

Summary of Benefits



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

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

Not all benefits are listed. For services not listed, see the Table of Contents, the Index at

the back of the book, or call UMP Customer Service at 1-888-849-3681.

In order to be covered, all services must be medically necessary (see the definition on pages 113–115).

If you see an unfamiliar term, see the alphabetical list of definitions on pages 107–121.

This Certificate of Coverage applies only to dates of service between the day your coverage begins (but no earlier than January 1, 2015) and the day your coverage ends (no later than December 31, 2015).



ALERT! If you have coverage under another health plan, see pages 62–67.

Deductibles and Limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Deductible	<ul style="list-style-type: none"> ▪ \$1,400 for one person on the account ▪ \$2,800 for two or more persons on an account (family) <p>If you qualified for the 2015 SmartHealth wellness incentive, PEBB will deposit \$125 into your Health Savings Account.</p>	<ul style="list-style-type: none"> ▪ This deductible applies to all services, including prescription drugs, unless specifically stated the services are not subject to the deductible. ▪ For a family account, you must meet the entire \$2,800 deductible. ▪ You pay toward this deductible before the plan pays for covered services. ▪ You don't have to pay the deductible for some services. ▪ Not all services count toward this deductible. 	9–10
Out-of-pocket limit	<ul style="list-style-type: none"> ▪ \$4,200 for one person on the account ▪ \$8,400 for two or more persons on an account (family) 	<ul style="list-style-type: none"> ▪ Your deductible and prescription drug costs count toward this limit. ▪ Not all services count toward this limit. 	11–12

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Deductibles and Limits *(continued)*

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Health Savings Account (HSA) <i>If the subscriber is age 55 or older, may contribute up to an additional \$1,000.</i>	Maximum annual contribution: <ul style="list-style-type: none"> ▪ Account with one person \$3,350 ▪ Account with two or more persons: \$6,650 	You may pay for any qualified medical expenses (see definition on page 119) from your HSA, including: <ul style="list-style-type: none"> ▪ Services that apply to your deductible. ▪ Services that are not covered by the plan, but are still qualified medical expenses 	12
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

How Much Will I Pay?

The table below describes how much you'll pay for services. Unless otherwise noted, all payment is based on the allowed amount, which is the fee accepted as payment by a preferred provider, and services are subject to the deductible. See the Summary of Benefits table on pages 16–20 for which type of service applies to a specific benefit.

Type of Service	How Much You Pay
Standard Subject to the deductible; see page 13.	How much you pay (your coinsurance) depends on the provider's network status: <ul style="list-style-type: none"> ▪ Preferred providers — You pay 15% of the allowed amount. ▪ Out-of-network providers — You pay 40% of the allowed amount; the provider may balance bill (see page 108). ▪ Participating providers — You pay 40% of the allowed amount; the provider may not balance bill. Indicated by \$\$ in the provider directory on regence.com.
Preventive Preventive services are not subject to the deductible (you don't have to pay your deductible before the plan pays).	How much you pay (your coinsurance) depends on the provider's network status: <ul style="list-style-type: none"> ▪ Preferred and participating providers — You pay \$0; the plan pays in full. ▪ Out-of-network providers — You pay 40%; the provider may balance bill.

How Much Will I Pay? *(continued)*

Type of Service	How Much You Pay
<p>Inpatient Subject to the deductible; see pages 9–10.</p> <ul style="list-style-type: none"> ▪ Facility charges and professional services (such as physicians and lab tests) are usually billed separately. See a specific benefit — for example, diagnostic tests — for how these related services are covered. ▪ Professional providers may contract separately from a facility. Even if a facility is preferred, a professional provider may not be. ▪ Most inpatient services require both: <ul style="list-style-type: none"> ▪ Preauthorization: See page 54 for a description of how this works. ▪ Notification: Your provider must notify the plan upon admission to a facility; see page 55 for a description of how this works. <p>Note that most inpatient services require both preauthorization and plan notification.</p>	<p>How much you pay (your coinsurance) depends on the provider’s* network status:</p> <ul style="list-style-type: none"> ▪ Preferred providers — You pay 15% of the allowed amount. ▪ Out-of-network providers — You pay 40% of the allowed amount; the provider may balance bill (see page 108). ▪ Participating providers — You pay 40% of the allowed amount; the provider may not balance bill. Indicated by \$\$ in the provider directory on regence.com. <p>Services are considered inpatient only when you are admitted as an inpatient to a facility. See definition of “Inpatient Stay” on page 112.</p> <p><i>*A facility, such as a hospital, may be referred to as a “provider.”</i></p>
<p>Special Subject to the deductible; see page 13.</p>	<p>These services have unique payment rules, which are described in the “How much will I pay?” column on pages 16–20.</p>

What else do I need to know?

- ◆ Some services aren’t covered; see pages 57–61 for some of the services not covered by the plan.
- ◆ You don’t need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services; see page 5.
- ◆ Preexisting conditions: There is no waiting period; medically necessary services are covered from the effective date of your medical coverage.

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Summary of Benefits

Only certain services are listed in the table. For those not listed, see the alphabetical list of covered benefits on pages 21–42, check the Index, or call Customer Service at 1-888-849-3681.

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

- ♦ Services that require preauthorization (see page 54 for how this works); see current list at www.hca.wa.gov/ump or call 1-888-849-3681.
- ♦ Services for which your provider must notify the plan; see current list at www.hca.wa.gov/ump or call 1-888-849-3681.
- ♦ Services that aren’t covered (exclusions; see pages 57–61).

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

Benefit/Service	How much will I pay? <i>(See pages 14–15 for description of payment types)</i>	For more information: See page(s)	Any limitations or exclusions?
Ambulance	Special: 20% of the allowed amount for preferred or out-of-network providers. Out-of-network providers may balance bill.	22, 57, 61	Covered only for a medical emergency (see definition on page 113).
Applied Behavior Analysis (ABA) Therapy	Standard	22	Specific preauthorization requirements; see page 22.
Chemical Dependency Treatment			
<i>Inpatient Services</i>	Inpatient	24, 59	<ul style="list-style-type: none"> ▪ Inpatient admission and some other services require plan notification.* ▪ Treatment in residential facilities requires preauthorization.*
<i>Outpatient Services</i>	Standard	24, 59	May be subject to review for medical necessity. Some services require plan notification.*
Chiropractic Physician Services		39	See “Spinal and Extremity Manipulations” on page 20.
Contraceptive Services for Women	Preventive or Standard	29–30, 38	See pages 29–30 for services that are covered as preventive. Some contraceptive services may be covered as Standard.

*For services requiring preauthorization or plan notification: See the list of services at www.hca.wa.gov/ump, or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 54-55 for how this works.

Benefit/Service	How much will I pay? <i>(See pages 14–15 for description of payment types)</i>	For more information: See page(s)	Any limitations or exclusions?
Diabetes Care Supplies	Special: Paid under the prescription drug benefit; see pages at right.	26, 65-66	See page 66 if Medicare is your primary coverage.
Diabetes Control Program: NOT ME	Preventive	26	Only the NOT ME program is covered.
Diabetes Prevention Program: NOT ME	Preventive	26-27	Only the NOT ME program is covered.
Diagnostic Tests, Laboratory, and X-Rays	Standard	27, 57, 59, 61	Usually billed separately from related office visits or inpatient services.
Durable Medical Equipment, Supplies, and Prostheses	Standard	27–29, 42, 45, 58, 59, 110	May require preauthorization.* Some breast pumps are covered as preventive; see page 36.
Emergency Room (ER)	Standard	29, 113	Services determined not to be due to a medical emergency (page 113) are not covered in an emergency room setting.
Family Planning Services	Standard <i>Some contraceptive services are covered as preventive; see pages 29–30.</i>	29–30, 58	Not covered: <ul style="list-style-type: none"> ▪ Infertility services ▪ Reversal of sterilization
Hearing Aids	Special: Plan pays up to \$800.	31	Limited to \$800 plan payment per three calendar years.
Hearing Exams, Routine	Standard	31, 38	Newborn hearing screening is covered as preventive.
Home Health Care	Standard	32, 40, 58, 59, 112, 113	See page 32 for what is covered. Specific services are not covered; see exclusion 24 on page 58. Maintenance (page 113) and custodial (page 109) care are not covered.
Hospice Care (Includes respite care)	Special: Paid at 100% after meeting deductible.	32, 112, 119	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime.

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**For services requiring preauthorization or plan notification: See the list of services at www.hca.wa.gov/ump, or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 54-55 for how this works.*

Summary of Benefits, continued

Benefit/Service	How much will I pay? <i>(See pages 14–15 for description of payment types)</i>	For more information: See page(s)	Any limitations or exclusions?
Hospital Services			
<i>Inpatient Services</i>	Inpatient	32-33, 35-36, 58	All elective inpatient admissions (except maternity) require preauthorization.* Plan notification is required for all hospital admissions within 24 hours of admission.* Some services require preauthorization.*
<i>Outpatient Services</i>	Standard	32-33, 35-36, 58	Some services require preauthorization.*
Immunizations (Vaccines)	Preventive (usually)	39, 58, 115	Covered under CDC recommendations; see page 39. <i>Not covered for travel or employment.</i>
Mammograms (Diagnostic)	Standard	33–34	Must be billed as diagnostic by the provider.
Mammograms (Screening)	Preventive	33–34	Women age 40 and older: Covered every one to two years. Women under age 40: Covered as preventive only for women at increased risk; see page 33 for details. For women under age 40 and not at increased risk, see pages 33–34.
Massage Therapy	Standard	34, 59	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and Breast Reconstruction	Standard	28, 34	All inpatient services require plan notification.*

**For services requiring preauthorization or plan notification: See the list of services at www.hca.wa.gov/ump, or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 54-55 for how this works.*

Benefit/Service	How much will I pay? <i>(See pages 14–15 for description of payment types)</i>	For more information: See page(s)	Any limitations or exclusions?
Mental Health Treatment			
<i>Inpatient Services</i>	Inpatient	34, 59	<ul style="list-style-type: none"> ▪ Inpatient admission and some other services require plan notification.* ▪ Treatment in residential facilities requires preauthorization.*
<i>Outpatient Services</i>	Standard	34, 59	Some services require plan notification.*
Naturopathic Physician Services	Standard	7, 34-35, 51, 57	Herbs, vitamins, and other supplements are not covered. See page 51 for exceptions.
Obstetric and Newborn Care	Inpatient (Standard for related outpatient visits) <i>Some breast pumps are covered as preventive; see page 36.</i>	35–36, 40	For non-routine services for a newborn, you may pay an additional deductible or separate coinsurance; see page 36. See page 35 for coverage of circumcision, which is not a preventive service.
Office Visits	Standard	37, 59	See page 38 for routine exams covered as preventive.
Physical, Occupational, Speech, and Neurodevelopmental Therapy	Standard <i>Inpatient services are usually charged separately from facility charges.</i>	37	Inpatient: 60 days maximum per calendar year. Outpatient: 60 visits maximum per calendar year.
Prescription Drugs	15% after deductible is met.	43–53	See exclusions on pages 57–61, and other limits on pages 47–50.
Preventive Care <i>Includes vaccines, routine exams, some screening tests</i>	Preventive	33, 36, 38–39, 51, 118	Only certain services are covered as preventive; see pages 38–39. See pages 29–30 for contraception covered as preventive.
Skilled Nursing Facility	Inpatient <i>Some services may be billed separately (such as physical therapy).</i>	39, 57, 59, 60, 120	Maintenance care (page 113) and custodial care (page 109) are not covered.

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*For services requiring preauthorization or plan notification: See the list of services at www.hca.wa.gov/ump, or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 54-55 for how this works.

Summary of Benefits, continued

Benefit/Service	How much will I pay? (See pages 14–15 for description of payment types)	For more information: See page(s)	Any limitations or exclusions?
Spinal and Extremity Manipulations	Standard	39, 59	Limited to 10 visits per calendar year.
Surgery			
<i>Inpatient Services</i>	Inpatient	34, 37, 40, 41, 58, 108, 119	See page 23 for coverage of bariatric surgery. Some services require preauthorization and/or plan notification.*
<i>Outpatient Services</i>	Standard	34, 37, 40, 41, 58, 108, 119	Some services require preauthorization.*
Tobacco Cessation Program	Preventive	41, 52, 60	Only the <i>Quit for Life</i> program is covered for ages 18 and above. See page 41 for drugs and nicotine replacement supplies covered. See page 41 for tobacco cessation services for members ages 17 and under.
Vision Care (Related to Diseases and Disorders of the Eye)	Standard	42, 57, 58, 59	
Vision Exams, Routine	Preventive	42, 58, 59	One per calendar year. \$65 annual limit on contact lens fitting fees.
Vision Hardware, Adults (Over age 18) Glasses, contact lenses	Special: You pay any amount over \$150; network status of provider does not matter. No deductible.	42	Plan pays up to \$150 per two calendar years (resets every even year).
Vision Hardware, Children (Age 18 and under) Glasses, contact lenses	Special: No deductible. Eyeglasses: You pay \$0 for one set of standard or deluxe frames and lenses per year. Contact lenses: You pay 15% of billed charges.	42	Plan pays for one pair of eyeglasses per year at 100% of billed charges. See page 42 for options that aren't covered. No limit on number of contact lenses covered.
Well-Child Visits	Preventive	38–39	See pages 38–39.

*For services requiring preauthorization or plan notification: See the list of services at www.hca.wa.gov/ump, or call 1-888-849-3681. Many services require both preauthorization and plan notification. See pages 54-55 for how this works.