be medically necessary as described in this COC, subject to the maximums, limits, exclusions, deductibles, coinsurance, and copays.
  - 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, color, national origin, age, disability, or religion.

As a plan member, you have the responsibility to:

- Comply with requests for information by the date given.
- Confirm provider and facility network status before every visit.

  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.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Keep your mailing address current by reporting changes to the PEBB Program. Send your address changes to:

  Health Care Authority
  PEBB Program
  PO Box 42684
  Olympia, WA 98504
- 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 copays, 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 form you receive from the plan in a timely manner to prevent delay in claims payment.
- Understand how to contact the plan for more information and help with any covered service or information described in this COC.
- Understand how UMP coverage coordinates with other insurance coverage you may have, including Medicare.
- Understand your plan benefits, including what is covered, preauthorization and notice requirements, and other information described in this COC.

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. See the Directory pages at the beginning of this booklet for links and contact information.

You may find the following information in this COC:

- Benefit exclusions, reductions, and maximums or limits (see the "What the plan does not cover" section)
- Clear explanation of complaint and appeal procedures (see the "Complaint and appeal procedures" section)
- Definition of terms (see the "Definitions" section)
- List of covered expenses (see the "List of benefits" section)
- Preventive health care benefits that are covered
- Process for preauthorization, notice, or review

You may find the following on the UMP website or by contacting UMP Customer Service:

- Accreditation information, including measures used to report the plan's performance, such as consumer satisfaction survey results or Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Clinical coverage criteria applicable to health care services and supplies that require preauthorization
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services
- General reimbursement or payment arrangements between the plan and preferred providers
- Information on the plan's care management programs
- Notice of privacy practices (includes plan policy for protecting the confidentiality of health information; see "Confidentiality of your health information" on page 97)
- Online directory of preferred providers, including both primary care providers and specialists
- Procedures to follow for consulting with providers
- The Summary of Benefits and Coverage (SBC)
- When the plan may retroactively deny coverage for preauthorized medical services

The following are available through your Regence account or by contacting UMP Customer Service:

- Medical claims history and medical deductible status
- Online directory of preferred providers, including both primary care providers and specialists

You may contact UMP Customer Service for an annual accounting of all payments made by the plan that have been counted against medical payment limits, day limits, visit limits, or other limits on your coverage. The plan will provide a written summary of payments within 30 calendar days of your request. Some of this information is also available through your Regence account.

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 the UMP Notice of Privacy Practices, available online on the HCA website at **hca.wa.gov/ump-privacy** or by contacting UMP 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.

How to designate an authorized representative

> **TIP:** Because of privacy laws, the plan usually cannot share information on appeals or complaints with family or other persons unless the member is a minor, or the plan has received written authorization to release personal health information to the other person.

In most cases, the plan must have written authorization to communicate with anyone but the member. 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 ages 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:

- Communicate with the plan on your behalf regarding an appeal in process.
- Share your protected health information.
- Talk to the plan about claims or services.

To authorize release of protected health information, you must complete an Authorization to Disclose Protected Health Information form. To get the forms, follow the instructions below:

- Medical benefits: Contact UMP Customer Service or use your Regence account (see Directory for link and contact information).

Send the form to the address on the form. UMP 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 (e.g., receiving an outcome of an appeal); and
- Who is designated to receive or release the information.

Release of information

The plan or HCA 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 do not provide the information when requested.

Relationship to Blue Cross and Blue Shield Association

HCA, on behalf of itself and its members, hereby expressly acknowledges that this contract constitutes an agreement solely between HCA and Regence BlueShield, 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 the contractor Regence BlueShield to use the Washington license for those counties designated in its service area.

Right to receive and release needed information

Regence BlueShield may need certain facts about your health care coverage or services provided 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 this plan. See page 97 for more information about the confidentiality of your health information.

Right of recovery

The plan has the right to a refund of incorrect payments. The 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 UMP nor Regence BlueShield provides any health care services, neither may 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 either UMP or Regence BlueShield. Neither Regence BlueShield nor UMP is responsible for the quality of health care you receive, except as provided by law.

In addition, UMP 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 UMP's control.

Governing law

The plan is governed by and construed in accordance with the laws of the United States of America and by applicable laws of Washington State without regard to its conflict of law rules.

Anti-assignment

Members may not assign this COC, or any rights, interests or obligations contained in this COC, in whole or in part, to a third party (including, but not limited to, providers of medical services), without the plan's written consent. Any attempt to assign any rights, interests or obligations contained in this COC, in whole or in part, to a third party is void and/or invalid, and the plan will not recognize it.

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 in writing and signed by one of HCA's authorized officers.

Acronyms

ABA – Applied Behavior Analysis [Therapy]

ACP – Accountable Care Program

ASC – Ambulatory surgery center

CDC – Centers for Disease Control and Prevention

CDHP – Consumer-directed health plan

CHIP – Children's Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of benefits

COBRA – Consolidated Omnibus Budget Reconciliation Act

COC – Certificate of coverage

COE – Centers of Excellence Program

DME – Durable medical equipment

DPP – Diabetes Prevention Program

EOB – Explanation of benefits

EOMB – Explanation of Medicare benefits

ER – Emergency room

ERB – Employee and Retiree Benefits [Division]

FDA – Food and Drug Administration

FMLA – Family Medical Leave Act

FSA – Flexible spending arrangement

HCA – Health Care Authority

HDHP – High-deductible health plan

HIPAA – Health Insurance Portability and Accountability Act

HRA – Health reimbursement arrangement

HRSA – Health Resources and Services Administration

HSA – Health savings account

HTCC – Health Technology Clinical Committee

IRC – Internal Revenue Code

IRO – Independent review organization

IRS – Internal Revenue Service

MSN – Medicare Summary Notice

NMSN – National Medical Support Notice

P – Preventive

P&T – Pharmacy and Therapeutics Committee

PCP – Primary care provider

PEBB – Public Employees Benefits Board

PFML – Paid Family and Medical Leave

PPACA – Patient Protection and Affordable Care Act

PPO – Preferred Provider Organization

RCW – Revised Code of Washington

REMS – Risk Evaluation and Mitigation Strategies

SBC – Summary of Benefits and Coverage

SEBB – School Employees Benefits Board

TMJ – Temporomandibular joint

TRS – Telecommunications Relay Service

UMP – Uniform Medical Plan

V – Value tier

WAC – Washington Administrative Code

Eligibility and enrollment

In these sections, the term "retiree" or "retiring employee" includes a retiring employee from a Public Employees Benefits Board (PEBB) employing agency or employer group, and an elected or full-time appointed official of the legislative and executive branch of state government. The term "retiree" or "retiring school employee" includes a retiring school employee from a School Employees Benefits Board (SEBB) organization or employer group. Additionally, "health plan" is used to refer to a plan offering medical, dental, vision, or any combination of these coverages developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for subscribers and dependents

Those described in this section must be enrolled and stay enrolled in Medicare Part A and Part B to enroll in or continue enrollment in this medical plan.

Retiree eligibility

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found under "Appeal rights."

Survivor eligibility

The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined upon receipt of *their election to enroll*. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

COBRA continuation coverage eligibility

The PEBB Program determines whether subscribers are eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage upon receipt of their election to enroll. If the subscriber requests to enroll in and is not eligible for COBRA continuation coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Retired employee of a former employer group eligibility

The PEBB Program determines whether a retired employee or a retired school employee of a former employer group is eligible to self-pay coverage in PEBB Continuation Coverage (Employer Group Ended Participation) upon receipt of their election to enroll. If the retired employee or the retired school employee requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Dependent eligibility

The following are eligible dependents:

- Legal spouse
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.

- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
  - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
  - **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
  - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
  - **Children of the subscriber's state-registered domestic partner,** based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
  - **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.
  - **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
  - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
    - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
    - The subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
    - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
    - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
    - The PEBB Program, with input from the medical plan, will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Retiree and survivor deferring enrollment

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor may defer (postpone) enrollment in PEBB retiree insurance coverage if they meet the substantive eligibility requirements to enroll and also meet the procedural requirement by electing to defer enrollment using Benefits 24/7, the online enrollment system, or by submitting a *PEBB Retiree Election Form (form A)* to the PEBB Program within the enrollment timelines.

If a retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor chooses to defer enrollment in PEBB medical, enrollment in PEBB dental and PEBB vision will also be deferred. Deferring enrollment in PEBB retiree insurance coverage will also defer enrollment for all eligible dependents, except as described below.

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor who does not enroll in PEBB retiree insurance coverage is only eligible to enroll later if they have deferred enrollment. Enrollment may be deferred as follows:

- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the retiree or survivor is enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.
- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the retiree or survivor is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in PEBB retiree insurance coverage may be deferred when the retiree or survivor is enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage. Eligible dependents who are not enrolled in Medicaid coverage that provides creditable coverage may be enrolled.
- Beginning January 1, 2014, a retiree or a survivor who are not eligible for Medicare Part A and Part B may defer enrollment in PEBB retiree insurance coverage when they are enrolled in qualified health plan coverage through a health benefit exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in PEBB retiree insurance coverage may be deferred when the retiree or survivor is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Beginning January 1, 2025, a retiree or a survivor who is enrolled in Medicare may defer enrollment in PEBB retiree insurance coverage when they permanently live in a location outside of the United States.

Exception: A retiree may defer enrollment in PEBB retiree insurance coverage during the period of time they are enrolled as a dependent in a medical plan sponsored by PEBB or School Employees Benefits Board (SEBB), including such coverage under COBRA or continuation coverage. They do not need to elect to defer enrollment online or submit a *PEBB Retiree Election Form*.

Enrollment in PEBB retiree insurance coverage is automatically deferred if a retiree or a survivor becomes eligible for the employer contribution toward PEBB or SEBB benefits. They do not need to elect to defer enrollment online or submit a *PEBB Retiree Election Form*.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage may enroll as described in the section titled "Retiree and survivor enrollment following deferral."

Retiree and survivor enrollment

An eligible retiree, a survivor, or their dependent can enroll in only one PEBB medical plan, even if eligibility criteria is met under two or more subscribers.

An eligible retiring employee or a retiring school employee must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the employee's or the school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible elected or full-time appointed official must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of a retiree who is enrolled at the time of the retiree's death will be enrolled in the same PEBB health plan coverage they were enrolled in under their own account with no gap in coverage. To make changes to their PEBB health plan coverage, they must submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree. An eligible survivor of a retiree who is not enrolled at the time of the retiree's death, must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

An eligible survivor of an employee or school employee must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible employee or school employee determined to be retroactively eligible for disability retirement must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of an emergency service personnel killed in the line of duty must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or
- The last day the survivor was covered under any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

A retiree or a survivor who deferred enrollment in PEBB retiree insurance coverage and is enrolling in a PEBB retiree health plan, must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB*

Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage must also submit evidence of continuous enrollment. The online enrollment must be completed or the forms must be received no later than 60 days after a loss of other qualifying coverage.

A retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States must also submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived. The online enrollment must be completed or the forms must be received no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends. See "Retiree and Survivor enrollment following deferral" for additional enrollment timelines.

COBRA continuation coverage and retired employees of a former employer group enrollment

A COBRA continuation coverage subscriber, a retired employee or a retired school employee of a former employer group or their dependent can enroll in only one PEBB medical plan, even if eligibility criteria is met under two or more subscribers.

A subscriber enrolling in PEBB Continuation Coverage (COBRA) and a retired employee or retired school employee of a former employer group may enroll by using Benefits 24/7, the online enrollment system, or by submitting the applicable *PEBB Continuation Coverage Election/Change* form and any supporting documents to the PEBB Program.

For PEBB Continuation Coverage (COBRA), the online enrollment must be completed or the PEBB Program must receive the election form no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program, whichever is later. For retired employees of a former employer group, the online enrollment must be completed or the PEBB Program must receive the required form no later than 60 days after the employer group's date of termination.

Premiums and applicable premium surcharges associated with continuing PEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for continuing PEBB medical coverage" and the *PEBB Continuation Coverage Election Notice*.

Note: Enrollment in the PEBB Program's Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) may not be retroactive. If a subscriber elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in the transitional UMP coverage during the gap month(s) prior to when the UMP Classic Medicare with Part D (PDP) begins.

Dependent enrollment

To enroll an eligible dependent, the subscriber must include the dependent's information using Benefits 24/7, the online enrollment system, or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program is unable to verify their eligibility within the PEBB Program enrollment timelines.

Dependents who are enrolled in PEBB medical must be enrolled in the same PEBB medical plan as the subscriber.

Exception: If a subscriber selects the Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP), non-Medicare enrollees will be enrolled in UMP Classic.

A subscriber may also enroll an eligible dependent during the PEBB Program's annual open enrollment or during a special open enrollment. See "Making changes."

Medicare eligibility and enrollment

Medicare Part A and Part B

Any enrollee must be enrolled and stay enrolled in Medicare Part A and Part B to enroll in or continue enrollment in this plan.

A retiree, a survivor, or their dependents enrolled in PEBB retiree insurance coverage are required to enroll and stay enrolled in Medicare Part A and Part B, if eligible. This is a condition of their enrollment in any PEBB retiree health plan. If this procedural requirement is not met, eligibility will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

Medicare Part D

This medical plan includes Medicare Part D prescription drug coverage. Medicare members can be enrolled in only one Medicare Part D plan at a time. If a subscriber or their enrolled dependent chooses to enroll in a separate Medicare Part D plan, enrollment in this medical plan may be terminated. The subscriber should contact the PEBB Program to determine what options may be available.

When medical coverage begins

Retirees, survivors and dependents

For an eligible retiring employee or retiring school employee and their eligible dependents, medical coverage begins the first day of the month after the retiring employee's or retiring school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement and their eligible dependents, medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible elected or full-time appointed official and their eligible dependents, medical coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their eligible dependents, medical coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree's death, medical coverage will begin the first day of the month following the retiree's death.

For an eligible survivor of an employee or school employee and their eligible dependents, medical coverage begins the first day of the month following the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible survivor of an emergency service personnel killed in the line of duty and their eligible dependents, medical coverage begins on the date chosen, as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, medical coverage for the retiree or the survivor and their

eligible dependents begins the first day of the month after the loss of the other qualifying coverage. For a retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States, medical coverage for the retiree or the survivor and their eligible dependents begins the first day of the month after the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

COBRA continuation coverage subscribers and dependents

For a COBRA continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, medical coverage begins the first day of the month following the day they lost eligibility for PEBB medical.

Retired employees of a former employer group and dependents

For a retired employee of a former employer group and their eligible dependents enrolling when newly eligible, medical coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

All subscribers and dependents

For a subscriber or their eligible dependents enrolling during the PEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first day of the month following the later of, the event date, or the date the online enrollment election using Benefits 24/7 or the required form is received by the PEBB Program.

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 coverage will begin as follows:

- **For a newly born child,** medical coverage will begin the date of birth;
- **For a newly adopted child,** medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- **For a spouse or state registered domestic partner** of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended dependent or a dependent child with a disability**, medical coverage will begin the first day of the month following the later of the event date or eligibility certification, whichever is later.

Making changes

Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child, as described under "Dependent eligibility." The notice must be received online using Benefits 24/7 or by written request to the PEBB Program within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB medical under one of the continuation coverage options described in "Options for continuing PEBB medical coverage."
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.

- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

Voluntary termination

A subscriber may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the medical plan will be terminated on the last day of the month when the *PEBB Medicare Plan Disenrollment Form (form D)* is received.

A retiree or a survivor who voluntarily terminates their enrollment in a medical plan also terminates all other health plan enrollment and enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

Retiree and Survivor deferring enrollment

An enrolled retiree or survivor may defer enrollment in PEBB retiree insurance coverage at any time by submitting the request online using Benefits 24/7 or the *PEBB Retiree Change Form (form E)* along with any other required forms and supporting documents to the PEBB Program. Enrollment in PEBB retiree insurance coverage will be deferred effective the first of the month following the date the *PEBB Medicare Plan Disenrollment Form (form D)* is received. A retiree or a survivor who deferred their enrollment may enroll as described in "Retiree and Survivor enrollment following deferral."

Retiree and Survivor enrollment following deferral

A retiree or a survivor who defers enrollment in PEBB retiree insurance coverage:

- **While enrolled in employer-based group medical or such coverage under COBRA coverage or continuation coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or continuation coverage ends.
- **While enrolled in a federal retiree medical plan as a retiree or dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- **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 Program's 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 plan.
- **While enrolled in qualified health plan coverage through a health benefit 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 Program's annual open enrollment period, or no later than 60 days after exchange coverage ends.
- **While enrolled in CHAMPVA** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.
- **While enrolled in Medicare and permanently living outside of the United States and who moves back to the United States, may enroll in a PEBB medical plan during the PEBB Program's annual**

open enrollment period, or no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

- **While enrolled as a dependent** in a medical plan sponsored by PEBB or SEBB, including coverage under COBRA or continuation coverage, may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the enrollment in a medical plan sponsored by PEBB or SEBB ends, or such coverage under COBRA or continuation coverage ends. The evidence of continuous enrollment required to enroll as described below may include a health plan sponsored by a Washington State educational service district if enrollment was deferred prior to January 1, 2024.

Note: Enrollment in the PEBB Program's Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) may not be retroactive. If a subscriber elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in the transitional UMP coverage during the gap month(s) prior to when the UMP Classic Medicare with Part D (PDP) begins.

For a retiree or a survivor to enroll in a PEBB medical plan, the enrollment must be completed online using Benefits 24/7 or the PEBB Program must receive a *PEBB Retiree Election Form (form A)*, any other required forms and supporting documents during the timelines described in this section.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage, must also submit evidence of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period.

A retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States must submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived while the retiree or survivor enrolled in Medicare lives outside of the United States.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage as described above may also enroll in a PEBB medical plan if they receive formal notice that HCA has determined it is more cost-effective to enroll in a PEBB medical plan than a medical assistance program.

A retiree or a survivor should contact the PEBB Program or visit **hca.wa.gov/pebb-retirees** to get the required forms, information on premiums, and a list of available medical plans.

Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment and if a specific life event creates a special open enrollment period.

Annual open enrollment changes

A subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

- Enroll in a medical plan following a deferral (Retiree or survivor only)
- Defer their enrollment in a medical plan (Retiree or survivor only)
- Terminate their enrollment in a medical plan
- Enroll or remove eligible dependents
- Change their medical plan

A subscriber must submit the election change online using Benefits 24/7 or submit the required *PEBB Retiree Open enrollment Election/Change Form (form A-OE) or PEBB Continuation Coverage Election/Change form (as appropriate)* along with any other required forms, and any supporting documents to the PEBB Program. The change must be completed online, or the forms must be received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year.

Special open enrollment changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

The subscriber must provide evidence of the event that created the special open enrollment.

To disenroll from this medical plan, the change in enrollment must be allowable under federal regulations.

To make an enrollment change, the subscriber must submit the change online using Benefits 24/7 or submit the required *PEBB Retiree Change Form (form E) or PEBB Continuation Coverage Election/Change form (as appropriate)* along with any other required forms to the PEBB Program. The change must be completed online, or the PEBB Program must receive the forms no later than 60 days after the event that creates the special open enrollment. In addition, the PEBB Program will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

- A subscriber has six months from the date of their or their dependent's enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The change must be made online or the PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the subscriber or their dependent.
- When a subscriber or their dependent is enrolled in this medical plan, they may disenroll during a special enrollment period as allowed under federal regulations. The new medical plan coverage will begin the first day of the month following the date the *PEBB Medicare Plan Disenrollment Form (form D)* is received.
- A subscriber has seven months to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) that begins three months before they or their dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. A subscriber may also enroll themselves or their dependent in a MAPD plan or UMP Classic Medicare with Part D (PDP) before their last day of the Medicare Part B initial enrollment period. The change must be made online or the forms must be received by the PEBB Program no later than the last day of the month prior to the month the subscriber or their dependent enrolls in the MAPD plan or UMP Classic Medicare with Part D (PDP).
- 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 complete the request online or notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their 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).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan, as described in PEBB Program rules. If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director of HCA or their designee.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependents enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber 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 not limit its consideration to the following:
  - Active cancer treatment, such as chemotherapy or radiation therapy

- Treatment following a recent organ transplant
- A scheduled surgery
- Recent major surgery still within the postoperative period
- Treatment for a high-risk pregnancy

- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

Special open enrollment events that allow adding or removing a dependent

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their 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).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- 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 and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

When medical coverage ends

Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB medical plan.
- The end of the month after a termination notice for non-payment of premiums is sent.
- The first of the month following the date the *PEBB Medicare Plan Disenrollment Form (form D)* is received, when an enrolled retiree or survivor requests to defer enrollment in PEBB retiree insurance coverage.
- The last day of the month the *PEBB Medicare Plan Disenrollment Form (form D)* is received, when a subscriber requests to voluntarily terminate enrollment in a medical plan.

A subscriber will be responsible for payment of any services received after the date medical coverage ends, as described above.

Final premium payments

The subscriber is responsible for timely payment of premiums and applicable premium surcharges.

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

An exception occurs when an enrolled retiree dies on or after June 6, 2024. A state law that took effect June 6, 2024, requires HCA to waive the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

If an enrollee is hospitalized

An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is eligible for PEBB Continuation Coverage as described in "Options for continuing PEBB medical coverage."

Options for continuing PEBB medical coverage

A subscriber and their dependents covered by this medical plan may be eligible to continue enrollment under PEBB Continuation Coverage (COBRA) if they lose eligibility. PEBB Continuation Coverage (COBRA) temporarily extends group insurance coverage if certain circumstances occur that would otherwise end the subscriber or their dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal COBRA laws and regulations and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. Refer to the *PEBB Continuation Coverage Election Notice* for details.

A retiree or survivor and their dependents covered by this medical plan who lose eligibility for PEBB retiree insurance coverage when their employer group ends participation with the Health Care Authority, may be eligible to continue their enrollment under PEBB Continuation Coverage (Employer Group Ended Participation).

The PEBB Program administers these coverages. Call the PEBB Program at 1-800-200-1004 (TRS: 711) for details.

Options for continuing coverage under PEBB Retiree Insurance Coverage

A dependent becoming eligible as a survivor of a retiree or a COBRA continuation coverage subscriber whose coverage ends may be eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

General provisions for eligibility and enrollment

Termination for just cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider's request to terminate an enrollee's coverage from this plan for just cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program
- Knowingly providing false information
- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
  - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium
  - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

Appeal rights

Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Learn more at **hca.wa.gov/pebb-appeals**.

Fax: 360-763-4709

Mail:
Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver:
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Any enrollee may appeal a decision regarding the administration of a PEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of Washington State is hereby amended to comply with the minimum requirements of such law or regulation.

PEBB customer service

For questions about PEBB eligibility and enrollment, please call the PEBB Program at 1-800-200-1004 (TRS:711) or visit **hca.wa.gov/pebb**.

For questions about Medicare, please call the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or visit **medicare.gov**.

Definitions

Allowed amount, medical services

Allowed amount for medical services is the most the plan pays for a specific covered service or supply. The allowed amount is determined as follows:

- **For preferred providers** that are within the Regence BlueShield service area, the Preferred Provider Organization (PPO) contract with Regence BlueShield is the relevant contract that determines the allowed amount. For preferred providers that are outside the Regence BlueShield service area, the contract with another Blue Cross or Blue Shield organization in the BlueCard® Program for its PPO network is the relevant contract that determines the allowed amount.
- **For participating providers** that are within the Regence BlueShield service area, the participating provider contract with Regence BlueShield is the relevant contract that determines the allowed amount. For participating providers that are outside the Regence BlueShield service area, the contract with another Blue Cross or Blue Shield organization in the BlueCard® Program is the relevant contract that determines the allowed amount.

- **For out-of-network providers** who are within the Regence BlueShield service area and not contracted with Regence BlueShield, the amount Regence has determined to be reasonable charges for covered services and supplies is the allowed amount.

  The allowed amount may be based upon the billed charges for some services, as determined by Regence or as otherwise required by law. If a provider is not in the network, as described above, but has a contract with Regence, the allowed amount is based on the negotiated rate.

- **For out-of-network providers 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 BlueShield 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 BlueShield'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 covered billed 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 considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also consider 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 BlueShield would then calculate your liability for any covered services according to applicable law.

Charges more than the allowed amount are not reimbursable. For questions regarding the basis for determination of the allowed amount, contact UMP Customer Service.

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.

Annual open enrollment

Annual open enrollment is a period of time defined by HCA when a subscriber may 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.

Appeal

See the "Complaint and appeal procedures" section for an explanation of appeals and how the process works. For appeals related to PEBB eligibility or enrollment see "Appeal rights" in the "Eligibility and Enrollment" section for more information.

Authorized representative

An **authorized representative** is someone you have designated in writing to communicate with the plan on your behalf. See page 97 for how this works.

Balance billing

Balance billing is a provider billing you for the difference between the billed amount and the allowed amount. Preferred and participating providers cannot balance bill you for covered services above the allowed amount. See an example of how this works in the "Sample payments to different provider network status" section.

When you receive nonemergency services at a network hospital, network hospital outpatient department, network critical access hospital, or network ambulatory surgical center in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider. For nonemergency services performed at one of these facilities outside of Washington State, you still pay the network rate, but in some states, an out-of-network provider may be allowed to ask you to waive some of your balance billing protections.

When you receive covered ground or air ambulance services in Washington State, you pay the network rate and cannot be balance billed regardless of the network status of the provider.

At an out-of-network facility, when you receive emergency services you cannot be balance billed.

Birthday rule

In some instances, the **birthday rule** is used to determine which group health plan will pay first for the dependent children of married, living together and not married, legally separated, or divorced parents. This rule looks at only the month and day, not the year, of the parents' birthdays. For example, the plan of a parent born April 14 is primary over the plan of a parent born August 21. If both parents have the same birthday, the plan that has covered either parent the longest is primary.

Business day

Business days are Mondays through Fridays, except for legal holidays observed by Washington State.

Calendar day

A **calendar day** is any day of the week regardless of whether it is observed as a legal holiday by Washington State.

Calendar year

A **calendar year** is January 1 through December 31.

Chronic migraine

A **chronic migraine** is having a headache on 15 or more days per month of which eight or more days are a migraine.

Clinical review

Clinical review is when the plan has a clinical professional review medical records related to treatment to determine if 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 percent of the allowed amount. This includes most medical services.

COBRA Continuation Coverage

COBRA Continuation Coverage means the temporary continuation of PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA includes eligibility and administrative requirements under federal COBRA laws and regulations, and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

Coordination of benefits (COB)

For members covered by more than one group health plan, **coordination of benefits (COB)** is the method the plan uses to determine which plan pays first, which pays second, and the amount paid by each plan. See description and examples in the "If you have other medical coverage" section.

Copay

Copay is a set dollar amount you pay when receiving specific services, treatments, or supplies, such as chiropractic, acupuncture, massage therapy, inpatient hospitalization, or emergency room visits.

Cost-share .

Cost-share means the amount you pay for a service or supply This may be a deductible, coinsurance, copay, 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 prescription drugs that are ordinarily self-administered.

Deductible, medical

Your **medical deductible** is a fixed dollar amount you must meet each calendar year for health care expenses before the plan starts paying for covered services. You pay the first $250 per member in medical expenses to your providers $750 maximum if you have a family of three or more on one account). Only expenses covered by the plan apply to your deductible. For example, if you receive LASIK surgery (see exclusion on 70), the plan does not apply this payment to your medical deductible. Some services are not subject to this deductible (see the "Summary of benefits" section). See the "What you pay for medical services" section for details on how your medical deductible works.

Dependent

A **dependent** is an eligible spouse, state-registered domestic partner, child, or other eligible family member as described in "Dependent eligibility" (see the "Eligibility for subscribers and dependents" section on page 100) that is either covered by or eligible to be covered by the plan under the subscriber's account.

Detoxification

Detoxification is a medically supervised treatment program for individuals with alcohol or drug intoxication, designed to rid the body of toxic substances and manage withdrawal symptoms.

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 may diagnose a developmental delay.

Durable medical equipment (DME)

Durable medical equipment (DME) 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 page 70 for examples of equipment that is not covered.

Effectiveness

Effectiveness means the extent to which a specific intervention, procedure, service, level of service, supply, may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects under real-world circumstances.

Efficacy

Efficacy is the extent to which a specific intervention, procedure, service or supply produces the desired effect under ideal conditions (in a controlled environment under lab circumstances).

Elective contact lenses

Elective contact lenses are covered lenses under the frame limit in lieu of coverage for eyeglasses.

Emergency

See the "Medical emergency" definition.

Employer group

Employer group for the Public Employees Benefits Board (PEBB) Program means those counties, municipalities, political subdivisions, the Washington health benefits exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a

contractual agreement with the Health Aare Authority (HCA) to participate in benefit plans developed by the PEB board.

Employer group for the School Employees Benefits Board (SEBB) Program means an employee organization representing school employees and a tribal school as defined in RCW 28A.715.010, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.

Employing agency

Employing agency means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by chapter 41.05 RCW.

Enrollee

Enrollee means a person who meets all eligibility requirements and is enrolled in benefits, and for whom applicable premium payments have been made.

Experimental or investigational

Experimental or investigational means any treatment that is not recognized by the plan as conforming to standard medical care for the condition, disease, illness, or injury being treated. "Treatment" in this setting may include any intervention, therapy, procedure, facility, equipment, drug usage, device, service, supply, intervention, biologic product or drug. Experimental and investigational treatments are not covered, even if the treatment is considered medically necessary. The plan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the treatment to determine if it is experimental or investigational.

A treatment meeting any of the following criteria is considered experimental or investigational:

- Approval of the treatment or one of its components by one or more government agencies (e.g., FDA) is required but has not been obtained at the time the treatment is requested or administered.
- The improvement has not been shown to be attainable outside the laboratory or clinical research setting.
- The scientific evidence does not permit conclusions concerning the effect of the treatment on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.
- The scientific evidence does not show that the treatment is as beneficial as any established alternatives.
- The treatment has not been demonstrated to improve net health outcomes.
- The treatment has scientific evidence to support its use, but not for the specific indication for which it is being requested.
- The treatment is a drug or device that is prescribed for other than its FDA-approved use(s) and is not recognized as "effective" for the use for which it is being prescribed. To be considered "effective" for other than its FDA-approved use, a prescription drug or device must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant peer-reviewed medical literature; or by the U.S. Secretary of Health and Human Services.
- The treatment is considered to be experimental or investigational by U.S. standards.

- The treatment is drug combination therapy, when the scientific literature only supports the drug's use as monotherapy and not when utilized in combination with other drugs.
- The treatment is drug monotherapy, when the scientific literature only supports the drug's use when utilized in combination with other drugs.
- The treatment is not provided by a provider that has demonstrated medical proficiency in the provision of the treatment.
- The treatment is only available in the U.S. as part of a clinical trial or research program for the illness or condition being treated.
    - Although the plan does not pay for items, drugs, devices, or services (including items, drugs, devices, or services provided in a clinical trial) for investigational use, the plan does not deny qualified individuals from participating in approved clinical trials. The terms "qualified individual" and "approved clinical trial" are defined in 42 U.S.C. §300gg-8. If a qualified individual is participating in an approved clinical trial, the plan will not deny, limit, or impose additional conditions on the coverage for routine patient costs for items and services furnished in connection with participation in the trial and will not discriminate against the individual on the basis of the individual's participation in such trial. The plan will apply its standard terms and conditions for routine patient costs for items and services furnished in connection with participation in the trial.
- The treatment is the subject of an on-going phase I or phase II clinical trial or is the research, experimental, study, or investigational arm of an on-going phase III clinical trial.

Explanation of Benefits (EOB)

An **Explanation of Benefits (EOB)** is a detailed account of each medical claim processed by the plan, which the plan sends to you to notify you of claim payment or denial. You may also sign in to your Regence account or contact UMP Customer Service to request a copy of an EOB (see Directory for link and contact information). You will need to provide identifying information over the phone.

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 members. See the definition of "Allowed amount, medical services" for more details.

Gestational Parent

The individual who carries the pregnancy and gives birth.

Grievance

A **grievance** is also called a complaint. See the "Complaint and appeal procedures" section for details on how these are handled.

Habilitative (neurodevelopmental) services

Habilitative (neurodevelopmental) services are health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-

language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Authority (HCA)

The **Health Care Authority (HCA)** is the Washington State agency that administers the Uniform Medical Plan (UMP Classic, UMP Classic Medicare with Part D (PDP), UMP Select, UMP CDHP, and the UMP Plus plans: UMP Plus–Puget Sound High Value Network and UMP Plus–UW Medicine Accountable Care Network), in addition to the following health care programs: Washington Prescription Drug Program, PEBB Program, SEBB Program, Behavioral Health and Recovery, and Apple Health (also known as Medicaid).

Health intervention

Health intervention is a prescription drug, 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. A health intervention may also 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 new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health outcomes

Health outcomes are results that affect health status as measured by the length or quality (primarily as perceived by the member) of a person's life.

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 member's home or in a hospice facility to terminally ill members. Hospice care includes services such as pain care relief for terminally ill members without the intent to cure, and support services for their families.

Hospital

A **hospital** is an institution accredited under the Hospital Accreditation Program of the Joint Commission and licensed by the state where it is located. A hospital has a defined course of therapeutic intervention and special programming in a controlled environment. A hospital also offers a degree of security, supervision, and structure. Hospital patients must be medically monitored with 24-hour medical availability and 24-hour onsite services as defined in federal guidelines outlining *Conditions of Participation for Hospitals*.

The term hospital does not include a convalescent nursing home or institution (or a part of one) that:

- Furnishes primarily domiciliary or custodial care.
- Is operated as a school.

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

Inpatient copay

The **inpatient copay** is what you pay for inpatient services at a preferred facility, such as a hospital, or skilled mental health, nursing, or substance use disorder facility. Members pay $200 per day up to $600 per facility admission. The inpatient copay does not apply to your medical deductible but does apply to the medical out-of-pocket limit.

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

Inpatient rate

The **inpatient rate** means that the plan pays 100 percent of the allowed amount after you pay your deductible and copay at preferred facilities.

The plan pays for professional services, such as provider visits or lab tests, based on the provider's network status during an inpatient stay:

- Preferred providers: You pay 15 percent of the allowed amount after you meet your medical deductible. The plan pays 85 percent of the allowed amount.

  Note: For behavioral health professional services, the plan pays 100 percent of the allowed amount.
- Participating providers: You pay 40 percent of the allowed amount after you meet your medical deductible. The plan pays 60 percent of the allowed amount.
- Out-of-network providers: You pay 40 percent of the allowed amount after you meet your medical deductible. You pay all charges billed to you above the allowed amount (known as balance billing). The plan pays 60 percent of the allowed amount.

Inpatient stay

An **inpatient stay** begins when you are admitted to a hospital or other medical facility, and ends when you are discharged from that facility.

Independent review organization (IRO)

An **independent review organization (IRO)** conducts the independent (or external) review of an appeal. 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, or HCA. 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 applicable COC. The plan pays the IRO's charges. See "External review (independent review)" on page 90.

Intensive Outpatient Program

Intensive Outpatient Program (IOP) is an outpatient program that is licensed as a facility or agency by the appropriate state agency and is provided under the supervision of a psychiatrist or psychiatric extender. IOP is intended to provide treatment on an outpatient basis, does not include boarding or housing, and is intended to provide treatment interventions in a structured setting, with patients returning to their home environments each day. IOP is a minimum of three hours per day, three days per week.

Limited benefit

TIP: This definition applies only to those benefits in which it is used in this COC. Other benefits have additional limits related to medical necessity or preauthorization of services (see the "Limits on plan coverage" section).

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.

For benefits limited to a certain number of visits, any visits that are applied to your medical deductible 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 12 chiropractor sessions to your medical deductible, you may receive coverage for 12 more sessions in that calendar year, for a total of 24 visits (the visit maximum for chiropractic services). For benefits limited to a certain dollar amount (e.g., hearing aids), you pay all charges billed to you above the maximum dollar amount. Any amounts billed above the maximum dollar limit do not apply to your out-of-pocket limit.

These limits apply **per member**.

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 their license provides services coded under a limited benefit (e.g., 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 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 benefit limits.

Maintenance care

Maintenance care is a health intervention after the member 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 several 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 COC).

Medical benefit

Medical benefit refers to services subject to your medical deductible, and copay or coinsurance. See the "What you pay for medical services" section 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 that not seeking immediate medical treatment at an emergency room would result in any one of the following:

- Places the member's health, or with respect to pregnancy, the health of an unborn child, in serious jeopardy;
- Causes serious impairment to bodily functions; or
- Causes serious dysfunction of any bodily organ or part.

Medical food

Medical food is food administered under the supervision of a provider, intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements.

Medically necessary or medical necessity

> **ALERT!** The provider or member must provide documentation demonstrating medical necessity when requested by the plan, or the plan may deny services as not medically necessary. The plan may not cover some medically necessary services. All benefits or services that are medically necessary are subject to the plan's coverage limitations, exclusions, and provisions of the plan. It is important to review this COC or verify coverage with UMP Customer Service before receiving services.

Medically necessary or medical necessity means health care services, supplies, or interventions that a licensed health care provider recommends and all the following conditions are met:

- The purpose of the service, supply, or intervention is to prevent, evaluate, treat, or diagnose an illness, injury, disease, or its symptoms.
- The level of service, supply, or intervention is appropriate considering the potential benefits and harm to the member.
- The level of service, supply, or intervention is known to be effective in improving health outcomes.
- The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.
- The service, supply, or intervention is not being recommended for reasons of convenience to the patient or health care provider.
- For services that the HTCC has reviewed, and that UMP has implemented, medical necessity is established only when HTCC's coverage conditions are met.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply does not make it medically necessary.

The plan may require proof that services, interventions, or supplies (including court-ordered care) are medically necessary. Depending on the circumstances, such proof may be documentation about the member's condition or scientific evidence about the effectiveness of the treatment.

The plan will not provide benefits if the required proof is not received, or does not adequately justify the medical necessity of the or service supply. Claims processing may be delayed if proof of medical necessity is required but not adequately 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 member indications being considered.

For services that the HTCC has reviewed, and that UMP has implemented, state law requires that UMP use the HTCC's coverage criteria in determining whether the service is medically necessary. When the HTCC determines that a service is not covered, then the service is not covered by the plan. If the HTCC determines that a service is covered, then the HTCC's criteria (if any) determine medical necessity. The HTCC's decisions and related documentation are available on the HCA website at **hca.wa.gov/hta**.

For services, interventions, or supplies related to an HTCC review, the plan first uses scientific evidence, then professional standards, then expert opinion to determine coverage.

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 may 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 based on professional standards of care or expert opinion.

A level of service, supply, or intervention is considered cost effective if the benefits and harms relative to the costs represent an economically efficient use of resources for members with this condition. The plan applies this criterion based on the individual member's medical situation and characteristics. Cost-effective does not always mean the lowest price.

Preventive services not covered by the plan's preventive care benefit will still be covered under the medical benefit if the outlined criteria are met for medical necessity.

Member

A **member** is a retiree, former employee or former dependent in COBRA Continuation Coverage, survivor, retired employee of a former employer group, or dependent enrolled in the plan (see also the "Enrollee" definition).

Necessary contact lenses

Necessary contact lenses are contact lenses that are prescribed by your provider for other than elective or cosmetic purposes. Necessary contact lenses are used to treat specific conditions for which contact lenses provide better visual correction.

Network

Network is the preferred and participating facilities, providers, and suppliers your health plan contracts with to provide health care services.

Network provider

A **network provider** is a preferred or participating provider. See the "Participating provider" definition and the "Preferred provider" definition for specific details.

Network rate

The **network rate** means the plan pays 85 percent of the allowed amount for preferred providers after you meet your medical deductible.

Network status

Network status refers to whether a provider is preferred, participating, or out-of-network with the plan. You may find out the network status of your provider by visiting the UMP Provider search or by contacting UMP Customer Service (see Directory for link and contact information).

Noncovered services

Noncovered services refers to any medical service that is not covered by the plan. Some services may be medically necessary, yet still are not covered. See the "What the plan does not cover" section. When the HTCC determines that a service is not covered, then the service is not covered by the plan.

Nonduplication of benefits

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

Normal benefit

The plan's **normal benefit** is the dollar amount the plan would normally pay if no other group health plan had the primary responsibility to pay the claim for a benefit.

Occupational injury or illness

An **occupational injury or illness** is one resulting from work that is for pay or profit.

Orthognathic and Telegnathic surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure, growth, or TMJ disorders, or to correct orthodontic problems that cannot be easily treated with braces.

Telegnathic surgery means skeletal advancement to enlarge and stabilize the pharyngeal airway to treat obstructive sleep apnea.

Out-of-network provider(s)

An out-of-network provider is a health care provider that is:

- In the Regence BlueShield service area, but is not contracted as part of Regence BlueShield's PPO network; or
- Outside the Regence BlueShield service area, but is not contracted with another Blue Cross or Blue Shield organization in the BlueCard® Program (designated as a provider in the PPO network) to provide services and supplies to plan members.

See page 12 for a description of how services by these providers are covered.

Out-of-network provider(s), vision

Out-of-network provider(s), vision do not have a contract with the current carrier.

Out-of-network rate, medical

Out-of-network providers are paid at the **out-of-network rate**. When you receive medical services from out-of-network providers, you pay 40 percent of the allowed amount after you meet your medical deductible. You pay all charges billed to you above the allowed amount (known as balance billing). The plan pays 60 percent of the allowed amount.

Out-of-pocket limit, medical

The **medical out-of-pocket limit** is the most you pay during a calendar year for covered medical services before the plan pays 100 percent of the allowed amount for preferred providers. This limit does not include your premium, balance-billed charges, or services the plan does not cover. For more information on how this works, see the "Medical out-of-pocket limit" section.

For this plan, your medical out-of-pocket limit including dependents is $2,500 per person and $5,000 per family.

Outpatient rate

The plan's **outpatient rate** depends on the provider's status:

- Preferred providers: You pay 15 percent of the allowed amount after you meet your medical deductible. The plan pays 85 percent of the allowed amount.
- Participating providers: You pay 40 percent of the allowed amount after you meet your medical deductible. The plan pays 60 percent of the allowed amount.
- Out-of-network providers: You pay 40 percent of the allowed amount after you meet your medical deductible. You pay all charges billed to you above the allowed amount (known as balance billing). The plan pays 60 percent of the allowed amount.

Outpatient surgery center

See the "Ambulatory surgery center (ASC)" definition.

Outward Bound

An international network of outdoor education organizations whose aim is to foster the personal growth and social skills of participants by using challenging expeditions in the outdoors.

Partial Hospitalization Program

Partial Hospitalization Program (PHP) is an outpatient program that is provided under the supervision of an attending psychiatrist or psychiatric extender. PHP is intended to provide treatment on an outpatient basis, does not include boarding or housing, and is intended to provide treatment interventions in a structured setting, with patients returning to their home environments each day. PHP is a minimum of five hours per day, five days per week.

Participating provider

A **participating provider** is:

• Contracted with Regence BlueShield but is not in your plan's preferred network, and they cannot balance bill you.

• Considered out of network for your plan, except for the following services:

    ▪ Covered preventive services.

- Mental health or substance use disorder.
- Emergency services for a medical emergency (including air ambulance).

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.

Physician services

Physician services are health care services provided or coordinated by a licensed medical physician, such as a:

- Doctor of osteopathic medicine (D.O.)
- Medical doctor (M.D.)
- Naturopathic physician (N.D.)

Find the complete list of covered provider types on the UMP website at **ump.regence.com/pebb/benefits/providers/covered-providers**. UMP website at **ump.regence.com/sebb/benefits/providers/covered-providers**.

Plan

Plan, as referred to in this document, means Uniform Medical Plan Classic Medicare with Part D (PDP), a self-insured PPO plan offered by the PEBB Program. In the eligibility section (see "Eligibility and enrollment" on page 100. "Plan" may include other plans not sponsored by the: PEBB Program. In the "If you have other medical coverage" section, "plan" may mean any health insurance coverage.

Preauthorization

Preauthorization is plan approval for coverage of specific services or supplies, 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, the plan may deny the claim. See the "Preauthorizing medical services" section for how this works. A list of medical services that require preauthorization is available on the UMP Policies that affect your care webpage or by contacting UMP Customer Service (see Directory for link and contact information).

Preferred provider(s)

A **preferred provider** is a provider:

- In the Regence service area and contracted as part of Regence BlueShield's PPO 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.

Preferred Provider Organization (PPO)

A **Preferred Provider Organization (PPO)** is a health plan that has a network of providers who have agreed to provide services at discounted rates. Members may self-refer to most specialists. UMP Classic Medicare with Part D (PDP) is a PPO.

Prenatal

Prenatal means during pregnancy.

Preventive care

Preventive care means those services described by the Public Health Services Act, Section 2713:

- Covered immunizations recommended by the CDC.
- Evidence-informed preventive care and screenings for women as described in HRSA Guidelines in accordance with 45 CFR §147.130 (a)(iv).
- Evidence-informed preventive care screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Services with an A or B rating by the U.S. Preventive Services Task Force.

Preventive rate

Covered preventive services are **not** subject to your medical deductible. The plan's **preventive rate** depends on the provider's status:

- Preferred providers: You pay $0. The plan pays 100 percent of the allowed amount.
- Participating providers: You pay $0. The plan pays 100 percent of the allowed amount.
- Out-of-network providers: You pay 40 percent of the allowed amount. You pay all charges billed to you above the allowed amount (known as balance billing). The plan pays 60 percent of the allowed amount.

Primary care provider (PCP)

A **primary care provider (PCP)** is a physician (see the "Physician services" definition), nurse practitioner, or physician assistant who provides, coordinates, or helps a member access a range of health care services. See page 13 for a list of specialties that may be a primary care provider.

Primary payer

The **primary payer** is the insurance plan that processes the claim first when a member has more than one group insurance plan covering the services and the plans must coordinate benefits.

Professional services

Professional services are non-facility medical services performed by professional providers, including, but not limited to, medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

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

A **provider network** is a group of providers who negotiate a contract with Regence BlueShield to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates (see the "Allowed amount, medical services" definition). The Regence

BlueShield, including the BlueCard Program, provider network for UMP Classic Medicare members in 2025 consist of preferred and participating providers.

Public Employees Benefits Board (PEBB)

The **Public Employees Benefits Board (PEBB)**, is a group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) plan

A **Public Employees Benefits Board (PEBB) plan** is one of several health benefit plans, including the Uniform Medical Plan (UMP Classic, UMP Classic Medicare with Part D (PDP) UMP Select, UMP Consumer-Directed Health Plan, and UMP Plus plans: UMP Plus–Puget Sound High Value Network and UMP Plus–UW Medicine Accountable Care Network), offered through the PEBB Program to eligible public employees, former employees and dependents in Continuation Coverage, retirees, survivors, retired employees of a former employer group, and their eligible dependents. The PEB Board designs benefits and eligibility and is administered by HCA as part of a comprehensive benefits package.

Public Employees Benefits Board (PEBB) Program

The **Public Employees Benefits Board (PEBB) Program** is the HCA program that administers PEBB benefit eligibility and enrollment.

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 BlueShield service area

The **Regence BlueShield 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. Check the Regence website at **regence.com** for up-to-date information.

Rehabilitative services

Rehabilitative services are health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Residential treatment facility

Residential treatment facility means a facility that offers a defined course of therapeutic intervention and special programming in a controlled environment; offers a degree of security, supervision, and structure; and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically monitored with 24-hour medical availability and 24-hour onsite clinician services.

Residential treatment facilities typically do not include halfway houses; supervised living; group homes; wilderness courses or camps; Outward Bound; outdoor youth programs; boarding houses; or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by providers in such settings may be covered if they are billed separately and otherwise would be covered.

Respite care

Respite care is continuous care for a homebound hospice member of more than four hours a day to provide family members temporary relief from caring for the member.

Retired employee of a former employer group

A retired employee of a former employer group includes a retired employee from a PEBB employer group and a retired school employee of a SEBB employer group who is continuing enrollment in PEBB health plan coverage by self-paying premiums after losing eligibility for PEBB retiree insurance coverage upon the employer group ending participation in insurance plans and contracts with the Health Care Authority (HCA).

Routine

Routine services are those provided as preventive, not because of an injury or illness. In the case of covered immunizations, routine refers to covered immunizations included on the CDC schedules (see page 52).

Same-day surgery center

See the "Ambulatory surgery center (ASC)" definition.

School Employees Benefits Board (SEBB)

The **School Employees Benefits Board (SEBB)** is a group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board (SEBB) Organization

School Employees Benefits Board (SEBB) Organization means a public school district or educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).School Employees Benefits Board (SEBB) Program

The **School Employees Benefits Board (SEBB) Program** is the program within HCA that administers insurance and other benefits for eligible school employees and eligible dependents.

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. Scientific evidence also refers to findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, scientific evidence does 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.

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 group 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 the "If you have other medical coverage" section 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.

Special rate

The plan's **special rate** is for services that have unique payment rules. These rules are described in the table (see the "How much you pay for covered services" column) located in the "Types of services" section.

Standard rate

The plan's **standard rate** depends on the provider's status:

- Preferred providers: You pay 15 percent of the allowed amount after you meet your medical deductible. The plan pays 85percent of the allowed amount.
- Participating providers: You pay 40 percent of the allowed amount after you meet your medical deductible. The plan pays 60 percent of the allowed amount.
- Out-of-network providers: You pay 40 percent of the allowed amount after you meet your medical deductible. You pay all charges billed to you above the allowed amount (known as balance billing). The plan pays 60 percent of the allowed amount.

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

State-registered domestic partner

State-registered domestic partner means an adult who meets the requirements for a valid state-registered domestic partnership and has been issued a certificate of state-registered domestic partnership

by the Washington State Secretary of State, or an adult whose legal union (other than a marriage) was validly formed in another jurisdiction and is substantially equivalent to a domestic partnership under Washington law.

Subscriber

A **subscriber** is a retiree, former employee or former dependent in COBRA Continuation Coverage, retired employee of a former employer group, or survivor who is the primary certificate holder and plan member.

Substance use disorder

Substance use disorder is an illness characterized by a physiological or psychological dependency on a controlled substance or alcohol.

Substance use disorder facility

A **substance use disorder facility** is an institution, or part of an institution, that specifically treats dependency on a controlled substance or alcohol and meets all of these criteria:

- Is certified by the Washington State Division of Behavioral Health and Recovery (DBHR), or for facilities outside of the Regence BlueShield service area, is contracted with the local BlueCard® network
- Is licensed by the state
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs
- Performs services under full-time supervision of a physician or registered nurse
- Provides services, for a fee, to persons receiving substance use disorder treatment, including room and board, as well as 24-hour nursing

Unicompartmental

Unicompartmental refers to a diagnosis or procedure affecting only one part, or "component," of a joint (e.g. knee) as opposed to more than one part of a joint.

Uniform Medical Plan

Uniform Medical Plan Classic Medicare with Part D (PDP) is a self-insured PPO health plan offered through the PEBB Program and managed by HCA.

Choice Network provider, vision

Choice Network provider, vision means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to members. This plan's provider network is Choice Network.

Disclosures

See Disclosures under Part two: Your Medicare Part D prescription drug coverage

Part two

Your Medicare Part D prescription drug Evidence of Coverage

2025

Evidence of Coverage (EOC)

UMP Classic Medicare with Part D (PDP)

S5975-808

Uniform Medical Plan

ArrayRx

January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of UMP Classic Medicare with Part D (PDP)

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact ArrayRx Customer Service at 1-833-599-8539. (TTY users should call 711.) Hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. This call is free.

This plan, UMP Classic Medicare with Part D (PDP), is offered by Moda Health Plan, Inc. Moda is the administrator of ArrayRx. (When this *Evidence of Coverage* says "we," "us," or "our," it means Moda Health Plan, Inc., administrator of ArrayRx. When it says "plan" or "our plan," it means UMP Classic Medicare with Part D (PDP).)

This information is available in large print. Please call ArrayRx Customer Service if you need plan information in another format or language.

Benefits, premiums, deductibles, and copayments may change on January 1, 2026.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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OMB Approval 0938-1051 (Expires: August 31, 2026)

2025 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in UMP Classic Medicare with Part D (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another health plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, UMP Classic Medicare with Part D (PDP).

UMP Classic Medicare with Part D (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered drugs* refer to the prescription drug coverage available to you as a member of UMP Classic Medicare with Part D (PDP).

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact ArrayRx Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how UMP Classic Medicare with Part D (PDP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months in which you are enrolled in UMP Classic Medicare with Part D (PDP) between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of UMP Classic Medicare with Part D (PDP) after December 31, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve UMP Classic Medicare with Part D (PDP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You meet the eligibility requirements for the Public Employees' Benefit Board (PEBB) Program coverage and are eligible for enrollment in the UMP Classic Medicare with Part D (PDP) plan
- You have Medicare Part A and Medicare Part B
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

Section 2.2 Here is the plan service area for UMP Classic Medicare with Part D (PDP)

UMP Classic Medicare with Part D (PDP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes the United States, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Employees and Retirees Benefits (ERB) Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.3 U.S. Citizen or Lawful Presence

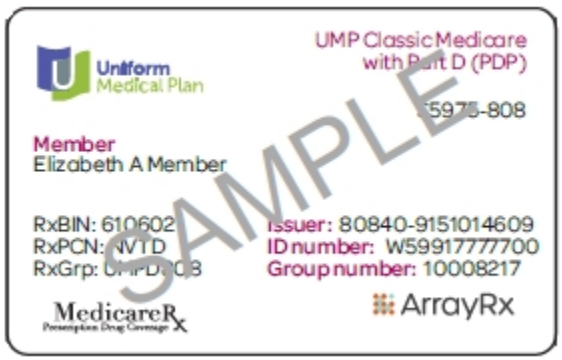
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UMP Classic

Medicare with Part D (PDP) if you are not eligible to remain a member on this basis. UMP Classic Medicare with Part D (PDP) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your UMP Classic Medicare with Part D (PDP) membership card, also called Member Identification (ID) card, for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample UMP Classic Medicare with Part D (PDP) membership card to show you what yours will look like:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan UMP Classic Medicare with Part D (PDP) membership card is damaged, lost, or stolen, call ArrayRx Customer Service right away and we will send you a new card.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare along with your medical ID card.

Section 3.2 Pharmacy Directory

The *Pharmacy Directory,* located at *ArrayRxSolutions.com/UMP* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Pharmacy Directory*, you can get a copy from ArrayRx Customer Service. You can also find this information on our website at ArrayRxSolutions.com/UMP.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in UMP Classic Medicare with Part D (PDP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the UMP Classic Medicare with Part D (PDP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will post an online copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (ArrayRxSolutions.com/UMP) or call ArrayRx Customer Service.

SECTION 4 Your monthly costs for UMP Classic Medicare with Part D (PDP)

Your costs may include the following:

- UMP Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the programs might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. ArrayRx sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call ArrayRx Customer Service and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called "2025 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov/medicare-and-you). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 UMP Plan Premium

As a member of our plan, you pay a monthly plan premium.

Your coverage is provided through a contract with the Health Care Authority (HCA). HCA will notify you of your monthly premium for our plan.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, you must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in UMP Classic Medicare with Part D (PDP), Moda Health Plan, Inc. will let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.

- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is $36.78.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.15. This rounds to $5.10. This amount will be billed to you separately by Moda Health Plan, Inc. if you have a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were

paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Moda Health Plan, Inc. will be billing you for your late enrollment penalty if you have one. Please be sure to pay your late enrollment penalty if you have one or you will be disenrolled from the plan.

There are two options for payment to Moda Health Plan, Inc.

Option 1: Paying by check

You may pay your monthly late enrollment penalty directly to our Plan. This method is called Direct Pay. If you choose Direct Pay for your method to pay your plan premium, Moda Health Plan, Inc. will send you a monthly statement. Direct Pay premium statements are mailed on the 8th of each month with a due date of the 1st of the following month. Please make sure your check or money order is payable to Moda Health Plan, Inc., not Medicare, CMS, or HHS. Please include your ID number on your check. Your ID number can be found on your UMP Classic Medicare with Part D (PDP) membership card.

Mail your check or money order to:

Moda Health Plan, Inc.
Attn: Accounting
P.O. Box 4220
Portland, OR 97208

You may drop off a payment **in person** at:

Moda Health Plan, Inc.
601 S.W. Second Ave., Suite 700
Portland, OR 97204

Option 2: Electronic Funds Transfer (EFT) from your checking account

Instead of paying by check or money order, you can have your monthly late enrollment penalty automatically withdrawn from your checking account. This method is called EFT (Electronic Funds Transfer) using the Automated Clearing House (ACH). If you choose EFT for your method to pay your plan premium, you may call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711) to request an EFT form and instructions be mailed to you. Customer Service is available from 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call

will be handled by our automated phone systems outside business hours. You can also download the form by visiting our website at ArrayRxSolutions.com/UMP. Print the EFT form and instructions. Mail your form to the address listed on the instructions. Once your EFT takes effect, EFT premium deductions from your checking account will occur on the 5th of each month.

If you have questions about your late enrollment penalty statement, please call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711). Customer Service is available from 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1 – March 31 (closed on Thanksgiving and Christmas), and weekdays April 1 – September 30. Your call will be handled by our automated phone systems outside business hours.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the Social Security Administration (SSA). It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your UMP premium (if you have one) and you'll get a bill from Moda Health Plan, Inc. for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are four ways you can pay your UMP plan premium.

Option 1: Paying by check

You can pay your plan premium by check or money order. Each month you will be sent a statement telling you how much you owe. Plan premiums are due on or before the 15th of each month. Make your checks payable to: **Health Care Authority**

Mail your premium to:

Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Option 2: Electronic Debit Service (EDS) from your bank account

Instead of paying by check or money order, you can have your monthly plan premium automatically withdrawn from your checking or savings account. This method is called EDS (Electronic Debit Service). If you choose EDS for your method to pay your plan premium, you may call ERB Customer Service 1-800-200-1004 or visit hca.wa.gov/employee-retiree-benefits/retirees/paying-benefits to request an EDS form which includes submission instructions. Until the EDS takes place, which may take up to 6 to 8 weeks, you are responsible for paying your premium with a check (or see the other payment options). Once your EDS takes effect, EDS premium deductions will come directly from your bank account on the 15th of each month. If the 15th falls on a Saturday, Sunday, or holiday, the withdrawal will occur on the next business day.

Option 3: You can have your premium deducted from your pension

To have the premium deducted from your pension, subscribers would select this option on their enrollment request forms. You may call ERB Customer Service 1-800-200-1004 or visit hca.wa.gov/employee-retiree-benefits/retirees/paying-benefits to find out if this option is available to you.

Option 4: You can pay by cash

You may also pay in cash and deliver to the Health Care Authority. Lobby hours are Monday through Friday, 8 a.m. to 4 p.m. (Pacific Time). Please do not mail cash.

Deliver your premium in cash at:

Health Care Authority (HCA)
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Changing the way you pay your plan premium

You can request to change your payment method in writing at any time. If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. To change your payment method, please call ERB Customer Service 1-800-200-1004 or visit hca.wa.gov/employee-retiree-benefits/retirees/paying-benefits .

What to do if you are having trouble paying your plan premium

Your plan premium is due in HCA's office by the 15th day of the month. If HCA has not received your premium by the time frame indicated in the notice, they will send you another notification telling you that your plan membership will end if they do not receive your premium payment within the time frame indicated.

If you are having trouble paying your premium on time, please contact ERB Customer Service to see if they can direct you to programs that may help with your plan premium.

If we end your membership because you did not pay your premiums, you will still have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

If you think HCA has wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 7 of this document tells how to make a complaint, or you can call us at 1-800-200-1004 between 8 a.m. to 4 p.m., Pacific Time, Monday through Friday. TTY users should call 711. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in October and the change will take effect on January 1.

If a member qualifies for "Extra Help" with their prescription drug costs, Moda Health Plan, Inc. will be sending you a check each month to help you with your plan costs. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

Contact ERB Customer Service about these changes:

- Changes to your name, your address, or your phone number
- If your designated responsible party (such as a caregiver) changes.

Contact ArrayRx Customer Service about these changes:

- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling ArrayRx Customer Service or ERB Customer Service. Phone numbers for Customer Service are printed on the back cover.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, ArrayRx will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call ArrayRx Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)

- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 UMP Classic Medicare with Part D (PDP) contacts (how to contact us, including how to reach ArrayRx Customer Service)

How to contact the Employees and Retirees Benefits (ERB) Customer Service

For assistance with plan premiums, updating your name, and address and phone number changes, please call or write to Employees and Retirees Benefits (ERB) Customer Service. They will be happy to help you.

Method	ERB Customer Service – Contact Information
CALL	**1-800-200-1004** Calls to this number are free. ERB Customer Service is available from 8 a.m. to 4 p.m., Pacific Time, Monday through Friday. ERB Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-360-725-0771**
WRITE	**Health Care Authority (HCA)** PO Box 42684 Olympia, WA 98504 Online support: support.hca.wa.gov/hcasupport
WEBSITE	**www.hca.wa.gov**

How to contact our plan's ArrayRx Customer Service

For assistance with pharmacy claims, billing, member drug card questions, or other pharmacy related questions, please call or write to UMP Classic Medicare with Part D (PDP) (ArrayRx Customer Service). We will be happy to help you.

Method	ArrayRx Customer Service – Contact Information
CALL	**1-833-599-8539** Calls to this number are free. ArrayRx Customer Service is available from 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. ArrayRx Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
WRITE	**ArrayRx** **Medicare ArrayRx Customer Service** P.O. Box 40327 Portland, OR 97240-0327 Email: UMPRXMedicare@modahealth.com
WEBSITE	ArrayRxSolutions.com/UMP

How to contact us when you are asking for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-800-207-8235** **Medicare Pharmacy Coverage Decisions**
WRITE	**ArrayRx** **Medicare Pharmacy Coverage Decisions** P.O. Box 40327 Portland, OR 97240-0327 Email: UMPRXMedicare@modahealth.com

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. **1-855-466-7211 Expedited Medicare Pharmacy Appeal and Grievance (voicemail only)** This is a voicemail only number that can be used to submit an expedited oral appeal. If you need to submit an expedited oral appeal, please leave your name, phone number, member identification number (if available), and the details of your denial. We will call you back and confirm the details of your case.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-833-949-1888** **Medicare Pharmacy Appeal and Grievance**
WRITE	**ArrayRx** **Medicare Pharmacy Appeal and Grievance** PO Box 40384 Portland, OR 97240-0384 Email: UMPRXMedicare@modahealth.com

How to contact us when you are making a complaint

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints – Contact Information
CALL	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day. **1-855-466-7211 Expedited Medicare Pharmacy Appeal and Grievance (voicemail only)** This is a voicemail only number that can be used to submit an expedited oral complaint. If you need to submit an expedited oral complaint, please leave your name, phone number, member identification number (if available), and the details of your complaint. We will call you back and confirm the details of your case.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-833-949-1888** **Medicare Pharmacy Appeal and Grievance**
WRITE	**ArrayRx** **Medicare Pharmacy Appeal and Grievance** P.O. Box 40384 Portland, OR 97240-0384 Email: UMPRXMedicare@modahealth.com
MEDICARE WEBSITE	You can submit a complaint about UMP Classic Medicare with Part D (PDP) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement or to pay the pharmacy bill, see Chapter 5 (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	**1-833-599-8539** Calls to this number are free. Office hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. When leaving a message, please include your name, phone number, member identification number (if available) and the time you called. A representative will return your call the next business day.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-855-668-8550** **Medicare Pharmacy Claims**
WRITE	**Manual Claims** **UMP Classic Medicare with Part D (PDP)** P.O. Box 1039 Appleton, WI 54912-1039

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UMP Classic Medicare with Part D (PDP): • **Tell Medicare about your complaint:** You can submit a complaint about UMP Classic Medicare with Part D (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. You can find a list of the State Health Insurance Assistance Programs in each state we serve in Appendix 4 at the back of this document.

SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. You can find a list of the Quality Improvement Organizations in each state we serve in Appendix 1 at the back of this document.

Your state Quality Improvement Organization has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Your state Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact your state Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact your state Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security

telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov/

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency in your state. For a list of Medicaid agencies by state, please refer to Appendix 3 at the back of this document.

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (See Section 6 of this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please call ArrayRx Customer Service at 1-833-599-8539 to request assistance with obtaining best available evidence. If you have information from your state of residence or Social Security that says what your copayment should be, call ArrayRx Customer Service first so we can note this in our system. Then fax the information to Attn: Medicare ArrayRx Customer Service at 1-800-207-8235. If you are at the pharmacy, your pharmacy can call ArrayRx Customer Service and fax us a copy of your documentation.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact ArrayRx Customer Service if you have questions.

What if you have "Extra Help" and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's "Extra Help" pays first.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

Refer to Appendix 2 at the back of this document for a list of contact information for State Pharmaceutical Assistance Programs by state.

What if you have "Extra Help" and coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance (See Appendix 2 at the back of this document for a list of AIDS Drug Assistance Programs).

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please see Appendix 2 at the back of this document for a list of AIDS Drug Assistance Programs.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	**1-833-380-8050** Calls to this number are free. Office hours are: • 8 a.m.- 8 p.m. PST Monday through Friday from April 1-September 30 • 8 a.m.- 8 p.m. PST seven days a week from October 1 – March 31 (closed on Thanksgiving and Christmas) Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. This number requires special telephone equipment and is available for people who have difficulties with hearing or speaking.
FAX	**1-440-557-6525**
WRITE	UMP Classic Medicare with Part D (PDP) MPPP Support Department 810 Sharon Dr. Westlake, OH 44145 Email: MPPPsupport@RxPayments.com
WEBSITE	ArrayRxSolutions.com/UMP

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or ERB Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for ERB Customer Service or ArrayRx Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**.

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2025* handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter. Or you can fill your prescription through the plan's mail-order service.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the Drug List for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 of this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term *covered drugs* means all of the Part D prescription drugs that are on the plan's Drug List.

There are no network pharmacies outside of the United States and its territories.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (ArrayRxSolutions.com/UMP), and/or call ArrayRx Customer Service.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from ArrayRx Customer Service or use the *Pharmacy Directory*. You can also find information on our website at ArrayRxSolutions.com/UMP.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact ArrayRx Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.

To locate a specialized pharmacy, look in your *Pharmacy Directory,* at *ArrayRxSolutions.com/UMP* or call ArrayRx Customer Service.

Section 2.3 Using the plan's mail-order service

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail you can call ArrayRx Customer Service at the number listed on the back of this document. To find a network mail-order pharmacy, you may use the pharmacy locator tool at ArrayRxSolutions.com/UMP. If you use a mail-order pharmacy not in the plan's network, your prescription may not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If your order is delayed, call ArrayRx Customer Service for assistance (phone numbers are printed on the back cover of this document).

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply (also called an *extended supply*) of *maintenance* drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory,* located at *ArrayRxSolutions.com/UMP* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call ArrayRx Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. **Please check first with ArrayRx Customer Service** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- Prescriptions related to care for a medical emergency or urgently needed care.
- A network pharmacy that provides 24-hour services is not within a reasonable driving distance.
- You are unable to fill a prescription that is not regularly stocked at an in-network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- You are traveling outside of your plan service area and you run out of or lose your covered Part D drugs or become ill and need a covered Part D drug, and cannot access a network pharmacy.
- Self-administered Part D drugs provided in an outpatient setting (such as a provider clinic).

Note: Prescriptions filled at an out-of-network pharmacy in the situations listed above are limited to a 30-day supply.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the Drug List for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to *drugs*, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 10 for definitions of the types of drugs that may be on the Drug List.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (For more about this, see Section 7.1 in this chapter.)
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 7.)

Section 3.2 There are 6 cost-sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic – Lowest tier, includes generic drugs

  Tier 2 – Generic – Tier includes generic drugs

  Tier 3 – Preferred Brand – Tier includes preferred brand drugs

  Tier 4 – Non-Preferred Drug – Tier includes non-preferred drugs

  Tier 5 – Specialty Tier – Highest tier includes specialty drugs

  Tier 6 – Vaccines – Tier includes Part D vaccines

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have 4 ways to find out:

1. Check the most recent Drug List we provide electronically.
2. Visit the plan's website (ArrayRxSolutions.com/UMP). The Drug List on the website is always the most current.
3. Call ArrayRx Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (also called the "Drug Price Estimator" found at ArrayRxSolutions.com/UMP or by calling ArrayRx Customer Service). With this tool you can search for drugs on the Drug List to see an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

Please note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact ArrayRx Customer Service to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (See Chapter 7.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan, based on specific criteria, before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Our vacation override policy allows you to obtain an early refill for your prescription(s) prior to traveling outside of the United States (US), or if you expect you will run out of your medication(s) while traveling where there are no contracted pharmacies. You are allowed only two (2) vacation overrides per plan year. You should contact us for your vacation override request no more than two (2) weeks prior to travel.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be. Go to Section 5.3 to learn what you can do.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered**. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.**
- **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.**

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an **exception** and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call ArrayRx Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call ArrayRx Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary (Drug List) or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call ArrayRx Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's Drug List.

See Chapter 10 for definitions of the drug types discussed in this chapter.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we may make a change based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.
    - If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking.

You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

Changes to the Drug List that do not affect you during the current plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are *excluded*. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label use* is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your UMP Classic Medicare with Part D (PDP) membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility?

If you are admitted to a hospital or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory,* located at *ArrayRxSolutions.com/UMP* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact ArrayRx Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in UMP Classic Medicare with Part D (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it.

Some drugs may be covered under Medicare Part B in some situations and through UMP Classic Medicare with Part D (PDP) in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or UMP Classic Medicare with Part D (PDP) for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable, and the choices you have for drug coverage. (If the coverage from the Medigap policy is creditable, it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact ArrayRx Customer Service.

CHAPTER 4:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call ArrayRx Customer Service and ask for the *LIS Rider*.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" (also called the "Drug Price Estimator") to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time," meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay at an indicated pharmacy. You can also obtain information provided by the "Real-Time Benefit Tool" by calling ArrayRx Customer Service.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called *cost-sharing*, and there are two ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

- The amount you pay for drugs when you are in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium(s)
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan

- Payments for your drugs that are made by the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling ArrayRx Customer Service.

How can you keep track of your out-of-pocket total?

- We will help you. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for UMP Classic Medicare with Part D (PDP) members?

There are three **drug payment stages** for your prescription drug coverage under UMP Classic Medicare with Part D (PDP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium(s) regardless of the drug payment stage. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the Part D Explanation of Benefits (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called *year-to-date* information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show UMP Classic Medicare with Part D (PDP) your membership card (also called ID card) every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at ArrayRx Customer Service. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs

The Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. You will pay a yearly deductible of $100 on Tier 3, Tier 4 and Tier 5 drugs. **You must pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs** until you reach the plan's

deductible amount. For all other drugs, you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $100 for your Tier 3, Tier 4 and Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 6 cost-sharing tiers

Every drug on the plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 – Preferred Generic – Lowest tier, includes generic drugs

  Tier 2 – Generic – Tier includes generic drugs

  Tier 3 – Preferred Brand – Tier includes preferred brand drugs

  Tier 4 – Non-Preferred Drug – Tier includes non-preferred drugs

  Tier 5 – Specialty Tier – Highest tier, includes specialty drugs

  Tier 6 – Vaccines – Tier includes Part D vaccines

- On Tiers 3 and 4 you won't pay more than $35 for a one-month supply of each covered insulin product.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy.

- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 and the plan's *Pharmacy Directory,* located at *ArrayRxSolutions.com/UMP*.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

As shown in the table below, the amount of the copayment depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$10 copay	$10 copay	$10 copay	$10 copay

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 3 for details.) (up to a 30-day supply)
Cost-Sharing Tier 3 (Preferred Brand) You won't pay more than $35 for a one month supply of each covered insulin product.	$40 copay	$40 copay	$40 copay	$40 copay
Cost-Sharing Tier 4 (Non-Preferred Drug) You won't pay more than $35 for a one month supply of each covered insulin product.	$75 copay	$75 copay	$75 copay	$75 copay
Cost-Sharing Tier 5 (Specialty Tier)	$90 copay	$90 copay	$90 copay	$90 copay
Cost-Sharing Tier 6 (Vaccines)	$0 copay	$0 copay	$0 copay	$0 copay

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Please see Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an *extended supply*). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (90-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$20 copay	$20 copay

Tier	**Standard retail cost sharing (in-network)** (90-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 3 (Preferred Brand) You won't pay more than $70 for up to a two-month supply or $80 for up to a three month supply of each covered insulin product.	$80 copay	$80 copay
Cost-Sharing Tier 4 (Non-Preferred Drug) You won't pay more than $70 for up to a two-month supply or $105 for up to a three month supply of each covered insulin product.	$150 copay	$150 copay
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Cost-Sharing Tier 6 (Vaccines)	A long-term supply is not available for drugs in Tier 6.	A long-term supply is not available for drugs in Tier 6.

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,000 out-of-pocket limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage**,** you pay nothing for your covered Part D drugs.

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible. Refer to your plan's Drug List or contact ArrayRx Customer Service for coverage and cost-sharing details about specific vaccines.

Our plan provides coverage for a number of Part D vaccines. Because coverage for vaccines can be complicated, we suggest that you call ArrayRx Customer Service prior to receiving any vaccinations if you have any concerns.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.

- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine administration.

CHAPTER 5:
Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

2. When you pay the full cost for a prescription because you don’t have your UMP Classic Medicare with Part D (PDP) membership card with you

If you do not have your UMP Classic Medicare with Part D (PDP) membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan’s Drug List or it could have a requirement or restriction that you didn’t know about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 60 days** of the date you received the service, item, or drug.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (ArrayRxSolutions.com/UMP) or call ArrayRx Customer Service and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Manual Claims
UMP Classic Medicare with Part D (PDP)
P.O. Box 1039
Appleton, WI 54912-1039

Fax: 1-855-668-8550

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call ArrayRx Customer Service.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with UMP Classic Medicare with Part D (PDP) Medicare Pharmacy Appeal and Grievance Department (see Chapter 2, Section 1). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered drugs

You have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call ArrayRx Customer Service.

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of UMP Classic Medicare with Part D (PDP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call ArrayRx Customer Service:

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an *advance directive* to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive

forms from organizations that give people information about Medicare. You can also contact ArrayRx Customer Service to ask for the forms.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state's Department of Health.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call ArrayRx Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call ArrayRx Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call ArrayRx Customer Service.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered drugs.
    - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your UMP Classic Medicare with Part D (PDP) membership card whenever you get your Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must pay your UMP plan premiums.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, notify ERB Customer Service** so they can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you** cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to ArrayRx Customer Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs within the list of the State Health Insurance Assistance Programs in each state we serve in Appendix 4 at the back of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether prescription drugs are covered or not, the way they are covered, and problems related to payment for prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for prescription drugs, including payments. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or

if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Part D appeals are discussed further in Section 5 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at ArrayRx Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call ArrayRx Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at ArrayRxSolutions.com/UMP). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *Formulary*.
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first). **Ask for an exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an *exception*. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for brand name drugs or Tier 4 for generic drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 6 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a biological product, you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.

- If the drug you're taking is a brand name drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called *alternative* drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A *fast coverage decision* is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which are available on our website ArrayRxSolutions.com/UMP/Drug-Coverage-Determination. Chapter 2 has

contact information. You, your representative, or your doctor (or other prescriber) may submit a request for a coverage determination electronically using our secure form. Fill out all of the required information, attach any supporting documents and submit. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the *supporting statement*,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A *fast appeal* is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal decision is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a *fast appeal*.
- The requirements for getting a *fast appeal* are the same as those for getting a *fast coverage decision* in Section 5.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request or call us at 1-833-599-8539.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-855-466-7211.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website Hca.wa.gov/assets/pebb/ump-medicare-coverage-redetermination-appeal.pdf. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- You, your representative or your doctor (or other prescriber) may submit a request for an appeal electronically using our secure form. This secure form can be accessed at ArrayRxSolutions.com/UMP/ Drug-Coverage-Redetermination. Fill out all of the required information, attach any supporting documents, and submit.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

<u>Step 4:</u> If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 5.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a *fast appeal*.
- If the organization agrees to give you a *fast appeal*, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have

not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to send payment to you **within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called *upholding the decision*. It is also called *turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your

request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 7.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our customer service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our customer service or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling ArrayRx Customer Service is the first step.** If there is anything else you need to do, ArrayRx Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You, the member, or your authorized representative may file a complaint. You must make the complaint within 60 calendar days from the date of the event or incident that caused you to make a complaint. If you miss the deadline, you may still make the

complaint and request an extension of the time frame. Your request may be in writing and include the reason you did not make the complaint on time.

If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call ArrayRx Customer Service (phone numbers are printed on the back cover of this document) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf or on our website at ArrayRxSolutions.com/UMP.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

You can mail your complaint to:

ArrayRx
Attn: Medicare Appeal and Grievance
PO Box 40384
Portland, OR 97240-0384

Or fax your complaint to:

1-833-949-1888
Attn: Medicare Appeal and Grievance

If you call ArrayRx Customer Service at 1-833-599-8539 (TTY users call 711), they will record the complaint and repeat back to you the complaint as written, to confirm the accuracy. The complaint will be noted with the time and the date. If you mail, fax, or deliver your complaint, the received date and time will be noted on your letter. ArrayRx Customer Service is available from 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours.

We have 30 calendar days from the date the complaint was received to make a decision. Sometimes we may need more time to make a decision on your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we find a need for additional information and the delay is in your best interest. If we need more time, you will receive a letter requesting the extra time and explaining why we need more time to make a decision.

If your complaint is regarding quality of care, the letter you receive with the outcome of our decision will include your right to file a quality of care grievance with the Quality Improvement Organization (QIO) in your state.

If we turn down your request for a "fast" coverage determination, a "fast" redetermination or a "fast" appeal and you have not yet received the drug, you have the right to file a "fast" complaint. Indicate clearly on your request you would like a "FAST

COMPLAINT REQUEST". You may file a "fast" complaint by phone (call 1-855-466-7211) or fax as listed above. We will respond to your "fast" complaint in writing within 24 hours of receipt of your "fast" complaint.

- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a *fast coverage decision or* a *fast appeal*, we will automatically give you a *fast complaint*.** If you have a *fast complaint*, it means we will give you an answer **within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about UMP Classic Medicare with Part D (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

The information in this chapter is for general Medicare enrollment. Contact ERB Customer Service for details regarding enrollment and Plan Change guidelines. Ending your membership in UMP Classic Medicare with Part D (PDP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as open enrollment periods. Please contact ERB Customer Service 1-800-200-1004 between 8 a.m. to 4 p.m., Pacific Time, Monday through Friday, for more information on ending membership in our plan.

If you request disenrollment at a time other than your group's open enrollment periods, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

Section 2.1 You can end your membership during the Annual Enrollment Period

You will have the opportunity to end your membership in the UMP Classic Medicare with Part D (PDP) for 2026 during the Public Employee Benefits Board (PEBB) open enrollment period. If you have any questions or would like more information about when you can end your group membership, contact ERB Customer Service 1-800-200-1004 between 8 a.m. to 4 p.m., Pacific Time, Monday through Friday.

You can also end your membership in our plan during the **Annual Enrollment Period** (also known as the *Annual Open Enrollment Period*). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period is from** October 15 to December 7. The UMP open enrollment period for plan year 2026 is from October 27, 2025 to November 24, 2025. Medicare plans not insured through HCA have an annual enrollment period from October 15 to December 7.

- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - A different HCA Medicare health plan. You can end your membership in the UMP Classic Medicare with Part D (PDP) plan by selecting a different UMP plan during UMP open enrollment period. The UMP open enrollment period for plan year 2026 is from October 27, 2025 to November 24, 2025. Coverage under your new plan will begin January 1, 2026.
    - Another Medicare prescription drug plan,
    - Original Medicare *with* a separate Medicare prescription drug plan,
    - Original Medicare *without* a separate Medicare prescription drug plan,
        - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
    - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

      If you enroll in most Medicare health plans while enrolled in UMP Classic Medicare with Part D (PDP), you will be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1. Make sure the PEBB Program receives your request to end coverage before December 31.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of UMP Classic Medicare with Part D (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- If you have moved out of your plan's service area
- If you have Medicaid

- If you are eligible for "Extra Help" with paying for your Medicare prescriptions
- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE) (PACE is not available in all states. If you would like to know if PACE is available in your state, please contact ArrayRx Customer Service.)

Note: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare prescription drug plan
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
- If you enroll in most Medicare health plans, you will automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins.

Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call ERB Customer Service** 1-800-200-1004 between 8 a.m. to 4 p.m., Pacific Time, Monday through Friday.
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

You may request disenrollment by writing to HCA.

Please contact ERB Customer Service 1-800-200-1004 between 8 a.m. to 4 p.m., Pacific Time, Monday through Friday, for more information on ending membership in our plan.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another HCA plan	• Enroll in a new Public Employees' Benefit Board (PEBB) Medicare plan during the PEBB Open Enrollment period
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. • You will automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• A Medicare health plan.	• Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from UMP Classic Medicare with Part D (PDP) when your new plan's coverage begins. • If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send a written request (contact ERB Customer Service if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send a written request to disenroll**. Contact ERB Customer Service if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. You will be disenrolled from UMP Classic Medicare with Part D (PDP) and only have Original Medicare.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan.

- **Continue to use our network pharmacies or mail order services to get your prescriptions filled**.

SECTION 5 UMP Classic Medicare with Part D (PDP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

UMP Classic Medicare with Part D (PDP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, call ERB Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your UMP Classic Medicare with Part D (PDP) membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for two months.
    - We must notify you in writing that you have two months to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call ERB Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

UMP Classic Medicare with Part D (PDP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or can make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at ArrayRx Customer Service. If you have a complaint, such as a problem with wheelchair access, ArrayRx Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, UMP Classic Medicare with Part D (PDP), as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 10:
Definitions of important words

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for prescription drugs after you pay any deductibles.

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed *copayment* amount that a plan requires when a specific drug is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called *coverage decisions* in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Customer Service is dedicated to providing the highest level of service to customers by providing the information needed to understand your membership and use your plan benefits. This is offered through telephone, email, and written contact. When a non-English speaking caller needs to obtain information, we use a language interpretation service to facilitate the discussion. Chapter 2 has contact information.

Daily cost-sharing rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your *daily cost-sharing rate* is $1 per day.

Deductible – The amount you must pay for prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a *generic* drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Lawfully Present – Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare.

Unlawful presence is defined in Section 212(a)(9)(B)(ii) of the Immigration and Nationality Act (INA) to mean that an alien is deemed to be unlawfully present in the U.S. if the alien is (1) present after the expiration of the period of stay authorized by the Secretary of Homeland Security or (2) present without being admitted or paroled.

For most individuals, the period of stay authorized is noted on their I-94 card and they will begin to accrue unlawful presence the day following the date in their I-94 card. Additionally, if USCIS finds (while adjudicating an application for immigration benefit) that the individual has violated their nonimmigrant status, unlawful presence will begin the day after USCIS denies the benefit (or after the I-94 expires, whichever is earlier).

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help." Chapter 2 has contact information.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for *cost sharing* above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's *out-of-pocket* cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact ArrayRx Customer Service.

Part C – See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications. This tool is also called the Drug Price Estimator.

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

CHAPTER 11:
Appendix

Appendix 1 Quality Improvement Organization

You may contact the Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) in your state listed below if available at qioprogram.org/immediate-advocacy.

Alabama	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Alaska	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
American Samoa	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	684-699-3330 Toll-free 855-694-2929 Fax 711 TTY
Arizona	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY
Arkansas	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
California	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY
Colorado	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY

Connecticut	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Delaware	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
District of Columbia	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Florida	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Georgia	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Guam	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	671-685-2689 Toll-free 855-694-2929 Fax 711 TTY
Hawaii	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY
Idaho	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY

Illinois	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Indiana	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Iowa	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Kansas	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Kentucky	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Louisiana	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
Maine	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Maryland	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY

Massachusetts	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Michigan	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Minnesota	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Mississippi	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Missouri	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Montana	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Nebraska	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-755-5580 Toll-free 855-694-2929 Fax 711 TTY
Nevada	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	877-588-1123 Toll-free 855-694-2929 Fax 711 TTY

New Hampshire	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
New Jersey	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
New Mexico	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
New York	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
North Carolina	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
North Dakota	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Northern Mariana Islands	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	670-989-2686 Toll-free 855-694-2929 Fax 711 TTY
Ohio	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY

Oklahoma	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY
Oregon	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
Pennsylvania	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Puerto Rico	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
Rhode Island	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
South Carolina	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
South Dakota	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Tennessee	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0751 Toll-free 844-878-7921 Fax 711 TTY
Texas	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-315-0636 Toll-free 844-878-7921 Fax 711 TTY

Utah	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY
Vermont	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-319-8452 Toll-free 844-878-7921 Fax 711 TTY
Virgin Islands	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	866-815-5440 Toll-free 855-236-2423 Fax 711 TTY
Virginia	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Washington	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-305-6759 Toll-free 844-878-7921 Fax 711 TTY
West Virginia	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-396-4646 Toll-free 855-236-2423 Fax 711 TTY
Wisconsin	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701-1105 www.livantaqio.cms.gov/	888-524-9900 Toll-free 855-236-2423 Fax 711 TTY
Wyoming	KEPRO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609 www.keproqio.com/	888-317-0891 Toll-free 844-878-7921 Fax 711 TTY

Appendix 2 – State Pharmaceutical Assistance Program (SPAP)

You can contact the SPAP in your state listed below if available. Not all states offer an SPAP. The list is also available online at: www.medicare.gov/plan-compare/#/pharmaceutical-assistance-program/states?year=2024&lang=en

Alabama	334-206-5364	HIV Office of Prevention and Care Alabama Department of Public Health The RSA Tower, Suite 1200 201 Monroe Street Montgomery, Alabama 36104 www.alabamapublichealth.gov/hiv/
Alaska	800-478-2437	Alaskan AIDS Assistance Association AIDS Drug Assistance Program (ADAP) 1057 W. Fireweed Lane, Suite 102 Anchorage, AK 99503 www.alaskanaids.org/client-services/aids-drug-assistance-program-adap
Arizona	800-334-1540	Arizona Department of Health Services 150 North 18th Avenue Phoenix, Arizona 85007 www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/?index.php#aids-drug-assistance-program-home
Arkansas	800-462-0599	Arkansas Department of Health Ryan White Program 4815 West Markham Street Little Rock AR 72205-3867 www.healthy.arkansas.gov/programs-services/topics/ryan-white-program
California	833-422-4255	California State Department of Public Health AIDS Drug Assistance Program P.O. Box 997377 MS 0500 Sacramento CA 95899-7377 www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx
Colorado	303-692-2000	Colorado Department of Public Health & Environment State Drug Assistance Program (SDAP) 4300 Cherry Creek Drive South Denver CO 80246 cdphe.colorado.gov/state-drug-assistance-program

Connecticut	800-424-3310	Connecticut Department of Public Health C/O Magellan Rx PO Box 13001 Albany NY 12212-3001 ctdph.magellanrx.com/member/homesecure
Delaware	844-245-9580	Delaware Prescription Assistance Program PO Box 950 New Castle, DE 19720-0950 www.dhss.delaware.gov/dhss/dmma/dpap.html
District of Columbia	202-671-4815	District of Columbia ADAP 2201 Shannon Place SE Washington, DC 20020 dchealth.dc.gov/DC-ADAP
Florida	850-245-4422	AIDS Drug Assistance Program 4052 Bald Cypress Way Tallahassee FL 32399 www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html
Georgia	404-657-2700	Georgia AIDS Drug Assistance Plan Department of Public Health 200 Piedmont Avenue, SE Atlanta, Georgia 30334 dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	808-733-9360	Hawai'i State Department of Health HIV Drug Assistance Program (HDAP) 3627 Kilauea Avenue, Suite 306 Honolulu, HI 96816 health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/
Idaho	800-424-5734	Idaho Department of Health and Welfare AIDS Drug Assistance Program (ID ADAP) 1720 Westgate Drive Boise, ID 83704 healthandwelfare.idaho.gov/providers/hiv-std-and-hepatitis-providers/ryan-white-provider-resources

Illinois	800-825-3518	Illinois Department of Public Health Ryan White Part B Program 525 West Jefferson Street, First Floor Springfield, IL 62761 dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services.html
Indiana	866-267-4679	HoosierRx 402 W Washington, Rm. 372 Indianapolis, IN 46204 www.in.gov/medicaid/members/member-programs/hoosierrx/
	800-382-9480	Indiana Department of Health HIV Services Program ADAP 2 N. Meridian St. Indianapolis IN 46204 www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/
Iowa	515-204-3746	Iowa Health and Human Services Bureau of HIV, STI and Hepatitis 321 E. 12th Street Des Moines IA 50319 stophiviowa.org
Kansas	785-296-8844	Kansas Department of Health and Environment Ryan White Part B Program 1000 SW Jackson, Suite 210 Topeka KS 66612 www.kdhe.ks.gov/355/Ryan-White-Part-B-Program
Kentucky	800-420-7431	Kentucky AIDS Drug Assistance Program (KADAP) 275 E Main St, HS2E-C Frankfort KY 40621 www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Louisiana	504-568-7474	Louisiana Health Access Program 1450 Poydras St, Suite 2136 New Orleans LA 70112 www.lahap.org/
	225-342-9500	Louisiana Department of Health SHHP Program PO Box 629 Baton Rouge, LA 70821-0629 ldh.la.gov/page/shhp
Maine	207-287-3707	Department of Health and Human Services Ryan White Part B Program 109 Capitol Street, 11 State House Station Augusta ME 04333 www.maine.gov/dhhs/ofi/programs-services
Maryland	800-551-5995	Maryland Senior Prescription Drug Program c/o International Software Systems Inc. PO Box 749 Greenbelt, Maryland 20768-0749 marylandspdap.com
	410-767-6535	Maryland AIDS Drug Assistance Program (MADAP) 1223 W Pratt Street Baltimore, MD 21223 health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
Massachusetts	800-243-4636	Prescription Advantage P.O. Box 15153 Worcester MA 01615-0153 www.prescriptionadvantagema.org/
Michigan	888-826-6565	Michigan Drug Assistance Program P.O. Box 30727 Lansing, MI 48909 www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program

Minnesota	651-431-2398	Minnesota Department of Human Services AIDS Drug Assistance Program (ADAP) P.O. Box 64972 St. Paul, MN 55164-0972 mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp
Mississippi	888-343-7373	Mississippi State Department of Health Ryan White Part B Care and Treatment Division PO Box 1700 Jackson, MS 39215-1700 msdh.ms.gov/page/14,13047,150.html
Missouri	573-751-6439	Missouri Department of Health & Senior Services PO Box 570 Jefferson City, MO 65102 health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
Montana	406-444-5622	Montana Ryan White HIV Treatment Program PO Box 4210 Helena, MT 59604-4210 dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	800-922-0000	Nebraska Medicine Ryan White HIV/AIDS Program 987400 Nebraska Medical Center Omaha, NE 68198-7400 www.nebraskamed.com/hiv/ryan-white-assistance

Nevada	888-475-3219	Nevada Department of Health and Human Services Nevada Medication Assistance Program (NMAP) 400 West King Street, Suite 300 Carson City, NV 89703 nvmap.magellanrx.com/home
New Hampshire	603-271-4502	New Hampshire AIDS Drug Assistance Program (ADAP) 29 Hazen Drive Concord NH 03301 www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap
New Jersey	800-792-9745	NJ PAAD Program P.O. Box 715 Trenton NJ 08625-0715 www.nj.gov/humanservices/doas/services/l-p/paad/
	877-613-4533	NJ AIDS Drug Distribution program (NJADDP) P. O. Box 360 Trenton, NJ 08625-0360 www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml
	800-792-9745	NJ Senior Gold Discount card program P.O. Box 715 Trenton, NJ 08625-0715 www.nj.gov/humanservices/doas/services/q-z/senior-gold/
New Mexico	866-306-1882	New Mexico Medical Insurance Pool 1223 St. Francis Drive, Ste. B. Santa Fe, NM 87505 www.nmmip.org/
New York	800-332-3742	New York State Department of Health EPIC Program PO Box 15018 Albany NY 12212-5018 www.health.ny.gov/health_care/epic/

New York (continued)	800-542-2437	New York State Department of Health Uninsured Care Programs Empire Station P.O. Box 2052 Albany NY 12220-0052 www.health.ny.gov/diseases/aids/general/resources/adap/index.htm
North Carolina	919-733-3419	North Carolina HIV Medication Assistance Program (NC HMAP) 1902 Mail Service Center Raleigh NC 27699-1902 epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	701-328-2310	North Dakota Health & Human Services ND Ryan White Program 600 East Boulevard Ave Bismarck, ND 58505-0250 www.hhs.nd.gov/health/diseases-conditions-and-immunization/HIV/LivingwithHIV/RyanWhite
Ohio	800-777-4775	Ohio HIV Drug Assistance Program 246 N High Street Columbus OH 43215 odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
Oklahoma	405-271-4636	Oklahoma AIDS Drug Assistance Program 1000 NE Tenth & Stonewall Mail Drop 0308 Oklahoma City, OK 73117-1299 www.rxresource.org/prescription-assistance/oklahoma-aids-drug-assistance-program.html
Oregon	971-673-0144	CAREAssist Program 800 NE Oregon Street, Suite 1105 Portland, OR 97232 www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/index.aspx

Pennsylvania	800-225-7223	Pennsylvania Department of Health Chronic Renal Disease Program (CRDP) 625 Forster St. 7th Floor East Wing Harrisburg, PA 17120-0701 www.health.pa.gov/topics/programs/Chronic-Renal-Disease/Pages/Chronic%20Renal%20Disease.aspx
	800-433-4459	Special Pharmaceutical Benefits Program - Mental Health P.O. Box 2675 Harrisburg PA 17105-2675 www.dhs.pa.gov/providers/Providers/Pages/Special-Pharmaceuticals.aspx
	800-225-7223	PACE/PACENET PO Box 8806 Harrisburg, PA 17105-8806 pacecares.magellanhealth.com/
	800-922-9384	Department of Health Special Pharmaceutical Benefits Program/ADAP P.O. Box 8808 Harrisburg, PA 17105-8808 www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
Puerto Rico	787-765-2929	Departamento de Salud Programa Ryan White Parte B/ADAP PO Box 70184 San Juan PR 00936-8184 https://www.salud.pr.gov/CMS/137
Rhode Island	401-462-0560	Rhode Island Pharmaceutical Assistance to Elders (RIPAE) 57 Howard Ave Cranston RI 02920 oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance
South Carolina	800-856-9954	Medicare D Assistance Program (MAP) 3rd Floor Mills/Jarrett Box 101106 Columbia SC 29211 scdhec.gov/aids-drug-assistance-program

South Dakota	800-592-1861	South Dakota Department of Health Ryan White Part B CARE Program 615 E. 4th St Pierre, SD 57501-1700 doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/
Tennessee	(615) 741-7500	Tennessee Department of Health Ryan White Part B Program 710 James Robertson Parkway Nashville, TN 37243 www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html
Texas	800-222-3986	Texas Kidney Health Care Program P.O. Box 149030 Mail Code 1938 Austin, TX 78714-9947 www.hhs.texas.gov/services/health/kidney-health-care
	800-255-1090	Texas THMP State Pharmacy Assistance Program (SPAP) Attn: MSJA MC 1873 P.O. Box 149347 Austin, TX 78714-9347 www.dshs.texas.gov/hivstd/meds/spap
Utah	801-538-6311	Utah Department of Health & Human Services Ryan White HIV/AIDS Program Cannon Health Building 288 N 1460 W Salt Lake City, Utah 84116 ptc.health.utah.gov/treatment/ryan-white/
Vermont	855-899-9600	Department of Vermont Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671-1010 dvha.vermont.gov/

Virgin Islands		Not available
Virginia	855-362-0658	Virginia Medication Assistance Program (VA MAP) P.O. Box 2448 Richmond, Virginia 23218-2448 www.vdh.virginia.gov/disease-prevention/vamap/
Washington	877-376-9316	Early Intervention Program (EIP) PO Box 47841 Olympia, WA 98504-7841 doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services
Washington DC	202-442-5955	DC Health DC AIDS Drug Assistance Program 2201 Shannon Place SE Washington, DC 20020 dchealth.dc.gov/DC-ADAP
West Virginia	304-232-6822	West Virginia Health & Human Resources Ryan White Part B Program 350 Capitol Street, Room 125 Charleston, WV 25301 oeps.wv.gov/rwp/pages/default.aspx
Wisconsin	800-657-2038	Wisconsin Department of Health Services SeniorCare: Prescription Drug Assistance Program 1 West Wilson Street Madison, WI 53703 www.dhs.wisconsin.gov/seniorcare/index.htm
	800-991-5532	Wisconsin AIDS/HIV Drug Assistance Program (ADAP) 1 West Wilson Street Madison, WI 53703 www.dhs.wisconsin.gov/hiv/adap.htm
Wyoming	307-777-3562	Wyoming Department of Health Communicable Disease Treatment Program 401 Hathaway Building Cheyenne, WY 82002 health.wyo.gov/publichealth/communicable-disease-unit/hiv/

Appendix 3 –State Medicaid Agencies

You may contact the State Medicaid Agencies in your state listed below if available. The list is also available online at: www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu

State	Agency Name and Website	Toll-free Number
Alabama	Medicaid Agency of Alabama medicaid.alabama.gov/	800-362-1504
Alaska	Alaska Department of Health and Social Services health.alaska.gov/dpa/Pages/medicaid/default.aspx	800-780-9972
American Samoa	American Samoa Medicaid State Agency medicaid.as.gov/	684-699-4777
Arizona	Arizona Health Care Cost Containment System (AHCCCS) azahcccs.gov/	800-523-0231
Arkansas	Arkansas Department of Human Services humanservices.arkansas.gov	800-482-5431
California	Department of Health Care Services www.dhcs.ca.gov/	800-541-5555
Colorado	Health First Colorado www.healthfirstcolorado.com/	800-221-3943
Connecticut	Connecticut Medicaid portal.ct.gov/HUSKY/How-to-Contact-Us	855-805-4325
Delaware	Delaware Medicaid & Medical Assistance dhss.delaware.gov/dhss/dmma/	866-843-7212
District of Columbia	DC Medicaid dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship	202-727-8370
Florida	Florida Agency for Health Care Administration ahca.myflorida.com/	888-419-3456
Georgia	Georgia Medicaid dch.georgia.gov/	866-211-0950
Guam	Department of Public Health and Social Services dphss.guam.gov/division-of-public-welfare/	671-300-8853
Hawaii	Hawaii Med_QUEST Division medquest.hawaii.gov	808-524-3370
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) www.shiba.idaho.gov	877-456-1233
Illinois	Illinois Department of Healthcare and Family Services hfs.illinois.gov/	800-843-6154
Indiana	Indiana Family and Social Services Administration http://www.in.gov/fssa/dfr/medicaid-health-plans/	800-403-0864
Iowa	Iowa Department of Human Services hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs	800-338-8366

Kansas	KanCare kancare.ks.gov/	800-792-4884
Kentucky	Kentucky Cabinet for Health and Family Services chfs.ky.gov/Pages/index.aspx	855-306-8959
Louisiana	Healthy Louisiana ldh.la.gov/subhome/48	888-342-6207
Maine	Maine Department of Health and Human Services www.maine.gov/dhhs/	855-797-4357
Maryland	Maryland Department of Health health.maryland.gov/mmcp/Pages/MedicaidCheckIn-Participants.aspx	855-642-8572
Massachusetts	MassHealth www.mass.gov/topics/masshealth	800-841-2900
Michigan	Michigan Department of Health & Human Services www.michigan.gov/mdhhs	833-599-6444
Minnesota	Minnesota Department of Human Services mn.gov/dhs/	800-657-3672
Mississippi	Mississippi Division of Medicaid medicaid.ms.gov/	800-421-2408
Missouri	Missouri Department of Social Services www.dss.mo.gov	573-751-3425
Montana	Montana Department of Public Health & Human Services dphhs.mt.gov/	800-362-8312
Nebraska	Nebraska Department of Health and Human Services dhhs.ne.gov/Pages/default.aspx	855-632-7633
Nevada	Nevada Department of Health and Human Services dhhs.nv.gov/	877-638-3472
New Hampshire	New Hampshire Department of Health and Human Services www.dhhs.nh.gov/	844-275-3447
New Jersey	New Jersey Department of Human Services www.state.nj.us/humanservices/	800-701-0710
New Mexico	New Mexico Human Services Department www.hsd.state.nm.us/	800-283-4465
New York	New York State Department of Health www.health.ny.gov/health_care/medicaid/changes/	855-355-5777
North Carolina	North Carolina Medicaid medicaid.ncdhhs.gov	888-245-0179

North Dakota	North Dakota Department of Human Services www.hhs.nd.gov/applyforhelp	800-755-2604
Northern Mariana Islands	Commonwealth Medicaid Agency medicaid.cnmi.mp/	670-664-4880
Ohio	Ohio Department of Medicaid medicaid.ohio.gov/	800-324-8680
Oklahoma	Oklahoma Health Care Authority oklahoma.gov/ohca.html	800-987-7767
Oregon	Oregon Health Care healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania	Pennsylvania Department of Human Services www.dhs.pa.gov/Pages/default.aspx	800-692-7462
Puerto Rico	Medicaid Program https://www.medicaid.pr.gov/	787-641-4224
Rhode Island	Rhode Island Executive Office of Health and Human Services eohhs.ri.gov	855-840-4774
South Carolina	South Carolina Health Connections Medicaid www.scdhhs.gov/	888-549-0820
South Dakota	South Dakota Department of Social Services dss.sd.gov/	800-597-1603
Tennessee	Tennessee Department of Health www.tn.gov/health.html	855-259-0701
Texas	Texas Health and Human Services www.hhs.texas.gov	800-335-8957
Utah	Utah Department of Health Medicaid medicaid.utah.gov	866-435-7414
U. S. Virgin Islands	Virgin Islands DHS www.dhs.gov.vi/	340-774-0930
Vermont	Department of Vermont Health Access dvha.vermont.gov	855-899-9600
Virginia	Virginia Department of Medical Assistance Services www.dmas.virginia.gov/#/index	833-522-5582
Washington	Washington Stage Health Care Authority www.hca.wa.gov/	800-562-3022

West Virginia	West Virginia Department of Health and Human Resources dhhr.wv.gov/Pages/default.aspx	877-716-1212
Wisconsin	Wisconsin Department of Health Services www.dhs.wisconsin.gov	800-362-3002
Wyoming	Wyoming Department of Health health.wyo.gov	855-294-2127

Appendix 4 –State Health Insurance Assistance Programs (SHIP)

You may contact the SHIP in your state listed below if available. The list is also available online at: www.shiphelp.org

State	Agency Name and Website	Toll-free Number
Alabama	State Health Insurance Assistance Program (SHIP) www.alabamaageline.gov/	800-243-5463
Alaska	Alaska Medicare Information Office (SHIP) www.medicare.alaska.gov	800-478-6065
Arizona	Arizona State Health Insurance Assistance Program (SHIP) des.az.gov/services/older-adults/medicare-assistance	800-432-4040
Arkansas	Senior Health Insurance Information Program (SHIIP) www.shiipar.com/landing-page/	800-224-6330
California	California Health Insurance Counseling and Advocacy Program (HICAP) www.aging.ca.gov/hicap/	800-434-0222
Colorado	Senior Health Insurance Assistance Program (SHIP) doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	888-696-7213
Connecticut	Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES) portal.ct.gov/ADS-CHOICES	800-994-9422
Delaware	Delaware Medicare Assistance Bureau delawareinsurance.gov/DMAB/	800-336-9500
District of Columbia	Health Insurance Counseling Project (HICP) dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship	202-727-8370
Florida	Serving Health Insurance Needs of Elders (SHINE) www.floridashine.org/	800-963-5337
Georgia	Georgia State Health Insurance Assistance Program aging.georgia.gov/georgia-ship	866-552-4464
Guam	Guam Medicare Assistance Program (GUAM MAP) Dphss.guam.gov/	671-735-7415
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) www.hawaiiship.org/	888-875-9229
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) www.shiba.idaho.gov	800-247-4422
Illinois	Senior Health Insurance Program (SHIP) www2.illinois.gov/aging/ship/Pages/default.aspx	800-252-8966

Indiana	State Health Insurance Assistance Program (SHIP) www.in.gov/ship/	800-452-4800
Iowa	Senior Health Insurance Information Program (SHIP) shiip.iowa.gov/	800-351-4664
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	800-860-5260
Kentucky	State Health Insurance Assistance Program (SHIP) chfs.ky.gov/agencies/dail/Pages/ship.aspx	877-293-7447
Louisiana	Senior Health Insurance Information Program (SHIIP) www.ldi.la.gov/consumers/senior-health-shiip	800-259-5300
Maine	Maine State Health Insurance Assistance Program (SHIP) www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	800-262-2232
Maryland	State Health Insurance Assistance Program (SHIP) aging.maryland.gov/Pages/state-health-insurance-program.aspx	800-243-3425
Massachusetts	Serving Health Insurance Needs of Everyone (SHINE) www.mass.gov/health-insurance-counseling	800-243-4636
Michigan	Michigan Medicare Assistance Program (MMAP Inc.) www.mmapinc.org	800-803-7174
Minnesota	Minnesota Senior LinkAge Line mn.gov/senior-linkage-line/	800-333-2433
Mississippi	State Health Insurance Assistance Program (SHIP) www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/	844-822-4622
Missouri	Missouri State Health Insurance Assistance Program (SHIP) missouriship.org/	800-390-3330
Montana	Montana State Health Insurance Assistance Program (SHIP) dhhs.mt.gov/sltc/aging/ship	800-551-3191
Nebraska	Nebraska SHIP doi.nebraska.gov/consumer/senior-health	800-234-7119
Nevada	Nevada Medicare Assistance Program (MAP) www.nevadacareconnection.org/care-options/types-of-services/healthcare/medicare-assistance-program-map/	800-307-4444
New Hampshire	New Hampshire State Health Insurance Assistance Program (SHIP) - ServiceLink Resource Center www.servicelink.nh.gov/medicare/index.htm	866-634-9412
New Jersey	State Health Insurance Assistance Program (SHIP) nj.gov/humanservices/doas/services/q-z/ship/	800-792-8820
New Mexico	New Mexico ADRC - State Health Insurance Assistance Program (SHIP) www.nmaging.state.nm.us/	800-432-2080

New York	Health Insurance Information, Counseling and Assistance (HIICAP) aging.ny.gov/health-insurance-information-counseling-and-assistance	800-701-0501
North Carolina	Seniors Health Insurance Information Program (SHIIP) www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip	855-408-1212
North Dakota	State Health Insurance Counseling Program (SHIC) www.insurance.nd.gov/shic-medicare	888-575-6611
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) www.insurance.ohio.gov/about-us/divisions/oshiip	800-686-1578
Oklahoma	Senior Health Insurance Counseling Program (SHIP) www.map.oid.ok.gov	800-763-2828
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) shiba.oregon.gov/	800-722-4134
Pennsylvania	PA MEDI - Pennsylvania Medicare Education and Decision Insight www.aging.pa.gov	800-783-7067
Puerto Rico	State Health Insurance Assistance Program (SHIP) agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx	877-725-4300
Rhode Island	Senior Health Insurance Program (SHIP) oha.ri.gov/Medicare	888-884-8721
South Carolina	State Health Insurance Assistance Program (SHIP) www.aging.sc.gov/	800-868-9095
South Dakota	Senior Health Information and Insurance Education (SHIINE) www.shiine.net/	800-536-8197
Tennessee	State Health Insurance Assistance Program (SHIP) www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html	877-801-0044
Texas	Health Information, Counseling, and Advocacy Program (HICAP) hhs.texas.gov/services/health/medicare	800-252-9240
Utah	Senior Health Insurance Information Program (SHIP) daas.utah.gov/seniors/	800-541-7735
Vermont	State Health Insurance Assistance Program (SHIP) asd.vermont.gov/services/ship	800-642-5119
Virgin Islands	State Health Insurance Assistance Program (SHIP) ltg.gov.vi/departments/vi-ship-%20medicare/	340-772-7368
Virginia	Virginia Insurance Counseling & Assistance Program (VICAP) www.vda.virginia.gov/vicap.htm	800-552-3402

Washington	Statewide Health Insurance Benefits Advisors (SHIBA) www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/	800-562-6900
West Virginia	State Health Insurance Assistance Program (SHIP) www.wvship.org/	877-987-4463
Wisconsin	State Health Insurance Assistance Program (SHIP) www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	800-242-1060
Wyoming	State Health Insurance Assistance Program (SHIP) www.wyomingseniors.com/	800-856-4398

Important documents for your Part D prescription drug plan

The documents below describe your benefits and coverage rules. Here's how you can **access them online**:

Evidence of Coverage (EOC)

The EOC shows all of your prescription drug coverage details. Use it to find out how to get coverage for the prescriptions you need. Every year, we post the following year's EOC online at ArrayRxSolutions.com/UMP by October 15th.

Pharmacy Directory

The directory lists in-network pharmacies available to you. Visit ArrayRxSolutions.com/UMP to access our online searchable directory. PDF versions are also available online.

List of Covered Drugs (Formulary)

The Formulary tells which Part D prescription drugs are covered under the Part D benefit on your plan. The formulary is posted online:

ArrayRxSolutions.com/UMP

If you have a question about covered drugs, please call **ArrayRx Customer Service 1-833-599-8539.**

You can also view your plan documents by logging into your Member Dashboard account at ArrayRxSolutions.com/UMP

If you would like any of these documents mailed to you, contact **ArrayRx Customer Service**: **1-833-599-8539** or **UMPRXMedicare@modahealth.com**

Moda Health Plan, Inc. is a PDP with a Medicare contract. Moda is the administrator of ArrayRx. Enrollment depends on contract renewal.

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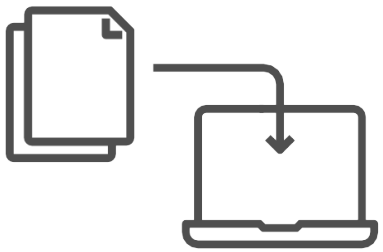
Uniform Medical Plan ArrayRx

Get plan documents delivered to you online



Online documents give you easy access to all your Part D Medicare information.

To receive an email from ArrayRx when new materials are available, visit ump.regence.com/ump/signin and log in to your prescription Part D member dashboard. If you don't have an account, you can create one. Once logged in, select the "Coverage" tab. Next, click on "Pharmacy" and then "Access Benefits". From here, you can update your email under "Contact info" and make your electronic delivery preference under "Communication preferences".

Once you request electronic delivery, you will no longer receive this hard copy document in the mail, unless you request it.

Questions? Call ArrayRx Customer Service at 1-833-599-8539.

ArrayRxSolutions.com/UMP

Uniform Medical Plan ArrayRx

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan because you have high drug costs.

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January– December). Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option for drugs covered by Part D. **All plans offer this payment option and participation is voluntary.**

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). There's no cost to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs earlier in the calendar year, this payment option spreads out what you'll pay each month across the calendar year (Jan – Dec), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your monthly expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work?

The prescription drug law caps your out-of-pocket costs at $2,000 in 2025. This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail order and specialty pharmacies). Instead, you'll get a bill each month from your health or drug plan. Your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Even though you won't pay for your drugs at the pharmacy, you're still responsible for the costs. If you want to know what your drug will cost before you take it home, call your plan or ask the pharmacist.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription (or refill an existing prescription) because as new out-of-pocket drug costs get added to your monthly payment, there are fewer months left in the year to spread out your remaining payments.

How do I know if this payment option might not be the best choice for me?

This payment option might not be the best choice for you if:

- Your yearly drug costs are low.
- Your drug costs are the same each month.

- You're considering signing up for the payment option late in the calendar year (after September).
- You don't want to change how you pay for your drugs.
- You get or are eligible for Extra Help from Medicare.
- You get or are eligible for a Medicare Savings Program.
- You get help paying for your drugs from other organizations, like a State Pharmaceutical Assistance Program (SPAP), a coupon program, or other health coverage.

Who can help me decide if I should participate?

- **Your health or drug plan:** Visit your plan's website, or call your plan to get more information. If you need to pick up a prescription urgently, call your plan to discuss your options.
- **Medicare:** Visit Medicare.gov/prescription-payment-plan to learn more about this payment option and if it might be a good fit for you.
- **State Health Insurance Assistance Program (SHIP):** Visit shiphelp.org to get the phone number for your local SHIP and get free, personalized health insurance counseling.

How do I sign up?

Visit your health or drug plan's website, or call your plan to start participating in this payment option at any time during the plan year.

Need this information in another format or language?

To get this material in other formats like large print, braille, or another language, contact your Medicare drug plan at the phone number on the back of your membership card. If you need help contacting your plan, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

ArrayRx

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, religion, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call ArrayRx Customer Service at:

1-833-599-8539 (TTY: 711)

If you think we did not offer these services, or discriminated against you, you can file a written complaint. Please mail or fax it to:

ArrayRx
Attn: Appeals Unit
PO Box 40384
Portland, OR 97240-0384
Fax: 1-833-949-1888

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
1-855-232-9111
compliance@modahealth.com

You can also file a civil rights complaint with:

The U.S. Department of Health and Human Services, Office for Civil Rights

- Online complaint portal - ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail - U.S. Department of Health and Human Services
  200 Independence Ave S.W.
  HHH Building, Room 509F
  Washington, D.C. 20201
- Phone - 1-800-368-1019
  1-800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-599-8539. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-599-8539. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，**帮**助**您**解答**关**于健康或药物保险的任何疑 问。如果**您**需要此翻译服务，请致电 1-833-599-8539 。我们的中文工作人员很乐意**帮**助**您**。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-599-8539 。我們講中文的人員將樂意為**您**提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-599-8539. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-599-8539. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-599-8539 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-599-8539. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-599-8539 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Uniform Medical Plan ArrayRx

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-599-8539. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-599-8539 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-599-8539 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-599-8539. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-599-8539. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1- 833-599-8539. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-599-8539. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-599-8539 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

ArrayRx Customer Service – Contact Information	
Call	**1-833-599-8539 ArrayRx Customer Service** Calls to this number are free. Office hours are 8 a.m.– 8 p.m. (Pacific Time), seven days a week October 1–March 31 (closed on Thanksgiving and Christmas), and weekdays April 1–September 30. Your call will be handled by our automated phone systems outside business hours. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. This number is available 24 hours a day, seven days a week.
Write	**ArrayRx** Attn: Medicare ArrayRx Customer Service P.O. Box 40327 Portland, OR 97240-0327 Email: UMPRXMedicare@modahealth.com
Fax	**1-800-207-8235** Attn: Medicare ArrayRx Customer Service
Website	**ArrayRxSolutions.com/UMP**

Employees and Retirees Benefits (ERB) Customer Service – Contact Information	
Call	**1-800-200-1004 ERB Customer Service** Calls to this number are free. ERB Customer Service is available from 8 a.m. to 4 p.m., Pacific Time, Monday through Friday.
TTY	**711** Calls to this number are free. This number is available 24 hours a day, seven days a week.
Write	**Health Care Authority (HCA)** PO Box 42684 Olympia, WA 98504 Online Support: **support.hca.wa.gov/hcasupport**
Fax	**1-360-725-0771**
Website	**www.hca.wa.gov**

State Health Insurance Assistance Programs – Contact Information
State Health Insurance Assistance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. See Appendix 4 at the back of this for a list of State Health Insurance Assistance Programs.

PO Box 40327 | Portland, OR 97240-0327

Important UMP Classic Medicare with Part D (PDP) Information