Uniform Medical Plan

2020 UMP Consumer-Directed Health Plan (PEBB)
Certificate of Coverage

Self-Insured by the State of Washington • Effective January 1, 2020

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

HCA 54-549 8/19)

Directory: Medical services

Contact type and description	Contact information
UMP Customer Service	**Call:** 1-888-849-3681 (TRS: 711) Monday through Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Live chat:** Sign in to your Regence account at **regence.com** Monday through Friday: 7 a.m. to 5 p.m. (Pacific) **Email:** Send secure email via your Regence account at **regence.com** ▪ If you are a UMP member living internationally and you have questions about your benefits and coverage, you can use email, live chat, or Skype to contact UMP Customer Service. You may request to have a customer service representative call you at a scheduled time during normal business hours. ▪ If you're 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, seven days a week.
Network provider directory	**Call:** 1-888-849-3681 (TRS: 711) Monday through Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Live chat:** Sign in to your Regence account at **regence.com** Monday through Friday: 7 a.m. to 5 p.m. (Pacific) **Provider search: regence.com/ump/pebb/finding-doctors**
Nurse line (Advice 24)	**Call:** 1-800-267-6729 (TRS: 711)
Medical appeals, complaints, grievances, and general correspondence	**Call:** 1-888-849-3681 (TRS: 711) Monday through Friday: 5 a.m. to 8 p.m.; Saturday: 8 a.m. to 4:30 p.m. (Pacific) **Live chat:** Sign in to your Regence account at **regence.com** Monday through Friday: 7 a.m. to 5 p.m. (Pacific) **Fax:** 1-877-663-7526 **Email:** Send secure email via your Regence account at **regence.com** **Mail:** ASO Member Appeals Regence BlueShield PO Box 91015 Seattle, WA 98111-9115
Preauthorization For providers submitting medical service preauthorization requests	**Call:** 1-888-849-3682 (TRS: 711) Monday through Friday: 7 a.m. to 5 p.m. (Pacific) **Fax:** 1-877-663-7526 **Visit: availity.com**

Directory: Medical services, continued

Contact type and description	Contact information
Access to medical claims	**Visit:** Sign in to your Regence account at **regence.com**
Claims mailing address For members submitting medical service claims	**Fax:** 1-877-357-3418 **Mail:** Regence BlueShield PO Box 1106 Lewiston, ID 83501-1106
HealthEquity Health Savings Account (HSA) trustee	**Call:** 1-844-351-6853 (TRS: 711) – 24 hours, 7 days a week **Visit: learn.healthequity.com/pebb**
Medicare	**Call:** 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) 24 hours, seven days a week Visit: **medicare.gov** or **MyMedicare.gov**
Eligibility, enrollment, and address changes	**Employees:** Contact your personnel, payroll, or benefits office **Continuation Coverage:** Call the PEBB Program: 1-800-200-1004 (TRS: 711) Monday through Friday: 8 a.m. to 4:30 p.m. (Pacific) **Visit: hca.wa.gov/erb**
Tobacco cessation services See page 66	American Cancer Society's Quit for Life program **Call:** 1-866-784-8454 24 hours, seven days a week **Visit: quitnow.net**

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following. Employees: Your personnel, payroll, or benefits office. Retirees and PEBB Continuation Coverage members: The Health Care Authority at 1-800-200-1004 (TRS: 711).

Directory: Prescription drug services

Contact type and description	Contact information
Prescription drugs Contact customer service, locate network pharmacies, ask prescription drug questions, access prescription drug claims	Washington State Rx Services (WSRxS) **Call:** 1-888-361-1611 (TRS: 711) 24 hours a day, seven days a week **Visit:** Find a link to your pharmacy account at **regence.com/ump/pebb/benefits/prescriptions**
Network mail-order pharmacy Order new prescriptions and refills, check order status, manage prescriptions, track your package	Postal Prescription Services (PPS) **Call:** 1-800-552-6694 Monday through Friday: 6 a.m. to 6 p.m. (Pacific) Saturday: 9 a.m. to 2 p.m. (Pacific) **Providers fax:** 1-800-723-9023 **Mailing a prescription order:** Postal Prescription Services PO Box 2718 Portland, OR 97208-2718 **Visit:** Sign in to your account at **ppsrx.com**
Network specialty pharmacy Order new prescriptions and refills for specialty drugs	Ardon Health **Call:** 1-855-425-4085 (TRS: 711) Monday through Friday: 8 a.m. to 7 p.m. (Pacific) Saturday: 8 a.m. to 12 p.m. (Pacific) **Providers fax:** 1-855-425-4096
Prescription drug paper claims, complaints and appeals See instructions for submitting a claim on page 103.	**Call:** 1-888-361-1611 (TRS: 711) Monday through Friday: 7:30 a.m. to 5:30 p.m. (Pacific) **Fax claims to:** 1-800-207-8235 **Fax appeals to:** 1-866-923-0412 **Email:** Send secure email through your account at **regence.com/ump/pebb/benefits/prescriptions** **Mail:** WSRxS PO Box 40168 Portland, OR 97240-0168 **Visit:** Find claim forms at **hca.wa.gov/ump-forms-pubs**
Prescription drug preauthorization For providers and pharmacists submitting prescription drug preauthorization requests.	WSRxS **Call:** 1-888-361-1611 (TRS: 711) Monday through Friday: 7:30 a.m. to 5:30 p.m. (Pacific) **Fax:** 1-800-207-8235 **Visit: covermymeds.com** (see page 73)

Online services

Visit **regence.com** to:

- Register for an account to get personalized information.
- View your Explanations of Benefits (EOBs).
- Find providers in your plan's network.
- Review and submit medical claims.
- Access customer service via live chat.
- View or order your UMP member ID card.
- Access resources and programs.

Visit **regence.com/ump/pebb** to:

- Access information on BlueCard® or Blue Cross Blue Shield Global® Core.
- Access the certificates of coverage (this booklet) and the Summaries of Benefits and Coverage (SBCs) for all plans, as well as the Uniform Glossary of Terms (UGT).
- Access UMP medical policies.
- Access wellness tools.
- Download or print documents and forms.
- Download the Regence mobile application.
- Find a preferred provider.
- Get cost estimates for treatment of common medical conditions.
- Review complaints and appeals procedures.

Visit **blue.regence.com/trgmedpol** to view Regence medical policies.

Visit **regence.com/ump/pebb/benefits/prescriptions** to:

- Find a link to your pharmacy information.
- Locate network pharmacies, including Choice90 or network vaccination pharmacies.
- Find information on prescription drugs, over-the-counter drugs, herbal or vitamin products and drug interactions.
- Get estimates of drug costs, retail or mail order.
- Refill mail-order prescriptions.
- Review complaints and appeals procedures.
- Review the UMP Preferred Drug List, covered prescription drugs, quantity limits, preauthorization coverage criteria, whether subject to the Therapeutic Interchange Program (TIP).

Visit the HCA home page at **hca.wa.gov** to:

- Compare medical plans.
- Find health technology reviews.
- Learn more about the Health Technology Clinical Committee (HTCC).

Visit the HealthEquity member portal at **learn.healthequity.com/pebb** to:

- Log in to your personal member portal.
- Check your Health Savings Account (HSA) balance.
- View and pay a provider's claim that has already been processed by UMP.
- Make deposits directly from your bank account using electronic funds transfer.
- Manage your investments (for accounts with more than $2,000).
- Check your transaction history.
- Find forms to get reimbursed for expenses you paid out of pocket.
- View and print monthly account statements.

Acronyms

ABA – Applied Behavior Analysis

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

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

HSA – Health savings account

HTCC – Health Technology Clinical Committee

IRC – Internal Revenue Code

IRO – Independent Review Organization

IRS – Internal Revenue Service

NMSN – National Medical Support Notice

P&T – Pharmacy and Therapeutics

PCP – Primary care provider

PEBB – Public Employees Benefits Board

PFMLA – Paid Family and Medical Leave Act

PPACA – Patient Protection and Affordable Care Act

PPO – Preferred Provider Organization

PPS – Postal Prescription Services

PV – Preventive

REMS – Risk Evaluation and Mitigation Strategies

SBC – Summary of Benefits and Coverage

SEBB – School Employees Benefits Board

TIP – Therapeutic Interchange Program

TMJ – Temporomandibular joint

TRS – Telecommunications Relay Service

UGT – Uniform Glossary of Terms

UMP – Uniform Medical Plan

WSRxS – Washington State Rx (prescription drug) Services

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" on page 32. 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 beginning on page 143.

If you still have questions

- Medical services: Call UMP Customer Service at 1-888-849-3681 (TRS: 711) Monday through Friday, 5 a.m. to 8 p.m., and Saturday 8 a.m. to 4:30 p.m. (Pacific)
- Pharmacy services: Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711). Calls are taken 24 hours a day, seven days a week

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

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About UMP CDHP

Uniform Medical Plan Consumer-Directed Health Plan (UMP CDHP) is a self-funded health plan offered through the Washington State Health Care Authority's Public Employees Benefits Board (PEBB) Program and administered by Regence BlueShield in partnership with HealthEquity, the trustee (manager) of your health savings account (HSA), and Washington State Rx Services (WSRxS). All prescription drugs, services, or other benefit changes may require approval by the PEB Board when benefits are procured for the next calendar year.

UMP CDHP is a high-deductible health plan (HDHP) with an HSA (see definition on page 149). This meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The benefits described in this certificate of coverage are designed for use with an HSA under federal tax law.

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

Features of UMP CDHP

UMP CDHP is a health plan that covers the same services as UMP Classic. You have a higher deductible for covered services for a lower premium.

Families have one combined deductible (see definition on page 146). Families must pay their total family deductible before the plan pays for services, including prescription drugs. Some services, including covered preventive care, are exempt from the deductible (see page 19), which means the plan will pay for some services even before you meet your deductible. A plan becomes a family plan once the subscriber adds a dependent (see page 146 for definition).

A major feature of UMP CDHP is a health savings account (HSA), which allows you and your employer to deposit money into a savings account. You may use the money in your HSA to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles and coinsurance), including some expenses and services that this plan may not cover. Unlike a medical flexible spending arrangement (FSA), you do not have to spend all the money in your account each year; it rolls over into the next year. And if you use your HSA funds only to cover qualified medical expenses, you will achieve a tax savings.

If you or your dependents are enrolled in UMP CDHP and want to enroll in another health plan, you and your dependents may only enroll in other high-deductible health plans. The second high-deductible health plan cannot include an HSA.

When enrolled in UMP CDHP, you may not also be enrolled in any of the following plans:

- Medicare Part A or Part B.
- Medicaid (called "Apple Health" in Washington).
- Another comprehensive medical plan, such as a spouse or state-registered domestic partner's plan.
- A Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP) account, unless you convert it to a limited VEBA MEP.
- TRICARE.
- A medical flexible spending arrangement (FSA) or health reimbursement arrangement (HRA). This also applies if your spouse has a medical FSA, even if you are not covering your spouse on UMP CDHP. This does not apply if the medical FSA or HRA is a limited purpose account, or for a post-deductible medical FSA.

Finding a health care provider

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 preferred providers will save you money. To find out if a provider is preferred, participating or out-of-network, visit **regence.com/ump/pebb/finding-doctors** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Preferred providers are in the Preferred Provider Organization (PPO) network that applies to UMP CDHP members.

- Most covered services are paid at 85 percent; you pay 15 percent of the allowed amount after you pay your deductible.
- The plan pays 100 percent of the allowed amount for covered preventive care services, including covered immunizations (see page 59 for examples).
- The provider will not bill you for charges above the allowed amount.
- Preferred providers are labelled in the online provider directory with a bar icon and category 1: Category 1 BEST COVERAGE .
- If you see a preferred provider, you will not have to file a claim if the plan is your primary coverage.

ALERT! Some providers are preferred at one practice location but not another (example: urgent care clinics). Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have any questions about the network status of a provider at a specific location.

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

- Most covered services are paid at 60 percent of the allowed amount; you pay 40 percent of the allowed amount after you pay your deductible.
- The plan pays 100 percent of the allowed amount for covered preventive care services, including covered immunizations (see page 59 for examples).
- The provider may not bill you for charges above the allowed amount.
- The providers are labelled in the online provider directory with a bar icon and category 2: Category 2 .
- If you see a participating provider, you will not have to file a claim if the plan is your primary coverage.

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

- Most covered services are paid at 60 percent of the allowed amount; you pay 40 percent of the allowed amount after you pay your deductible. 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.
- The plan pays 60 percent of the allowed amount for covered preventive care services; you pay 40 percent of the allowed amount after you pay your deductible. You will pay all charges above the allowed amount (balance billing).
- Some covered immunizations are paid in full, such as flu shots.

- The 40 percent coinsurance you pay to out-of-network providers will **not** apply to your out-of-pocket limit.
- Any amount you pay above the allowed amount does not apply to your deductible or out-of-pocket limit.
- You may have to pay all charges at the time of service and then 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, payment may be delayed or denied.
- The provider may not be familiar with UMP prescription drug guidelines and prescribe drugs subject to higher cost or not covered by the plan.
- Payment for covered out-of-network services may be sent to you or the provider.

Note: Some services and supplies are not covered by the plan (see page 89) 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. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to find out if a service or supply is covered.

TIP: Allowed amount is the most the plan pays for a specific covered service or supply (see page 143). 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 (see page 145).

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 page 17). 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 provider search at **regence.com/ump/pebb/finding-doctors**.
- Call UMP Customer Service at 1-888-849-3681 (TRS: 711).
- Log in to your account at **regence.com**, where you have access to more information about providers, as well as other tools (see page 4).
- Use the Regence mobile application to find providers in your network.
- To find providers outside the U.S., call the Blue Cross Blue Shield Global® Core Service Center at 1-800-810-2583 or call collect at 1-804-673-1777. You can also use the online provider search tool at **bcbsglobalcore.com**.

To locate preferred pharmacies, see pages 75–76.

Sample payments to different provider types

The table on page 13 shows how much you pay for professional services from preferred, participating, and out-of-network providers when UMP is your primary medical insurance. For these examples, assume you have paid your deductible and have not reached your out-of-pocket limit. See descriptions of these provider types beginning on page 11. These are examples only and may not reflect your specific situation.

Provider type	Must provider accept allowed amount?	Balance billing allowed?	Itemized payments	You owe provider
Preferred provider	Yes. You pay 15% of the allowed amount (coinsurance).	No	Billed charge: $1,000 Allowed amount: $900 Plan pays 85%: -$765 **You pay 15%: $135**	$135
Participating provider	Yes. You pay 40% of the allowed amount (coinsurance).	No	Billed charge: $1,000 Allowed amount: $900 Plan pays 60%: -$540 **You pay 40%: $360**	$360
Out-of-network provider	No. You pay 40% of the allowed amount (coinsurance), plus all charges above the allowed amount.	Yes	Billed charge: $1,000 Allowed amount: $900 Plan pays 60%: -$540 You pay 40%: $360 plus $100 over allowed amount. **You pay $460.**	$460*

*This amount does not apply to your out-of-pocket limit (see page 22). See page 19 for a description of how your deductible works.

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 services must be covered services and within the scope of the facility's license to be covered.

All preferred and participating providers are covered provider types. If you see an out-of-network provider who is not a covered provider type, 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 deductible or out-of-pocket limit.

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

Primary care providers

A primary care provider (PCP) is a physician (see "Physician services" on page 156), nurse practitioner, or physician assistant who provides, coordinates, or helps a member access a range of health care services. A PCP helps you receive preventive care, such as covered immunizations, well-child visits for your children, cancer screenings (e.g., breast, cervical, prostate), and may help coordinate care for you when you need to see specialists. You are not required to choose a PCP. However, the benefit to choosing a PCP is that they may help prevent and treat health care conditions early and promote your health and well-being. To be designated as a PCP, a provider must be one of the provider types and practice under one of the specialties listed in the table 14.

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
- OB/GYN or Obstetrics
- Pediatrics (for patients 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 services provided by an out-of-network provider at the network rate. You may request a network waiver only when you do not have access to a preferred provider able to provide medically necessary services within 30 miles of the patient's residence. **The fact that a service or supply is prescribed or furnished by a provider does not, by itself, make it a medically necessary covered service** (see definition on page 152).

ALERT! When requesting a network waiver after services are processed, you must submit your request within 180 days of receiving notice of payment (your Explanation of Benefits; see page 148) for the related services. See "After your visit" on below for details.

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 (see page 87 for how to find the list of services requiring preauthorization). Your network waiver request should be included with the preauthorization request. See "Information needed to submit a network waiver request" 15 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 will pay your cost-share as though the provider was preferred for medical services the plan has approved through this waiver.
- The plan pays 100 percent of the allowed amount for covered preventive services, including covered immunizations.

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 "Complaint and appeal procedures" beginning on page 106 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 on pages 86–89 for more information about requesting medical services preauthorization from the plan.

Where to send your network waiver request

ASO Member Appeals
Regence BlueShield
PO Box 91015
Seattle, WA 98111-9115

If you have questions about the network waiver process, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

ALERT! If a network waiver is approved, you must still pay your cost-share for most medical services (see page 14 for more information). Services provided under an approved network waiver apply to your deductible and out-of-pocket limit. Network waivers for ongoing services may require periodic review.

How a health savings account (HSA) works

ALERT! If you enroll in a consumer-directed health plan with an HSA, you may not have a medical FSA. If you have both an HSA and a medical FSA, you may be subject to tax penalties.

The subscriber is the owner of the HSA. They get the tax advantages associated with an HSA and pay any taxes or penalties that result if the HSA does not comply with Internal Revenue Service (IRS) rules. The

subscriber may contribute funds to the HSA within certain limits. Money from the HSA may be used tax-free to pay for qualified medical expenses of the subscriber and their IRS dependents (able to be claimed as a tax dependent). See page 21 for details of how this works with UMP CDHP.

The trustee (manager) of your HSA, HealthEquity, features a member portal at **learn.healthequity.com/pebb**. When you sign in to your **regence.com** account, you may also find a link to the HealthEquity portal. Find out which services are available in the portal by reading the "Online services" section on page 4.

ALERT! You and your dependents may only enroll in other high-deductible health plans; however, they cannot include an HSA.

Out-of-area services

Any area outside of Washington State is considered out-of-area.

Regence BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "BlueCard® Programs." Whenever you obtain health care services outside of Regence's service area, the claims for these services may be processed through one of these BlueCard® Programs, and may include negotiated National Account arrangements available between Regence and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of Regence's service area, you will obtain care from health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, you may obtain care from out-of-network providers. Regence's payment practices in both instances are described 17.

BlueCard® Program

Under the BlueCard® Program, when you access covered services within the geographic area served by a Host Blue, Regence will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever you access covered services outside Regence's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Regence.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that 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 would then calculate your liability for any covered services according to applicable law.

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.

Negotiated National Account arrangements

As an alternative to the BlueCard® Program, your claims for covered services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Regence by the Host Blue.

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

Member Liability Calculation. When covered services are provided outside of Regence's service area by out-of-network providers, the amount you pay for such services will generally be based on either the Host Blue's out-of-network provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, Regence may use other payment bases, such as billed covered charges, the payment Regence would make if the health care services had been obtained within Regence's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Regence will pay for services rendered by out-of-network providers. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.

Services received outside the United States

ALERT! The plan does not cover prescription drugs ordered through mail-order pharmacies located outside the U.S. See "Prescription drugs purchased outside the U.S." on page 77 to learn more.

Blue Cross Blue Shield Global® Core

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, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

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 applicable deductible. 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 **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, seven days a week.

When services received outside the U.S. are covered

The plan covers the same benefits as described in this certificate of coverage if the services received outside the U.S. are or have:

- Medically necessary (see definition on page 152).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by U.S. standards.
- Met all medical policy criteria.
- Covered by the plan.

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 are admitted to the hospital, call the Blue Cross Blue Shield Global® Core Service Center to notify the plan of your admission.
- If you need urgent medical care, contact the Blue Cross Blue Shield Global® Core Service Center for help finding a network provider.

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, seven days a week).

- To use the online provider search tool, register and log in at **bcbsglobalcore.com**.
- Visit 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 log in 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. The deductible amount for a single person (subscriber only) enrolled in the plan is $1,400; for more than one person enrolled in the plan, the deductible is $2,800. See "How the deductible works with more than one person" on page 20 for more information. You pay your providers until you pay your deductible for the year, then the plan begins to pay for covered services.

The deductible applies to all services unless otherwise stated in this certificate of coverage. See below for services that are exempt from the deductible.

What does not count toward your deductible

The following out-of-pocket expenses do **not** count toward your $1,400 deductible:

- Charges for service visits over benefit limits. For example, the annual benefit limit for acupuncture is 16 visits. Costs for more than 16 visits are not covered by the plan, and do not count toward your deductible.
- Charges for services over benefit maximums. For example, the maximum for adult vision hardware is $150 every two calendar years. Charges over this amount do not apply to your medical deductible.
- Out-of-network provider charges above the allowed amount. See table on page 12.
- Services that are exempt from the deductible, even if you had out-of-pocket costs. For example, covered preventive care received from an out-of-network provider.
- Services you pay for that are not covered by the plan (see pages 89–97).

TIP: You may use money from your HSA to pay for noncovered services if they are qualified medical expenses (see definition on page 159).

Services exempt from the deductible

The plan pays the allowed amount for services (subject to cost-share) listed on the next page even if you have not met your deductible. When you see a preferred or participating provider, you do not have to pay the deductible before the plan pays for these services:

- Some contraceptive supplies and services (see pages 43–44).

- Covered preventive care, including covered immunizations (see pages 58–59).
- Diabetes Control Program (see page 40).
- Diabetes Prevention Program (see page 40).
- Required second opinions (see page 60).
- Routine vision care: exams, glasses, and contacts (see page 70).
- Tobacco cessation services (see page 66).

How the deductible works with more than one person

If you cover only yourself, your deductible is $1,400. You must pay this amount for covered services not exempt from the deductible (including covered prescription drugs) before the plan begins to pay for covered services.

If you cover yourself and at least one other person, your deductible is $2,800. You must pay this amount for covered services not exempt from the deductible (including covered prescription drugs) before the plan begins to pay for covered services. You must pay this amount for covered services for all covered persons combined before the plan pays for any services, including prescription drugs (other than those exempt from the deductible). Once the deductible is met, the plan begins paying for covered services.

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

ALERT! If you receive services with a benefit limit (such as massage therapy or physical therapy) before meeting your deductible, those visits still apply to the benefit limit. For example, if you pay out of pocket for a massage therapy visit because you have not met your deductible, that visit **will** apply to the maximum of 16 visits per calendar year. See definition of "Limited benefit" on page 150 for more information.

Coinsurance

Coinsurance is the percentage of the allowed amount you pay for most medical services and for prescription drugs when the plan pays less than 100 percent. After you have paid your deductible, you pay the following percentages for most medical services. See page 72 for how much you pay for prescription drugs.

- **For preferred providers:** 15 percent of the allowed amount.
- **For participating providers:** 40 percent of the allowed amount.
- **For out-of-network providers:** 40 percent of the allowed amount and you may be balance billed, which means you will pay any amount an out-of-network provider bills that is above the allowed amount.

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

Note: Some hospital-based physicians may not be preferred providers even though they work in a preferred facility. When you receive services in Washington, Oregon, and Idaho at a preferred hospital or preferred ambulatory surgical facility, but receive services from out-of-network surgeons, anesthesiologists, emergency department providers, radiologists, or laboratories, you cannot be balance billed (see page 145).

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: The provider may ask you to pay your deductible, when applicable, at the time of service. You will be billed for your coinsurance amounts after services are provided. In these cases, check your EOB to make sure the amount you paid is accurately reflected in the Member Responsibility section. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) with questions.

Health savings account (HSA)

The State of Washington will contribute $700.08 for one person, and $1,400.04 for more than one person enrolled in the plan, deposited in equal amounts over the calendar year. Employer contributions are made only during those months you are enrolled in UMP CDHP. You may also make contributions to your HSA account. To confirm the maximum annual contribution limits, visit **irs.gov/government-entities/federal-state-local-governments/where-can-i-learn-more-about-health-savings-accounts-hsa-and-health-reimbursement-arrangements-hra**. The State of Washington's contributions apply to the limits, as does the SmartHealth wellness incentive (see below).

You may use your HSA to pay for member cost-sharing and other qualified medical expenses as described in Internal Revenue Code (IRC) 223(d)(2), including expenses not normally covered by the plan. You may use HSA funds to pay for expenses for your spouse or tax dependents, even if they are not covered by UMP CDHP. The IRS determines which services are eligible for reimbursement through an HSA, and who may pay for services using HSA funds. For details on how to use your HSA, including a list of items and services that you may pay for with your HSA funds, visit **learn.healthequity.com/pebb/hsa/** or call 1-844-351-6853.

If you earned the SmartHealth wellness incentive

The subscriber (see definition on page 162), except a Medicare subscriber who is enrolled in the retiree plan, is the only member eligible to qualify for and earn the SmartHealth wellness incentive. A federal requirement mandates a minimum deductible for CDHPs. Therefore, the PEBB Program is not allowed to reduce the UMP CDHP deductible by $125.

If you earned the wellness incentive for 2019, the PEBB Program will deposit $125 into your HSA in January 2020. This applies to your maximum annual contribution. You may need to adjust your payroll contributions to make sure you do not exceed your maximum allowed contribution for the year.

How to pay using your Health Savings Account

After a claim is processed, you may log in to your HealthEquity HSA to view your medical claims. You may pay for qualified medical expenses (see page 159) by:

- Using your HealthEquity debit card at the time of service.
- Logging in to your HSA and designating payment to be sent by HealthEquity directly to the provider.

  Note: You may make a partial payment using this method.

- Logging in to your HSA and paying yourself back for a qualified medical expense you paid using non-HSA funds. For example, if you paid cash at your provider's office for qualified medical expenses, you may reimburse yourself from your HSA.

Out-of-pocket limit

The out-of-pocket limit is the most you pay during a calendar year for covered services from preferred providers and covered prescription drugs from network pharmacies. After you meet your combined (medical and prescription) out-of-pocket limit for the year, the plan pays for covered services by preferred providers only at 100 percent of the allowed amount and covered prescription drugs at network pharmacies at 100 percent. **Expenses are counted from January 1, 2020, or your first day of enrollment (whichever is later); through December 31, 2020, or your last day of enrollment (whichever is earlier).**

Your out-of-pocket limit depends on the number of persons enrolled in the plan:

- One person enrolled: $4,200.
- Two or more persons enrolled: $8,400. Once a member meets $6,900 in covered out-of-pocket expenses annually, the plan will pay for covered services at 100 percent for that member.

What counts toward this limit

- Your coinsurance paid to preferred and participating providers (see page 12).
- Your coinsurance paid to network pharmacies (see page 72).
- Your deductible.

What does not count toward this limit

A. Amounts paid by the plan, including services covered in full.
B. Your monthly premiums.
C. Your coinsurance paid to out-of-network providers and out of network pharmacies.
D. Balance billed amounts (see page 145).
E. Services not covered by the plan (see pages 89–97).
F. Prescription drugs not covered or excluded by the plan (see page 83).
G. Amounts that are more than the maximum dollar amount paid by the plan. For example, the plan pays a maximum of $150 for adult vision hardware once every two calendar years. Any amount you pay over $150 does not count toward the medical out-of-pocket limit.
H. Amounts paid for services over a benefit limit. For example, the benefit limit for acupuncture is 16 visits. If you have more than 16 acupuncture visits in one year, you will pay in full for those visits, and what you pay will not count toward this limit (see page 150).

What you pay after reaching this limit

You are still responsible for paying C through H after you meet your out-of-pocket limit.

You still pay for participating and out-of-network provider services

Covered services by participating and out-of-network providers are paid by the plan at 60 percent of the allowed amount. Even after you meet your out-of-pocket limit, you still pay 40 percent coinsurance for

participating and out-of-network provider services. Out-of-network providers may balance bill you (see page 145).

Note: The 40 percent coinsurance you pay to an out-of-network provider, and any balance billed amounts do not count toward your out-of-pocket limit. However, the coinsurance paid to out-of-network providers does apply to your deductible. Balance billed amounts never apply toward your deductible or out-of-pocket limit.

Summary of services and payments

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 UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions about benefits or limitations.

On the next several pages, you will find a summary of your plan benefits 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.

Not all benefits are listed. For services not listed, see the table of contents or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

All services must be medically necessary (see definition on page 152) to be covered. **If you see an unfamiliar term, see the alphabetical list of definitions on pages 143–163.**

This certificate of coverage applies only to dates of service between the day your coverage begins (no earlier than January 1, 2020) and the day your coverage ends (no later than December 31, 2020).

ALERT! If you have coverage under another health plan, see pages 97–102.

Deductibles and limits

Deductibles and limits	Dollar amounts	What else you need to know	For more information: See page(s)
Deductible	▪ $1,400 for one person enrolled. ▪ $2,800 for two or more persons enrolled. See page 21 if you earned the SmartHealth wellness incentive in 2019 for plan year 2020.	▪ This deductible applies to all services, including prescription drugs, unless specifically stated the services are not subject to the deductible. ▪ For an account of more than one enrolled member, you must meet the entire $2,800 deductible. ▪ You must pay the deductible before the plan pays for covered medical services. ▪ Not all services count toward this deductible.	19–23

Deductibles and limits	Dollar amounts	What else you need to know	For more information: See page(s)
Out-of-pocket limit	▪ $4,200 for one person enrolled. ▪ $8,400 for two or more persons enrolled.	▪ Your deductible, medical coinsurance, and prescription drug coinsurance apply to this limit. ▪ Not all services apply to this limit. ▪ Once one member meets $6,900 in covered out-of-pocket expenses annually, the plan will pay for covered services at 100% for that member when they see a preferred provider or network pharmacy.	22
Health Savings Account (HSA)	To confirm the maximum annual contribution, visit the IRS website at: **irs.gov/government-entities/federal-state-local-governments/where-can-i-learn-more-about-health-savings-accounts-hsa-and-health-reimbursement-arrangements-hra**	You may pay for any qualified medical expenses (see definition on page 159) from your HSA, including: ▪ Services that apply to your deductible. ▪ Services that are not covered by the plan but are still qualified medical expenses.	21
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 below describes how much you and the plan will pay for services. Unless otherwise noted, all payments are based on the allowed amount and services are subject to the deductible. See the "Summary of benefits" table on pages 32–34 to find the types of services (standard, preventive, outpatient, inpatient, facility fees, and special) and how they are paid.

Type of service	How much the plan pays for covered services	How much you pay for covered services
Standard	▪ **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.	You must pay your deductible, the first $1,400 in charges per member up to a maximum of $2,800 for a family of three or more, before the plan begins to pay. After that, how much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers:** You pay 15% of the allowed amount. The provider may not balance bill you. ▪ **Participating providers:** You pay 40% of the allowed amount. The provider may not balance bill you. ▪ **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.
Preventive	▪ **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.	Covered preventive services are **not** subject to the deductible. How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers:** You pay $0. The provider may not balance bill you. ▪ **Participating providers:** You pay $0. The provider may not balance bill you. ▪ **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.
Outpatient	▪ **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.	Outpatient services are subject to the deductible and coinsurance. 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 may not balance bill you. ▪ **Participating providers:** You pay 40% of the allowed amount. The provider may not balance bill you. ▪ **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.

Type of service	How much the plan pays for covered services	How much you pay for covered services
Inpatient	The plan pays 85% of the allowed amount after you meet your deductible. 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. ▪ **Participating providers:** The plan pays 60% of the allowed amount. ▪ **Out-of-network providers:** The plan pays 60% of the allowed amount.	Inpatient services are subject to the deductible. Most inpatient services require both preauthorization (see page 86) and notice (your provider must notify the plan upon admission to a facility; see page 87). Services are considered inpatient only when you are admitted to a facility. See definition of "Inpatient stay" on page 150. When you are admitted to a facility, you pay: ▪ Your deductible; and ▪ Fees for professional services such as, but not limited to, provider consultations or lab tests. The amount you pay depends on the provider's network status: ▪ **Preferred providers:** You pay 15% of the allowed amount. The provider may not balance bill you. ▪ **Participating providers:** You pay 40% of the allowed amount. The provider may not balance bill you. ▪ **Out-of-network providers:** You pay 40% of the allowed amount. The provider may balance bill you.
Facility	▪ **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.	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 Explanation of Benefits or other documents. How much you pay depends on the provider's network status: ▪ **Preferred providers:** You pay 15% of the allowed amount; the provider may not balance bill you. ▪ **Participating providers:** You pay 40% of the allowed amount; the provider may not balance bill you. ▪ **Out-of-network providers:** You pay 40% of the allowed amount; the provider may balance bill you.
Special		These services have unique payment rules, which are described in the "How much you will pay" column on pages 32–34.

What else you need to know

- Some services are not covered (see pages 89–97).

- There is no waiting period for preexisting conditions.
- You will save money by seeing preferred providers (see page 12).

Benefits: what the plan covers

Guidelines for coverage

ALERT! The fact that a provider prescribes, orders, recommends, or approves a service or supply does not mean it is covered or medically necessary (see page 152).

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

- Be received by a member on a day between the date coverage begins (but no sooner than January 1, 2020) and the date coverage ends (but no later than December 31, 2020); and
- Be listed as covered; and
- Meet the plan's coverage policies and preauthorization requirements; and
- Follow coverage determinations of the Health Technology Clinical Committee; and
- Be medically necessary (see definition on page 152).

Limits and exclusions may apply to plan benefits. See both the benefit description and "What the plan does not cover" starting on page 89.

Some services require preauthorization and/or notice before you receive treatment. See page 87 for how to find a list of these services, or call UMP Customer Service to ask if a certain service is covered, requires preauthorization, or requires notice.

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 calling UMP Customer Service at 1-888-849-3681 (TRS: 711).**

UMP CDHP is a self-insured PPO health plan offered through the Washington State Health Care Authority's PEBB Program and administered by Regence BlueShield and WSRxS. All prescription drugs, services, or other benefit changes may require approval by the PEB Board when benefits are procured for the next calendar year. For example, prescription drugs newly approved by the U.S. Food and Drug Administration (FDA) may require approval by the PEB Board before the plan will cover them.

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 at **hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews.** Contact UMP Customer Service if you have questions about specific services that the HTCC has reviewed.

Created by Washington State law chapter 70.14 RCW (Revised Code of Washington), 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 in making its determination.

How HTCC decisions affect UMP benefits

Under state law, the plan must comply with HTCC decisions. 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, that means the service is not medically necessary in any circumstance.

Some HTCC decisions include a requirement to follow FDA or Centers for Medicare and Medicaid Services (CMS) guidelines. You may review these guidelines at **fda.gov** or **cms.gov**.

Where to find HTCC decisions

This certificate of coverage contains a summary of how HTCC decisions are covered. You may view the list of services that the HTCC has reviewed or currently has under review at **hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews**. The website includes:

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

You may also call UMP Customer Service at 1-888-849-3681 (TRS: 711) with questions about coverage of conditions, if any, for HTCC technologies.

List of HTCC decisions

Topic	Coverage level
Applied Behavioral Analysis (ABA) for Autism for children diagnosed with Autism Spectrum Disorder	Covered with limitations
Appropriate imaging for breast cancer screening in special populations for members aged 40 to 74	Covered with limitations
Arthroscopic knee surgery for osteoarthritis of the knee	Not a covered benefit
Artificial disc replacement	Covered with limitations
Autologous blood and platelet-rich plasma injections	Not a covered benefit
Bariatric surgery	Covered with limitations
Bone growth stimulators	Covered with limitations

Topic	Coverage level
Bone morphogenic proteins for use in lumbar spinal fusion	Covered with limitations
Breast MRI for screening for breast cancer	Covered with limitations
Bronchial thermoplasty for asthma	Not a covered benefit
Cardiac nuclear imaging	Covered with limitations
Cardiac stents	Covered with limitations
Carotid artery stenting	Covered with limitations
Catheter ablation procedures for supraventricular tachyarrhythmia, including atrial flutter and atrial fibrillation	Covered with limitations
Cervical spinal fusion for degenerative disc disease	Covered with limitations
Chronic migraine and chronic tension-type headache with onabotulinumtoxinA (Botox)	Covered with limitations
Cochlear implant bilateral vs unilateral for ages 12 months or older	Covered with limitations
Computed tomographic angiography for detection of coronary artery disease	Covered with limitations
Computed tomographic colonography (CTC)	Not a covered benefit
Coronary artery calcium scoring	Not a covered benefit
Discography for chronic low back pain and lumbar degenerative disc disease	Covered with limitations
Electrical neural stimulation	Not a covered benefit
Extracorporeal membrane oxygenation in adults	Covered with limitations
Extracorporeal shock wave therapy for musculoskeletal conditions	Not a covered benefit
Facet neurotomy	Covered with limitations
Fecal microbiota transplantation for c. difficile infection	Covered with limitations
Femoroacetabular impingement (FAI) syndrome hip surgery procedures	Not a covered benefit

Topic	Coverage level
Functional neuroimaging for primary degenerative dementia or mild cognitive impairment	Not a covered benefit
Gene expression profile testing of cancer tissue	Covered with limitations
Genomic micro-array and whole exome sequencing for children	Covered with limitations
Glucose monitoring, continuous	Covered with limitations
Hip resurfacing	Not a covered benefit
Hyaluronic acid/viscosupplementation for the treatment of pain associated with osteoarthritis of the knee	Covered with limitations
Hyperbaric oxygen therapy for tissue damage including wound care and treatment of central nervous system conditions	Covered with limitations
Imaging for rhinosinusitis with Sinus Computed Tomography	Covered with limitations
Implantable infusion pumps for treatment of chronic non-cancer pain	Not a covered benefit
Intensity modulated radiation therapy	Covered with limitations
Knee joint replacement or knee arthroplasty	Covered with limitations
Lumbar fusion for degenerative disc disease for individuals 17 years of age and older	Not a covered benefit
Microprocessor-controlled lower limb prosthesis for the knee	Covered with limitations
Negative pressure wound therapy for home use	Covered with limitations
Nonpharmacological treatments for treatment-resistant depression	Covered with limitations
Novocure (i.e., Optune) (tumor treating fields)	Not a covered benefit
Osteochondral allograft and autograft transplantation	Covered with limitations
Peripheral nerve ablation for limb pain	Not a covered benefit
Pharmacogenetic testing for patients being treated with oral anticoagulants	Not a covered benefit
Positron emission tomography scans for lymphoma	Covered with limitations

Topic	Coverage level
Proton beam therapy	Covered with limitations
Robotic assisted surgery	Covered with limitations
Routine ultrasound for pregnancy	Covered with limitations
Sacroiliac joint fusion for chronic pain in patients 18 and older	Not a covered benefit
Screening and monitoring tests for osteopenia/osteoporosis	Covered with limitations
Sleep apnea diagnosis and treatment in adults	Covered with limitations
Spinal cord stimulation for chronic neuropathic pain	Not a covered benefit
Spinal injections	Covered with limitations
Stereotactic radiation surgery and stereotactic body radiation therapy	Covered with limitations
Surgery for symptomatic lumbar radiculopathy or sciatica	Covered with limitations
Testosterone testing	Covered with limitations
Tympanostomy tubes in children aged 16 years and younger	Covered with limitations
Upper endoscopy for GERD and GI symptoms	Covered with limitations
Upright/positional MRI	Not a covered benefit
Vagal nerve stimulation for patients 12 years of age or older	Covered with limitations
Varicose veins	Covered with limitations
Vertebroplasty, kyphoplasty, sacroplasty	Not a covered benefit
Vitamin D screening and testing	Covered with limitations

Summary of benefits

All covered services and limitations are not listed in the table below. See the alphabetical list of all covered services on pages 35–71.

Please read the pages listed in the "For more 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 87)
- Services that are not covered (exclusions) (see pages 89–97)
- Services that require preauthorization (see page 87)

If you have questions about your benefits, benefit limitations, services that require preauthorization or notice, or services not covered by the plan, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Benefit/service	How much you will pay (See pages 19–23 for description of types of services)	For information: See page(s)
Ambulance	Special: 20% of the allowed amount for any provider. Applies to your out-of-pocket limit.	35, 90, 97
Applied Behavior Analysis (ABA) Therapy	Standard rate[1]	35
Breast health	See "Mammograms and Digital Breast Tomosynthesis (DBT)" on page 52.	37
Chiropractic treatment	Standard rate[1]	See "Spinal and extremity manipulations" on page 61.
Diagnostic tests, laboratory, and x-rays	Standard rate[1]	40, 52, 89–97
Durable medical equipment, supplies, and prostheses	Standard rate[1]	41–43, 91, 95, 146
Emergency room (ER)	Standard rate[1] You are usually billed separately for: ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests	43, 151
Home health care	Standard rate[1]	46, 92, 149, 151

[1] See page 161 for the definition of standard rate.

Benefit/service	How much you will pay (See pages 19–23 for description of types of services)	For information: See page(s)
Hospice care	Special: ▪ Medical services paid at 100% after meeting the deductible. ▪ Prescription drugs paid at 100% after meeting the deductible. ▪ End-of-life counseling while in hospice paid at 100% after meeting deductible.	47, 150, 160
Hospital services	Inpatient rate[2] Outpatient/professional: Standard rate[1]	48, 54–56, 92
Mammograms	Diagnostic: Standard rate[1] Screening: Preventive rate[3]	52
Mental health treatment	Inpatient rate[2] Outpatient services: Standard rate[1]	53, 93, 95
Naturopathic physician services	Standard rate[1]	13, 53, 85, 91
Obstetric and newborn care	Inpatient rate[2] Outpatient services: Standard rate[1]	54–56, 95
Office visits	Standard rate[1]	56, 94
Physical, neurodevelopmental, occupational, and speech therapy	Standard rate[1]	56
Prescription drugs	No deductible: Preventive 0% After meeting the deductible: 15%	71

[1] See page 161 for the definition of standard rate.

[2] See page 150 for the definition of inpatient rate.

[3] See page 158 for the definition of preventive rate.

Benefit/service	How much you will pay (See pages 19–23 for description of types of services)	For information: See page(s)
Preventive care and immunizations	Preventive care: Preventive rate[3] Immunizations: Preventive rate[3] (usually)	52, 55, 58–60, 79, 158
Skilled nursing facility	Inpatient rate[2] Some services may be billed separately, such as physical therapy.	60, 92, 96, 161
Spinal and extremity manipulations	Standard rate[1]	61
Substance use disorder treatment	Outpatient/professional: Standard rate[1]	64, 95
Surgery	Standard rate[1]	39, 48, 53, 56, 65, 67, 92, 97, 144, 155, 159
Tobacco cessation	Preventive rate[3]	66
Vision care exam (routine)	Preventive rate[3]	70, 90, 92, 94
Vision hardware, adults (over age 18) (Glasses, contact lenses)	Special: ▪ No medical deductible ▪ Plan pays up to $150 every two calendar years	70
Vision hardware, children (ages 18 and under) (Glasses, contact lenses)	Special: No medical deductible. ▪ Eyeglasses: You pay $0 up to the allowed amount for one set of standard frames and lenses per year; **or** ▪ Contact lenses: You pay $0 up to the allowed amount for a one-year supply when purchased in lieu of eyeglasses.	70

[1] See page 161 for the definition of standard rate.

[2] See page 150 for the definition of inpatient rate.

[3] See page 158 for the definition of preventive rate.

Note: For services requiring preauthorization or plan notification: See the list of services at **regence.com/ump/pebb/benefits/policies** or call UMP Customer Service at 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See page 88 for how this works.

List of benefits

Acupuncture

The plan covers up to 16 visits for acupuncture treatment per calendar year. See definition of "Limited benefit" on page 150.

Ambulance

The plan pays 80 percent of the allowed amount for ambulance services, which must be medically necessary (see page 152). Ambulance services for personal or convenience purposes are not covered.

Ground ambulance

Professional ground ambulance services are covered in a medical emergency:

- From the site of the medical emergency to the nearest facility equipped to treat the medical emergency (see definition on page 151).
- 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.
- From a facility to home.

Air or water ambulance

Air and 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 (see page 151).
- Air or water ambulance is medically necessary (see page 152).
- 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. ABA Therapy services must be preauthorized by the plan before services are performed, or services will not be covered.

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.

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

As for other covered services, you receive the highest-level benefit by using preferred providers. See page 12 for differences in your cost for preferred, participating, and out-of-network providers. To find a preferred provider, visit **regence.com/ump/pebb/finding-doctors** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

More information on ABA Therapy, including how to request preauthorization, is available at **regence.com/ump/pebb/benefits/policies** in the "Clinical policies" section.

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

Autism treatment

To determine how a service, supply, or intervention is covered, please see that specific benefit. For example, speech or occupational therapy is addressed on page 56 under the "Physical, occupational, speech, and neurodevelopmental therapy" benefit, while mental health coverage is found under "Mental health treatment" on page 53. If a specific benefit is subject to limits, such as number of visits, these limits apply to services, supplies, or interventions for an autism diagnosis the same as for any other diagnosis.

TIP: This description does not apply to Applied Behavior Analysis (ABA) Therapy. See "Applied Behavior Analysis (ABA) Therapy" on page 35 for details.

Bariatric surgery

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, non-Medicare adults ages 18 and over are covered for Roux-en-Y, sleeve gastrectomy, and laparoscopic adjustable gastric banding procedures. No other procedure will be considered for coverage.

If you are Medicare-eligible or close to becoming eligible for Medicare and are considering bariatric surgery, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Related care following bariatric surgery

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

UMP will cover surgical follow-up care related to a bariatric procedure such as complications, needed revisions, and Lap Band fills to prior bariatric surgery. 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, need for revision, or require Lap Band fills for ongoing medically necessary services 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.

Breast health screening tests

See also "Mammograms" on page 52 for more information about breast health screening tests. The tests listed below may be covered for diagnostic purposes as indicated under plan medical policy.

Services covered

Members ages 40 and older: Breast health screening tests are covered as preventive in addition to a digital mammogram. See "How much you will pay" on page 32.

Members under age 40: See page 52 under "Mammogram" for how preventive breast health screening tests are covered for high-risk members.

Services not covered

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

Non-high-risk patients:

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

High-risk patients:

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

Care Gap Closure Program

Care Gap Closure Program encourages members to receive recommended preventive and chronic care services and screenings, also known as "gaps in care." These include screenings for cancer, diabetes, and more at no cost to you. This support includes helping members find a primary care provider, making appointments, ensuring members understand their benefits, and providing members ongoing support through case management as appropriate. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for more information.

Chiropractic physician services

See "Spinal and extremity manipulations" on page 61.

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.

Most dental services are not covered by the plan. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these is not covered. However, your PEBB dental plan may cover these services. Refer to your dental plan's certificate of coverage, found at **hca.wa.gov/erb**, for more information.

What is covered by the plan

You pay 20 percent of the allowed amount for dental services covered by the plan unless otherwise stated, and the provider may balance bill you (see definition on page 145). **Only the following medically necessary dental services are covered by the plan:**

Fluoride treatment

Under certain circumstances, the plan may cover fluoride supplements (see page 78). The application of fluoride varnish may be covered for infants and children starting at the age of primary tooth eruption in primary care practices, for prevention of tooth decay (dental caries); coverage depends on the network status of the medical provider as described on pages 11–13. Health care providers, such as your child's medical primary care provider, may apply fluoride varnish.

You pay 20 percent of the allowed amount for dental services covered by the plan, and the provider may balance bill you (see definition on page 145).

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

Accidental injuries

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

The actual treatment may extend beyond 30 days if your provider determines 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, and you must be currently enrolled in the plan during the entire course of treatment. The plan does not cover treatment after UMP coverage ends.

Example: You have an accident on March 12, 2020, resulting in injuries that are covered by the plan. Your treatment plan must be finalized no later than April 11, 2020. All related treatment must be completed by December 31, 2021 (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; or
- Extends past the end of the calendar year following the accident or your enrollment in the plan.

Oral surgery

TIP: See page 66 for information about TMJ disorder treatment.

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

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate.
- Gum reduction for gingival hyperplasia due to Dilantin® or phenytoin use.
- Services related to cancer and treatment of cancer, including but not limited to jaw reconstruction.

  Treatment of a fracture or dislocation of the jaw or facial bones.
- Treatment related to chronic conditions that result in loss or damage of teeth.

Note: UMP is not affiliated with the Uniform Dental Plan (UDP). If you are enrolled in UDP, please contact UDP for information. Visit **hca.wa.gov/erb** and select "Contact" to find UDP contact information.

Diabetes care supplies

TIP: If a health plan other than UMP is your primary payer (see definition on page 158), claims for diabetes care supplies may be paid differently (see page 39).

Medical

Diabetes supplies listed below are covered under your plan's medical benefit:

- Insulin pump and pump supplies are covered under the medical benefit as durable medical equipment. See page 42 for coverage of insulin pumps and related supplies.
- Continuous glucose monitors must be preauthorized and are covered only under the medical benefit. See the definition of medical benefit on page 151.

Prescription drug

Diabetes supplies listed below are covered under your plan's prescription drug benefit. To be covered, you must get a written prescription for these drugs and supplies and purchase them from a pharmacy. For questions, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

You save money and avoid having to submit your own claims when you purchase these diabetes supplies from a WSRxS network pharmacy. Locate a network pharmacy at **regence.com/ump/pebb/benefits/prescriptions** or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

The following diabetes care supplies are covered under the UMP Preferred Drug List:

- Preferred test strips
- Insulin syringes
- Lancets

For more information, see "Exceptions covered" on page 78.

Diabetes Control Program

TIP: The Diabetes Control Program is exempt from the deductible and is offered at no additional cost for UMP members ages 18 and older.

For non-Medicare members ages 18 and older with a diagnosis of diabetes, the plan offers the Diabetes Control Program administered by the Case Management Program at Regence at no cost to the member. Case managers are trained to help you reduce the risk of complications of diabetes by tracking and controlling blood sugar, cholesterol levels, blood pressure, and weight in a series of quarterly consultations.

You may find out if you qualify for the program by visiting your primary care provider for a blood sugar laboratory test. Your primary care provider will tell you if you meet criteria once the laboratory results are available. If you qualify for the Diabetes Control Program, you may self-refer by calling 1-866-543-5765.

Diabetes education

The plan covers diabetes self-management training and education, including nutritional therapy by registered dieticians. When diabetes education includes nutritional therapy, the nutritional therapy services are not subject to the 12-visit lifetime limit stated under "Nutrition counseling and therapy" on page 54.

Diabetes Prevention Program (DPP)

For non-Medicare members ages 18 and older, the plan DPP at no cost to the member.

If you have prediabetes or are at high risk of developing prediabetes you have access to a virtual (online) DPP through Omada Health.

You may take an online screening questionnaire to see if you meet the program's criteria by visiting **go.omadahealth.com/deployments/wapebb**, creating an account, and logging in. If you meet the criteria, you may participate in the program at no cost to you. The virtual program includes a professional health coach, a wireless scale, and weekly online classes with a small group of participants who provide real-time support.

Instead of the online questionnaire, you may meet the criteria for the program:

- If your provider ordered a blood sugar test in the last 12 months; and
- The test showed you are in the prediabetes range.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for more information.

Diagnostic tests, laboratory, and x-rays

The plan pays the standard rate for covered diagnostic tests, laboratory, and x-rays when medically necessary (see definition on page 152). If there are alternative diagnostic approaches with different fees, the plan will cover the least expensive, evidence-based diagnostic method. See **regence.com/ump/pebb/benefits/policies** or call UMP Customer Service at 1-888-849-3681 (TRS: 711) for a list of services requiring preauthorization.

Covered services include:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Colonoscopy performed to diagnose disease or illness. See the list on page 58 for coverage of preventive or screening colonoscopy.

- Electrocardiograms (EKG, ECG).
- Prostate cancer screening (prostate-specific antigen [PSA] testing): All PSA testing is covered under the medical benefit (subject to the deductible and coinsurance), even if billed as preventive.
- Skin allergy testing.

TIP: See page 52 to learn how the plan covers mammograms.

Tests not covered

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

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

Dialysis

For covered professional and facility services necessary to perform dialysis, the plan pays 85 percent of the allowed amount. For dialysis services, amounts paid to out-of-network facilities (including balance-billed amounts; see page 145) will apply to your medical out-of-pocket limit.

Durable medical equipment, supplies, and prostheses

TIP: The plan covers durable medical equipment (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 "Finding a preferred DME provider" on page 42.

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. Some items require preauthorization. Find the list of supplies that require a preauthorization at **hca.wa.gov/ump-forms-pubs** and search "durable medical equipment" or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

The plan pays the standard rate for DME services and supplies that 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 "Mastectomy and breast reconstruction" on page 53.
- Breast pumps for pregnant and nursing women (see page 41).
- Casts, splints, crutches, trusses, and braces.

- Continuous Positive Airway Pressure (CPAP) devices and related supplies.
- Diabetic shoes, only as prescribed for a diagnosis of diabetes. See "Foot orthotics" on page 42.
- Elemental formulas for Eosinophilic Gastrointestinal Disorders (EGIDs). This is covered as durable medical equipment under the medical benefit.
- Insulin pumps and related pump supplies (see "Insulin pumps and related pump supplies" on page 42).
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- 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 option) 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.

The plan limits coverage of DME to one item of a particular type of equipment and the accessories needed to operate the item. The plan also cover the repair or replacement of DME due to normal use or a change in the patient's condition (including the growth of a child). You are responsible for the entire cost of any additional pieces of the same or similar 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 patient 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, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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

To find a preferred DME supplier, go to **regence.com/ump/pebb/finding-doctors** and 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 & Medical Supplies Supplier."

Note: 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.

You should now have a list of network DME suppliers. Note that different DME suppliers carry different types of supplies. You may need to call to confirm that a supplier has what you need.

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

Emergency room

TIP: If you need immediate care but your situation is not a medical emergency (see page 151). See "Urgent care" on page 68 for how to get treatment at a lower cost than in an emergency room.

Facility charges for emergency room treatment are covered for diagnosis and treatment of an injury or illness covered by the plan. Covered services are paid at 85% of the allowed amount after you pay the deductible.

Charges for professional services may be billed separately from facility (hospital or emergency room) charges. The plan pays these professional services based on the allowed amount, network status of the provider, and services provided.

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

If your emergency room visit is not the result of a medical emergency (see definition on page 151), the plan may not pay for emergency services.

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 deductible. Outside of hospice, these services are paid as a medical benefit (see page 151), subject to the deductible and coinsurance. For more information on hospice care, see page 47.

Family planning services

The plan covers some contraceptive drugs and devices at the preventive rate. Male condoms and spermicides are covered at 100 percent after you pay the deductible.

Services related to voluntary and involuntary termination of pregnancy (abortion or miscarriage) are covered under the medical benefit (see page 151).

Education and counseling related to contraception are paid at the preventive rate (see page 158).

If you receive care from an out-of-network provider, services are paid at the standard rate and you may be balance billed. If you go to a non-network pharmacy, you may have to pay at the time of purchase and submit a claim for reimbursement (see pages 104–105). You must get over-the-counter contraceptive supplies from a network pharmacy for these items to be covered (see "Over-the-counter contraceptives" on page 44).

Contraceptives

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

Contraceptives are covered under the prescription drug benefit. Contraceptives include but are not limited to birth control pills, emergency contraception (the "morning after" pill), vaginal rings, patches, implants, injectables (such as Depo-Provera), condoms, and spermicides.

You may purchase up to a 12-month supply for contraceptives. Call Washington State Rx Services (WSRxS) Customer Service at 1-888-361-1611 (TRS: 711) for information on how to obtain a 12-month supply. The replacement of lost, expired, or stolen contraceptives is not covered.

Women may receive emergency contraception over the counter without a prescription. When possible, it is best to obtain a prescription as not all pharmacies have prescribing authority. If you go to a pharmacy without a prescription and the pharmacy does not have prescribing authority, you will need to submit a claim to WSRxS. Members will need to contact the pharmacy directly for information on prescribing authority.

Barrier devices

All barrier devices requiring a prescription, fitting, insertion or removal are paid at the preventive rate when you see a preferred or participating provider or use a network pharmacy. Barrier devices requiring a prescription or fitting include intrauterine devices (IUDs), diaphragms, and cervical caps.

Over-the-counter contraceptives

Over-the-counter contraceptives are covered under the pharmacy benefit only if approved by and registered with the FDA. Male condoms and spermicides are subject to the deductible.

For the plan to cover FDA-registered over-the-counter contraceptives, you must present your UMP member ID card and make your purchase at the pharmacy counter. When possible, it is best to obtain a prescription as not all pharmacies have prescribing authority. If you go to a pharmacy without a prescription and the pharmacy does not have prescribing authority, you will need to submit a claim to WSRxS.

ALERT! To receive plan coverage for an approved over-the-counter contraceptive, you must purchase from a network pharmacy, present your UMP member ID card and make your purchase at the pharmacy counter.

Sterilization

When you see a preferred provider, sterilization procedures, such as tubal ligation or vasectomy, are covered as follows:

- For females: Covered as preventive (not subject to the deductible and the plan pays 100 percent of the allowed amount).
- For males: Paid at 100 percent of the allowed amount after paying $1,350 of your deductible.

Services and products not covered under the family planning benefit

The following services and products are not covered by the plan as a family planning benefit:

- Over-the-counter products not approved by and registered with the FDA.
- 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 trimming of toenails and removal or trimming of corns or calluses. These services are covered only for a diagnosis of diabetes and when provided by an approved provider type. Maintenance foot care provided outside the diagnosis of diabetes is not covered.

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 page 55. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) with any questions.

Headaches, chronic migraine or chronic tension type

The treatment for chronic migraine and chronic tension type headaches is limited.

Treatment of chronic migraine with OnabotulinumtoxinA (Botox) is only covered 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 prescription drug 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 patient has received a maximum of five treatment cycles.

The following treatments are **not covered:**

- Treatment of chronic tension-type headaches with Botox is not covered; and
- Treatment of chronic migraine or chronic tension-type headaches with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (such as chiropractic services) are not covered.

Hearing care (diseases and disorders of the ear)

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

Hearing exam and hearing aids

Hearing exam (routine)

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

The plan pays 85% percent of the allowed amount 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

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

- Purchase of a hearing aid (monaural or binaural) prescribed as a result of an exam for the treatment of hearing loss, including:
  - Ear mold(s).

- Hearing aid instrument.
- Initial battery, cords, and other ancillary equipment.
- Warranty (only as included with the initial purchase).
- Follow-up consultation within 30 days after delivery of hearing aid.

- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

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

Hearing aid items not covered

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

- Charges incurred after your 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:

- Hearing aid batteries
- Alerting devices
- 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 for FM/DM systems, receivers and transmitters
- Assistive listening devices for microphone transmitters
- Assistive listening devices for TDD machines
- Assistive listening devices, supplies, and accessories not otherwise specified

Home health care

ALERT! See page 89 for services not covered by the plan.

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

- Visits for part-time or occasional skilled nursing care and for physical, occupational, and speech therapy.
- Related services such as occasional care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of a registered nurse (RN), licensed practical nurse (LPN), or physical, occupational, or speech therapist.

- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.
- Home care of wounds resulting from injury or surgery.
- End-of-life counseling (see page 43).

For services that may be covered under another benefit, such as nutritional counseling or follow-up care for bariatric surgery, see that benefit in this certificate of coverage for coverage rules and limitations. These limitations apply even if the services are provided in the home or by a home health provider. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) 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 patients 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 deductible. The plan covers hospice care for terminally ill members for no more than six months. See page 43 for coverage of end-of-life counseling.

If you need hospice care, your provider will refer you to the program. For alternative caregivers, you may call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Prescription drugs

For covered prescription drugs, UMP members in hospice care receive special coverage when using network pharmacies, including the network specialty pharmacy and the network mail-order pharmacy.

- **Until the deductible is met,** the member pays the full cost (allowed amount) for covered prescription drugs.
- **After the deductible is met,** the plan pays for all covered prescription drugs purchased through a network pharmacy at 100 percent of the allowed amount for members in hospice care.

This applies **only to the member in hospice care.** Other members covered under the same account pay for their covered prescription drugs as described on pages 71–89.

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

ALERT! The member still pays the full cost for noncovered prescription drugs. If the member purchases covered prescription drugs from a non-network pharmacy (see page 77), the plan covers under normal benefits as described on pages 71–73.

Respite care

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

Hospital services

ALERT! Many services provided in a hospital setting require preauthorization or notice, or both. Failure to request or receive preauthorization, or to notify the plan, may result in complete denial of claims. See page 86 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 (see definition on page 152). Some services require preauthorization. See page 87 for how to find the list of these services or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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 upon admission. 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 "Emergency room" on page 43). All covered professional services are paid at the standard rate. .

Outpatient

Services are considered "outpatient" when you are not admitted to the hospital. Your cost depends on the services provided, such as lab tests, and the network status of the provider(s) involved in your care. Some services require preauthorization. See page 87 for how to find the list or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Not all providers at a preferred hospital are preferred providers

Some hospital-based physicians (such as, but not limited to, anesthesiologists and emergency room doctors) who work in a preferred hospital, or other preferred facility, may not be preferred providers. If a participating or out-of-network provider bills separately from the hospital, you pay 40 percent of the allowed amount. Out-of-network providers may not balance bill you in this circumstance when you receive care in Washington and boarder states (Idaho and Oregon).

Infusion drug site of care program

The plan covers provider-administered infusion drugs when administered at an approved site of care. Approved sites of care include some outpatient hospital facilities, standalone infusion sites, doctor's offices, and home infusion. Infusion drugs in the site of care program require preauthorization by the plan before services are performed, or services will not be covered. Your provider must submit a preauthorization request for an unapproved site of care. See page 86 for preauthorization instructions.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for the drugs covered under the site of care program and more information or help finding an approved site of care near you.

Joint replacement surgery, knees and hips–Centers of Excellence (COE) Program

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

- Presurgical consultations.
- Travel costs (see "Travel benefits" on page 50).
- Hospitalization and surgery.
- Postsurgical check-ups.

For this procedure, patients work with Premera Blue Cross (Premera) — the administrator of the program — and Virginia Mason — the COE — to ensure that their treatment is consistent with established standards of medical care.

If you receive services related to joint replacement that are not covered under the COE Program, you will pay your normal UMP cost-share, depending on the services received and the network status of the provider(s). This may be a deductible (page 19), coinsurance (page 20), or amounts not covered by the plan. Services billed to the plan outside of the COE Program are subject to the plan's preauthorization requirements.

COE for single knee and single hip joint replacement: Virginia Mason

Virginia Mason is the only provider approved to perform single knee and single hip replacement under the COE Program. Virginia Mason has proven that they provide high-quality joint replacements at predictable costs, using the most up-to-date medical guidelines and services.

Who is eligible to participate in the COE Program?

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

- A member enrolled in UMP Classic or UMP CDHP.
- Not enrolled in Medicare as your primary coverage.
- Age 18 or older.

Virginia Mason must determine if surgery for joint replacement is appropriate based on established medical guidelines. You may find these guidelines at **breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf**.

How to apply for the COE Program

If you are interested in participating in the COE Program:

- You may self-refer by calling Premera at 1-855-784-4563 (TRS: 711).
- Your regular provider may refer you.

You may receive information in the mail about the COE Program, which will explain how the program works and whom to contact for more information.

After applying:

- Premera screens applicants to initially determine whether they are eligible to be considered for the COE Program.
- Premera refers eligible applicants to Virginia Mason for further assessment.

- Virginia Mason will review medical records of eligible applicants to determine if they are medically appropriate candidates for surgery under the COE Program.
- If you are approved for surgery, Virginia Mason will provide you with a list of Virginia Mason surgeons to choose from.

Note: You may be required to follow a plan Virginia Mason gives you as a condition of approval for surgery, such as a plan for weight loss or tobacco cessation.

What happens after you're approved to participate in the program

Premera will provide a booklet describing your journey through the program. Premera will assign you a dedicated case manager who will walk you through each step of the process.

Travel benefits

Members having surgery under the COE Program may qualify for assistance with travel and lodging expenses. These expenses may include partial coverage by Premera for mileage, flights, parking, and lodging.

To be covered by the program, **all travel must be arranged through Premera**. This travel may be arranged by calling Premera at 1-855-784-4563 (TRS: 711).

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

TIP: Reimbursement for travel expenses is based on cost or current IRS rates for medical expenses, whichever is less, and may not cover all of your costs. For the IRS rates, visit **irs.gov/tax-professionals/standard-mileage-rates**.

You may be partially reimbursed for expenses related to:

- Mileage for driving within Washington. To qualify for reimbursement for mileage, members must live at least 60 driving miles from Virginia Mason, located at 1100 9th Ave, Seattle, WA 98101.
- Flights departing from and arriving at airports within Washington or Portland International Airport. You must depart from the airport closest to your residence.
- Ground transportation from Seattle-Tacoma International Airport to Virginia Mason.
- Lodging expenses (excluding meals) at a COE designated hotel. Premera must arrange all lodging.
- Parking at Virginia Mason and parking at your departing airport.

What is included in the COE Program

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

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

- Assessment(s).
- Surgery.
- Hospital stay.

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

What is not included in the COE Program

If you receive services outside of the COE Program, or choose to receive services at Virginia Mason that are not related to your single knee or single hip replacement surgery, covered services will be processed at the standard rate.

The following services are **not** included in the COE Program (but may be covered by other plan benefits):

- Care received as part of the plan Virginia Mason gives you as a condition of program approval, regardless of where you receive care. Examples of plan requirements include tobacco cessation and weight loss programs.
- Physical therapy that is not provided during your hospitalization.
- Follow-up care other than the initial postsurgical checkup at Virginia Mason. An example of follow-up care is a visit with your regular doctor.
- Prescription drugs received from a pharmacy upon discharge from the hospital.
- Convenience items, such as a personal phone.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions about services not included in the COE Program.

What happens if you do not qualify for the program

If Virginia Mason determines you are not an appropriate candidate for joint replacement surgery, you may choose a provider other than Virginia Mason for your total joint replacement. Services received outside the COE Program are processed according to the plan's medical policies, benefit structure, and the network status of your provider.

Appeals related to the COE Program

TIP: Appeal deadlines and other rules remain the same. See page 107 for details of how appeals work.

UMP members may appeal denials made by Premera. Appeals must be submitted to Premera. Decisions made by your Virginia Mason provider(s) regarding your medical appropriateness for surgery are not made by the plan or Premera and are therefore not appealable to the plan or Premera.

An appeal for services related to the COE Program must be submitted within 180 days of denial to Premera via fax at 1-800-995-2430 (secure inbound fax) or to the address below (and not to Regence):

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

Knee arthroplasty, total

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.

TIP: You may be eligible to have your knee or hip joint replacement surgery covered in full. See "Joint replacement surgery, knees and hips–Centers of Excellence (COE) Program" on page 49.

Mammogram and Digital Breast Tomosynthesis (DBT)

ALERT! Not all mammograms are paid at 100 percent (preventive). Only screening mammograms are considered preventive. Diagnostic mammograms are subject to the deductible and coinsurance. Claims are paid based on how the service is billed by your provider.

Screening (preventive)

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

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

How much you will pay

For all members, if you see a:

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

Diagnostic (medical)

The plan pays standard rate for medically necessary mammograms to diagnose a medical condition under the "Diagnostic tests, laboratory, and x-rays" benefit. There are no age requirements for diagnostic mammograms and DBT. The service must be ordered by a covered health care provider and billed as a diagnostic mammogram.

ALERT! See "Breast health screening tests" on page 37 for coverage of diagnostic testing other than mammograms.

Massage therapy

The plan pays the standard rate for up to 16 massage therapy visits per calendar year for covered diagnoses when you see a preferred provider. If you pay for visits before you meet your deductible, those visits apply to the 16-visit limit. See the definition of "Limited benefit" on page 150. You must have a prescription for massage therapy treatment from another covered provider type, such as a physician. Massage therapy is not covered by the plan when you see a participating or out-of-network provider.

ALERT! Only preferred massage therapists are covered. To find a preferred massage therapist, use the provider search at **regence.com/ump/pebb/finding-doctors** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Mastectomy and breast reconstruction

ALERT! See page 67 for coverage of breast reconstruction or mastectomy services related to transgender services.

The plan pays the standard rate for mastectomy as treatment for disease, illness, or injury, as well as:

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

Mental health treatment

The plan covers mental health services for members with neuropsychiatric and mental health conditions. Marriage or family counseling is not covered. Please see page 44 for details about coverage for substance use disorder treatment. The amount the plan pays depends on the provider's network status (see page 102).

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

- Inpatient admission, including to a residential treatment facility.
- Partial Hospitalization Program (PHP).

Inpatient

Services are considered "inpatient" when you are admitted to a facility. To be covered, residential treatment programs must be licensed to provide residential treatment solely to persons requiring residential substance use disorder treatment or to persons diagnosed with a mental health condition requiring residential treatment. Non-emergency inpatient services must be preauthorized by the plan. See page 86 for details. Contact UMP Customer Service at 1-888-849-3681 (TRS: 711) about preauthorization requirements. See the bullets on page 87 for services that require plan notice.

Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 151). All covered professional services are paid based on the allowed amount.

Outpatient

ALERT! See page 35 for preauthorization requirements related to Applied Behavior Analysis (ABA) Therapy services.

Outpatient mental health services are covered the same as any other medical service. The plan pays based on the allowed amount and the network status of the provider. Most outpatient mental health services do not require preauthorization. See bullets on page 87 for services requiring plan notice.

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 medical necessity definition on page 152).

The plan does not cover herbal, homeopathic, or other dietary supplements (including vitamins and minerals, except as described on page 91), even if prescribed by a covered provider type.

Nurse line

UMP's nurse line is provided by Advice24, offering you access to a nurse 24 hours a day, seven days a week at no cost to you. Registered nurses provide immediate symptom assessment, health information, and advice. They can help you decide if you need to go to the emergency room, make a doctor appointment, or care for your symptoms at home. UMP members can call the nurse line at 1-800-267-6729 (TRS: 711).

Nutrition counseling and therapy

TIP: See "Diabetes education" on page 40 for how these services are covered for diabetics.

The plan covers up to 12 visits per lifetime for nutrition counseling and therapy services. Similar services may be covered under other benefits that are not subject to the 12-visit limit, including but not limited to Diabetes Control Program (see page 40), Diabetes education (see page 40), and the Diabetes Prevention Program (see page 40).

Obstetric and newborn care

BabyWise

BabyWise is covered at no cost to you. As an expectant mother, the program helps you manage your health throughout pregnancy. BabyWise offers access to a nurse line, maternity support and education 24 hours a day, seven days a week. It also includes a smartphone application to help you track milestones, identify symptoms, and get one-click access to the nurse line. To enroll in BabyWise, please call 1-888-569-2229 or visit **regence.com**.

Services for obstetric and newborn care

Services for pregnancy and its complications are covered. See "Covered provider types" on page 13 for providers whose services are covered by the plan. Covered professional services include:

- Prenatal and postnatal care.
- Amniocentesis and related genetic counseling and testing during pregnancy.
- Prenatal testing (follows state regulations in Washington Administrative Code 246-680-020).
- Vaginal or cesarean delivery.
- Care of complications associated with pregnancy, including pregnancies resulting from fertility or infertility treatment.

Early elective deliveries may not be covered. See "Deliveries before 39 weeks gestation" on page 55.

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

- Any remaining deductible for the mother.
- Coinsurance for professional services for the mother while hospitalized.
- The deductible for the newborn; however, if only covered preventive care services (see page 55) are billed for the newborn, you will not pay the newborn's deductible or coinsurance when you see a preferred provider.

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

A newborn dependent of a female member 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 mother's plan coverage for the first 21 days. Visit **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 plan network, to discuss your options call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Deliveries before 39 weeks gestation

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

- Due to a medical emergency (see definition on page 151) affecting the mother or baby.
- Indicated due to a medical condition of the mother or baby for which a delivery is medically necessary (see definition on page 152).
- Labor begins spontaneously (without medical intervention) before the mother reaches 39 weeks of gestation.

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

- Scheduled for convenience and not for medical necessity or medical emergency affecting the mother or baby.
- Neither the mother nor baby have a medical condition for which immediate delivery is medically necessary.

Talk to your doctor about whether early delivery is for a medically necessary reason. For questions about this policy, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Services covered as preventive

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

- Screening for diabetes during pregnancy.
- HIV counseling and testing.
- Purchase of manual and electric breast pumps for pregnant and nursing women, plus supplies included with the initial purchase. Hospital-grade pumps are not covered.
- Use of low dose aspirin (81mg/day) after 12 weeks' gestation in women at high risk of preeclampsia. You must have a prescription from your provider and purchase from a network pharmacy to get the prescription drug at no cost; see "Products covered under the preventive care benefit" on page 79.

See page 55 for more prenatal, newborn, and well-baby services that are covered as preventive. See page 79 for coverage of prenatal vitamins.

Lactation (breastfeeding) counseling

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

Limitations on ultrasounds during pregnancy

The following limits do not apply to high-risk pregnancies. For example, a multiple pregnancy is considered high risk. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to learn what is covered for high-risk pregnancies.

Ultrasounds during pregnancy are covered as follows:

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

Adding a new dependent to your coverage

For information about how to enroll new dependents in your health plan, search in the *Employee Enrollment Guide* or the *Retiree Enrollment Guide* at **hca.wa.gov/employee-retiree-benefits/forms-and-publications**.

Office visits

The plan pays for office visits for covered conditions under the medical benefit (see page 151). Preventive care visits to preferred providers as described under "Preventive care" beginning on page 58 are covered in full and are not subject to the deductible.

Orthognathic surgery

Orthognathic surgery (see definition on page 155) must be preauthorized by the plan according to the plan's medical policy. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions. See page 66 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 patients have less pain, so they can return to normal activities, when possible.

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

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

Preauthorization is not required for post-procedural pain management in an inpatient setting; for example, to treat acute pain due to trauma, acute post-thoractomy pain, and acute postoperative pain.

Physical, occupational, speech, and neurodevelopmental therapy

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

- An acute injury or illness.
- Worsening or aggravation of a chronic injury.
- A congenital anomaly (such as cleft lip or palate).

- Conditions of developmental delay, including autism.

You must have a prescription for physical, occupational, speech, and neurodevelopmental therapy services from another covered provider type (see page 13), such as a physician.

Preauthorization is required for more than six visits per injury or episode of care for physical, occupational, or speech therapies.

Inpatient services

Preauthorization is required for inpatient admissions for physical, occupational, speech, and neurodevelopmental therapy services. The plan covers rehabilitation therapy services provided during inpatient hospitalization up to 60 visits combined per calendar year (see definition of "Limited benefit" on page 150). You must pay your coinsurance for inpatient services.

Outpatient services

The plan covers outpatient physical, occupational, speech, and neurodevelopmental therapy services up to 60 visits combined per calendar year, counting all types of therapies listed here (see definition of "Limited benefit" on page 150).

For the purposes of this benefit, developmental delay (see definition on page 146) means a significant lag in achieving skills such as:

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

Population Health Model

Population Health Model (PHM) provides support for members with acute, chronic, or complex needs to address the unique needs of members with major illness episodes or severe illness conditions at no charge to the member. PHM also includes:

- Maternity support.
- Behavioral health care management.
- Hospital readmission prevention.
- Preventive and clinical care reminders.
- Palliative care support.
- Emergency room overutilization.
- Tertiary care management.
- Enhanced inpatient management.
- International care support.
- Health.
- Wellness.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for more information.

Prescription drugs

Please see "Your prescription drug benefit" starting on page 71.

Preventive care

ALERT! This benefit covers **only** services that meet the criteria below. If you receive services during a preventive care visit that do not meet these requirements, 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 (see page 25).

Covered preventive care services are paid at the preventive rate. You do not have to meet your deductible before the plan pays the allowed amount for services covered under the preventive care benefit. When you see a network provider for these services, you pay nothing. If you see an out-of-network provider, you pay 40 percent of the allowed amount (see page 143), and the provider may balance bill you. If you do not have access to a network provider for preventive care services, see page 14 for how to request a network waiver.

For a list of services covered as preventive, see **healthcare.gov/preventive-care-benefits**. This site also features links to specific preventive services covered for women and children. 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 "Covered immunizations" on page 59.

Examples of services covered under the preventive care benefit include:

- Preventive visits such as well-baby care and annual physical exams.
- Preventive vision acuity screening from birth through 18 years of age.
- Intensive behavioral counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors.
- Screening for hepatitis B for pregnant women and non-pregnant adolescents and adults at high risk.
- Routine screenings for men and women.
- Certain radiology and lab tests such as screening mammograms (see page 52).
- Screening procedures such as colonoscopy (see page 40 for coverage of colonoscopy performed to diagnose or treat disease or illness).
- One-time screening by ultrasound for abdominal aortic aneurysm, for men ages 65-75 who have ever smoked.
- Immunizations as specified under "Covered immunizations" on page 59.
- Hearing tests as part of a newborn screening.
- Fluoride for prevention of dental decay when prescribed by primary care provider to children ages six months and older, and when water is fluoride deficient (see page 78 for coverage. See page 38 for coverage of fluoride varnish).
- Certain screening tests performed during pregnancy (see page 56 for more on prenatal care).
- Certain low to moderate dose of statin prescription drugs to adults ages 40 and over.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to ask if a medical service is covered as preventive. Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) for questions about preventive prescription drugs.

The following specific services for women are covered as preventive:

- Human Papillomavirus (HPV) testing for women ages 30 and over, once every three years.

- Chlamydia and gonorrhea testing in sexually active women ages 24 and younger, and for women ages 25 and older who are at increased risk for infection.
- Education and counseling regarding contraception.
- Counseling and screening for HIV, counseling and screening for interpersonal and domestic violence, and counseling for sexually transmitted infections.

For additional services covered as preventive for women, see "Family planning services" on page 43, "Mammograms" on page 52, and "Obstetric and newborn care" on page 54.

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

ALERT! Follow-up visits or tests as a result of your preventive care visit are not covered under the preventive care benefit. If the test or visit is normally covered by the plan and is medically necessary, the plan pays under the medical benefit (see definition on page 151).

Covered immunizations

The plan covers immunizations as included on the applicable immunization schedule (children, adolescents, adults) for U.S. residents by the Centers for Disease Control and Prevention (CDC). For a list of immunizations covered as preventive, visit **cdc.gov/vaccines/schedules/index.html** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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 the deductible. Covered immunizations given by the providers listed under "Where to get immunizations" on below are paid under the preventive care benefit. If you see an out-of-network provider for covered immunizations, you pay 40 percent of the allowed amount and may be balance billed.

TIP: Flu shots are covered as included on the applicable CDC immunization schedule. For a list of immunizations covered as preventive, find a link to the CDC immunization schedules at **regence.com/ump/pebb/benefits/prescriptions** or call 1-888-849-3681 (TRS: 711).

Where to get immunizations

Immunizations covered under the preventive care benefit are **covered at 100 percent** when received from a:

- Preferred provider.
- Network vaccination pharmacy (see page 75 and visit **regence.com/ump/pebb/benefits/prescriptions** or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) to find a pharmacy).
- Public health department.

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

Radiology

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

- Computed tomography (CT).
- Computed tomography angiography (CTA).
- Magnetic resonance imaging (MRI).
- Magnetic resonance angiography (MRA).
- Positron emission tomography (PET and PET-CT).
- Nuclear cardiology:
  - Myocardial perfusion imaging (MPI).
  - Blood pool imaging.
  - MUGA.
  - First pass ventriculography.
  - Infarct imaging.

Second opinions

This benefit covers:

- **Second opinions you choose to get.** The plan covers these under the medical benefit subject to the deductible and coinsurance.
- **Second opinions required by the plan.** The plan covers these at 100 percent (you do not pay toward your deductible or coinsurance). If you do not get a second opinion when required by the plan, coverage for services may be denied.
- **Expert Second Opinion (ESO) program.** You may be eligible to access the Expert Second Opinion (ESO) program for select services. Please contact UMP Customer Service at 1-888-849-3681 (TRS: 711) for a detailed list of services and criteria.

Skilled nursing facility

Skilled nursing facility services are paid at the inpatient rate. Services must be preauthorized by the plan before you are admitted to a skilled nursing facility (see page 86). In addition, the facility must notify the plan within 24 hours of your admission (see page 87).

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 (see definition on page 152).

When admitted into a skilled nursing facility that is primarily convalescent or custodial in nature, it is not covered.

Sleep therapy

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

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

Exception: the following supplies do not require a preauthorization:

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

Sleep therapy services performed at the following locations are not covered:

- Urgent-care facilities
- Inpatient hospitalization
- Emergency room services

Spinal and extremity manipulations

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

Visits that apply to your deductible also apply to your 10-visit limit (see "Limited benefit" on page 150).

Spinal injections

Some spinal injections must be preauthorized by the plan (see page 86 for how this works). The following therapeutic injections are covered for treatment of chronic pain:

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

See page 96 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. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for more information.

Spinal surgery

Preauthorization is required for inpatient and outpatient spinal surgery performed outside of the Centers of Excellence (COE) Program.

Spine Care–Centers of Excellence (COE) Program

The Centers of Excellence (COE) Program covers services related to spine care. The program includes, but is not limited to:

- An evaluation to determine if surgery is appropriate.
- Presurgical consultations.
- Travel costs (see "Travel benefits" on page 63).
- Hospitalization and surgery, if surgery is determined to be appropriate.
- Postsurgical check-ups.

For this program, patients work with Premera Blue Cross (Premera) — the administrator of the program — and the Centers of Excellence — Virginia Mason Medical Center and Capital Medical Center — to ensure that their treatment is consistent with established standards of medical care.

If you receive services related to spine care that are not covered under the COE Program, you will pay your normal UMP cost-share, depending on the services received and the network status of the provider(s). This may be a deductible (see page 19), coinsurance (see page 20), or amounts not covered by the plan. Services billed to the plan outside of the COE Program are subject to the plan's preauthorization requirements.

COE for spine care: Virginia Mason and Capital Medical Center

Virginia Mason and Capital Medical Center are the two providers approved to perform spine care evaluations and surgeries under the COE Program. These facilities have proven that they provide high-quality spine care at predictable costs, using the most up-to-date medical guidelines and services.

Who is eligible to participate in the COE Program?

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

- A member enrolled in UMP Classic or UMP CDHP.
- Not enrolled in Medicare as your primary coverage.
- Age 18 or older.

Virginia Mason or Capital Medical Center must determine if surgery for spine care is appropriate based on established medical guidelines. You may find these guidelines at **breecollaborative.org/wp-content/uploads/4.Lumbar-Fusion-Bundle.pdf**.

How to apply for the COE Program

- Self-refer by calling Premera at 1-855-784-4563 (TRS: 711).
- Ask your regular provider to refer you.

You may receive information in the mail about the COE Program, which will explain how the program works and whom to contact for more information.

After applying:

- Premera screens applicants to initially determine whether they are eligible to be considered for the COE Program.
- Based upon the COE selected by the participant, Premera refers eligible applicants to Virginia Mason or Capital Medical Center for further assessment.

- Virginia Mason or Capital Medical Center will review medical records of eligible applicants and perform a full evaluation to determine if they are medically appropriate for surgery under the COE Program.
- If you are approved for surgery, Virginia Mason or Capital Medical Center will provide you with a list of surgeons to choose from at their respective facilities.

Note: You may be required to follow a plan Virginia Mason or Capital Medical Center gives you as a condition of approval for surgery, such as a plan for weight loss or tobacco cessation.

What happens after you're approved to participate in the program

Premera will provide a booklet describing your journey through the program. Premera will assign a dedicated case manager who will walk you through each step of the process.

Travel benefits

Members having surgery under the COE Program may qualify for assistance with travel and lodging expenses. These expenses may include partial coverage by Premera for mileage, flights, parking, and lodging.

To be covered by the program, **all travel must be arranged through Premera**. This travel may be arranged by calling Premera at 1-855-784-4563 (TRS: 711).

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

TIP: Reimbursement for travel expenses is based on cost or current IRS rates for medical expenses, whichever is less, and may not cover all of your costs. For a link to the IRS rates, visit **irs.gov/tax-professionals/standard-mileage-rates**.

You may be partially reimbursed for expenses related to:

- Mileage for driving within Washington. To qualify for reimbursement for mileage, members must live at least 60 driving miles from Virginia Mason, located at 1100 9th Ave, Seattle, WA 98101, or Capital Medical Center, located at 3900 Capital Mall Drive SW, Olympia, WA 98502.
- Flights departing from and arriving at airports within Washington or Portland International Airport. You must depart from the airport closest to your residence.
- Ground transportation from Seattle-Tacoma International Airport to Virginia Mason or Capital Medical Center.
- Lodging expenses (excluding meals) at a COE designated hotel. Premera must arrange all lodging.
- Parking at Virginia Mason or Capital Medical Center and parking at your departing airport.

What is included in the COE Program

Premera will help you understand how the COE Program works, what is covered and what is not, connect you with Virginia Mason or Capital Medical Center providers, and work to resolve any questions or issues you may have.

In general, all eligible expenses associated with a spine care evaluation and a spine care surgery (if determined surgically appropriate) under the COE Program are covered. If surgery is recommended, this includes expenses from the day you arrive for your pre-operative visit through discharge, including your:

- Assessment(s).
- Surgery.

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

What is not included in the COE Program

If you receive spine care services outside of the COE Program, or choose to receive services at Virginia Mason or Capital Medical Center that are not related to your spine care evaluation or surgery, covered services will be processed at the standard rate.

The following services are **not** included in the COE Program (but may be covered by other plan benefits):

- Care received as part of the plan Virginia Mason or Capital Medical Center gives you as a condition of program approval, regardless of where you receive care. Examples of plan requirements include tobacco cessation and weight loss programs.
- Physical therapy that is not provided during your hospitalization.
- Follow-up care other than the initial postsurgical checkup at Virginia Mason or Capital Medical Center. An example of follow-up care is a visit with your regular doctor.
- Prescription drugs received from a pharmacy upon discharge from the hospital.
- Convenience items, such as a personal phone.

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions about services not included in the COE Program.

What happens if you do not qualify for the program

If the COE Program determines you are not an appropriate candidate for spine care surgery, but you wish to have the surgery anyway, you may choose a provider other than Virginia Mason or Capital Medical Center for your spine care. Services received outside the COE Program are processed according to the plan's medical policies, benefit structure, and the network status of your provider.

Appeals related to the COE Program

TIP: Appeal deadlines and other rules remain the same. See page 107 for details of how appeals work.

UMP members may appeal denials made by Premera. Appeals must be submitted to Premera. Decisions made by your Virginia Mason or Capital Medical Center provider(s) regarding your medical appropriateness for surgery are not made by the plan or Premera and are therefore not appealable to the plan or Premera.

An appeal for services related to the COE Program must be submitted within 180 days of denial to Premera via fax at 1-800-995-2430 (secure inbound fax) or to the address below (and not to Regence):

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

Substance use disorder treatment

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

Non-emergency inpatient services for substance use disorder treatment must be preauthorized by the plan (see page 86 for details). Contact UMP Customer Service at 1-888-849-3681 (TRS: 711) about preauthorization requirements. To be covered, residential treatment programs must be licensed to provide residential treatment solely to persons requiring residential substance use disorder treatment or to persons diagnosed with a mental health condition requiring residential treatment. See page 53 for more information on inpatient mental health treatment.

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

- Detoxification.
- Inpatient admission, including to a residential treatment facility.
- Intensive Outpatient Program (IOP).
- Partial Hospitalization Program (PHP).

Inpatient

ALERT! Your provider must notify the plan upon admission when you receive inpatient services for substance use disorder treatment. Inpatient substance use disorder services for which the plan is not notified may not be covered. Inpatient treatment is subject to clinical review (see definition on page 145).

Services are considered "inpatient" when you are admitted to a facility. Professional services (for example, doctors or lab tests) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see definition on page 151).

Outpatient

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

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

- The purpose of the service is to treat or diagnose a medical condition;
- Outpatient services are the appropriate level of services considering the potential benefits of the services;
- The level of service is known to be effective in improving health outcomes; and
- The level of service recommended for your condition is cost-effective compared to alternative interventions including no intervention. See the definition of "Medically necessary services, supplies, drugs, or interventions" on page 152.

Surgery

The plan pays for covered surgical services according to the network status of the provider (see page 13). 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. See the list of services that require preauthorization at **regence.com/ump/pebb/benefits/policies**. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions.

The plan covers the following services as outpatient:

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

ALERT! All surgeries must follow the plan's coverage rules. We recommend that you call UMP Customer Service at 1-888-849-3681 (TRS: 711) before any procedure to ask if it is covered or requires preauthorization.

Temporomandibular joint (TMJ) treatment

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

Tobacco cessation services

ALERT! If you get nicotine replacement therapy or prescription drugs for tobacco cessation at a non-network pharmacy, or purchase at a cash register other than the pharmacy counter, and submit a claim, you may not receive full reimbursement from the plan. See page 75 for how to locate a network pharmacy.

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

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

Nicotine replacement therapy

The plan covers only certain nicotine replacement therapy products (such as gum, patches, sprays, inhalers, tablets, or lozenges) as preventive (at no cost to you). Those that are preventive are listed with "PV" in the Tier column on the UMP Preferred Drug List. Over-the-counter drugs are normally not covered by the plan, but nicotine replacement products are covered when they are purchased at a network pharmacy using your UMP member ID card.

You may get nicotine replacement therapy directly from the Quit for Life program (see "Quit for Life program" on page 67), or by following these steps:

- Get a prescription from your provider.
- Take the prescription to a network pharmacy.
- Make your purchase at the pharmacy counter of a network pharmacy. Give your prescription and your UMP member ID card to the pharmacist. The purchase must be submitted through the prescription drug system to be covered.

If you get a nicotine replacement therapy product not designated as preventive, it will not be covered by the plan and you will pay the full cost. To request full coverage of non-preventive nicotine replacement therapy for a medical reason, see "How to request an exception" on page 67.

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

Counseling

The plan covers in-person counseling related to tobacco cessation at the preventive rate (see page 25) when you see a preferred or participating provider.

Phone or online counseling is covered only through the Quit for Life program described on page 67. UMP members ages 17 and under may use the Smokefree Teen program as explained below.

How to request an exception

To request coverage of a prescription drug or nicotine replacement therapy not usually covered under this benefit, see "Preauthorizing drugs" on page 81 for how to request an exception. If your exception is approved, you will receive the approved product or prescription drug at no cost.

Quit for Life program

TIP: UMP members ages 17 and under may access similar support services through the Smokefree Teen program at **teen.smokefree.gov** or by calling 1-800-QUIT-NOW (784-8669).

UMP members ages 18 and older may participate in the Quit for Life tobacco cessation program. This program offers phone counseling, medications, and other tools and resources. To learn more, visit **quitnow.net** or call 1-877-719-9004.

If you get nicotine replacement therapy or prescription drugs for tobacco cessation that are not designated as preventive on the UMP Preferred Drug List ("PV" in the Tier column), you will pay as described above.

For nicotine replacement therapy, you may get supplies sent to you from Quit for Life or get a prescription from your provider and purchase as described under "Nicotine replacement therapy" above.

ALERT! You may attest for an exemption to the PEBB tobacco use premium surcharge if you or a dependent are tobacco-free for two months, enroll in Quit for Life (for members ages 18 and over), or access the information and resources aimed at teens in Smokefree Teen (for members ages 13 through 17). Visit the PEBB Program website at **hca.wa.gov/erb** for details about the surcharge.

Transgender services

The following services associated with a diagnosis of gender dysphoria are covered at the standard rate for outpatient services and at the inpatient rate for inpatient services.

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

This is not a complete list of medical and surgical treatments of gender dysphoria in transgender individuals. For more information on transgender services, please visit **regence.com/ump/pebb/benefits/policies** to find a link to the clinical criteria for transgender services. Some services and prescription drugs associated with gender dysphoria may require preauthorization.

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 for the standard rate the donor's covered expenses as primary, regardless of any other coverage the donor may have. Covered donor expenses include costs to remove the donor's organ and treat complications directly resulting from the donor's surgery.

Urgent care

See "Emergency room" on page 43 for care during a medical emergency (definition on page 151).

- 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. These services are paid at the standard rate, according to the provider's network status. Visit **regence.com/ump/pebb/finding-doctors** to find preferred urgent care facilities.

Virtual care

Doctor On Demand

Doctor On Demand is a virtual care service that gives you access to providers 24 hours a day, seven 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 website or Doctor On Demand smartphone application.

Providers review a patient's history and symptoms, perform an exam, and recommend treatment, which may include prescription drugs, and lab work. Doctor On Demand providers can treat most common health conditions, including:

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

A Doctor On Demand virtual care appointment is paid at the standard rate. 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, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Telemedicine services

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

"Store and forward technology" is a term used for the transfer of a covered person'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 patient. It does not include the use of audio-only telephone, 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 health care service is medically necessary;
- The health care 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 health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and
- The health care 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.

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

- Community mental health centers.
- Federally qualified health centers.
- Home or any location determined by the individual receiving the service.
- Hospitals.
- Rural health clinics.
- Physician's or other health care provider's offices.
- Renal dialysis centers (except independent renal dialysis centers).
- Skilled nursing facilities.

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

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

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

- Audio-only telephone, email or fax transmissions between doctor and patient.
- 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 person 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.

Vision care (diseases and disorders of the eye)

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

Following cataract surgery, vision hardware (contact lenses or eyeglasses, including frames and prescription lenses) is covered as durable medical equipment (see page 41). These services are paid at the standard rate.

Vision exams (routine)

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

The plan pays the preventive rate for one routine eye exam for each member per calendar year.

Vision hardware (eyeglasses and contact lenses)

TIP for members who are enrolled in another health plan (medical or vision): If your primary plan pays for vision hardware and you submit a claim to UMP as your secondary plan, UMP will only pay the difference between the amount the primary plan paid and the amount UMP would have paid if it were the primary plan.

Adults (over age 18)

The plan pays a special rate for vision hardware. It pays up to $150 every two calendar years for prescription eyeglass lenses, frames, and contact lenses, including repairs; you do not need to meet your medical deductible. This $150 limit is renewed on January 1 of even years (2020, 2022, etc.). Any unused amount does not carry over into the next even plan year. The plan will not pay more than your actual cost for these items and services. You are responsible for any costs above the $150 limit.

Note: See "Vision care (diseases and disorders of the eye)" on page 70 for vision hardware coverage following cataract surgery.

You may buy your vision hardware anywhere. The maximum benefit of $150 applies no matter where you shop. If you go to a provider that does not bill the plan directly, you may submit a claim for glasses or contacts; see "Billing & payment: filing a claim" starting on page 102 for instructions.

Children ages 18 and under

The plan pays a special rate for vision hardware (eyeglasses: frames and lenses; contact lenses) for children ages 18 and under.

The plan will cover one hardware benefit per calendar year, not subject to the medical deductible, for children ages 18 and under as follows:

- Eyeglasses: The plan pays 100 percent of the allowed amount for one pair of standard frames plus lenses (including high-index); or,
- Contact lenses: The plan pays 100 percent of the allowed amount for a one-year supply of contact lenses instead of eyeglasses.

Note: The only other feature covered under this benefit is scratch-resistant coating. You will pay for any other additional features, such as but not limited to anti-reflective coating or tints.

Your prescription drug benefit

See the Directory on page 3 for prescription drug contact information.

Your plan's prescription drug benefit is managed by a partnership of companies known as Washington State Rx Services (WSRxS). These companies are:

- **Moda Health** — Administration (including preauthorization and appeals) and customer service.
- **MedImpact Healthcare Systems Inc.** — Pharmacy network management and prescription drug claims processing.
- **Postal Prescription Services** (PPS) — Network mail-order pharmacy.
- **Ardon Health** — Network specialty drug pharmacy.

When you have questions about your prescription drug coverage or need help finding a network vaccination pharmacy, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711). Contact the mail-order or specialty pharmacy directly for help placing or tracking prescription orders.

Note: Regence BlueShield does not provide prescription drug benefits for UMP. Always contact WSRxS with questions about your prescription drug coverage.

TIP: The UMP Preferred Drug List is available at **regence.com/ump/pebb/benefits/prescriptions**. You may also check prescription drug prices online with the Drug Price Check tool (the prices for drugs listed in this tool assume you have met your deductible).

The UMP Preferred Drug List

ALERT! Not all prescription drugs are listed on the UMP Preferred Drug List. If your prescription drug is not listed, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

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

- If a prescription drug is covered by the plan.
- How much you will pay for a prescription drug.
- If the prescription drug must be preauthorized (see page 81).
- If the prescription drug must be purchased from the plan's specialty pharmacy, Ardon Health (see page 82).
- If there are any limits on a prescription drug's coverage (see page 80).
- If there are less expensive alternatives.

The UMP Preferred Drug List is updated online throughout the year, and may change how a prescription drug is covered at any time. You may look up your prescription drugs online at **regence.com/ump/pebb/benefits/prescriptions** or by calling WSRxS New brand-name prescription drugs may not be covered during the first 180 days they are available. To check if a new prescription drug is covered, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Preferred drugs. Preferred drugs, including specialty preferred prescription drugs, have been reviewed by the Washington State Pharmacy and Therapeutics (P&T) Committee or by WSRxS and found to be safe and clinically effective when compared to other drugs in the same therapeutic class or category. These drugs have been found by WSRxS to be among the most cost-effective drugs for their therapeutic class or category due to their favorable pricing.

Noncovered prescription drugs. Noncovered prescription drugs are excluded unless a Preferred Drug List exception is requested and approved. These prescription drugs are not designated as preferred or nonpreferred. These prescription drugs have been reviewed by WSRxS, and they are not as cost-effective and do not have a clinically significant therapeutic advantage over the Preferred Drug List alternative(s). If you need to request an exception for a noncovered drugs, see section "Requesting an exception for noncovered drugs" on page 73. For information on how to receive discounts on noncovered prescription drugs, see "Use network pharmacies and show your UMP member ID card to get the plan discount" on page 76.

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

Who decides which prescription drugs are preferred?

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

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

For the plan to cover a prescription drug for you, it must be medically necessary (see page 152) for your health condition. Your provider may prescribe a drug or drug dosage that does not meet the plan's definition of medically necessary.

ALERT! A prescription drug may be designated as noncovered even if no generic equivalent is available. See page 73 for how you may request an exception.

What you pay for prescription drugs

ALERT! Hospice care: See page 47 for special prescription drug coverage while in hospice.

Until you meet your deductible (see page 19), you will pay the entire cost of your medical services and prescription drugs. Once you have met your combined (medical and prescription) deductible for the year,

you pay 15 percent of the drug's cost for covered prescription drugs when purchased through a network pharmacy up to your out-of-pocket limit. Once you reach your combined (medical and prescription) out-of-pocket limit, the plan pays 100 percent of covered prescription drugs at a network pharmacy. You may get up to a 90-day supply for most prescription drugs (except for specialty drugs; see page 82). For prescription drugs covered as preventive (see page 79), you do not pay the deductible or coinsurance when you use a network pharmacy.

If a prescription drug is not covered by the plan, it does not apply to your deductible or your out-of-pocket limit.

Note: You may use your HSA to pay for many prescription drugs not covered by the plan; see "Health savings account (HSA)" on page 21 for more information.

ALERT! When you use network pharmacies, retail or mail-order, you pay based on the prescription drug's allowed amount, a discounted price negotiated for the plan. If you use a non-network pharmacy of any type, the pharmacy may charge more than the allowed amount. You will have to pay this amount, which does not apply to your deductible or out-of-pocket limit and is not payable by the plan.

Note: Prescriptions ordered through mail-order pharmacies other than PPS or located outside the U.S. are not covered, even if you send in a claim.

Requesting an exception for noncovered drugs

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

If you are prescribed a noncovered drug, and you have tried all the alternative drugs and none are found to be effective, or if the alternatives are found to be not medically appropriate, you or your prescriber can request an exception by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Your prescriber can also use CoverMyMeds to request an exception. CoverMyMeds is a free online platform that accepts exception requests from electronic health record systems or directly through the CoverMyMeds portal. To get started, have your provider visit **covermymeds.com**.

Your prescribing provider must submit clinical information to request preauthorization of an exception. When an exception is approved by the plan based on the criteria below, you pay 15 percent of the drug's cost after you pay your deductible per 30-day supply.

If your exception request is denied, the plan's response letter will list every prescription drug that must be tried before you request another exception.

Preferred drug list exceptions and coverage determinations must be based on medical necessity. Because requesting a noncovered drug exception requires medical information, only your prescribing provider may submit the request. The prescribing provider will need to provide WSRxS with the following information:

- The prescribing provider's contact information;
- An explanation of why an exception should be granted;
- An explanation of how the requested medication therapy is evidence-based and generally accepted medical practice;

- Documentation of medical necessity for the requested prescription drug over all other preferred products; and
- At least one of the following items must also be included with the exception request:
  - Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives were tried for a clinically appropriate duration of treatment and failed to produce a therapeutic response. If the requested exception is for a brand-name prescription drug that has an FDA-approved generic equivalent, your prescribing provider must document your inadequate response to at least five manufacturers of the generic drug, or to all manufacturers of generic drug if there are fewer than five manufacturers, in addition to all other preferred therapeutic alternatives, before an exception is granted; **or**
  - Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives, including the required number of manufacturers of the same generic prescription drug, caused an adverse drug reaction that prevents you from taking the prescription drug as directed. If the requested exception is for a brand-name prescription drug that has an FDA-approved generic equivalent, your prescribing provider must document your adverse drug reaction to at least five manufacturers of the generic drug, or to all manufacturers of the generic drug if there are fewer than five manufacturers, in addition to all other preferred therapeutic alternatives, before an exception is granted.

ALERT! The exception process for noncovered drugs cannot be used for drugs that are excluded by UMP. For more information about drugs UMP does not cover, see page 85.

If you have other prescription drug coverage

If you have primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on page 102 will apply when UMP pays secondary to another plan. See "Submitting a claim for prescription drugs" beginning on page 104 for how to submit your prescription drug claim.

Note: UMP will not pay for noncovered drugs when UMP is secondary.

Using network pharmacies when UMP is secondary

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

Using mail-order pharmacies when UMP is secondary

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

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail-order pharmacy, then submit a paper claim for payment by UMP. See "Submitting a claim for prescription drugs" beginning on page 104 for how to do this.

Where to buy your prescription drugs

ALERT! If you use a non-network retail pharmacy, you will pay the entire cost of the prescription drug at the time of purchase and must submit a claim for reimbursement. However, only the allowed amount for covered drugs (see page 144) will apply to your deductible or out-of-pocket limit.

Pharmacies are contracted through a different network than medical providers. See pages 75–76 for how to confirm a pharmacy is in the plan's network.

Retail pharmacies

You may use any retail pharmacy, but you will save money if you use a network pharmacy. WSRxS has a large national network of retail pharmacies, which includes many independent and regional pharmacies in Washington State as well as national chains. Search for a network pharmacy at **regence.com/ump/pebb/benefits/prescriptions** or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

When you get your prescriptions at a network pharmacy, the pharmacy sends the claim to the plan for you, and you pay only your cost-share (coinsurance and deductible) as described on page 72.

Note: You will pay the entire cost for any prescription drug not covered by the plan, which will not apply toward your deductible or your out-of-pocket limit.

Many network retail pharmacies have vaccination pharmacists who may administer covered preventive immunizations at no cost to you. Find the list of network vaccination pharmacies (see definition on page 154), at **regence.com/ump/pebb/benefits/prescriptions**, or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

TIP: If you regularly purchase between an 84- and 90-day supply of a prescription drug, you may be able to save money by using a Choice 90 network pharmacy or PPS mail-order pharmacy. Search for a network pharmacy at **regence.com/ump/pebb/benefits/prescriptions** to find a Choice90 network pharmacy and compare prices.

Mail-order pharmacy

ALERT! PPS cannot ship outside of the U.S. See "Travel overrides for prescription drugs" on page 84 if you will be traveling.

Postal Prescription Services (PPS) is the plan's **only** network mail-order pharmacy. Prescriptions purchased through other mail order pharmacies are not covered if UMP is your primary plan. You may call PPS at 1-800-552-6694 or WSRxS Customer Service at 1-888-361-1611 (TRS: 711) for more information about mail order. To get started:

- Set up an account with PPS by going to **ppsrx.com** or calling PPS at the phone number listed above.
- Mail your prescription to PPS. Your provider may also electronically send or fax your prescription to PPS at 1-800-723-9023. Prescriptions faxed to PPS must:
  - Be faxed from the provider's office fax machine;
  - Be on the provider's letterhead; and
  - Include the patient's name, address, phone number, member ID number, and date of birth.

Note: Only a provider may fax in a prescription. You must follow these instructions to avoid a delay in filling your prescription.

ALERT! The plan does not cover other mail order pharmacies outside of PPS if UMP is your primary insurance. If UMP is your secondary insurance, you may use another mail order pharmacy.

Refills may be ordered through your online pharmacy account at **ppsrx.com**, or by calling PPS directly. Prescriptions are usually delivered within seven to 10 days after the pharmacy receives your prescription.

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

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

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

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

Use network pharmacies and show your UMP member ID card to get the plan discount

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

If UMP is your primary insurance coverage, always show your UMP member ID card at the pharmacy to make sure you pay the right amount for your prescription. If UMP is your secondary insurance coverage, show both plan member ID cards at the pharmacy and make sure they know which plan pays first so the pharmacy may bill the plans in the correct order. If UMP does not cover your prescription, and you have a Washington Prescription Drug Program (WPDP) Discount Card or another prescription discount card, show that card at the pharmacy to see if you can get a discount on prescriptions UMP does not cover.

If you are a Washington State resident and have a prescription the plan does not cover, such as noncovered drugs, you may be able to get a discount with the WPDP Discount Card. All Washington State residents are eligible for a card and joining the discount card program is free. The WPDP Discount Card:

- Cannot be combined with UMP or Medicare pharmacy benefits. If UMP or Medicare covers the prescription, you cannot use the card to get a discount.
- Cannot be used to cover any out-of-pocket payment, like coinsurance, for prescriptions.
- Does not cover prescription drugs prescribed to animals.

To learn more about the WPDP Discount Card, including how to enroll, visit **hca.wa.gov/pdp**.

Non-network pharmacies — retail

ALERT! The plan does not cover prescription drugs ordered through non-network or non-U.S. mail-order pharmacies.

You will always save money when you buy your prescriptions at network retail pharmacies. You may buy your prescriptions (except specialty drugs) at a non-network retail pharmacy, but you'll pay more if you do. If you get your prescriptions filled at a non-network pharmacy —the following applies:

- You need to submit your claim to WSRxS for reimbursement (see "Submitting a claim for prescription drugs" starting on page 104).
- You do not get the plan discount.
- You'll pay the difference between the allowed amount (see page 144) and what the pharmacy charges, and it will not apply to your deductible or out-of-pocket limit.
- The plan pays the allowed amount for prescription drugs covered by the plan, whether from a network or non-network retail pharmacy, under the coinsurance percentages as shown on page 72.
- Prescription drugs filled at a non-network pharmacy do not apply to the combined (medical and prescription) out-of-pocket limit.
- Non-network pharmacies will not know if a prescription drug must be preauthorized, has a quantity limit, or has other coverage limits. If you purchase a drug from a non-network pharmacy and limits apply, the plan may not cover or reimburse it.
- Specialty drugs purchased anywhere but through Ardon Health are not covered (see "Specialty drugs" on page 82), unless noted on the UMP Preferred Drug List. If Ardon Health does not have access to a specialty drug, you will be notified to fill your prescription at another network specialty pharmacy. If Ardon Health gains access to the specialty drug, you will receive notification to transfer your prescription to Ardon Health.

TIP: To submit claims for prescriptions purchased from non-network pharmacies (U.S. retail pharmacies, or international retail pharmacies), see "Submitting a claim for prescription drugs" on page 104.

Prescription drugs purchased outside the U.S.

If you purchase prescription drugs outside the U.S. for any reason, the following rules apply:

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

To submit a claim for a prescription drug purchased at retail pharmacies outside the U.S., see "Submitting a claim for prescription drugs" beginning on page 104. All necessary information must be included on the prescription drug claim form with drugs and dosage documented.

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

Guidelines for prescription drugs UMP covers

The plan is a self-insured PPO health plan offered through the Washington State Health Care Authority's PEBB Program and administered by Regence BlueShield and WSRxS. All prescription drugs, services, or other benefit changes may require approval by the PEB Board at the time benefits are procured for the next calendar year. For example, prescription drugs newly approved by the FDA may require approval by the PEB Board before they will be covered by the Plan.

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

- Has been reviewed by either the Washington State P&T Committee or WSRxS (see page 72), and has been placed on the UMP Preferred Drug List.
- Is not listed as noncovered or excluded on the UMP Preferred Drug List.
- Is medically necessary (see definition on page 152).
- Does not have a nonprescription alternative (see definition on page 155), including an over-the-counter alternative with similar safety, efficacy, and ingredients (see page 83).
- Has been dispensed from a licensed pharmacy employing licensed, registered pharmacists.
- Has been prescribed by a provider with prescribing authority within their scope of license.
- Is approved by the FDA.
- Is not classified as a vitamin (except as listed below), mineral, dietary supplement, homeopathic drug, or medical food.
- May be legally obtained in the U.S. only with a written prescription.
- Meets plan coverage criteria.

The plan may require that you try standard treatment(s) before it will cover a prescription drug for off-label use (prescribed for a use other than its FDA-approved label).

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

Exceptions covered

ALERT! The plan does not cover prescriptions that contain DHA (docosahexaenoic acid). DHA is a dietary supplement, and dietary supplements are not covered by the plan.

If you have a noncovered prescription drug not listed on the Preferred Drug List, you may request an exception. For the exception process, please refer to "Requesting an exception for noncovered drugs" on page 73.

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

- Certain nicotine replacement therapy products (see page 66).

- Covered contraceptive devices and drugs (see page 43).
- FDA approved over-the-counter contraceptives. For the plan to cover FDA-approved over-the-counter contraceptives, you must present your UMP member ID card and make your purchase at the pharmacy counter. When possible, get a prescription, as not all pharmacies have prescribing authority. If you go to a pharmacy without a prescription and the pharmacy does not have prescribing authority, you will need to submit a claim to WSRxS.
- Insulin and diabetes supplies such as test strips, lancets, and insulin syringes used in the treatment of diabetes. See "Diabetes care supplies" on page 39 for more information.
- Low-dose aspirin for pregnant women (see page 55).
- Other over-the-counter products that are specifically noted in the UMP Preferred Drug List as covered by the plan.
- Select generic over-the-counter prenatal vitamins without DHA for women of childbearing age.

The plan covers FDA-approved prescription drugs used for off-label use (prescribed for a use other than its FDA-approved label) only if it is not considered experimental or investigational by WSRxS and is recognized as effective for treatment:

- In a standard reference compendium (defined on page 161) as supported by peer-reviewed clinical evidence; or
- In most relevant peer-reviewed medical literature (defined on page 156), if not recognized in a standard reference compendium; or
- By the federal Secretary of Health and Human Services.

Products covered under the preventive care benefit

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

Some products are covered under the preventive care benefit, if they:

- Are recommended by the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (see page 59); and
- Conform to coverage guidelines (see page 78).

The brands and types of products covered are limited. Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) for more information on which ones are covered. You pay nothing if your provider writes you a prescription and you purchase these products from the pharmacy counter at a network pharmacy. If you purchase over-the-counter and send in a paper claim, you may pay part of the cost.

Contraceptive drugs and supplies are covered as preventive (see "Family planning services" on page 43 for details). See "Tobacco cessation services" on page 66 for products covered as preventive for tobacco cessation.

Some injectable drugs are covered only under the prescription drug benefit

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

- Prescription growth hormones.
- Prescription drugs to treat hepatitis C.
- Self-administered prescription drugs for rheumatoid-arthritis and multiple sclerosis.
- Self-administered prescription drugs.

Your pharmacy may submit a claim for these prescription drug classes to WSRxS.

A prescription drug may be approved for use for another condition but is still available only through the prescription drug benefit. Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) if you have questions.

Compounded prescription drugs

Compounded prescription drugs are the result of combining, mixing, or altering of ingredients by a pharmacist in response to a physician's prescription to create a new drug tailored to the specialized medical needs of an individual patient. Traditional compounding typically occurs when an FDA-approved prescription drug is unavailable, or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs. Compounded drugs costing more than $150 require preauthorization. Claims for compounded drugs require additional information submitted on the claim form. This information is available from the compounding pharmacy.

Limits on your prescription drug coverage

WSRxS may exclude, not cover, discontinue, or limit coverage for any prescription drug, or manufacturer's version of a drug for any of the following reasons:

- A more cost-effective alternative is available to treat the same condition.
- A nonprescription alternative (see definition on page 155), including an over-the-counter alternative (see definition on page 156), becomes available.
- A prescription drug is found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
- A prescription drug receives FDA approval for a new use.
- Generic, biosimilar, interchangeable biosimilar, or follow-on biologic prescription drugs become available.
- New prescription drugs are developed.
- The Washington State P&T Committee or WSRxS recommends a change (see page 72).
- The FDA denies, withdraws, or limits the approval of a product.
- There is a sound medical reason.
- There is lack of scientific evidence a prescription drug is as safe and effective as existing drugs used to treat the same or similar conditions.
- There is new scientific evidence demonstrating a prescription drug has been found to be less safe or effective than existing drugs to treat the same or similar conditions.

- Using free prescription drug samples does not guarantee coverage or waive requirements for preauthorization, step therapy, quantity limits, day supply limits or other limitations.

For approval, the prescription drug must be covered by the plan, be a covered prescription drug on the UMP Preferred Drug List, and be medically necessary for your health condition. Your provider may prescribe a prescription drug or drug dose that is not medically necessary (see definition on page 152).

Experimental or investigational (see page 147) prescription drugs are excluded by the plan. You may be liable for all charges if you receive services that are determined to be experimental or investigational (see "What the plan does not cover" section on pages 89–97). If you disagree with the plan's determination you have the right to an appeal; see page 106 for that process.

The limits and restrictions described from "Limits on your prescription drug coverage" on page 80 through "Refill too soon" on page 84 helps WSRxS monitor drug usage, safety, and costs. These limits and restrictions may be added or removed from prescription drugs at any time. You may find out if your prescription drug falls under any of these limits and restrictions by checking the UMP Preferred Drug List or calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Risk Evaluation and Mitigation Strategies (REMS) program

A Risk Evaluation and Mitigation Strategy (REMS) is a drug safety program that the FDA can require for certain prescription drugs with serious safety concerns to help ensure the benefits of the drug outweigh its risks. REMS are designed to reinforce medication use behaviors and actions that support the safe use of that medication. While all drugs have labeling that informs health care stakeholders about possible risks, only a few prescription drugs require a REMS. REMS are not designed to mitigate all the adverse events of a medication; these are communicated to health care providers in the medication's prescribing information. Rather, REMS focuses on preventing, monitoring and/or managing a specific serious risk by informing, educating and/or reinforcing actions to reduce the frequency and/or severity of the event.

If the REMS program is not followed, the plan may not cover the restricted drug.

Preauthorizing drugs

Preauthorization is a process that helps ensure that prescription drug benefits are administered as designed and that plan members receive a drug therapy that is safe and effective for their conditions, and provides the greatest value. Some prescription drugs require preauthorization to determine whether they are medically necessary and meet criteria, or the plan will not cover them. You may find out if your prescription drug requires preauthorization by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711) or checking the UMP Preferred Drug List at **regence.com/ump/pebb/benefits/prescriptions**. You and your prescribing provider may also find the coverage criteria for your prescription drug by referring to the *Washington State Rx Services (Moda) preauthorization (UMP Plans) preauthorization requirements* at **hca.wa.gov/ump-forms-pubs**.

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

- Certain injectable drugs when purchased through a retail or network mail-order pharmacy.
- Compounded drugs.

If your prescription drug requires preauthorization, your pharmacist or prescribing provider may initiate a request through CoverMyMeds, a free online platform that accepts requests from electronic health records or directly through the CoverMyMeds Portal. To get started, your pharmacist or prescribing provider can go to **covermymeds.com**. They may also call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) to request it.

If you have an existing authorization from UMP for a brand name drug and a generic drug becomes available, you may need to renew your authorization to continue filling the brand drug. However, if you switch to the generic drug, a new preauthorization is not required until the existing authorization expires.

Note: Prescription drugs covered under the medical benefit rather than the prescription drug benefit have different rules for preauthorization. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for details.

Emergency fill

Emergency fill lets you get a limited quantity of certain prescription drugs while the plan processes your preauthorization request. This option is only available when a delay could result in emergency care, hospital admission, or a serious threat to your health or others in contact with you.

A list of emergency prescription drugs is available at **regence.com/ump/pebb/benefits/prescriptions** or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

You must bring your prescription to a network pharmacy and state that you need an emergency fill while the plan processes your preauthorization request. You pay your 15 percent coinsurance after you pay your combined deductible.

The plan will cover an emergency fill of up to a seven-day prescription drug supply; preauthorization requests are usually resolved within three to five business days.

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

Emergency fill limits

The following limits still apply to emergency fill prescription drugs:

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

Quantity limits

Certain prescription drugs have a per prescription limit on how much you get for each fill. If you need more than this limit allows, your pharmacist or prescribing provider may initiate a request through CoverMyMeds at **covermymeds.com** or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

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

Specialty drugs

ALERT! Ardon Health, the plan's network specialty pharmacy, cannot ship outside the U.S. See "Travel overrides for prescription drugs" on page 84 if you will be traveling.

Specialty drugs are high-cost injectable, infused, oral, or inhaled prescription drugs or products that require special handling and storage and are subject to additional rules. You may find out if a drug is a specialty drug by checking the UMP Preferred Drug List at **regence.com/ump/pebb/benefits/prescriptions**, or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Specialty drugs are covered only when purchased through the plan's network specialty drug pharmacy, Ardon Health, (1-855-425-4085 Monday through Friday, 8 a.m. to 7 p.m., or Saturday 8 a.m. to 12 p.m. (Pacific)). If Ardon Health does not have access to a specialty drug, you will be notified to fill your prescription at another network specialty pharmacy. If Ardon Health gains access to the specialty drug, you will receive notification to transfer your prescription to Ardon Health.

You may receive **up to** a 30-day supply for most specialty prescription drugs per prescription or refill. However, some may be limited to a 15-day supply due to high discontinuation rate, short duration of use, or to ensure that the prescription drug is not causing harmful side effects.

Specialty drugs require preauthorization. See "Preauthorizing drugs" on page 81 for how to request preauthorization. A patient care coordinator will work with you to schedule a delivery time for the prescription drug. The specialty pharmacy will deliver your prescription drugs anywhere in the U.S. that you choose, such as to your workplace or to a neighbor if you cannot be home for the delivery. Specialty prescription drugs often require special handling and storage. The plan is not responsible for replacement of lost, stolen, expired, or damaged prescription drugs or products (see page 95).

If your provider will be administering the prescription drug, you may have it shipped to the provider's office. However, once the provider's office receives the prescription drug, the provider takes responsibility for it.

Step therapy

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

If you or your provider feels that you need the Step 2 prescription filled as originally written without first trying the Step 1 drug, your pharmacist or prescribing provider may call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) and request coverage. You will have to pay the entire cost of the prescription drug if you have not tried the Step 1 drug and coverage has not been authorized before you get the Step 2 drug.

To find out if step therapy applies to your drug, check the UMP Preferred Drug List at **regence.com/ump/pebb/benefits/prescriptions**, or call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

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

Substitution under Washington State law

ALERT! New generic prescription drugs are released throughout the year. If you want to save money by using generics, ask your provider to allow substitution on your prescriptions, even if a generic drug is not available now. That way, when one becomes available, the pharmacist may automatically refill with the generic.

When a brand-name or biological prescription drug has a generic equivalent or interchangeable biosimilar (see definition on page 80), pharmacists in Washington State must substitute the generic equivalent or interchangeable biosimilar drug for the brand-name or biologic prescription drug.

Your provider may write the prescription "dispense as written" if they want you to get only the prescribed brand-name or biologic prescription drug, or you may tell the pharmacist you want the brand-name or biologic drug. Regardless of whether you or your prescriber ask the pharmacist to "dispense as written," if you get the noncovered prescription drug, the plan may not cover it. To request an exception for a noncovered drug, please see page 73.

Therapeutic Interchange Program (TIP)

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

You may find out if your prescription drug is affected by TIP by checking the UMP Preferred Drug List at **regence.com/ump/pebb/benefits/prescriptions** or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711). Not all noncovered prescription drugs are affected by TIP.

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

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

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

Regardless of whether you or your prescriber ask the pharmacist to "dispense as written," if you get the noncovered prescription drug, the plan may not cover it.

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

Travel overrides for prescription drugs

You may request a travel override to get an extra supply of prescription drugs for extended travel. All of the conditions listed on the next page apply.

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

To request a travel override, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Refill too soon

The plan will not cover a refill until 84 percent of the last prescription should be used up. Claims for therapeutic equivalents of the previously prescribed drug will also be denied. This also applies if your

prescription is damaged, destroyed, lost, or stolen. For example, if you get a 90-day supply and you try to refill this prescription before 76 days have passed, coverage will be denied. However, in the event of an emergency or other urgent circumstance, you may request an exception to override the refill too soon policy described above. The plan may require documentation to support your request. Approval of your request is at the sole discretion of the plan.

Early refill for a natural disaster

You may request an early refill for your prescription when you need to evacuate for a natural disaster. To request an early refill or to locate pharmacies that remain open near you, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

What to do if coverage is denied

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

- **Employees:** Your employer's personnel, payroll, or benefits office.
- **Retirees and PEBB Continuation Coverage:** PEBB Program at 1-800-200-1004 (TRS: 711).

If a network pharmacy (including the mail-order or specialty pharmacy) tells you that preauthorization is required, coverage is denied, or quantities are limited, you, your pharmacist, or your prescribing provider may call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) to request a coverage review or preauthorization.

If WSRxS denies the coverage request, you have the right to submit an appeal (see pages 106–111).

If your provider thinks you need the prescription drug immediately, they may request an expedited review by submitting all clinically relevant information to the plan by phone or fax. An expedited appeal replaces the first and second level appeals. WSRxS will decide regarding coverage of the prescription drug within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense.

Prescription drugs UMP does not cover

Prescription drugs not covered under the plan include but are not limited to:

Noncovered prescription drugs

- Noncovered prescription drugs without a UMP Preferred Drug List exception authorization.

Excluded prescription drugs

- Dental preparations, such as rinses and pastes.
- Dietary/food supplements, vitamins, minerals, herbal supplements, and medical foods.
- Experimental or investigational prescription drugs.
- Homeopathic drugs, including FDA-approved prescription products.
- Prescription drugs provided to a member in whole or in part, while the member is a patient in a mental health, substance use disorder, residential treatment or skilled nursing facility, hospital (emergency room or inpatient), or any other inpatient facility. Drugs provided in an inpatient setting is processed through the medical benefit.

- Prescription drugs not approved by the FDA.
- Prescription drugs that are repackaged.
- Prescription drugs that are found to be less than effective by the FDA's DESI classifications.
- Over-the-counter drugs, products containing an over-the-counter drug, or prescription drugs that have a nonprescription alternative (see page 155), except for the drugs specified under "Exceptions covered" on page 78.

Note: Prescription drugs with a nonprescription alternative — including an over-the-counter alternative having similar safety, efficacy, and ingredients — are not covered.

- Over-the-counter products not approved by and registered with the FDA.
- Prescription drug costs covered by other insurance. See page 102 for coordination with other plans.
- Prescription drugs that are not medically necessary (see definition on page 152).
- Prescription drugs under a REMS program required by the FDA when prescribed outside REMS guidelines (see page 81) for details.
- Products considered as a medical device by the FDA. Medical devices may be covered under your medical benefit (see page 151).

The plan also excludes prescription drugs to treat conditions that are not covered under the medical benefit. These include, but are not limited to, prescription drugs for:

- Cosmetic purposes.
- Fertility or infertility.
- Obesity (or weight loss).
- Promoting hair growth.
- Sexual dysfunction.

ALERT! Prescription drugs classified as proton pump inhibitors (PPIs) and nasal sprays for treatment of allergy have over-the-counter alternatives and are not covered for adults ages 18 and over. The plan does cover PPIs or nasal sprays for children under ages 18 with a prescription.

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 on pages 89–97, or is listed as a noncovered or excluded prescription drug section on page 85, you are responsible for paying all associated charges.

Preauthorizing medical services

ALERT! This section does not apply to prescription drugs. See page 81 for how to request preauthorization of covered drugs under the prescription drug benefit.

Some medical services and supplies require preauthorization by the plan 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** (see definition on page 152).

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

Your preauthorization role

ALERT! Excluded, experimental, and investigational services do not require a preauthorization because they are not covered by the plan. To confirm whether a service is covered, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

To be covered, some services, including but not limited to Applied Behavior Analysis (ABA) Therapy (see page 35) and bariatric surgery (see page 36), must be preauthorized before services are received. A preferred or participating provider may be required to request preauthorization before providing services.

An out-of-network provider is not obligated to obtain prior authorization 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.

It is beneficial for you to request an out-of-network provider to preauthorize services on your behalf prior to services being rendered. Because your provider has the clinical details and technical billing information needed for the preauthorization request, it is to your benefit that they submit a preauthorization request on your behalf.

You are encouraged to request that an out-of-network provider preauthorize certain services on your behalf to determine medical necessity before the services being rendered. They have the clinical details and technical billing information needed to submit a request. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to ask if a service requires preauthorization and how to submit a request.

You may be liable for all charges if you receive services that are determined to be not medically necessary, experimental or investigational, or not covered under this plan (see "What the plan does not cover" section on pages 89–97).

ALERT! See page 86 for how to appeal denial of a preauthorization request before receiving services.

Where to find the list of services and supplies requiring preauthorization or notice

For a list of services and supplies requiring preauthorization or notice, visit **regence.com/ump/pebb/benefits/policies**.

Request a printed list or ask questions by calling UMP Customer Service at 1-888-849-3681 (TRS: 711).

ALERT! The UMP preauthorization list is updated throughout the year. You may find a link to the current list of services that require preauthorization at **regence.com/ump/pebb/benefits/policies** or call UMP Customer Service at 1-888-849-3681 (TRS: 711) to determine if services require preauthorization or notice. 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 as listed at **regence.com/ump/pebb/benefits/policies** or call UMP Customer Service at 1-888-849-3681 (TRS: 711). 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. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) 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 at **regence.com/ump/pebb/benefits/policies**. The plan sends either an approval or denial of coverage.

If services that require preauthorization are not approved before being provided, coverage may be denied. The plan does not approve or deny preauthorization for services that are not on the UMP preauthorization list.

Preauthorization is usually requested by the provider performing the services.

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

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

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

If additional information is requested:

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

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

General information from UMP Customer Service is not a guarantee that a service is covered

For services not requiring preauthorization, you may call UMP Customer Service at 1-888-849-3681 (TRS: 711) 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 developed by independent organizations not affiliated with the plan. 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.

Case management

Case management is offered by the plan to help members with serious or complex health care needs coordinate their care. Services are provided at no additional cost to the member. A nurse case manager helps you find health care providers and services appropriate for your treatment. When preauthorization is requested for a condition that may benefit from case management services, or when the plan receives a claim for services indicating complex health needs, you will be contacted by case management staff.

Case management services help you:

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

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

Alternative benefits

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

Before alternative benefits will be 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 to 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 as specified in the written agreement. The rest of this certificate of coverage remains in force.

Case management as a condition of coverage

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

What the plan does not cover

TIP: If you have any questions about services not covered by the plan, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

This plan covers only the services and conditions specifically identified in this certificate of coverage. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. 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. Air ambulance, if ground ambulance would serve the same purpose.
2. Ambulance (all), to move you to a facility closer to your home or for purposes that are not medically necessary.
3. Autologous blood and platelet-rich plasma injections.
4. Bariatric surgery under the following circumstances:
   - BMI 30 to 34 without Type II Diabetes Mellitus.
   - BMI less than 30.
   - Patients younger than 18 years of age.
5. Bone growth stimulators for:
   - Nonunion of skull, vertebrae or tumor related.
   - Ultrasonic stimulator – delayed fractures and concurrent use with another noninvasive stimulator.
6. Bone morphogenetic protein-7 (rhBMP-7) for use in lumbar fusion.
7. Bronchial thermoplasty for asthma.
8. Cardiac nuclear imaging for:
   - Asymptomatic patients (does not apply to pre-operative evaluation of patients undergoing high-risk non-cardiac surgery or patients who have undergone cardiac transplant).
   - Patients with known coronary artery disease and no changes in symptoms.
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 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 plan paid 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 artery tomographic angiography (CCTA) for:
    - Patients who are asymptomatic or at high risk of coronary artery disease;
    - CCTA used for coronary artery disease investigation outside of the emergency department or hospital setting; and
    - CT scanners that use lower than 64-slice technology.
17. Coronary or cardiac artery calcium scoring.
18. Cosmetic services or supplies, including drugs and pharmaceuticals. However, the plan does cover:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly, such as cleft lip or palate, to improve or restore function.
19. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
20. Custodial care (see definition on page 146).

21. Deep brain stimulation and transcranial direct current stimulation when used as nonpharmacological treatments for treatment-resistant depression.
22. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed (see pages 37–39).
23. Dietary/food supplements, including but not limited to:
    - Herbal supplements, dietary supplements, medical foods, and homeopathic drugs.
    - Infant or adult dietary formulas (see "Exceptions covered" by the plan on page 78).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see page 78).
24. Dietary programs.
25. Discography for patients with chronic low back pain and lumbar degenerative disc disease. This does not apply to patients with the following conditions:
    - Radiculopathy.
    - Functional neurologic deficits (motor weakness or EMG findings of radiculopathy).
    - Spondylolisthesis greater than Grade 1.
    - Isthmic spondylolysis.
    - Primary neurogenic claudication associated with stenosis.
    - Fracture, tumor, infection, inflammatory disease.
    - Degenerative disease associated with significant deformity.
26. Drugs or medicines not covered by the plan as described in the "Your prescription drug benefit" section, see pages 71–86.
27. Drugs or medicines obtained through mail-order pharmacies located outside the U.S.
28. Educational programs, except as described under:
    - "Diabetes Control Program" on page 40.
    - "Diabetes education" on page 40.
    - "Diabetes Prevention Program" on page 40.
    - "Tobacco cessation services" on page 66.
29. Electrical Neural Stimulation (ENS), which includes Transcutaneous Electrical Nerve Stimulation (TENS) Units, outside of medically supervised facility settings (e.g., in home use).
30. Email consultations or e-visits, except as described under the Telemedicine benefit.
31. 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.
- Whirlpools, portable whirlpool pumps, or sauna baths.

32. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
33. Experimental or investigational services, supplies, or drugs.
34. Extracorporeal shock wave therapy for musculoskeletal conditions.
35. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
36. Facet neurotomy for the thoracic spine or headache.
37. Fecal microbiota transplantation for treatment of inflammatory bowel disease.
38. Foot care not related to diabetes: cutting of toenails; treatment for diagnosed corns and calluses; 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. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (example: chiropractic services). For chronic migraines and tension-type headaches, see page 45.
42. Hearing aid items:
    - 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 telephones.
- Assistive listening devices for televisions (including amplifiers and caption decoders).
- Assistive listening devices for use with cochlear implants.
- 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, 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 46. The plan does not cover the following services:
    - Private duty or continuous care in the member's home.
    - Housekeeping or meal services.
    - Care in any nursing home or convalescent facility.
    - Care provided by or for a member of the patient's family.
    - Any other services provided in the home that do not meet the definition of skilled home health care as described on page 46 or not specifically listed as covered in this certificate of coverage.
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.

- Reserved beds.
- Services and devices that are not medically necessary (see definition on page 152).
- Personal or convenience items.

47. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
48. Hyperbaric oxygen therapy treatment for:
    - Brain injury including traumatic (TBI) and chronic brain injury.
    - Cerebral palsy.
    - Multiple sclerosis.
    - Migraine or cluster headaches.
    - Acute and chronic sensorineural hearing loss.
    - Thermal burns.
    - Non-healing venous, arterial and pressure ulcers.
49. Imaging of the sinus for rhinosinusitis using X-ray or ultrasound.
50. Immunizations for the purpose of travel or employment, even if recommended by the CDC.
51. Implantable drug delivery systems (infusion pumps or IDDS) 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 35;
    - "Physical, occupational, speech, and neurodevelopmental therapy" on page 56; or
    - When part of treating a mental health disorder as described on page 53.
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 151).
64. Manipulations of the spine or extremities, except as described under "Spinal and extremity manipulations" on page 61.
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 patient'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. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (example: chiropractic services). For chronic migraines and tension-type headaches, see page 45.
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 42.
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 including:
    - For knee, hip, foot, or shoulder due to osteoarthritis or other conditions.
    - For adults and children.
79. Pharmacogenetic testing for patients being treated with oral anticoagulants.
80. Pharmacogenomics testing for depression, mood disorders, psychosis, anxiety, ADHD, and substance use disorder.
81. Positron Emission Tomography (PET) scans for routine surveillance of lymphoma.
82. Prescription drug charges over the allowed amount, regardless of where purchased.
83. Prescription drugs that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
84. Printing costs for medical records.
85. Proton beam therapy for individuals 21 years old and older for conditions other than:
    - Esophageal.
    - Head/neck.
    - Skull-based.
    - Hepatocellular carcinoma.
    - Brain/spinal.
    - Ocular.
    - Other primary cancers where all other treatment options are contraindicated after review by a multidisciplinary tumor board.
86. 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.
87. Recreation therapy.

88. Replacement of lost, stolen, or damaged durable medical equipment.
89. Replacement of prescription drugs that are any of the following:
    - Confiscated or seized by Customs or other authorities.
    - Contaminated.
    - Damaged.
    - Expired.
    - Lost or stolen.
    - Ruined.
90. Residential treatment programs that are not licensed to provide residential treatment solely to persons requiring residential substance use disorder treatment or diagnosed with a mental health condition and requiring residential treatment.
91. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).
92. 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.
93. Routine ultrasounds during pregnancy, except one in week 13 or earlier, one during weeks 16-22, or high-risk pregnancies (see description on page 54).
94. Sacroiliac joint fusion: Minimally invasive and open sacroiliac joint fusion procedures in adults, 18 years old and older, with chronic sacroiliac joint pain related to degenerative sacroiliitis and/or sacroiliac joint disruption.
95. 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.
96. Separate charges for records or reports.
97. Service animals: Any expenses related to a service animal.
98. Services covered by other insurance, including but not limited to:
    - Motor vehicle.
    - Homeowner's.
    - Renter's.
    - Commercial premises.
    - Personal injury protection (PIP).
    - Medical payments (Med-Pay).
    - Automobile no-fault.
    - General no-fault.
    - Underinsured or uninsured motorist coverage.
    - See page 112 for more about how this works.
99. Services delivered by providers or facilities delivering services outside the scope of their licenses.
100. Services or supplies:
    - That are not medically necessary for the diagnosis and treatment of injury or illness or restoration of physiological functions and are not covered as preventive care. This applies even if services are prescribed, recommended, or approved by your provider.
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member or any household member.
    - Provided by a resident physician or intern acting in that capacity.
    - That are solely for comfort.
    - For which you are not obligated to pay.

101. Services performed during a noncovered service.
102. 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.
103. 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:
        - Magnetic Resonance Imaging (MRI)
        - Hand Held Ultrasound (HHUS)
        - Automated Breast Ultrasound (ABUS)
    - High-risk patients:
        - Hand held ultrasound (HHUS)
        - Automated breast ultrasound (ABUS)
104. Services, supplies, or drugs related to occupational injury or illness (see page 155).
105. Services, supplies, or items that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
106. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.
107. Sleep apnea diagnosis and treatment as indicated in referenced Medicare national and local coverage determinations.
108. Sleep therapy services performed at the following locations are not covered:
    - Urgent-care facilities
    - Inpatient hospitalization
    - Emergency room services
109. Spinal cord stimulation for chronic neuropathic pain.
110. Spinal injections, therapeutic (except as described under "Spinal injections" on page 61) of the following types:
    - Medial branch nerve block injections.
    - Intradiscal injections.
    - Facet injections.
111. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
112. Stereotactic radiation surgery and stereotactic body radiation therapy: Stereotactic radiation surgery for conditions other than Central Nervous System primary and metastatic tumors and stereotactic body radiation therapy for conditions other than cancers of spine/paraspinal structures or inoperable non-small cell lung cancer, stage 1.
113. Surrogacy
114. Telephone or virtual consultations or appointments, except as described under "Telemedicine services" on page 68.

115. Travel, transportation, and lodging expenses, except as specified for ambulance services covered by the plan (see page 35), or approved travel and lodging costs related to the COE Program for single knee and single hip replacement (see page 49) and for spine care (see page 62).
116. 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).
117. Upright magnetic resonance imaging (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
118. Vagal nerve stimulation for the treatment of depression.
119. Vitamin D screening and testing as part of routine screening.
120. Weight control, weight loss, and obesity treatment:
    - **Non-surgical:** Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise or diet programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider, except as covered under "Diabetes Control Program" (see page 40)," "Diabetes Prevention Program" (see page 40), "Nutrition counseling and therapy" (see page 54), or "Preventive care" (see page 58).
    - **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.
121. Workers' compensation: When a claim for workers' compensation is accepted as being caused by a work-related injury or illness, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation.

If you have questions about whether a certain service or supply is covered, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

If you have other HDHP coverage

Coordination of benefits

Coordination of benefits (COB) happens when you have health coverage through two or more groups (such as your employer and your spouse's employer), and these two group health plans both pay a portion of your health care claims.

The rules beginning under "Who pays first?" on page 98 determine which plan pays first ("primary payer") and which pays second ("secondary payer"). See page 87 for a description of how the plan coordinates benefits when it pays second.

The plan processes claims differently depending on if it is the primary payer or the secondary payer. The differences are described in the next several pages.

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

Contact Regence BlueShield and WSRxS

If you or your dependents have other insurance, you must let Regence BlueShield and WSRxS know so claims are paid correctly. To do this, you must complete and submit a separate form for medical services and prescription drugs. See the table on page 98 for how to find the forms.

Each person claiming payment for benefits under the plan is required to give Regence and WSRxS any facts needed to apply these coordination of benefits rules and determine the correct benefits payable. If your coverage under other plans changes, please call the customer service phone numbers listed in the table on page 98.

Contact type	Medical services: Regence	Prescription drug services: WSRxS
Phone	Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to request a form.	Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711)
Online	Go to **hca.wa.gov/ump-forms-pubs**: ▪ In the "Search" box, type "Coordination of benefits." ▪ Choose "Medical Multiple Coverage Inquiry Form." ▪ You may fill out and submit online, or print out and mail or fax in.	Go to **hca.wa.gov/ump-forms-pubs** and search for "WSRxS Multiple Pharmacy Coverage Inquiry Form." Or submit through your pharmacy account at **regence.com/ump/pebb/benefits/prescriptions**.
Fax	1-877-357-3418	503-412-4058
Mail	Regence BlueShield Attn: UMP Claims PO Box 91015 MS BU386 Seattle, WA 98111-9115	WSRxS PO Box 40168 Portland, OR 97240-0168

Who pays first?

Note: If you cannot determine which plan pays first, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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

The following plan pays first:

- A plan covering the patient as an employee, subscriber, retiree, or the dependent of such an employee, subscriber, or retiree will pay before a COBRA or a state right of continuation plan.
- Any group plan that does not coordinate benefits.
- The plan that covers the patient as a subscriber, not a dependent.

- The plan that covers the patient (or their spouse or state-registered domestic partner) as an active employee pays before a plan that covers the patient as a retired employee.
- The plan that covers the patient (or their spouse or state-registered domestic partner) as an active employee if the other coverage is Medicare.
- The plan that has covered the patient (or their spouse or state-registered domestic partner) as a subscriber the longest, if there are two plans and the first five bullets do not determine which plan pays first.

For dependent children

A group plan is usually primary over Medicaid programs that cover children. If a dependent child has group coverage through their employer, the child's coverage pays first.

Dependent children of married parents

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

Exception for newborn children: Under Washington State law, the plan must cover newborns under the mother's coverage for the first 21 days of life. Therefore, the mother's plan pays first for covered charges during the first 21 days of life.

Dependent children of legally separated or divorced parents

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

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

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

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

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

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

In some cases, a court order determines payment for health care expenses. In those cases, **standard coordination of benefits rules may not apply**. You must promptly provide the plan with copies of the court order for the plan to determine which plan pays first.

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

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

What happens with federal and military plans?

UMP usually pays first over certain federal or military programs for veterans (retired military members).

When UMP pays first

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

What happens when UMP is supposed to pay first, but another plan did instead?

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

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

How UMP coordinates benefits when it pays second

UMP uses a type of coordination of benefits called **nonduplication of benefits** (see examples on page 100). When UMP pays second to another plan that covers you, we will pay only an amount needed to bring the total benefit up to the amount UMP would have paid if you did not have another plan.

The intent of this type of coordination of benefits is to maintain the level of benefits available through UMP. The nonduplication of benefits type of coordination is not designed to pay your covered expenses in full.

When UMP pays second, it coordinates with these types of plans:

- Governmental programs including, but not limited to, Medicare and Medicaid.
- Group, blanket or franchise health or disability insurance policies, health care service contractor and health maintenance organization group agreements issued by insurers, health care service contractors, and health maintenance organizations.
- Labor management trusteed plans, labor organization plans, employer plans, or employee benefit organization plans.

Note: If you have other primary coverage, visits paid by the primary plan also apply to UMP benefit limits.

How much you will pay when UMP pays second

When you see preferred providers under UMP (see definition on page 157), you will owe only the balance of the UMP allowed amount after your primary plan and UMP pay benefits for covered services. Your cost will usually be higher if you see out-of-network providers. See "Sample payments to different provider types" on page 12 for examples.

The examples in the table on page 101 assume that you have met your deductible.

Situation	Example	Preferred provider charge	UMP allowed amount	UMP normal benefit	Other plan pays	UMP pays	You pay your provider
UMP is primary, other plan is secondary	**EXAMPLE 1:** When UMP pays first (or is the only plan)	$200	$100	$85 (85% of $100)	N/A	$85	$15
UMP is secondary, other plan is primary	**EXAMPLE 2:** The other plan pays less than the normal UMP benefit	$200	$100	$85	$80	$5	$15
UMP is secondary, other plan is primary	**EXAMPLE 3:** The other plan pays as much (or more than) the normal UMP benefit	$200	$100	$85	$85	$0	$15

Please contact UMP Customer Service at 1-888-849-3681 (TRS: 711) for help with any questions if you are covered by more than one plan.

Submit secondary claims promptly

All health plans have a "timely filing" deadline. The timely filing deadline for UMP is 12 months from the date of service. If a claim is not submitted within a plan's timely filing deadline, UMP will deny it. If your primary plan delays payment on a claim, the claim must still be submitted to UMP within the filing deadline to prevent denial of the claim.

UMP will try to contact your primary plan for their benefit payment information or may estimate it to provide timely processing of your secondary benefit. Adjustments may be made when the primary plan pays their portion of your claim. Notifying your providers of any change to your coverage will help avoid errors and delays in processing of claims (see pages 102–105).

How are diabetes care supplies covered when UMP pays second?

UMP covers diabetes care supplies under the prescription drug benefit.

If you get your supplies from a pharmacy, ask if the pharmacy can bill both your primary plan and UMP. If your pharmacy does, you do not need to do anything further. If not, you will need to send a claim to WSRxS for secondary payment. See pages 104–105 for instructions.

If you get your supplies from a diabetes care supplier, the primary plan may process the claim as medical. In this case, you need to send your Explanation of Benefits and a claim form to WSRxS for secondary payment. See pages 102–105 for instructions.

Note: Nonduplication of benefits applies to these claims (see page 100), which means that UMP may pay nothing after your primary plan pays.

See "Diabetes care supplies" on page 39 for more about this benefit.

ALERT! A secondary claim for diabetes care supplies submitted to Regence BlueShield will be denied. The claim must be submitted to WSRxS.

How does coordination of benefits work with prescription drugs?

Some of the limits and restrictions to prescription drug coverage listed on pages 80–83 will apply when UMP pays second to another plan. See "Submitting a claim for prescription drugs" beginning on page 104 for how to submit your prescription drug claim.

When UMP pays second to another plan, nonduplication of benefits applies (see page 100). This means that UMP may pay nothing after your primary plan pays.

ALERT! If UMP pays second, you must still pay your deductible before UMP covers prescription drugs.

Using network pharmacies when UMP is secondary

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

Using mail-order pharmacies when UMP is secondary

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

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP. See "Submitting a claim for prescription drugs" on page 104 for how to do this.

Does UMP coordinate with occupational injury or illness (workers' compensation) claims?

No. When a claim for workers' compensation is accepted as being caused by a work-related injury or illness, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation. 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 certificate of coverage.

Billing & payment: filing a claim

Submitting a claim for medical services

When UMP is your primary insurance and your provider is preferred, 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 account at **regence.com** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

TIP: In the following section, Uniform Medical Plan refers to the administrative functions for submitting claims to UMP. Medical claims are handled by Regence BlueShield, and claims for prescription drugs are handled by WSRxS.

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.
- You have other insurance that pays first and UMP is secondary.

Out-of-network providers may submit a claim on your behalf; ask the provider.

How to submit a claim

TIP: If you purchase contact lenses or eyeglasses from an out-of-network provider that does not bill your plan, you must submit a claim for reimbursement. You may download the *Medical Claim Form* at **hca.wa.gov/ump-forms-pubs** or call UMP Customer Service at 1-888-849-3681 (TRS: 711) for a copy.

To submit a claim yourself, you'll need to obtain and mail the following documents:

- *Medical Claim Form* — You may find the form online at **hca.wa.gov/ump-forms-pubs** or you may request a form by calling UMP Customer Service at 1-888-849-3681 (TRS: 711).
- An itemized bill from your provider that describes the services you received and the charges.

The following information must appear on the provider's itemized bill for the plan to consider the claim for payment:

- Patient's name and member ID number, including the alpha prefix (three letters before member ID number).
- Description of the injury or illness.
- Date and type of service.
- Provider's name, address, and phone number.
- For ambulance claims, please also include the ZIP code of where the patient 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 Uniform Medical Plan, unless the primary plan's processing of the claim is delayed. Claims not submitted to Uniform Medical Plan within 12 months of the date of service will not be paid.

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

Reimbursement for services received from an out-of-network provider may be sent to the provider or to you in the form of a check listing both you and the provider as payees.

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
PO Box 1106
Lewiston, ID 83501-1106

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

Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have a question about the processing of your claim.

Important information about submitting claims

ALERT! You or your provider must submit claims within 12 months of the date you received health care services. This is called the "timely filing" deadline. The plan will not pay claims submitted more than 12 months after the date of service. See "Submit secondary claims promptly" on page 101 for how this works when you have other coverage that pays first.

For information about submitting claims for services outside of the U.S., call UMP Customer Service at 1-888-849-3681 (TRS: 711). You may have to pay services upfront and submit a claim for reimbursement.

If you have other health care coverage, see "If you have other medical coverage" on pages 97–102 for information on how the plan coordinates benefits with other plans.

Claims reimbursement

Most of the time, the plan will pay preferred providers directly. For claims submitted by you or an out-of-network provider, the plan will determine whether to pay you, the provider, or both. For a child covered by a legal qualified medical child support order (see page 121) the plan may pay the custodial parent or legal guardian of the child.

Claims determinations

You will be notified of action taken on a claim within 30 days of the plan receiving it. This 30-day period may be extended by 15 days when action cannot be taken on the claim due to:

- Circumstances beyond the plan's control. 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.

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 claim will be denied.

Submitting a claim for prescription drugs

ALERT! See "Products covered under the preventive care benefit" on page 79 for coverage of products such as contraceptive drugs, tobacco cessation drugs, nicotine replacement, or over-the-counter products covered as preventive.

You may need to submit your own prescription drug claim to WSRxS for reimbursement if you:

- Buy prescription drugs at a non-network retail pharmacy.

- Fail to show your UMP member ID card at a network pharmacy.
- Have other prescription coverage that pays first and UMP is secondary.

TIP: If you get a vaccine from an out-of-network provider, make sure that you submit your claim to Regence BlueShield as a medical claim (see page 102). Member-submitted vaccine claims sent to WSRxS will be denied.

Prescription drug claim forms are available online at **regence.com/ump/pebb/benefits/claims-appeals** or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711). Send the completed claim form, along with your pharmacy receipt(s), to:

WSRxS
Attn: Pharmacy Claims
PO Box 40168
Portland, OR 97240-0168
Fax 1-800-207-8235

It is a good idea to keep copies of all your paperwork for your records.

When you submit a prescription drug claim to WSRxS, the plan pays the claim based on the following rules, no matter where you purchased the drug:

- The plan pays based on the allowed amount. If the pharmacy charges you more than the allowed amount, you will pay your usual coinsurance (and deductible if applicable), plus the difference between what the plan paid and the pharmacy's charge.
- The plan pays all prescription drug claims, including non-network retail pharmacies, based on coinsurance (see page 72).
- If your claim exceeds the quantity limit allowed by the plan or the maximum days' supply, the plan will pay only for the amount of the prescription drug up to the quantity limit or maximum days' supply.
- If you receive a refill before 84 percent of the last supply you received should have been taken, the plan will not pay for it. This is called a "refill too soon" (see page 84).

You must submit prescription drug claims within 12 months of purchase. Claims for prescription drugs submitted more than 12 months after purchase will not be paid.

ALERT! If you do not show your UMP member ID card when purchasing a prescription at a WSRxS' network pharmacy, you will have to pay the full cash price and submit a *Prescription Drug Claim Form*. You will not receive the plan discount.

False claims or statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements 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.

Complaint and appeal procedures

TIP: In the following section, UMP refers to the administrative functions for appeals for UMP CDHP. Medical appeals are handled by Regence BlueShield, and appeals involving prescription drugs are handled by WSRxS, and Premera for the COE Program. See page 51 for Premera's contact information.

If you have any questions about appeals or complaints, contact us.

For questions about…	Contact
Medical services	ASO Member Appeals Regence BlueShield PO Box 91015 Seattle, WA 98111-9115 1-888-849-3681 (TRS: 711)
Prescription drugs	WSRxS Attn: Appeals PO Box 40168 Portland, OR 97240-0168 1-888-361-1611 (TRS: 711)

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

What is a complaint or grievance?

A complaint or grievance 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 (see page 106).

How to submit a complaint or grievance

For all complaints or grievances, we recommend first calling UMP Customer Service at 1-888-849-3681 (TRS: 711). Many issues may be resolved with a phone call. If an initial phone call does not resolve your grievance, you may submit your complaint or grievance:

- Over the phone: If you want a written response, you must request one.
- By mail, fax, or email (see page 111).

You will receive notice of the action on your complaint, or grievance within 30 calendar days of our receiving it. We will notify you if we need more time to respond.

What is an appeal?

An appeal is an oral or written request made by you or your authorized representative to Regence BlueShield or WSRxS 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 "Appeals related to eligibility" on page 111).
- 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 "Expedited appeals" on page 109.

You, your treating provider, or an authorized representative (see "How to designate an authorized representative" on page 141) may request an appeal for you. There are three levels to the appeals process:

- First-level appeal
- Second-level appeal
- Independent review

Each of those parts are described in further detail below.

If your request involves a decision to change, reduce, or terminate coverage for services, supplies, or prescription drugs already being covered, the plan must continue coverage for these services during your appeal. However, if the plan or the Health Care Authority upholds the decision to change, reduce, or terminate coverage, you will be responsible for any payments made by the plan during that period. If you request payment for denied claims or approval of services, supplies, or prescription drugs not yet covered by the plan, the plan will not cover the services, supplies, or prescription drugs while the appeal is under consideration.

The plan will consult with a health care professional on appeals where the plan's decision was based in whole or in part on a medical judgment. That includes decisions based on determinations that a treatment, prescription drug, or other item is experimental, investigational, or not medically necessary. In those cases, the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved.

You may send written comments, documents, and any other information when you request an appeal. The plan will consider all information submitted in 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.

How to submit an appeal

You may submit your request for an appeal **by telephone, mail, fax, or email** (see contact information on page 111). The plan will send confirmation upon receipt of your appeal. You will also receive notice of

the action on your appeal within 30 calendar days. We will ask your permission if we need more time to respond.

Information to provide with an appeal

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 subscriber's full name (the name of the employee or retiree covered by the plan).
- The patient's full name (the name of the employee, retiree, or dependent covered by the plan).
- The subscriber's 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.
- The dates when any services were provided.
- 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 ensure the most accurate decision.

First-level appeals

You may request a first-level appeal no more than 180 days after you receive notice of the action being appealed. If you do not request an appeal within this time, your appeal will not be reviewed, and you will not be able to continue further appeals (second-level and independent review).

First-level appeals for medical services are managed by Regence BlueShield and first-level appeals for prescription drugs are managed by WSRxS. Employees from Regence BlueShield and WSRxS reviewing the appeals will not have been involved in the initial decision you are appealing. Claim processing disputes will be reviewed by administrative staff. Appeals that involve issues requiring medical judgment about covering, authorizing, or providing health care will be evaluated by the staff of health care professionals at Regence BlueShield or WSRxS.

ALERT! Deadlines for submitting an appeal are based on the first date you are notified of how a claim processed, usually when the plan sends you an Explanation of Benefits (including services that applied to the deductible or were denied). The plan does not waive deadlines based on untimely billing by your provider.

Second-level appeals

If you disagree with the decision made on your first-level appeal, you may request a second-level appeal. Second-level appeals must be submitted no more than 180 days after the date of the letter responding to your first-level appeal. If you do not request an appeal within this time, your appeal will not be reviewed, and you will not be able to continue further appeals (independent review).

Second-level appeals for medical services are reviewed by Regence BlueShield employees, and second-level appeals for prescription drugs are handled by WSRxS. Employees from Regence BlueShield and WSRxS reviewing the appeals will not have been involved in, or subordinate to anyone involved in, reviewing the first-level appeal or the initial decision. If new or additional evidence or rationale is considered in reviewing your appeal, you will have the opportunity to review it free of charge and you may respond before the final decision.

Expedited appeals

Expedited appeals for medical services

If your appeal is based on one of the following situations, you may ask your provider to request an expedited appeal:

- You are currently receiving or prescribed treatment or benefits that would end because of the denial;
- 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.

An expedited appeal replaces the first- and second-level appeals. Regence BlueShield will decide on your expedited appeal within 72 hours of the request. Your provider must submit all clinically relevant information to the plan by phone or fax at:

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

If you disagree with the expedited appeal decision, your provider may request an expedited independent review.

Expedited appeals for prescription drugs

If you or your provider thinks you need a prescription drug immediately, you or your provider may request an expedited review by submitting all clinically relevant information to the plan by phone or fax at the numbers listed below. An expedited appeal replaces the first- and second-level appeals. WSRxS will decide regarding coverage of the prescription drug within 72 hours of the request.

In this case, you may choose to purchase a three-day supply at your own expense. If WSRxS' decision is to cover the prescription drug, WSRxS will reimburse you up to the allowed amount minus the member cost-share (coinsurance and deductible if applicable). If WSRxS decides not to cover the prescription drug (denies the appeal), you are responsible for the full cost of the drug.

Phone: 1-888-361-1611 (TRS: 711)
Fax: 1-866-923-0412 (for providers only)

Time limits for the plan to decide appeals

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

The time limits 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 (see page 141) 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.

Independent (external) review

If you have gone through both a first- and second-level appeal (or expedited appeal) and your appeal was based on one of the issues listed below, you may request an independent (or external) review:

- Deny;
- Modify;
- Reduce; or
- Terminate coverage of or payment for a health care service.

You may also request an independent review in the following situations:

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

You must request an independent review no more than 180 days after the date of the letter responding to your second-level appeal (or expedited appeal). Only the member or an authorized representative (see page 141) may request an independent review. You may authorize a representative to request an independent review on your behalf in writing or verbally by contacting UMP Customer Service.

TIP: An Independent Review Organization (IRO) will conduct the independent review. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not related to the plan, Regence BlueShield, WSRxS, or the Health Care Authority. An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the plan's decision is consistent with state law and the *2020 UMP CDHP (PEBB) Certificate of Coverage*. The plan will pay the IRO's charges.

Requesting an independent review

To request an independent review, see the contact information listed on page 111.

The plan — Regence BlueShield for medical services, and WSRxS for prescription drugs — will send the relevant information and correspondence to the IRO.

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 the Health Care Authority. If your appeal is reviewed by an IRO, 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 by 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 providers only, call UMP Customer Service at 1-888-849-3681 (TRS: 711) or send a secure email through your **regence.com** account.

For complaints or concerns about the quality of care you received from any provider (preferred or out-of-network):

- Call Washington State Department of Health at 360-236-4700 or 1-800-562-6900.
- Email **HSQAComplaintIntake@doh.wa.gov**.
- Visit **doh.wa.gov/AboutUs/DepartmentofHealth/Fileacomplaint**.

Appeals related to eligibility

Appeals related to eligibility and enrollment are handled by the PEBB Program and governed by Chapter 182-16 Washington Administrative Code (WAC).

Information on how to file an appeal is available:

- On the PEBB website at **hca.wa.gov/pebb-appeals**.
- By contacting the PEBB Appeals Unit at 1-800-351-6827.

Where to send complaints or appeals

ALERT! See page 51 and 64 for appeals related to the Centers of Excellence (COE) Program.

Many complaints and disputes can be resolved over the phone. If your situation is not resolved, you may send a complaint or appeal at the address listed below.

Contact type	Medical services: Regence	Prescription drugs: WSRxS
Phone	1-888-849-3681 (TRS: 711) Monday through Friday, 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m. (Pacific)	1-888-361-1611 (TRS: 711) Monday through Friday, 7:30 a.m. to 5:30 p.m. (Pacific)
Mail	ASO Member Appeals Regence BlueShield PO Box 91015 Seattle, WA 98111-9115	WSRxS Attn: Appeals PO Box 40168 Portland, OR 97240-0168
Email	Secure email through your account at **regence.com**	Secure email through your account at **regence.com/ump/pebb/benefits/prescriptions**
Fax	1-877-663-7526	1-866-923-0412

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 ensure timely payment of claims, it is important that you respond as directed in the letter, even if the answer is no. If you do not, coverage may be denied. You may call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions.

Legal rights and responsibilities

Coverage under the plan is not provided for medical, dental, prescription, 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, sports policies including excess or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage; or
- Services or supplies for work-related injury or illness, even when the service or supply is not a covered workers' compensation benefit under the workers' compensation plan.

ALERT! You must respond to any communication sent to you about other sources of benefits, or claims may be denied.

However, after expiration or exhaustion of the above no fault benefits, if you also have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced by the plan pending the resolution of a claim to the right of recovery 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.
- The plan may choose to recover expenses through subrogation to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. The plan is authorized, but not obligated, to recover any 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 must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the plan, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the plan of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - The filing of a lawsuit;
  - The making of a claim against any third party;
  - Scheduling of settlement negotiations in accordance with the plan (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the injury or illness that gives rise to the plan's right of reimbursement or subrogation (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 advanced for any illness or injury may be recovered through legal action to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained.
- Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, the plan is not waiving any right to reimbursement or subrogation.

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 incurred by you at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to the plan to less than the full amount of benefits paid by the plan.

Services covered by other insurance

The plan does not cover services that are covered by other insurance, including but not limited to no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no-fault coverage, commercial premises no fault medical coverage, sports policies including excess, underinsured or uninsured motorist coverage or similar contract or insurance. You are responsible for any cost-sharing required under the other coverage as allowed by state law. Once you have exhausted benefits (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 certificate of coverage.

Motor vehicle coverage

If you are involved in a motor vehicle accident, whether as a driver, passenger, pedestrian, or other capacity, you may have rights under multiple motor vehicle insurance no fault coverages and also against a third party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

Future medical expenses

Benefits for otherwise covered services may be excluded as follows:

- When you have received a recovery from another source relating to an illness or injury for services for which we normally would provide benefits. The amount of any exclusions under this provision, however, will not exceed the amount of your recovery.
- Until the total amount excluded under this subrogation provision equals the third-party recovery.

Eligibility and enrollment

In these sections, we use the term "subscriber" to refer to an employee or a Continuation Coverage subscriber. The term "enrollee" refers to a subscriber and their enrolled dependents. Additionally, "health plan" is used to refer to a plan offering medical or dental, or both, developed by the Public Employees Benefits Board (PEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The employee's employing agency will inform the employee whether or not they are eligible for benefits upon employment and whenever the employee's eligibility status changes. The communication will include information about the employee's right to appeal eligibility and enrollment decisions. Information about an employee's right to an appeal can be found on page 125 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program will determine eligibility for Continuation Coverage. If a subscriber is not eligible for Continuation Coverage, the PEBB Program will notify them of their right to appeal. Information about appealing a PEBB Program decision can be found on page 125 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the "Enrollment" section. The PEBB Program or employing agency verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from jurisdictions as defined in Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber's:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. 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;

c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

d. 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;

e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child 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; and

g. Children of any age with a developmental or physical disability that renders the child 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, within 60 days of the last day of the month 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 under this subsection if they later become incapable of self-support; and
- The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the subscriber.

4. Parents of the subscriber.

a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

- The parent maintains continuous enrollment in PEBB medical;
- The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
- The subscriber continues enrollment in PEBB insurance coverage; and
- The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

A subscriber or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same, or two different employers that participate in PEBB coverage may be enrolled as a dependent under only one parent.

An eligible employee may waive enrollment in PEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If an employee waives enrollment in PEBB medical, the employee cannot enroll eligible dependents.

How to enroll

An employee must submit a *PEBB Employee Enrollment/Change* or *PEBB Employee Enrollment/Change (for Medical Only Groups)* form to their employing agency when they become newly eligible for PEBB benefits. The form must be received no later than 31 days after the date the employee becomes eligible. If the employee does not return the form by the deadline, the employee will be enrolled in the Uniform Medical Plan Classic, a tobacco use surcharge will be incurred, and any eligible dependents cannot be enrolled until the PEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment.

To enroll an eligible dependent, the employee must include the dependent's enrollment information on the form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified.

A subscriber enrolling in Continuation Coverage may enroll by submitting the required forms to the PEBB Program. The election must be received by the PEBB Program no later than 60 days from the date the member's PEBB health plan coverage ended or from the postmark date on the election notice sent by the PEBB Program, whichever is later. The first premium payment and applicable premium surcharges are due no later than 45 days after the election period ends as described above. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA. For more information, see "Options for continuing PEBB medical coverage" on page 123.

A subscriber or their dependents may also enroll during the PEBB Program's annual open enrollment (see "Annual open enrollment" on page 117) or during a special open enrollment (see "Special open enrollment" beginning on page 118). The subscriber must provide proof of the event that created the special open enrollment.

A subscriber must provide notice to remove dependents who are no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child. The notice must be received within 60 days of the last day of the month the dependents no longer meet the eligibility criteria described in the "Eligibility" section on page 114. An employee must notify their employing agency. A Continuation Coverage subscriber must notify the PEBB Program. Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent losing eligibility to continue health plan coverage under one of the continuation coverage options described on page 123 of this certificate of coverage;
- The subscriber being billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When medical coverage begins

For an employee and their eligible dependents **enrolling when the employee is newly eligible,** medical coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

For a 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 plan coverage.

For a subscriber or their eligible dependents **enrolling during the PEBB Program's annual open enrollment,** medical coverage begins on 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 required form is received. If that day is the first of the month, coverage is effective on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage begins as follows:
   a. For an employee, medical coverage begins the first day of the month in which the event occurs;
   b. For the newly born child, medical coverage begins the date of birth;
   c. For a newly adopted child, medical coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
   d. For a spouse or state registered domestic partner of a subscriber, medical coverage begins the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a dependent child with a disability, medical coverage begins on the first day of the month following eligibility certification.

Annual open enrollment

An employee may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

- Change their medical plan;
- Waive their medical plan enrollment;
- Enroll after waiving medical plan enrollment; or
- Enroll or remove eligible dependents.

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

- Enroll in or terminate enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change their medical plan.

An employee must submit the change online in PEBB My Account or return the required form(s) to their employing agency. A Continuation Coverage subscriber must submit the change online in PEBB My Account or return the required form(s) to the PEBB Program. The form(s) must be received no later than

the last day of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits. The special open enrollment may allow a subscriber to:

- Enroll in or change their medical plan;
- Waive their medical plan enrollment;
- Enroll after waiving medical plan enrollment; or
- Enroll or remove eligible dependents.

To make an enrollment change, an employee must submit the required form(s) to their employing agency. A Continuation Coverage subscriber must submit the required form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program or employing agency will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exception: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should submit the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, 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. An employee should contact their personnel, payroll, or benefits office for the required forms. A Continuation Coverage subscriber should contact the PEBB Program. See "When can a subscriber enroll or remove eligible dependents" on page 120.

When can a subscriber change their health plan?

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

1. Subscriber gains a new dependent due to:
   a. Marriage or registering a state-registered domestic partnership;
   b. Birth, adoption, or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
   c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.

5. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;
6. 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);
7. Subscriber or their dependent becomes entitled to 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;
8. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
9. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber or their dependents entitlement to Medicare, the subscriber must select a new health plan;
10. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Subscriber or 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 if 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 is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy.

Note: If a member's provider or health care facility discontinues participation with this plan, the member may not change medical plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a continuity of care exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can an employee waive their medical plan coverage, or enroll after waiving coverage?

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

1. Employee gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Employee 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);

3. Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group medical;
4. Employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;

Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.

5. Employee or their dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;
6. Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and the change in residence resulted in the dependent losing their health insurance;
7. A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Employee or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Employee or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
10. Employee or their dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan; or
11. Employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

When can a subscriber enroll or remove eligible dependents?

To enroll a dependent, the subscriber must include the dependent's enrollment information on the form and provide any required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
   a. Marriage or registering a state-registered domestic partnership;
   b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.

5. Subscriber or their dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;

6. 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;
7. 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);
8. Subscriber or their dependent becomes entitled to 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; or
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

National Medical Support Notice (NMSN)

When an NMSN requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

1. The subscriber may enroll their dependent child and request changes to their health plan coverage as described under subsection (3) of this section. An employee submits the required form(s) to their employing agency. A Continuation Coverage subscriber submits the required form(s) to the PEBB Program.
2. If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:
   a. The child's other parent; or
   b. Child support enforcement program.
3. Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
   a. The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;
   b. An employee who has waived PEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;
   c. The subscriber's selected health plan will be changed if directed by the NMSN;
   d. If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; or
   e. If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.
4. Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.
5. When a NMSN requires a spouse, former spouse, or other individual to provide coverage for a dependent enrolled in PEBB coverage and that coverage is in fact provided, the dependent may be removed from the subscriber's PEBB insurance coverage prospectively.

Medicare entitlement

If a subscriber or their enrolled dependent becomes entitled to Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

For an employee and their enrolled spouse or state-registered domestic partner age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, an employee age 65 and older may choose to waive their PEBB medical plan and choose Medicare as their primary insurer. If an employee does so, the employee cannot enroll in PEBB medical. The employee can enroll again in PEBB medical during a special open enrollment or annual open enrollment.

In most situations, an employee and their spouse or state-registered domestic partner can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment. If Medicare entitlement is due to disability, the member must contact Medicare about deferral of premiums.

Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan will become secondary. See "Options for coverage under PEBB retiree insurance" on page 123.

If a Continuation Coverage subscriber or their dependent is entitled to Medicare, federal regulations require enrollment in Medicare the month before turning age 65. Otherwise, the Medicare effective date may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first entitled, a Medicare late enrollment penalty may apply.

When medical coverage ends

Medical coverage ends on the following dates:

1. On the last day of the month when any member ceases to be eligible;
2. On the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
   - On the date specified in an employee's letter of resignation; or
   - On the date specified in any contract or hire letter, or on the effective date of an employer-initiated termination notice.
3. On the date a medical plan terminates. If that should occur, the subscriber will be given the opportunity to enroll in another PEBB medical plan.

Premium payments and applicable premium surcharges become due the first of the month in which medical coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if a member dies or asks to terminate their medical plan before the end of the month.

If a member or newborn eligible for benefits under obstetric and newborn care is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the member is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The member is discharged from the hospital or from a hospital to which the member is directly transferred;
- The member is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The member is discharged from the skilled nursing facility or from a skilled nursing facility to which the member is directly transferred;

- The member is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical coverage ends, the member may be eligible for continuation coverage or conversion to other health plan coverage if they apply within the timelines explained in the "Options for continuing PEBB medical coverage" on page 123, or "Conversion of coverage" on page 124.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. 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 premiums 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, the subscriber's medical coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid.

An employee who needs the required forms for an enrollment or benefit change may contact their personnel, payroll, or benefits office. A Continuation Coverage subscriber may contact the PEBB Program at 1-800-200-1004 (TRS: 711).

Options for continuing PEBB medical coverage

An employee and their dependents covered by this medical plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for a PEBB medical plan member:

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the member's PEBB medical plan coverage ends due to a qualifying event. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some members who are not qualified beneficiaries under federal COBRA continuation coverage. PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types. A member who qualifies for both PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options. The PEBB Program administers both continuation coverage options. Refer to the *PEBB Continuation Coverage Election Notice* booklet for details.

A subscriber also has the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The subscriber's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Options for coverage under PEBB retiree insurance

A retiring employee, eligible elected or full-time appointed official leaving public office, or a dependent becoming eligible as a survivor is 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.

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB insurance coverage in accordance with the FMLA. The employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee's monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

If an employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency while on approved leave. For additional information on continuation coverage, see the section titled "Options for continuing PEBB medical coverage."

Paid Family Medical Leave Act

An employee on approved leave under the Washington state Paid Family and Medical Leave (PFML) program may continue to receive the employer contribution toward PEBB insurance coverage in accordance with the PFML. The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay the employee monthly premium contribution and applicable premium surcharges during this period to maintain eligibility. If the employee's monthly premium or applicable premium surcharges remain unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharges were paid.

If an employee exhausts the period of leave approved under PFML, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharges set by the HCA, with no contribution from the employing agency while on approved leave. For additional information on continuation coverage, see the section titled "Options for continuing PEBB medical coverage".

General information

Payment of premium during a labor dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employing agency may pay premiums directly to the plan or the Health Care Authority (HCA) if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or terminated, HCA shall notify the employee immediately by mail to the last address of record, that the employee may pay premiums as they become due.

If coverage is no longer available to the employee under this certificate of coverage, then the employee may purchase an individual medical plan from this plan at a premium rate consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Conversion of coverage

A member (including a spouse and dependent of a subscriber terminated for cause) have the right to switch from PEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan, and are not eligible for Medicare or covered

under another group insurance coverage that provides benefits for hospital or medical care. A member must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion program differ from those of the member's current group medical plan. To receive detailed information on conversion options under this medical plan, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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 coverage from this plan for Just Cause.

An eligible dependent may have coverage terminated by HCA for the following reasons:

1. 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;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharges when due;
4. Misconduct. Examples of such termination include, but are not limited to the following:
    a. 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; or
    b. 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 the HCA, its employees, or other persons.

The PEBB Program will enroll an employee and their eligible dependents in another PEBB medical plan upon termination from this plan.

Appeal rights

Any current or former employee of a state agency and their dependent may appeal a decision by the employing state agency regarding PEBB eligibility, enrollment, or premium surcharges to the employing agency.

Any current or former employee of an employer group or their dependent may appeal a decision made by an employer group regarding PEBB eligibility, enrollment, or premium surcharges to the employer group.

Any member may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Any member may appeal a decision regarding administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Medical plan eligibility and enrollment for a retiree or survivor

In these sections, we use the term "subscriber" to refer to a retiree or survivor. The term "enrollee" refers to a subscriber and their dependents. The term "retiree" or "retiring employee" includes an elected or full-time appointed official of the legislative and executive branch of state government eligible to continue enrollment in Public Employees Benefits Board (PEBB) retiree insurance coverage. The term "retiree" or "retiring school employee" includes a retiring non-represented employee of an educational service district (ESD) or retiring school employee from a School Employees Benefits Board (SEBB) organization. Additionally, "health plan" is used to refer to a plan offering medical or dental, or both, developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

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 a completed *PEBB Retiree Coverage Election Form*. 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 an appeal. Information about appealing a PEBB Program decision can be found on page 137 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

The PEBB Program determines if a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a completed *PEBB Retiree Coverage Election Form*. 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 an appeal. Information about appealing a PEBB Program decision can be found on page 137 of this certificate of coverage. For information on how to enroll, see the "Enrollment" section.

A retiree, a survivor, and their enrolled dependents are required to enroll in Medicare Part A and Part B if they are entitled. Any member who is entitled to Medicare must enroll and stay enrolled in Medicare Part A and Part B to enroll or continue enrollment in a PEBB retiree health plan. A subscriber must provide a copy of their or their dependent's Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of Medicare enrollment. If a subscriber or their dependent is not entitled to either Medicare Part A or Part B on their 65th birthday, a copy of the denial letter from the Social Security Administration must be provided to the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the "Enrollment" section. The PEBB Program verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber's:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;

b. 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;

c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

d. 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;

e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child 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; and

g. Children of any age with a developmental or physical disability that renders the child 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, within 60 days of the last day of the month 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 under this subsection if they later become incapable of self-support; and
- The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the subscriber.

4. Parents of the subscriber.

a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

- The parent maintains continuous enrollment in PEBB medical;
- The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
- The subscriber continues enrollment in PEBB insurance coverage; and
- The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

Deferring enrollment in a PEBB retiree health plan

A retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor who wants to defer enrollment in a PEBB retiree health plan must submit a *PEBB Retiree Coverage Election Form* to the PEBB Program within the PEBB Program's enrollment timelines. Deferring enrollment will also defer enrollment for all eligible dependents, except as described below. A retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor who do not enroll in a PEBB retiree health plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber 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 a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in Medicare Parts A and B and a Medicaid program that includes payment of medical and hospital benefits. Eligible dependents who are not enrolled in Medicaid coverage that includes payment of medical and hospital benefits may be enrolled.
- Beginning January 1, 2014, subscribers who are not eligible for Part A and Part B of Medicare may defer enrollment in a PEBB health plan when the subscriber is enrolled in coverage through a health care exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

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

If a retiree or a survivor defers enrollment in PEBB medical, enrollment must also be deferred for PEBB dental.

Note: PEBB retiree health plan enrollment is deferred if a retiree or a survivor becomes newly eligible for PEBB benefits as an employee and enrolls in a PEBB health plan. If a retiree or a survivor becomes newly eligible for SEBB benefits as a school employee and enrolls in a SEBB health plan, they should consider deferring enrollment in a PEBB retiree health plan.

How to enroll

A subscriber or dependent can enroll in only one PEBB medical plan even if eligibility criteria is met under two or more subscribers.

To enroll in PEBB retiree insurance coverage, a retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor must submit a *PEBB Retiree Coverage Election Form* along with any other required form(s) to the PEBB Program. The form(s) must be received within the required enrollment time limits described under "When medical coverage begins." The first premium payment and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends, as described in "When medical coverage begins."

A retiree or a survivor who requests to enroll an eligible dependent must include the dependent's enrollment information on the form and provide any required document(s) as proof of the dependent's eligibility to the PEBB Program. The PEBB Program will not enroll dependents if their eligibility is not verified.

A retiree or survivor may also enroll eligible dependents during the PEBB Program's annual open enrollment (see "Annual open enrollment" on page 131) or during a special open enrollment (see "Special open enrollment" on page 132). The retiree or survivor must provide proof of the event that created the special open enrollment.

If a retiree or a survivor elects to enroll a dependent in medical coverage, the dependent must be enrolled in the same PEBB medical plan as the retiree or survivor.

Exception: If a retiree or a survivor selects a Medicare Supplement Plan, non-Medicare members will be enrolled in the Uniform Medical Plan Classic.

A subscriber is required to notify the PEBB Program to remove dependents who are no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child. The notice must be received within 60 days of the last day of the month the dependents no longer meet the eligibility criteria described in the "Eligibility" section on page 126. Consequences for not submitting the notice within the required 60 days may include, but are not limited to:

- The dependent losing eligibility to continue health plan coverage under one of the continuation coverage options described on page 136 of this certificate of coverage;
- The subscriber being billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When medical coverage begins

For an eligible retiring employee or retiring school employee, and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.** Medical coverage begins the first day of the month after the loss of employer-paid coverage, COBRA coverage, or continuation coverage.

For an eligible elected or full-time appointed official and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the official leaves public office.** 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 dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the death of the retiree.** Medical coverage will be continued without a gap subject to payment of premiums and applicable premium surcharges.

For an eligible survivor of an employee or school employee and their dependents, the PEBB Program must receive the required form(s) **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, educational service district, or SEBB insurance coverage ends.** 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, educational

service district, or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement, and their dependents, the PEBB Program must receive the required form(s) and formal determination letter **no later than 60 days after the date on the determination letter.** Medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible survivor of an emergency service personnel killed in the line of duty, the PEBB Program must receive the required form(s) **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 a health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

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, the PEBB Program must receive the required forms **no later than 60 days after a loss of other qualifying coverage.** Medical coverage begins the first day of the month after the loss of the other qualifying coverage. See the "Enrollment following deferral" section for additional enrollment time lines.

For a retiree, a survivor, or their dependent enrolling **during the PEBB Program's annual open enrollment,** medical coverage begins on January 1 of the following year.

For a retiree, a survivor, or their dependent enrolling **during a special open enrollment,** medical coverage begins the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the coverage is effective on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage begins as follows:
   a. For the newly born child, medical coverage begins the date of birth;
   b. For a newly adopted child, medical coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
   c. For a spouse or state registered domestic partner of a subscriber, medical coverage begins the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a dependent child with a disability, medical coverage begins on the first day of the month following eligibility certification.

Enrollment following deferral

A retiree or survivor who defers enrollment in a PEBB retiree health plan:

- **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 coverage through a health care exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB 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 as a dependent in a medical plan sponsored by PEBB, a Washington State educational service district, 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, a Washington State educational service district, or SEBB ends, or such coverage under COBRA or continuation coverage ends.
- May enroll in a PEBB medical plan if they receive formal notice that the HCA has determined it is more cost-effective to enroll in PEBB medical than a medical assistance program.

To enroll in a PEBB medical plan, the PEBB Program must receive a *PEBB Retiree Coverage Election Form* along with any other required form(s) and proof of continuous enrollment in one or more qualifying coverages during the timelines described in this section.

A retiree or survivor should contact the PEBB Program or visit **hca.wa.gov/pebb-retirees** to get the required form(s), information on premiums, and available medical plans.

Annual open enrollment

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

- Enroll in a medical plan following a deferral;
- Defer or terminate their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change their medical plan.

The subscriber must submit the change online in PEBB My Account or return the required form(s) and any other required documents to the PEBB Program. The form(s) must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Exceptions:

- An enrolled retiree or survivor may defer enrollment in a PEBB retiree health plan at any time by submitting the required form(s) to the PEBB Program. Enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the required form(s) are received. If the forms are received on the first day of the month, enrollment will be deferred effective that day.

- A retiree or survivor who deferred their enrollment in a PEBB retiree health plan may enroll as described in the "Enrollment following deferral" section.
- An enrolled retiree or survivor may voluntarily terminate enrollment in a PEBB retiree health plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB retiree health plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, enrollment will be terminated on the last day of the previous month. 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.

Special open enrollment

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

Exceptions:

- An enrolled retiree or survivor may defer enrollment in a PEBB retiree health plan at any time by submitting the required form(s) to the PEBB Program. Enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the required form(s) are received. If the forms are received on the first day of the month, enrollment will be deferred effective that day.
- A retiree or survivor who deferred their enrollment in a PEBB retiree health plan may enroll as described in the "Enrollment following deferral" section.
- An enrolled retiree or survivor may voluntarily terminate enrollment in a PEBB retiree health plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB retiree health plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, enrollment will be terminated on the last day of the previous month. 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.

To make an enrollment change, the subscriber must submit the required form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required form(s), the PEBB Program will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exceptions:

- A subscriber has six months from the date of their or their dependents enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. 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.
- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, 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.

When may a subscriber change their health plan?

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

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.

5. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;
6. 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);
7. Subscriber or their dependent becomes entitled to 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;
8. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
9. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or their dependent's entitlement to Medicare the subscriber must select a new health plan;
10. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Subscriber or 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 if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy.

Note: If a member's provider or health care facility discontinues participation with this plan, the member may not change medical plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a

continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can a subscriber enroll or remove eligible dependents?

To enroll a dependent, the subscriber must include the dependent's enrollment information on the form and provide any required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering for a state-registered domestic partnership;
    b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. 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);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.

5. 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;
6. 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 the change in residence resulted in the dependent losing their health insurance;
7. 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.);
8. Subscriber or their dependent becomes entitled to 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;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Medicare entitlement

Medicare Part A and Medicare Part B

If a subscriber or their enrolled dependent becomes entitled to Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare entitled subscriber or their dependent must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. The only exception is if retirement occurred before July 1, 1991, or the member is a dependent

of an employee or school employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage. In most cases, Medicare will become the primary insurance coverage, and the PEBB retiree medical plan will become the secondary insurance coverage.

Medicare Part D

The PEBB Program has determined that this medical plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, a subscriber or their enrolled dependent cannot enroll in a Medicare Part D plan and remain in this medical plan. If the subscriber terminates this medical plan, they may contact the PEBB Program to request a certificate of creditable coverage. If creditable prescription drug coverage is not maintained, Medicare Part D premiums may be higher in the future.

If a subscriber or their enrolled dependent chooses to enroll in a Medicare Part D plan, PEBB retiree insurance coverage may only be continued by enrolling in the PEBB-sponsored Medicare supplement plan.

When medical coverage ends

Medical coverage ends on the following dates:

1. On the last day of the month when any member ceases to be eligible;
2. On the date a medical plan terminates. If that should occur, the subscriber will be given the opportunity to enroll in another PEBB medical plan; or
3. On the last day of the month in which the monthly premium and applicable premium surcharges were paid. The subscriber is responsible for timely payment of premiums and applicable premium surcharges. 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, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid. A full month's premium is charged for each calendar month of coverage. Payments are not prorated during any month, even if a member dies or if the subscriber requests to terminate their medical plan before the end of a month.

If a member or newborn eligible for benefits under obstetric and newborn care is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the member is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The member is discharged from the hospital or from a hospital to which the member is directly transferred;
- The member is discharged from a skilled nursing facility when directly transferred from a hospital when the nursing facility confinement is in lieu of hospitalization;
- The member is discharged from a skilled nursing facility or from a skilled nursing facility to which the member is directly transferred;
- The member is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical coverage ends, a member may be eligible for continuation coverage or conversion to other health plan coverage if they apply within the timelines explained in the "Options for continuing PEBB medical coverage" below or "Conversion of coverage" on below.

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 law and regulation and also includes coverage for some members who are not qualified beneficiaries under federal COBRA continuation coverage.

The PEBB Program administers this coverage. Contact the PEBB Program at 1-800-200-1004 (TRS: 711) or refer to the *PEBB Continuation Coverage Election Notice* booklet for details.

Options for continuing coverage under PEBB retiree insurance

A dependent becoming eligible as a survivor of a retiree is 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 information

Conversion of coverage

A member (including a spouse and dependent of a subscriber terminated for cause) have the right to switch from PEBB group medical coverage to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan, and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care. A member must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion plan differ from those of the member's current group medical plan. To obtain detailed information on conversion options under this medical plan, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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 coverage from this plan for Just Cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

1. 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;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharges when due;

4. Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:
    a. 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;
    b. 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 the 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 member may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges (if applicable) to the PEBB Appeals Unit. Learn more at **hca.wa.gov/pebb-appeals**.

Fax: 360-586-9080

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 member may appeal a decision regarding the administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Customer service

For questions about PEBB retiree eligibility and enrollment, please contact the PEBB Program at 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/pebb-retirees**. For questions about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or visit **medicare.gov**.

General provisions

UMP is administered by third-party vendors under contract with the Washington State Health Care Authority.

What you need to know: your rights and responsibilities

To ensure 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:

- Be treated with respect.
- Be informed by your providers about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Ask your provider to submit secondary claims to Medicare, if applicable.
- On request, receive information from the plan about:
  - How new technology is evaluated for inclusion as a covered service.
  - Technologies and treatments currently under review by the Health Technology Clinical Committee (HTCC).
  - Services and treatments that have completed HTCC review and how that affects coverage by UMP.
  - How the plan reimburses providers.
  - Preauthorization review requirements.
  - Providers you select and their qualifications.
  - The plan and preferred providers.
  - Your covered expenses, exclusions, reductions, and maximums or limits.
- Keep your medical records and personal information confidential as described in the Notice of Privacy Practices, available online at **regence.com/ump/pebb**.
- Get a second opinion about your provider's care recommendations.
- Make decisions with your providers about your health care.
- Make recommendations about member rights and responsibilities.
- Have a translator's assistance, if required, when calling the plan.
- Complain about or appeal plan services or decisions, or the care you receive.
- Receive:
  - All covered services and supplies determined to be medically necessary as described in this certificate of coverage, subject to the maximums, limits, exclusions, deductibles, and coinsurance.
  - Courteous, prompt answers from the plan.
  - Timely, proper medical care without discrimination of any kind — regardless of health status or condition, sex, ethnicity, race, marital status, color, national origin, age, disability, or religion.
  - A written explanation from the plan about any request to refund an overpayment.

As a plan member, you have the responsibility to:

- Understand your plan benefits, including what is covered, preauthorization and notice requirements, and other information described in this certificate of coverage.
- Understand how to contact the plan for more information and help with any covered service or information described in this certificate of coverage.

- Contact the plan as soon as possible if you do not understand what is covered, if you have any questions, or if you need information.
- Keep your mailing address current by reporting changes as follows:
  - **Employees:** to your personnel, payroll, or benefits office.
  - **Retirees and PEBB Continuation Coverage members:** to the PEBB Program. Send your address changes to:
    Health Care Authority
    PEBB Program
    PO Box 42684
    Olympia, WA 98504
- Confirm provider and facility network status before every visit.
- Understand how UMP coverage coordinates with other insurance coverage you may have, including Medicare.
- Enroll in Medicare Part A and Part B if you are retired and you or your enrolled dependents are entitled to Medicare Part A and Part B. You must notify the PEBB Program when you enroll.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with the plan or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your coinsurance and deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to the plan any outside sources of health care coverage or payment.
- Return your completed Multiple Coverage Inquiry questionnaire you receive from the plan in a timely manner to prevent delay in claims payment.
- Use preferred providers when available.

Information available to you

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. You may find the following information in this certificate of coverage:

- Benefit exclusions, reductions, and maximums or limits (see pages 89–97).
- Clear explanation of complaint and appeal procedures (see pages 106–111).
- Definition of terms (see pages 143–163).
- List of covered expenses (see pages 27–71).
- Policies regarding prescription drug coverage and how the plan adds and removes drugs from the UMP Preferred Drug List (see pages 72 and 78).
- Preventive health care benefits that are covered (see pages 58 and 79).
- Process for preauthorization, notice, or review (see page 86-89and page 110).

You may find the following at **regence.com/ump/pebb**, or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711):

- Accreditation information, including measures used to report the plan's performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.
- 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 141).
- 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) and Uniform Glossary of Terms (UGT).
- When the plan may retroactively deny coverage for preauthorized medical services.

The following are available through your medical online account at **regence.com** or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711):

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

The following are available at **regence.com/ump/pebb/benefits/prescriptions** or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711):

- The UMP Preferred Drug List.
- Clinical coverage criteria applicable to prescription drugs that require preauthorization.
- Prescription drug claims history and deductible status (through your online prescription drug account).

You may also call UMP Customer Service at 1-888-849-3681 (TRS: 711) for an annual accounting of all payments made by the plan that have been counted against medical payment limits, day limits, visit limits, or other limits on your coverage. The plan will provide a written summary of payments within 30 calendar days of your request. Some of this information is also available through your online account at **regence.com**.

You may call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) with questions about coverage of and limitations on prescription drugs.

The plan does not prevent or discourage providers from telling you about the care you require, including various treatment options and whether the provider thinks that care is consistent with the plan's coverage criteria. You may, at any time, get health care outside of plan coverage for any reason; however, you must pay for those services and supplies. In addition, the plan does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of your health information

The plan follows our *Notice of Privacy Practices,* available online at **regence.com/ump/pebb** or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711). 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 members or other persons unless the patient is a minor, or the plan has received written authorization to release personal health information to the other person.

In most cases, the plan must have written authorization to communicate with anyone but the member (patient). However, a parent or legal guardian may act as a representative for a member under age 13 without written authorization, except for issues involving contraceptive use. For members 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:

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

To authorize release of protected health information, you must complete an Authorization to Disclose Protected Health Information form. The forms for medical and prescription drug appeals are different. To get the forms, follow the instructions below:

- Medical appeals: Call UMP Customer Service at 1-888-849-3681 (TRS: 711) or use your **regence.com** account.
- Prescription drug appeals: Call WSRxS Customer Service at 1-888-361-1611 (TRS: 711) or download the form at **hca.wa.gov/ump-forms-pubs**.

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 Washington State Health Care Authority may require you to give information when needed to determine eligibility, administer benefits, or process claims. This could include medical and other records. The plan could deny coverage if you do not provide the information when requested.

Relationship to Blue Cross and Blue Shield Association

The Washington State Health Care Authority (HCA), on behalf of itself and you, expressly acknowledges its understanding that the administrative services contract constitutes an agreement solely between the HCA and Regence BlueShield. Regence BlueShield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield

plans (the association). The association permits Regence BlueShield to use the Blue Cross and Blue Shield service marks in the state of Washington, for those counties designated in the service area, and that Regence BlueShield is not contracting as the agent of the association.

The HCA, on behalf of itself and you, further acknowledges and agrees that it has not entered into the administrative services contract based upon representations by any person or entity other than Regence BlueShield. The HCA also acknowledges that no person or entity other than Regence BlueShield will be held accountable or liable to HCA or you for any of Regence BlueShield's obligations to the HCA or you created under such agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield other than those obligations created under other provisions of the administrative services contract.

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 UMP. See page 141 for more information about the confidentiality of your health information.

Right of recovery

UMP has the right to a refund of incorrect payments. UMP 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, Regence BlueShield will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the plan by reason of epidemic, disaster, or other cause or condition beyond Regence BlueShield's control.

Governing law and discretionary language

The plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Washington State Health Care Authority delegates discretion to Regence BlueShield and WSRxS for the purposes of paying benefits under this plan only if it is determined that you are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations. The scope of judicial review is limited to a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. The reservation of discretion made

under this provision only establishes the scope of review that a court will apply when you seek judicial review of a determination under the plan, and the court will determine the level of deference that it will accord such determinations.

Anti-assignment

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

No waiver

The failure or refusal of either party to demand strict performance of the plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the plan will be considered waived unless such waiver is reduced to writing and signed by one of the Washington State Health Care Authority's authorized officers.

Definitions

Allowed amount, medical services

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 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 "Preferred Provider Organization (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 (providers not contracted with Regence BlueShield) within the Regence BlueShield service area, the amount Regence has determined to be reasonable charges for covered services and supplies.

The allowed amount may be based upon the billed charges for some services, as determined by Regence or as otherwise required by law. Where, although it does not qualify as a preferred provider hereunder, one of these providers has a contract with Regence, the provider will accept the allowed amount as payment in full.

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 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 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, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Allowed amount, prescription drugs

The **allowed amount for prescription drugs** is based on WSRxS' contractually agreed reimbursement, unless other contractual arrangements or terms apply. All covered prescription drug claims are paid based on this allowed amount.

Ambulatory surgery center (ASC)

An **ambulatory surgery center (ASC)** is a health care facility that specializes in providing surgery, pain management, and certain diagnostic services in an outpatient setting. ASC-qualified procedures are typically more complex than those done in a doctor's office but not so complex as to require an overnight stay. Procedures commonly performed in these centers include colonoscopies, endoscopies, cataract surgery, orthopedic, and ENT (ear, nose, and throat) procedures. An ASC may also be known as an outpatient surgery center or same-day surgery center.

Annual open enrollment

Annual open enrollment is a period of time defined by the HCA when you 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 pages 106–111 for an explanation of appeals and how the process works.

Authorized representative

An **authorized representative** is someone you have designated in writing to communicate with the plan on your behalf. See page 141 for how this works.

Balance billing

Balance billing is a provider billing you for the difference between the billed amount and the allowed amount. Allowed amount is the most the plan pays for a specific covered service or supply. For example, if the billed amount is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Preferred and participating providers may not balance bill you for covered services above the allowed amount. See an example of how this works on page 12.

Brand-name drug

A **brand-name drug** is a prescription drug sold under the proprietary name or trade name selected by the manufacturer.

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 inpatient treatment to determine if inpatient treatment is medically necessary.

Coinsurance

Coinsurance is the percentage of the allowed amount you must pay the provider on claims for which the plan pays less than 100 percent of the allowed amount. This includes most medical services and prescription drugs.

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. Please see description and examples in "If you have other medical coverage" on page 97.

Cost-share

Cost-share means the amount you pay for a service, supply, or prescription drug. This may be a deductible (see page 19), coinsurance (see page 20), or amounts not covered by the plan.

Custodial care

Custodial care is care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising prescription drugs that are ordinarily self-administered.

Deductible

The **deductible** is a fixed dollar amount you must pay each calendar year for your health care expenses before the plan starts paying for covered services. For this plan, you must pay your deductible for medical and prescription drug expenses before the plan starts paying for covered medical services and covered prescription drugs. You pay the first $1,400 in health care expenses one member enrolled; you pay the first $2,800 in health care expenses for two or more members enrolled. . Only expenses covered by the plan apply to your deductible. For example, if you receive LASIK surgery (see exclusion on page 92), the plan does not cover that service; therefore, the amount you pay is not applied to your deductible. Some services are exempt from this deductible (see the "Summary of benefits" on pages 32–34). See page 19 for details on how the deductible works.

Dependent

A **dependent** is a spouse, state-registered domestic partner, child, or other eligible family member covered by the plan under the subscriber's account (see "Eligible dependents" on page 114).

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 91 for examples of DME that are not covered.

Efficacy

Efficacy is the extent to which a specific intervention, procedure, service, supply, or prescription drug produces the desired effect under ideal conditions (in a controlled environment under lab circumstances).

Emergency

See "Medical emergency."

Emergency fill

Emergency fill is a process where the plan covers a limited quantity of a prescription drug on an emergency basis while the plan processes your drug preauthorization request.

Enrollee

An **enrollee** is an eligible employee, former employee or former dependent, survivor, or dependent enrolled in this plan (see also "Member," "Subscriber," and "Dependent").

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 (prescription or non-prescription)' 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, in the plan's judgment, experimental or investigational:

- Approval of the treatment or one of its components by one or more government agencies (e.g., U.S. Food and Drug Administration (FDA)) is required but has not been obtained at the time the agent is requested or administered.
- The treatment has not been demonstrated to improve net health outcome.
- 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 improvement has not been shown to be attainable outside the laboratory or clinical research setting.
- The treatment is not provided by a provider that has demonstrated medical proficiency in the provision of the treatment.
- The treatment is considered to be experimental or investigational by U.S. standards.
- The treatment is only available in the United States as part of a clinical trial or research program for the illness or condition being treated.
- 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.
- 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 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 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 (see definition on page 161) or, if not, then in a majority of relevant peer-reviewed medical literature (see definition on page 156); or by the United States Secretary of Health and Human Services. See on page 80 for more information on experimental or investigational drugs.

Explanation of Benefits (EOB)

An **Explanation of Benefits (EOB)** is a detailed account of each medical claim processed by the plan, which is sent to you to notify you of claim payment or denial. You may also sign in to your Regence account at **regence.com** or call UMP Customer Service at 1-888-849-3681 (TRS: 711) to request a copy of an EOB. 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 enrollees. See "Allowed amount, medical services" on page 143 for more details.

Formulary

The UMP Preferred Drug List is sometimes called a **formulary** (see page 71).

Generic drug

A **generic drug** is a prescription drug with the same active ingredient(s), but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent. A generic drug is therapeutically equivalent to the brand-name prescription drug, which means it works like the brand-name drug in dosage, strength, performance, and use. All generic drugs sold in the U.S. must be reviewed and approved by the FDA, and meet the same quality and safety standards as brand-name drugs.

Generic equivalent

A **generic equivalent** is a generic prescription drug that has the same active ingredients as its brand-name counterpart. For a generic drug to be considered "equivalent," it has to be approved by the FDA as being interchangeable with that brand-name drug. Under Washington State law, the pharmacist is required to dispense a generic equivalent in place of a brand-name drug, unless your provider objects. See "Substitution under Washington State Law" page 83 for how this works.

Grievance

A **grievance** is also called a complaint. See page 106 for details on how these are handled.

Health Care Authority (HCA)

The **Health Care Authority (HCA)** is the Washington State agency that administers the Uniform Medical Plan (UMP Classic, 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; or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A health intervention is new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Health Savings Account (HSA)

A **Health Savings Account** (HSA) is a tax-advantaged spending and savings account that may be used to pay for qualified medical expenses. IRS rules govern who may have an HSA and how the funds may be spent. The HSA is funded by pre-tax contributions from you, your employer, or both. See page 21 for information on contribution limits. You may contribute up to the annual limit even if your health plan deductible is lower. The rates are subject to change every year, adjusted for inflation.

High-deductible health plan (HDHP)

A **high-deductible health plan (HDHP)** is any plan with an annual deductible of at least $1,400 for an individual or $2,800 for a family. UMP CDHP is an HDHP with an HSA.

Home

Home is where the member is located at the time of service other than facility or other place of origin.

Home health agency

A **home health agency** is an agency or organization that:

- Provides a program of home health care;
- Practices within the scope of its license as a provider of home health services; and
- Is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a preferred provider.

Hospice

Hospice is services provided by a state-licensed hospice program in the home or in a hospice facility to terminally ill patients. Services include pain relief care and support services that address the needs of terminally ill patients and their families without intent to cure.

Hospital

A **hospital** is an institution accredited under the Hospital Accreditation Program of the Joint Commission and licensed by the state where it is located. Any exception to this must be approved by the plan.

The term hospital **does not** include a convalescent nursing home or institution (or a part of one) that:

- Furnishes primarily domiciliary or custodial care (see definition on page 146).
- Is operated as a school.
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Inpatient rate

The plan pays 100 percent of the allowed amount after your deductible at preferred facilities.

The plan pays for professional services, such as provider consultations or lab tests based on the provider's network status during an inpatient stay:

- Preferred providers: The plan pays 85 percent of the allowed amount.
- Participating providers: The plan pays 60 percent of the allowed amount.
- Out-of-network providers: 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, WSRxS, or the Health Care Authority. An IRO is intended to provide unbiased, independent clinical and benefit expertise, as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the plan's decision is consistent with state law and the applicable COC. The plan pays the IRO's charges.

Limited benefit

TIP: This definition applies only to those benefits in which it is used in this certificate of coverage. Other benefits have additional limits related to medical necessity (see pages 152–153) or preauthorization of services (see page 86).

A **limited benefit** is a benefit that is limited to a certain number of visits or a maximum dollar amount. The limit applies to these benefits even if the provider prescribes additional visits and even if the visits are medically necessary. The plan does not make exceptions to benefit limits.

For benefits limited to a certain number of visits, any visits that are applied to your deductible (see page 19) also count against your annual visit or dollar limit. In addition, visits that are paid by another health plan that is primary apply to the plan limit. For example, if your primary plan applies your first six massage therapy sessions to your deductible, you may receive coverage for 10 more sessions in that calendar year, for a total of 16 visits (the visit maximum for massage therapy).

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 benefits.

Maintenance care

Maintenance care is a health intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed.

Maintenance care may apply to several different services, including but not limited to physical therapy, speech therapy, neurodevelopmental therapy, home health care, and skilled nursing care.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the yearly amount the federal government sets as the most each individual or family can be required to pay in cost-sharing during the plan year for covered services received from network providers at network facilities. It applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medical

Medical generally refers to all plan benefits and services other than those covered under preventive care and prescription drug benefits (except as the term is used in the eligibility sections of this certificate of coverage).

Medical benefit

Medical benefit refers to services subject to the deductible, and coinsurance. See pages 19–20 for a description of how this works.

Medical emergency

A **medical emergency** means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the person's health, or with respect to a pregnant female, her health or the health of her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Medical food

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 patient must provide documentation demonstrating medical necessity when requested by the plan, or services may be denied as not medically necessary. Some medically necessary services may not be covered by the plan. All benefits or services that are medically necessary are subject to the coverage limitations, exclusions, and provisions of the plan. It is important to review this certificate of coverage or verify coverage with UMP Customer Service at 1-888-849-3681 (TRS: 711) before receiving services.

Medically necessary or **medical necessity** means health care services, supplies, prescription drugs, or interventions that a treating licensed health care provider recommends, and all the following conditions are met:

- The purpose of the service, supply, intervention, or prescription drug is to treat or diagnose a medical condition.
- It is the appropriate level of service, supply, or intervention, or prescription drug dose considering the potential benefits and harm to the patient.
- The level of service, supply, intervention, or prescription drug dose is known to be effective in improving health outcomes.
- The level of service, supply, intervention, or prescription drug recommended for this condition is cost-effective compared to alternative interventions, including no intervention.
- For services that have been reviewed by the Health Technology Clinical Committee (HTCC), the HTCC's coverage conditions are met. HTCC decisions may be referenced at **hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews**.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, prescription drug, or drug dose does not, in itself, make it medically necessary.

The plan may require proof that services, interventions, supplies, or prescription drugs (including court-ordered care) are medically necessary. No benefits will be provided if the proof is not received or is not acceptable, or if the service, supply, prescription drug, or drug dose is not medically necessary. Claims processing may be delayed if proof of medical necessity is required but not provided by the health service provider.

The plan uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and interventions not yet in widespread use for the medical condition and patient indications being considered. State law requires that UMP determine whether a service or intervention is covered based on decisions made by the Health Technology Clinical Committee (HTCC) (see page 32); these decisions may be referenced at **hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews**. If the HTCC determines that a health technology (service) will be covered only under certain conditions, the plan is required by law to use the HTCC coverage criteria when evaluating whether the service is medically necessary. If the HTCC determines that a service will not be covered, then the service is considered to be not medically necessary by the plan.

The plan uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and interventions not yet in widespread use for the medical condition and patient indications being considered.

For health technologies that have been reviewed by the HTCC and are covered with limitations, the plan uses the HTCC's coverage criteria to determine medical necessity. For other services, interventions, or supplies the plan first uses scientific evidence, then professional standards, then expert opinion to determine effectiveness. "Effective" means that the prescription drug, drug dose, intervention, supply, or level of service may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. The scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determining medical necessity. If no scientific evidence is available, professional U.S. standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that the plan should deny coverage of interventions in the absence of conclusive scientific evidence. Interventions may meet the plan's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, prescription drug, or intervention is considered "cost effective" if the benefits and harms relative to the costs represent an economically efficient use of resources for the patients with this condition. The plan applies this criterion based on the characteristics of the individual patient. Cost-effective does not necessarily mean the lowest price.

Preventive services not covered by the plan's preventive care benefit will still be covered under the medical benefit if medically necessary.

A "health intervention" is an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, or palliate a medical condition (such as a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity" the plan does not consider a health intervention separately from the medical condition and patient indications it is applied to.

"Treating provider" means a licensed health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes 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.

Member

A **member** is an eligible employee, retiree, former employee or former dependent, survivor, or dependent enrolled in the plan (see also "Enrollee").

Network

Network is the facilities, providers, and suppliers your health plan contracts with to provide health care services.

Network pharmacy

A **network pharmacy** contracts with WSRxS to provide prescription drug coverage to UMP members at the contracted rate (allowed amount). See pages 75–76 for details of the advantages of using network pharmacies.

Network rate

The **network rate** means payment at the in-network level.

Network status

Network status refers to whether a provider is preferred, participating, or out-of-network with the plan.

Network vaccination pharmacy

A **network vaccination pharmacy** is a pharmacy that contracts with WSRxS to give covered immunizations to plan members at the network rate. You may find out which pharmacies are contracted at **regence.com/ump/pebb/benefits/prescriptions** or by calling WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Noncovered prescription drugs

Noncovered prescription drugs refer to any drug that is only covered through exception. Some drugs may be medically necessary, yet still are not covered. See "Prescription drugs UMP does not cover" on page 85.

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 “What the plan does not cover” on pages 89–97 Services that the Health Technology Clinical Committee (HTCC) determines are not covered are noncovered (excluded) services.

Nonduplication of benefits

Nonduplication of benefits is how UMP coordinates benefits when UMP is your secondary coverage (see definition on page 160). 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. See examples on page 100.

Non-network pharmacy

A **non-network pharmacy** does not contract with WSRxS. See page 77 for what happens if you use a non-network pharmacy to purchase covered prescription drugs.

Nonprescription alternative

A **nonprescription alternative** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you may buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Nonprescription drug

A **nonprescription drug** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you may buy without a prescription.

Normal benefit

The plan's **normal benefit** is the dollar amount of the benefit the plan would normally pay if no other group health plan had the primary responsibility to pay the claim.

Occupational injury or illness

An **occupational injury or illness** is one resulting from work that is for pay or profit.

Orthognathic surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure, growth, sleep apnea, or TMJ disorders; or to correct orthodontic problems that cannot be easily treated with braces.

Out-of-network provider(s)

An **out-of-network provider** is a health care provider that is:

- In the Regence BlueShield service area, but is not contracted as part of Regence BlueShield's Preferred Provider Organization 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 "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

See page 22 for a description of how services by these providers are covered.

Out-of-pocket limit

The **out-of-pocket limit** is the most you pay during a calendar year for covered medical services and prescription drugs before the plan pays 100 percent of the allowed amount to preferred providers and network pharmacies. This limit does not include your premium, balance-billed charges, or services the plan does not cover; see also page 22 for other costs that do not apply to this limit. For more information on how this works, see page 22 under "out-of-pocket limit."

For this plan, the limit is $4,200 for one member enrolled in the plan, or $8,400 if there is two or more members enrolled in the plan. However, no one member may exceed $6,900 in covered out-of-pocket expenses annually. Once the out-of-pocket limit has been reached, the plan pays 100 percent of the allowed amount for covered medical services from preferred providers and 100 percent of the allowed amount for covered prescription drugs and products for the rest of the calendar year. See page 22 for what does and does not apply to this limit.

Your deductible (see page 19) does apply to this limit.

Outpatient rate

- Preferred providers: The plan pays 85 percent of the allowed amount.
- Participating providers: The plan pays 60 percent of the allowed amount.
- Out-of-network providers: The plan pays 60 percent of the allowed amount.

Over-the-counter alternative

An **over-the-counter alternative** drug is a drug that you may buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Over-the-counter drugs

Over-the-counter drugs are medications you may get without a prescription.

Over-the-counter equivalent

An **over-the-counter equivalent** is a drug you may buy without a prescription that has identical active ingredients and strengths as a prescription drug or product in a comparable dosage form.

P&T Committee

See "Pharmacy & Therapeutics Committee."

Participating provider

A **participating provider** is contracted but is in another network. The plan pays these providers at the out-of-network rate (most covered services are paid at 60 percent), but the provider may not balance bill you. Coinsurance paid to a participating provider applies to the out-of-pocket limit. Covered preventive services from participating providers will be paid by the plan at 100 percent of the allowed amount. Covered mental health or substance use disorder services from participating providers will be considered in network.

Peer-reviewed medical literature

Peer-reviewed medical literature is scientific studies printed in journals or other publications in which original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related websites or in-house publications of pharmaceutical manufacturers.

Pharmacy & Therapeutics (P&T) Committee

Pharmacy & Therapeutics (P&T) Committee is a group of providers and other health care professionals who review prescription drugs and make recommendations on the preferred status of prescription drugs on the UMP Preferred Drug List (see page 72).

Physician services

Physician services are health care services provided or coordinated by a licensed medical physician, such as a:

- Medical Doctor (M.D.)

- Doctor of Osteopathic Medicine (D.O.)
- Naturopathic physician (N.D.)

Find the complete list of covered provider types at **regence.com/ump/pebb/benefits/providers/covered-providers**.

Plan

Plan, as referred to in this document, means Uniform Medical Plan Consumer-Directed Health Plan (UMP CDHP), a self-insured PPO plan offered by the PEBB Program. In the eligibility sections (see pages 114–137), "plan" refers to any PEBB-sponsored plan. In the "If you have other medical coverage" section beginning on page 88, "plan" may mean any health insurance coverage.

Preferred Provider Organization (PPO)

A **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 CDHP is a PPO.

Preauthorization

Preauthorization is approval by the plan for coverage of specific services, supplies, or prescription drugs before they are provided to the member. Preauthorization is not a guarantee of coverage. If you or your provider do not receive preauthorization for certain medical services or prescription drugs, the claim may be denied. See "Preauthorizing medical services" on page 86 for how this works. A list of medical services that require preauthorization is available at **regence.com/ump/pebb/benefits/policies** or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711). See page 81 for information on prescription drugs that must be preauthorized.

Preferred drug

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

Preferred Drug List

The UMP **Preferred Drug List** is a list available online that specifies how prescription drugs are covered by the plan. By using this list, you may find out if a prescription drug is covered, if the drug must be ordered through the plan's specialty drug pharmacy, and whether the drug has any limitations (such as needing preauthorization or quantity limits; see pages 80–83).

The UMP Preferred Drug List is based on the Washington Preferred Drug List and recommendations by one of the P&T Committees that partner with WSRxS (see "Who decides which drugs are preferred?" on page 72 for more information).

If your prescription drug is not listed, call WSRxS Customer Service at 1-888-361-1611 (TRS: 711).

Preferred provider(s)

A **preferred provider** is a provider:

- In the Regence service area and contracted as part of Regence BlueShield's Preferred Provider Organization network; or
- Outside the Regence service area and contracted with another Blue Cross or Blue Shield organization in the BlueCard® Program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Prenatal

Prenatal means during pregnancy.

Prescription drug

Prescription drug means a drug approved by the U.S. Food and Drug Administration that can be dispensed only with an order given by a properly authorized person. The designation of a medication as a prescription drug is made by the U.S. Food and Drug Administration.

Preventive care

In this certificate of coverage, **preventive care** means those services described by the Public Health Services Act, Section 2713:

- Services with an A or B rating by the United States Preventive Services Task Force (USPSTF).
- Covered immunizations recommended by Centers for Disease Control and Prevention (CDC).
- Evidence-informed preventive care screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Evidence-informed preventive care and screenings for women as described in HRSA Guidelines in accordance with 45 CFR 147.131 (a).

Preventive rate

- Preferred providers: The plan pays 100 percent of the allowed amount.
- Participating providers: The plan pays 100 percent of the allowed amount.
- Out-of-network providers: The plan pays 60 percent of the allowed amount.

Primary care provider (PCP)

A **primary care provider (PCP)** is a physician (see "Physician services" on page 156), nurse practitioner, or physician assistant provides, coordinates, or helps a patient 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 such as (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 network of providers who are contracted to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates (see "Allowed amount, medical services" on page 143). Preferred providers for UMP CDHP members in 2020 consist of Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers in the BlueCard® Program designated as preferred providers.

Public Employees Benefits Board (PEBB)

The **Public Employees Benefits Board (PEBB)** is a group of representatives, appointed by the governor, that approves insurance benefit plans for employees and establishes eligibility criteria for participation in insurance benefit plans.

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 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, retirees, survivors, and their eligible dependents. Benefits and eligibility are designed by the PEB Board and administered by the Health Care Authority (HCA) as part of a comprehensive benefits package.

Public Employees Benefits Board (PEBB) Program

The **Public Employees Benefits Board (PEBB) Program** is the Washington State Health Care Authority program that administers PEBB benefit eligibility and enrollment.

Qualified medical expense

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

Quantity limit

A **quantity limit** is a limit on how much of a prescription drug you may get for a specific time period (days' supply).

Reconstructive surgery

Reconstructive surgery is surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Regence 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. Please check the website **regence.com** for up-to-date information.

Residential treatment facility

A **residential treatment facility** is a facility licensed to provide residential treatment 24 hours per day to patients requiring residential services such as individual and group counseling and education related to substance use disorder or a mental health diagnosis.

Respite care

Respite care is continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Routine

Routine services are those provided as preventive, not because of an injury or illness. In the case of covered immunizations, routine refers to covered immunizations included on the Centers for Disease Control and Prevention (CDC) schedules (see page 59).

Scientific evidence

Scientific evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Scope of practice

Scope of practice refers to the services a provider may perform and bill for, based on the provider's professional license as issued by local authorities. For example, some provider types may prescribe prescription drugs, and some may not.

Screening

Screening refers to services performed to prevent or detect illness in the absence of disease or symptoms.

Secondary coverage

When you are covered by more than one 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 "If you have other medical coverage" starting on page 97 for more information on how this plan coordinates benefits.

Skilled nursing care

Skilled nursing care is nursing and therapy care in your home or facility that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It is health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care.

Skilled nursing facility

A **skilled nursing facility** is an institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

SmartHealth

SmartHealth is a voluntary wellness program offered by the PEBB Program that allows eligible subscribers to earn wellness incentives. Medicare subscribers enrolled in the retiree plan are not eligible to earn the incentive.

The wellness incentive earned during the 2019 plan year reduces the subscriber's 2020 plan year medical deductible by $125. The wellness incentive earned during the 2020 plan year reduces the subscriber's 2021 plan year deductible by $125. More details on eligibility and program requirements are at **hca.wa.gov/pebb-smarthealth.**

Special rate

These services have unique payment rules, which are described in the "How much you will pay" column on page 25.

Specialty drugs

Specialty drugs are high-cost injectable, infused, oral, or inhaled prescription drugs or products that require special storage or handling and are subject to additional rules. Specialty drugs are identified on the UMP Preferred Drug List. See page 82 for information on how specialty drug prescriptions are handled.

Standard rate

- Preferred providers: The plan pays 85 percent of the allowed amount.
- Participating providers: The plan pays 60 percent of the allowed amount.
- Out-of-network providers: 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 an eligible employee, former employee or former dependent, 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 treatment facility

A **substance use disorder treatment facility** is an institution, or part of an institution, that specifically treats alcoholism or drug addiction and meets all of these criteria:

- Is licensed by the state.
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs.
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing.
- Performs the services under full-time supervision of a physician or registered nurse.
- Certified by the Washington State Division of Behavioral Health and Recovery (DBHR), or for facilities outside of the Regence BlueShield service area (see page 16), contracted with the local BlueCard® network.

Therapeutic alternative

A **therapeutic alternative** is a prescription drug that is not chemically identical to a nonpreferred drug but has similar effects when given in therapeutically equivalent doses.

Therapeutic equivalent

A **therapeutic equivalent** is a prescription drug that is chemically identical to a nonpreferred drug and is expected to have the same efficacy and toxicity when given in the same doses.

Therapeutic interchange

Therapeutic interchange is substitution of a nonpreferred prescription drug by a pharmacist with a preferred drug that is a therapeutic alternative or equivalent, with the endorsing provider's permission (see page 84).

Tobacco cessation services

Tobacco cessation services are provided for quitting tobacco use, through counseling, and nicotine replacement therapy products.

Uniform Medical Plan Consumer-Directed Health Plan (UMP CDHP)

Uniform Medical Plan Consumer-Directed Health Plan (UMP CDHP) is a self-insured PPO health plan offered through the PEBB Program and managed by the Health Care Authority. It features a tax-advantaged HSA.

Uniform
Medical Plan