Uniform Medical Plan

MEDICARE RETIREES: **See pages 104–111 for Medicare section**

2019 Uniform Medical Plan Classic
Certificate of Coverage

Self-Insured by the State of Washington • Effective January 1, 2019

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

HCA 54-550 (11/18)

Directory: Medical services

Contact type and description	Contact information
UMP Customer Service	Call: 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m. Pacific Time (PT) Saturday: 8 a.m. to 4:30 p.m. PT
Network provider directory	Call: 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m. PT Saturday: 8 a.m. to 4:30 p.m. PT Use the provider search at **www.hca.wa.gov/ump-providers-classic** Live Chat: Sign into your Regence account at **www.regence.com** Monday-Friday: 7 a.m. to 5 p.m. PT
Medical appeals, complaints, grievances, and general correspondence	Call: 1-888-849-3681 (TRS: 711) Monday–Friday: 5 a.m. to 8 p.m. PT Saturday: 8 a.m. to 4:30 p.m. PT Fax: 1-877-663-7526 Email: Send secure email via your Regence account at **www.regence.com** Mail: Uniform Medical Plan Attn: Appeals and Grievances PO Box 2998 Tacoma, WA 98401-2998
Preauthorization For providers submitting medical service preauthorization requests	Providers call: 1-888-849-3682 (TRS: 711) Monday-Friday: 7 a.m. to 5 p.m. PT Providers fax: 1-877-663-7526
Online access to medical claims	Sign in to your Regence account at **www.regence.com**
Claims mailing address For members submitting medical service claims	Mail: Regence BlueShield PO Box 1106 Lewiston, ID 83501-1106 Fax: 1-877-357-3418
Medicare	Call: 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) 24 hours, 7 days a week Visit: **www.medicare.gov** or **www.MyMedicare.gov**
Eligibility and enrollment, address changes	**Employees:** Contact your personnel, payroll, or benefits office **All other members:** Call the PEBB Program: 1-800-200-1004 (TRS: 711) Monday–Friday: 8 a.m. to 4:30 p.m. PT Visit: **www.hca.wa.gov/erb**
Tobacco cessation	American Cancer Society's *Quit for Life* program See "Tobacco cessation services" in the *Benefits: what the plan covers* section for detailed information. Call: 1-866-784-8454 - 24 hours, 7 days a week Visit: **www.quitnow.net/ump**

To obtain this booklet in another format (such as Braille or audio), call 1-888-849-3681 (TRS: 711).

Directory: Prescription drug services

Contact type and description	Contact information
Prescription drugs *Contact customer service, find network pharmacies, ask preferred drug questions*	Washington State Rx Services Call: 1-888-361-1611 (TRS: 711) - 24 hours a day, 7 days a week See end of *Prescription drug* section for more detailed contact information
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-Friday: 6 a.m. to 6 p.m. PT Saturday-Sunday: 9 a.m. to 2 p.m. PT Sign in to your account at **www.ppsrx.com**
Network specialty pharmacy *Order new prescriptions and refills for specialty drugs*	Ardon Health Call: 1-855-425-4085 (TRS: 711) Monday-Friday: 8 a.m. to 7 p.m. PT Saturday: 8 a.m. to 12 p.m. PT
Prescription drug paper claims, complaints and appeals	Call: 1-888-361-1611 (TRS: 711) Monday-Friday: 7:30 a.m. to 5:30 p.m. PT Fax claims to: 1-800-207-8235 Fax appeals to: 1-866-923-0412 Mail: Washington State Rx Services PO Box 40168 Portland, OR 97240-0168
Prescription drug preauthorization *For providers and pharmacists submitting prescription drug preauthorization requests.*	Washington State Rx Services Call: 1-888-361-1611 (TRS: 711) Monday-Friday: 7:30 a.m. to 5:30 p.m. PT Fax: 1-800-207-8235
Online access to prescription drug claims	Find a link to your pharmacy account at **www.hca.wa.gov/ump/log-your-accounts**

To obtain this booklet in another format (such as Braille or audio), call 1-888-849-3681 (TRS: 711).

How to use this book

For general topics, check the table of contents. For an overview of the most common benefits, see the "Summary of benefits" (see pages 26–34). The table shows:

- How much you will pay.
- Any limits on the benefit (such as number of visits or dollar amount).
- Whether preauthorization or notification is required.
- The page numbers where you can find more about a benefit.

To look up unfamiliar terms, see the "Definitions" section beginning on page 156.

Section for Medicare retirees

See our section just for retirees enrolled in Medicare on pages 104–111. In addition, throughout the rest of the book, look for the symbol below with accompanying blue text. This indicates information specific to Medicare retirees.

FOR MEDICARE RETIREES: Information especially for Medicare retirees.

If you still have questions

If you have specific questions, try these options:

- Search our website at **www.hca.wa.gov/ump.**
- Call UMP Customer Service for questions about medical services at 1-888-849-3681 (TRS: 711) Monday–Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m. Pacific Time.
- Call Washington State Rx Services for questions about pharmacy services at 1-888-361-1611 (TRS: 711). Calls are taken 24 hours a day, 7 days a week.

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

Table of contents

About Uniform Medical Plan Classic

Uniform Medical Plan Classic (UMP Classic) 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 and Washington State Rx Services. All prescription drugs, services, or other benefit changes may require approval by the PEB Board at the time of procurement of benefits for the next calendar year.

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

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

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

Online services

You can access plan information online at the UMP website, the Health Care Authority (HCA) website, and the Regence website.

Visit the UMP website at **www.hca.wa.gov/ump** to:

- Review complaints and appeals procedures.
- Access UMP medical policies.
- Find a preferred provider.
- Find a network pharmacy.
- Check what your prescription will cost.
- Order prescription refills through your mail-order pharmacy account.
- Find information on prescription drugs, over-the-counter drugs, herbal or vitamin products and drug interactions
- Download or print documents and forms.
- Find your certificate of coverage (this booklet) online.
- Access wellness tools.
- Access the Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms (UGT).

Visit the Health Care Authority website at **www.hca.wa.gov** to:

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

Visit the Regence website at **regence.com** to:

- Find a preferred provider.
- View your Explanation of Benefits (medical claims processing details).
- Access customer service via live chat.
- Access your personal Regence account.
- Access wellness tools.
- Get cost estimates for treatment of common medical conditions.
- View or order your UMP ID card.
- Access information on the BlueCard (Global Core) program.
- Download the Regence mobile application.

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

Finding a health care provider

FOR MEDICARE RETIREES: If you are retired and enrolled in Medicare, see "Should I see a preferred provider?" on page 108 for more information on choosing providers.

As a UMP member, you may see a preferred, participating, or out-of-network provider. The amount you pay for services depends on the network status of the provider. To see if a provider is a preferred or participating provider, visit **www.hca.wa.gov/ump-providers-classic** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

- **Preferred provider**: preferred under the preferred provider organization (PPO) network that applies to UMP Classic members.
  - Most covered services are paid at 85%. You pay 15% of the allowed amount after you pay your deductible.
  - The plan pays 100% of covered preventive care services.
  - The provider will not bill you for charges that exceed the allowed amount.
  - The providers are labelled in the online provider directory with a bar icon and category 1.
- **Participating provider**: contracts with Regence BlueShield or another BlueCard network as a participating provider.
  - Most covered services are paid at **60%**. You pay 40% of the allowed amount after you pay your deductible.
  - The plan pays 100% of covered preventive care services.
  - The provider will not bill you for charges that exceed the allowed amount.
  - The providers are labelled in the online provider directory with a bar icon and category 2.
- **Out-of-network provider**: not contracted with Regence BlueShield or another BlueCard network.
  - Most covered services are paid at **60%**. You pay 40% of the allowed amount after you pay your deductible. The provider may bill you for charges that exceed the allowed amount. This is called balance billing.
  - The plan pays 60% of the allowed amount for covered preventive care services. You pay 40% of the allowed amount after you pay your deductible. The provider may balance bill you.

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 BlueCard® and BlueCard (Global Core) programs (see page 12), so your health coverage is with you wherever you are. Your access to care includes many acute care hospitals, urgent care and ambulatory surgery centers, physician, and other health care professionals.

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

- Use the Provider Search at **www.hca.wa.gov/ump.**
- Call UMP Customer Service at 1-888-849-3681 (TRS: 711).
- Sign in to your account on **regence.com**, where you have access to more information about providers, as well as other tools (see page 7).

To find a network pharmacy, see page 74.

Why choose a preferred provider?

A preferred provider costs you the least

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

- You pay 15% of the allowed amount for most services after you pay your medical deductible.
- You pay nothing for covered preventive care services and covered immunizations. See "Preventive care" on page 56 for examples of such services.

- These providers can't bill you for charges that exceed the plan's allowed amount.
- You won't have to file a claim if the plan is your primary coverage.

Note: Some services and supplies are not covered by the plan (see page 90) 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 have to pay for those services or supplies, even if you see a preferred provider. You may call UMP Customer Service at 1-888-849-3681 (TRS: 711) to find out if a service or supply is covered.

ALERT! Some providers are preferred at one practice location but not another. Please 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 cost you more than preferred providers

When you visit preferred providers, you pay 15% of the plan allowed amount for covered services. With participating providers, you pay 40% of the plan allowed amount for covered services. See page 10 under "Sample payments to different provider types" for examples.

How are preferred and participating providers the same?

The following rules apply to both preferred and participating providers:

- **Balance billing:** These providers cannot charge you more than the plan allowed amount.
- **Preventive care:** Services covered as preventive by the plan are paid at 100%.
- **Medical out-of-pocket limit:** Once you meet your medical out-of-pocket limit (see page 17), covered services are paid at 100%.

Out-of-network providers cost you the most

- You pay 40% of the allowed amount for most services after you pay your medical deductible, **plus** 100% of any amount the out-of-network provider charges above the allowed amount.
- The 40% coinsurance you pay to out-of-network providers will **not** count toward your medical out-of-pocket limit.
- You will still have to meet your medical deductible before the plan begins to pay. Any amount you pay above the allowed amount does not count toward your medical deductible or medical out-of-pocket limit.
- You may have to pay all charges at the time of service and then send a claim form to the plan for reimbursement.
- The provider may not 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.

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

TIP: The allowed amount is the payment amount preferred and participating providers agree to accept from the plan. 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.

Sample payments to different provider types

This table shows how much you pay for professional services from preferred, participating, and out-of-network providers when UMP is your primary insurance. For these examples, assume you've paid your medical deductible and haven't met your medical out-of-pocket limit.

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 that exceed 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 medical out-of-pocket limit.*

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

Covered provider types

The plan pays 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 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 be responsible for all charges. As with all noncovered services, any payments you make to a noncovered provider type will not count toward your medical deductible or medical out-of-pocket limit.

See the list of covered provider types at **www.hca.wa.gov/ump-providers-classic**.

What is a primary care provider?

A primary care provider (PCP) is a physician (see "Physician services" on page 168), nurse practitioner, or physician assistant who provides, coordinates, or helps a member access a range of health care services. A primary care provider helps you receive preventive care such as covered immunizations, well-child visits for your children, cancer screenings (e.g., breast, cervical, prostate) and can 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 the provider can 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 on page 11.

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

When you don't have access to a preferred provider: network waivers

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 163).**

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 160) for the related services. See "After your visit" below for details.

When can I request a network waiver?

Before your visit

When services require a preauthorization, you may request a network waiver before services are provided. See page 88 for how to find the list of services requiring preauthorization. Your network waiver request should be included with the preauthorization request. See "Information needed to submit a network waiver request" below to learn what to include in your request.

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

- For medical services the plan has approved through this waiver, you will pay your cost share as though the provider was preferred.
- For covered preventive services, the plan pays 100%.

After your visit

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

Network waiver requests that are not approved in advance are considered an appeal and must be submitted within 180 days of receiving your Explanation of Benefits. See "Complaint and appeal procedures" beginning on page 120 for information about your appeal rights.

Information needed to submit a network waiver request

You should include all of the following documentation 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 of 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 87–88 for more information about requesting medical services preauthorization from the plan.

Where to send your network waiver request

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

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 11 for more information. Services provided under an approved network waiver count toward your medical deductible and out-of-pocket limit. Network waivers for ongoing services may require periodic review.

Services received outside the U.S.

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

Contact BlueCard (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.

BlueCard (Global Core) contact and online information

- Call the BlueCard (Global Core) Service Center at 1-800-810-BLUE (2583), or call collect 1-804-673-1177 (available 24 hours a day, 7 days a week).
- Use the provider search at **www.bcbsglobalcore.com/ProviderSearch**.
- Visit the BlueCard (Global Core) website at **www.bcbsglobalcore.com/Home**. After you create an account, you can find BlueCard information, get an international claim form, and submit claims electronically at **www.bcbsglobalcore.com/Home/ClaimForms.**

When are services outside the U.S. covered?

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

- Medically necessary (see definition on page 163).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by U.S. standards.
- Meeting all medical policy criteria.
- Covered by the plan.

Finding a preferred provider outside the U.S.

Under BlueCard (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., go to **www.bcbsglobalcore.com/ProviderSearch** or call the BlueCard Service Center: 1-800-810-BLUE (2583) or collect at 1-804-673-1177.

Important tips for receiving care outside the U.S.

- Always carry your UMP identification (ID) card.
- If you need emergency medical care, go to the nearest hospital.
- If you are admitted to the hospital, call the BlueCard (Global Core) Service Center (see above) to notify the plan of your admission.
- For non-emergency medical care outside the U.S., call the BlueCard (Global Core) Service Center to help you find a provider for the care you need.

Paying for care outside the U.S.

Inpatient services at a BlueCard contracted hospital

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

Services at a non-contracted hospital

When you receive services at a hospital not contracted with BlueCard, you pay the hospital at the time of service, then submit a claim with an itemized bill from the hospital to the plan for reimbursement (see "How do I submit a claim?" on page 112). You may ask the non-contracted hospital if they will submit a claim on your behalf.

Outpatient and professional provider services

If you receive outpatient care outside the U.S., you pay the facility or professional provider at the time of service, then submit a claim to the plan for reimbursement (see "How do I submit a claim?" on page 112). Covered services by BlueCard contracted providers are reimbursed at the network rate.

Submitting a claim for services outside the U.S.

If you receive inpatient services at a contracted hospital, the hospital will submit claims on your behalf. See "Inpatient services at a BlueCard contracted hospital" above.

For care from non-contracted hospitals and all outpatient care, you pay the provider at the time of service. To receive reimbursement from the plan for covered services, you must submit an international claim to the BlueCard Service Center. See "Contact BlueCard (Global Core)" on page 12 to find contact information or a claim form.

For all claims submitted either by the member or by the provider, Regence works with the BlueCard Service Center to translate claims, services, and account for currency differences. Specific services, charges, drugs and dosage must be documented. If you have questions about submitting a claim for services provided outside the U.S., call UMP Customer Service at 1-888-849-3681 (TRS: 711).

What you pay for medical services

Deductibles

A deductible is a fixed dollar amount you pay each calendar year before the plan begins paying most benefits. The medical deductible amount is $250 per person, with a maximum of $750 for a family of three or more people. See "How does the medical deductible work with families?" on page 16 for more information. When you first get services, you pay the first $250 in charges. After you pay that first $250, the plan begins to pay benefits for your care. This applies to each covered member, up to the $750 maximum.

You also pay a separate deductible for prescription drugs that fall under Tier 2 and Tier 3. See page 70 for more information on prescription drug tiers.

Prescription Tier Level	Definition of Tier	How much do you pay?
Preventive Tier	Preventive drugs required under the Affordable Care Act or recommended by the US Preventive Services Task Force.	No deductible
Value Tier	Specific high-value prescription drugs used to treat certain chronic conditions.	No deductible
Tier 1	Primarily low-cost generic drugs.	No deductible
Tier 2	Preferred brand-name drugs and high-cost generic drugs.	The prescription drug deductible is $100 per person, with a maximum of $300 for a family of three or more people
Tier 3	Nonpreferred drugs and brand-name drugs with generics available.	The prescription drug deductible is $100 per person, with a maximum of $300 for a family of three or more people

If you qualified for the SmartHealth wellness incentive

The subscriber (see definition on page 173) is the only member eligible to earn the SmartHealth wellness incentive. The 2019 incentive reduces the subscriber's medical deductible by $125. For details and examples of how the deductible reduction works for accounts with more than one member, visit **www.hca.wa.gov/ump/ump-classic/wellness-programs**. Then click on "How do I receive the $125 SmartHealth wellness incentive I earned?"

What doesn't count toward my medical deductible?

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

- Services you pay for that aren't covered by the plan (see pages 90–97 for some examples).
- Services that are exempt from the medical deductible, even if you had out-of-pocket costs. For example, covered preventive care received from an out-of-network provider.
- Charges for services exceeding benefit maximums. For example, the maximum for adult vision hardware is $150 every two calendar years. Charges over this amount do not count toward your medical deductible.
- Charges for services beyond benefit limits. For example, the annual benefit limit for acupuncture is 16 visits. Costs for more than 16 visits are not covered by the plan and do not count toward your medical deductible.
- Out-of-network provider charges that exceed the allowed amount (see table on page 10).
- Your inpatient hospital copayment (see page 17).
- Your emergency room copayment (see page 42).
- Prescription drug costs (see page 70 for the prescription drug deductible).

Which services are exempt from the medical deductible?

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

When you see a preferred or participating provider, you do not have to pay the medical deductible before the plan pays for these services:

- Covered preventive care and covered immunizations as described on pages 56–58.
- Routine vision care: exams, glasses, and contacts (page 67).
- Routine hearing care: exams and hearing aids (page 45).
- Contraceptive supplies and services (pages 43–44).
- Certain products available from network pharmacies (page 78).
- Preventive, Value, and Tier 1 prescription drugs. A prescription drug deductible applies to Tier 2 and Tier 3 drugs only (see page 70).
- Tobacco cessation services (page 65).
- Diabetes Control Program (page 39).
- Diabetes Prevention Program (page 40).
- Required second opinions (page 58).

How does the medical deductible work with families?

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

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

Note: Only services that are covered and are subject to the medical deductible count. See page 15 for a list of services that don't count.

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

ALERT! If you receive services with a benefit limit (such as massage therapy or physical therapy) before meeting your medical deductible, those visits will count toward the benefit limit. See definition of "Limited benefit" on page 162 for more information. Note: If you have other primary coverage, including Medicare, visits paid by your primary plan also count toward UMP benefit limits.

Coinsurance

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

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

- **For preferred providers:** 15% of the allowed amount.
- **For participating providers:** 40% of the allowed amount. See table on page 10 for details.
- **For out-of-network providers:** 40% 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.

See pages 68–86 for how much you pay for prescription drugs.

Copayment

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

- Emergency room copay: $75 per visit. See "Emergency room" on page 42 for details.
- Facility charges for services received while an inpatient at a hospital, mental health, substance use disorder, or skilled nursing facility: $200 per day copay (see "Inpatient copay" below).

Inpatient copay

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

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

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

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

When do I pay?

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

- First, 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.
- Second, the provider sends you a bill.
- Third, you pay the provider.

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

Medical out-of-pocket limit

ALERT! See page 72 for how the prescription drug out-of-pocket limit works. Prescription drug costs do not count toward your medical out-of-pocket limit.

The medical out-of-pocket limit is the most you pay during a calendar year for covered services from preferred and participating providers. After you meet your medical out-of-pocket limit for the year, the plan pays for covered services by preferred providers at 100% of the allowed amount. **Expenses are counted from January 1,**

2019, or your first day of enrollment (whichever is later); through December 31, 2019, or your last day of enrollment (whichever is earlier).

Your medical out-of-pocket limit depends on your enrollee type.

- **Employees and retirees not enrolled in Medicare**, including dependents: $2,000 per person and $4,000 per family. *
- **Retirees enrolled in Medicare Part A and Part B**, including dependents: $2,500 per person and $5,000 per family. *

  **"Family" means all members combined under one subscriber's account (2 or more enrolled).*

What counts toward this limit?

1. Your coinsurance paid to preferred and participating providers (see page 10).
2. Inpatient and emergency room copays.
3. Your medical deductible.

What doesn't count toward this limit?

1. Amounts paid by the plan, including services covered in full.
2. Your monthly premiums.
3. Prescription drug costs, including the prescription drug deductible. See page 72 for how the prescription drug out-of-pocket limit works (which is counted separately by Washington State Rx Services).
4. Your coinsurance paid to out-of-network providers (note that out-of-network coinsurance does count toward your medical deductible; see page 10).
5. Balance billed amounts (see definition on page 157).
6. Services not covered by the plan; for examples, see pages 90–97.
7. Amounts that are more than a maximum dollar amount paid by the plan. For example, the plan pays a maximum of $150 for adult vision hardware once every two calendar years. Any amount you pay over $150 does not count toward the medical out-of-pocket limit.
8. Amounts paid for services exceeding a benefit limit. For example, the benefit limit for acupuncture is 16 visits. If you have more than 16 acupuncture visits in one year, you will pay in full for those visits, and what you pay will not count toward this limit. See "Limited benefit" on page 162 for more benefits with this type of limit.

What will I pay for after reaching this limit?

You will still be responsible for paying numbers 2–8 above after you meet your medical out-of-pocket limit. See page 72 for how the prescription drug out-of-pocket limit works.

You still pay for out-of-network provider services

Services by out-of-network providers are paid by the plan at 60% of the allowed amount. Even after you meet your medical out-of-pocket limit, you will pay 40% coinsurance for out-of-network provider services and the provider may balance bill you (see definition on page 157).

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

Summary of payment

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'll find a summary of your plan benefits and what you'll pay for them. For a complete understanding of how a benefit works, it is important that you also read the pages listed in the "For more information" column.

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

In order to be covered, all services must be medically necessary (see definition on page 163). **If you see an unfamiliar term, see the alphabetical list of definitions on pages 156–174.**

This certificate of coverage applies only to dates of service between the day your coverage begins (no earlier than January 1, 2019) and the day your coverage ends (no later than December 31, 2019).

ALERT! If you have coverage under another health plan, see pages 98–103. If your other coverage is Medicare, see pages 104–111.

Deductibles and limits

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Medical deductible	$250 per person (maximum of $750 for a family of three or more) See page 15 if you qualified for the 2019 SmartHealth $125 wellness incentive.	▪ You pay toward the medical deductible before the plan pays for most covered medical services. ▪ You don't have to pay the medical deductible for some services. ▪ Not all services count toward this deductible.	15–16
Prescription drug deductible	$100 per person (maximum of $300 for a family of three or more)	▪ You pay the costs for Tier 2 and Tier 3 drugs until you reach this amount. ▪ The plan pays its share for Value Tier and Tier 1 drugs right away. You don't pay the deductible.	70–70
Medical out-of-pocket limit	$2,000 per person (maximum of $4,000 for a family of two or more) For Medicare-primary members: $2,500/$5,000	Your medical deductible and all coinsurance and copays for covered network services count toward this limit.	17
Prescription drug out-of-pocket limit	$2,000 per person (no family maximum)	Your prescription drug deductible and coinsurance count toward this limit.	72

What is it?	How much is it?	What else do I need to know?	For more information: See page(s)
Annual plan payment limit	None	No limit to how much the plan pays per calendar year.	Not applicable
Lifetime plan payment limit	None	No limit to how much the plan pays over a lifetime.	Not applicable

Types of services

The table below describes how much you will pay for services. Unless otherwise noted, all payments are based on the allowed amount and services are subject to the medical deductible. See the "Summary of benefits" table on pages 26–34 to find out which services fall under the standard, preventive, outpatient, inpatient, facility fees, and special categories.

Type of service	How much you pay
Standard Subject to the medical deductible and coinsurance.	You must pay your medical deductible, the first $250 in covered services, before the plan begins to pay. How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. The provider may not balance bill. ▪ **Participating providers**—You pay 40% of the allowed amount. The provider may not balance bill. ▪ **Out-of-network providers**—You pay 40% of the allowed amount. The provider may balance bill (see page 157).
Preventive Not subject to the medical deductible or coinsurance. See page 56 for a description of preventive services.	How much you pay (your coinsurance) depends on the provider's network status: ▪ **Preferred and participating providers**—You pay $0; the plan pays in full. ▪ **Out-of-network providers**—You pay 40% of the allowed amount. The provider may balance bill (see page 157).
Outpatient Subject to the medical deductible and coinsurance.	If you receive services at a facility that offers inpatient services (like a hospital) but you are not admitted, you pay for outpatient services. 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 the provider fees.

Type of service	How much you pay
Inpatient Subject to the medical deductible, copay, and coinsurance. Most inpatient services require both preauthorization (see page 87) and notification (your provider must notify the plan upon admission to a facility; see page 88).	You pay the $200 per day copayment at preferred facilities. ▪ Members not enrolled in Medicare: You pay $600 maximum per calendar year. ▪ Retirees and their dependents enrolled in Medicare: You pay $600 maximum per admission up to the medical out-of-pocket limit. **Note**: The inpatient copay counts toward your medical out-of-pocket limit. When you are admitted to a preferred facility, you will pay: ▪ Any remaining medical deductible; ▪ The inpatient copay; **and** ▪ Your coinsurance for professional services, such as doctor consultations and lab tests, which depends on the provider's network status. Services are considered inpatient only when you are admitted to a facility. See definition of "Inpatient stay" on page 162. **If you go to an out-of-network facility** for non-emergency inpatient care, you pay 40% of the allowed amount, and the facility may balance bill you (see page 157). See pages 9–10 for more information on out-of-network facility charges. **If you go to a preferred, participating, or out-of-network facility** and see an out-of-network provider, you will pay 40% of the allowed amount, and the facility may balance bill you.
Facility fees May be charged in addition to provider fees when accessing hospitals or clinics.	How much you pay depends on the provider's* network status: ▪ **Preferred providers**—You pay 15% of the allowed amount. ▪ **Participating providers**—You pay 40% of the allowed amount; the provider may not balance bill. ▪ **Out-of-network providers**—You pay 40% of the allowed amount; the provider may balance bill (see page 10). **A facility, such as a hospital, may be referred to as a "provider" on Explanation of Benefits or facility bills.*
Special (for example, ambulance) Subject to the medical deductible.	These services have unique payment rules, which are described in the "How much will you pay?" column on pages 10–34.

What else do I need to know?

- Some services are not covered. See pages 90–97 for a list of exclusions.
- You don't need a referral from the plan to see a specialist for most services. However, you will save money by seeing preferred providers, especially for preventive services. See page 8 for more information.
- There is no waiting period for preexisting conditions.
- You must be enrolled in this plan for the plan to pay for medically necessary covered services.

Benefits: what the plan covers

Guidelines for coverage

ALERT! The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply does not mean it is covered or medically necessary (see page 163).

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 an enrolled member on a day between the date your coverage begins (but no sooner than January 1, 2019) and the date your coverage ends (but no later than December 31, 2019); and
- Be listed as covered; and
- Meet the plan's coverage policies and preauthorization requirements; and
- Be medically necessary (see definition on page 163).

Limits and exclusions may apply to plan benefits. See both the benefit description and "What the plan doesn't cover" starting on page 90.

Some services require preauthorization and/or plan notification prior to receiving treatment. See page 88 for how to find the list or call UMP Customer Service to ask if a certain service is covered, requires preauthorization, or requires plan notification.

The following sections describe the benefits provided by this plan. Be sure to read them carefully for important information that can help you get the most from your health coverage. **If you do not understand the benefits, it is your responsibility to ask for help before receiving services by calling Customer Service at 1-888-849-3681 (TRS: 711).**

FOR MEDICARE RETIREES: If you also have Medicare coverage, see "For retirees enrolled in Medicare" on pages 104–111.

UMP Classic 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 and Washington State Rx Services. All prescription drugs, services, or other benefit changes may require approval by the PEB Board at the time of procurement of benefits 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 they will be covered by the Plan.

Health Technology Clinical Committee (HTCC)

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

What is the HTCC?

Created by Washington State law chapter 70.14 RCW, the Health Technology Clinical Committee (HTCC) is a committee of eleven 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 does HTCC affect my UMP benefits?

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

Under state law, the plan must comply with an HTCC determination. Determinations will either be covered, covered with conditions, or not covered. The HTCC determines the conditions, if any, under which the health technology will be included as a covered benefit and, if covered, the criteria the plan must use to decide whether the technology is medically necessary.

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 Food and Drug Administration (FDA) or Centers for Medicare and Medicaid Services (CMS) guidelines. You may review these guidelines at **www.fda.gov** or **www.cms.gov**.

Where do I 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 **www.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	Covered with limitations
Appropriate imaging for breast cancer screening in special populations	Covered with limitations
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
Bone morphogenic proteins for use in lumbar fusion	Covered with limitations
Breast MRI	Covered with limitations

Topic	Coverage level
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	Covered with limitations
Cochlear implant	Covered with limitations
Computed tomographic angiography for detection of coronary artery disease	Covered with limitations
Computed tomographic colonography	Not a covered benefit
Coronary artery calcium scoring	Not a covered benefit
Discography	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	Covered with limitations
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	Covered with limitations
Glucose monitoring	Covered with limitations
Hip resurfacing	Not a covered benefit
Hip surgery for femoroacetabular impingement syndrome	Not a covered benefit
Hyaluronic acid/viscosupplementation	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	Covered with limitations

Topic	Coverage level
Implantable drug delivery system for chronic non-cancer pain	Not a covered benefit
Intensity modulated radiation therapy	Covered with limitations
Knee arthroscopy for osteoarthritis of the knee	Not a covered benefit
Lumbar fusion for degenerative disc disease	Not a covered benefit
Microprocessor-controlled lower limb prosthesis	Covered with limitations
Negative pressure wound therapy	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
Pharmacogenetic testing for patients being treated with oral anticoagulants	Not a covered benefit
Pharmacogenomic testing for selected conditions	Not a covered benefit
Positron emission tomography scans for lymphoma	Covered with limitations
Proton beam therapy	Covered with limitations
Robotic assisted surgery	Covered with limitations
Routine ultrasound for pregnancy	Covered with limitations
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/sciatica	Covered with limitations
Testosterone testing	Covered with limitations
Total knee arthroplasty	Covered with limitations
Tympanostomy tubes in children	Covered with limitations
Upper endoscopy for GERD and GI symptoms	Covered with limitations
Upright/positional MRI	Not a covered benefit
Vagal nerve stimulation	Covered with limitations

Topic	Coverage level
Varicose veins	Covered with limitations
Vertebroplasty, kyphoplasty, sacroplasty	Not a covered benefit
Vitamin D screening and testing	Covered with limitations

Summary of benefits

Only certain services are listed in the table below. For those not listed, see the alphabetical list of covered benefits on pages 35–67.

Please read the pages listed in the "For more information" column for each benefit. Not all details are included in the table. Also review:

- Services that require preauthorization. See page 87 for details.
- Services for which your provider must notify the plan. See page 88 or call 1-888-849-3681 (TRS: 711).
- Services that aren't covered (exclusions). See pages 90–97.

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

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Acupuncture	**Standard**	35	Up to 16 visits per calendar year.
Ambulance	**Special:** 20% of the allowed amount for any provider. Out-of-network providers may balance bill. Counts toward your out-of-pocket limit.	35, 90, 96	Covered only for a medical emergency (see page 163) or when other means of transportation are considered unsafe due to your medical condition.
Applied Behavior Analysis (ABA) Therapy	Standard	35	Specific preauthorization requirements; see page 35. Only specified providers are covered.
Breast health See "Mammograms" below			
Chiropractic physician services		59	See "Spinal and extremity manipulations," page 32.

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Contraceptive services	Preventive	43–44, 56	For sterilization, see page 44.
Dental services	**Special:** You pay 20% of the allowed amount when you see a preferred provider for covered medical services. Dentists and other dental providers are not included in the UMP provider network.	37, 91	See "Dental services" on page 37 for limitations on covered services.
Diabetes care supplies	**Special:** Most diabetic care supplies are paid under the prescription drug benefit. Insulin pump and pump supplies are covered under the medical benefit as Durable medical equipment.	39, 42, 102, 107	See page 107 if Medicare is your primary coverage.
Diabetes Control Program	Preventive	39	Only this plan's diabetes control program is covered.
Diabetes Prevention Program	Preventive	40	Only this plan's diabetes prevention program is covered.
Diagnostic tests, laboratory, and x-rays	Standard	40, 55, 90–97	Usually billed separately from related office visits or inpatient services.
Durable medical equipment, supplies, and prostheses	Standard	41–42, 67, 91, 94, 158	May require preauthorization. * Some breast pumps are covered as preventive. See "Services covered as preventive" on page 54.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Emergency room (ER)	Standard, plus an ER copay of $75, medical deductible, and coinsurance. You are usually billed separately for: ▪ Facility charges ▪ Professional (physician) services ▪ Lab tests, x-rays, and other imaging tests	42, 163	If you are admitted as an inpatient directly from the ER, you won't owe the ER a copay (but will pay the inpatient copay). If your ER visit is determined to be a medical emergency, it will be paid at the network rate for both preferred and out-of-network facilities. Services determined not to be due to a medical emergency (page 163) may not be covered in an ER setting.
End-of-life counseling	If received as part of hospice services: Paid at 100% after meeting medical deductible. If received outside of hospice services: standard.	43	Total of 30 visits, all services combined per calendar year.
Family planning services	Standard	43–44, 93	Not covered: ▪ Fertility or infertility services ▪ Reversal of sterilization

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Headaches, chronic migraines or tension	Standard: Covered Botox injections for migraines. All other specified treatments not covered.	45	Botox injections for migraines covered with limitations. Not covered: ▪ Botox injections for tension-type headaches. ▪ Treatment of chronic migraines with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation therapy.
Hearing aids (Not subject to medical deductible)	**Special:** Plan pays up to $800.	45, 108	Limited to $800 plan payment per three calendar years.
Hearing exams, routine	Preventive	45, 56, 108	One per calendar year.
Home health care	Standard	46, 63, 92, 158, 161, 162	See page 46 for what is covered. Specific services are not covered. See page 92. Maintenance care (see page 162) and custodial care (see page 158) are not covered.
Hospice care (Includes respite care and prescription drugs)	**Special:** Medical services paid at 100% after meeting medical deductible. Prescription drugs paid at 100% after meeting the prescription drug deductible. End-of-life counseling while in hospice paid at 100% after meeting medical deductible.	46, 161, 172	Covered for terminally ill members for up to six months. Respite care is limited to 14 visits per lifetime. Prescription drugs: 100% coverage is limited to covered drugs purchased through a network pharmacy.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Hospital services (Inpatient services)	Inpatient	47, 53–55, 92, 108	Plan notification is required for all hospital admissions within 24 hours of admission. * Inpatient rehabilitation services require preauthorization. *
Hospital services (Outpatient services)	Standard	47	Some services require preauthorization. *
Immunizations (Vaccines)	Preventive (usually)	57, 93, 165	Covered under CDC recommendations. See page 57. Not covered for travel or employment.
Joint replacement surgery, knees and hips—Centers of Excellence (COE) Program	**Special:** When approved for the COE program, services are covered at 100%.	48–51	Must be 18 years old or older.
Mammograms (Diagnostic)	Standard	52	Must be billed as diagnostic by the provider.
Mammograms (Screening)	Preventive	37, 51	**Women age 40 and older:** Covered every year. **Women under age 40:** Covered as preventive only for women at increased risk; see page 51 for details. Covered with limitations for women not at increased risk; see page 52. See "Breast health screening tests" (see page 37) for other diagnostic tests.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Massage therapy	Standard	52, 93	Limited to 16 visits per calendar year. Only preferred massage therapists are covered.
Mastectomy and breast reconstruction	Inpatient (Standard for related outpatient visits)	41, 52	All inpatient services require plan notification. *
Mental health treatment (Inpatient services)	Inpatient	52, 95, 108	See page 52 about preauthorization of inpatient services. Plan notification is required at the time of admission. *
Mental health treatment (Outpatient services)	Standard	52, 93, 95, 108	See page 52 for services that require plan notification. *
Naturopathic physician services	Standard	10, 53, 84, 91, 108	Herbs, vitamins, and other supplements are not covered. See "Exceptions covered" on page 78 for exceptions.
Obstetric and newborn care	Inpatient (standard for related outpatient visits) *Some breast pumps are covered as preventive.*	53–55, 95	For non-routine services for a newborn, you may pay toward the baby's medical deductible or inpatient copay. See page 54 for coverage of circumcision for males, which is not a preventive service.
Office visits	Standard	55, 94	See pages 56–58 for routine exams covered as preventive.

For services requiring preauthorization or plan notification: See the list of services at **www.hca.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Physical, occupational, speech, and neurodevelopmental therapy	Standard *Charges for inpatient services are not included in the inpatient copay.*	55, 93, 162	**Inpatient:** 60 days maximum per calendar year. **Outpatient:** 60 visits maximum per calendar year.
Prescription drugs	See "Your prescription drug benefit" on pages 68–86.		See exclusions on pages 90–97, and other limits on pages 79–83.
Preventive care (Includes vaccines, routine exams, some screening tests)	Preventive	51, 54, 56–58, 78, 108, 170	Only certain services are covered as preventive; see pages 56–58. See page 54 for contraception covered as preventive.
Skilled nursing facility	Inpatient *Some services may be billed separately (such as physical therapy).*	58, 93, 96, 172	Maintenance care (page 162) and custodial care (page 158) are not covered.
Spinal and extremity manipulations	Standard	59, 93	Limited to 10 visits per calendar year.
Spine care—Centers of Excellence (COE) Program	**Special:** When approved for the COE program, services are covered at 100%.	59–62	Must be 18 years old or older.
Substance use disorder treatment (Inpatient services)	Inpatient	62, 95, 108	See page 62 for preauthorization of inpatient services. Plan notification is required at the time of admission. *

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Substance use disorder treatment (Outpatient services)	Standard	62, 95, 108	See page 62 for services that may require preauthorization. *
Surgery		38, 47, 52, 55, 63, 66, 92, 96, 157, 166, 171	Bariatric surgery: see page 36. Transgender surgery: see page 66.
Surgery (Inpatient services)	Inpatient		Some services require preauthorization and/or plan notification. *
Surgery (Outpatient services)	Standard		Some services require preauthorization. *
Telemedicine services	Standard	63	
Tobacco cessation services	Preventive	65	See page 65 for coverage of drugs and nicotine replacement supplies. See page 66 for tobacco cessation services for members ages 17 and under.
Transgender services	Standard	66	Some services require preauthorization and/or plan notification. See page 66 for covered services.
Urgent care	Standard You don't pay the ER copay for urgent care services at urgent care facilities.	66	

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 for how this works.*

Benefit/service	How much will you pay? (See pages 20–21 for description of types of services)	For more information: See page(s)	Any limitations or exclusions?
Vision care (Diseases and disorders of the eye)	Standard	67, 90, 92, 94	
Vision exams, routine	Preventive	67, 92, 94	One per calendar year. The plan pays up to $65 per year for contact lens fitting fees. You pay any additional charges.
Vision hardware, adults (over age 18) (Glasses, contact lenses)	**Special:** You pay any amount over $150; network status of provider does not matter. No medical deductible.	67	Plan pays up to $150 per two calendar years (resets every even year).
Vision hardware, children (age 18 and under) (Glasses, contact lenses)	**Special:** No medical deductible. **Eyeglasses:** You pay $0 for one set of standard frames and lenses per year; or **Contact lenses:** You pay $0 for a one-year supply when purchased in lieu of eyeglasses.	67	Plan pays for one pair of eyeglasses per year at 100% of the allowed amount, or a one-year supply of contact lenses (when purchased in lieu of eyeglasses). See page 67 for options that aren't covered. No limit on the number of contact lenses up to a one-year supply.
Well-child visits	Preventive	56–58	

For services requiring preauthorization or plan notification: See the list of services at **www.hca.wa.gov/ump-preauth-classic or call 1-888-849-3681 (TRS: 711). Many services require both preauthorization and plan notification. See pages 87–88 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 162.

Ambulance

The plan will pay 80% of the allowed amount for ambulance services, which must be medically necessary (see definition on page 163). Out-of-network providers may balance bill you. See page 157 for how this works. For these services, balance billed amounts **will** count toward your medical out-of-pocket limit. Ambulance services for personal or convenience purposes are not covered.

Ground ambulance

Professional ground ambulance services are covered in a medical emergency:

- From the site of the medical emergency to the nearest facility equipped to treat the medical emergency (see definition on page 163).
- From one facility to the nearest other facility equipped to provide treatment for your condition.

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

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

Air or water ambulance

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

- Ground ambulance is not appropriate.
- The situation is a medical emergency (see definition on page 163).
- Air or water ambulance is medically necessary (see definition on page 163).
- Transport is to the nearest facility able to provide the care you need.

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

Applied Behavior Analysis (ABA) Therapy

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

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

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

As for other covered services, you receive the highest-level benefit by using preferred providers. See page 10 for differences in your cost for preferred, participating, and out-of-network providers. To find a preferred provider, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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

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

Autism treatment

To determine how a particular service, supply, or intervention is covered, please see that specific benefit. For example, speech or occupational therapy is addressed on page 55 under the "Physical, speech, occupational, or neurodevelopmental therapy" benefit, while mental health coverage is found under "Mental health treatment" on page 52. 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 of your chosen facility's bariatric surgery requirements. This includes working with a multidisciplinary bariatric surgery team, ensuring that your surgery and postsurgical treatment meet all plan medical policies.

The plan covers only certain types of bariatric surgery procedures. If you meet the plan's clinical criteria, non-Medicare adults age 18 and over are covered for Roux-en-Y, sleeve gastrectomy, and laparoscopic adjustable gastric banding procedures. 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, contact Customer Service at 1-888-849-3681 (TRS: 711).

Related care following bariatric surgery

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

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

UMP will cover surgical follow-up care related to a bariatric procedure such as complications, needed revisions, and Lap Band fills to prior bariatric surgery if the follow-up surgery is appropriate and essential to the long-term success of the initial bariatric surgery.

Members who had a bariatric procedure prior to coverage under a UMP plan and have complications, need for revision, or require Lap Band fills for ongoing medically necessary services are not required to verify prior coverage or that they met Regence medical policy criteria for the 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 51 for more information about breast health testing. The tests listed below may be covered for diagnostic purposes as indicated under plan medical policy.

Services covered

Women ages 40 and older: Covered as preventive in addition to a digital mammogram. See "How much will I pay?" on page 51.

For women under age 40: See page 51 under "Mammogram" for how preventive breast health testing is covered for high-risk women.

Services not covered

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

Non-high-risk patients:

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

High-risk patients:

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

Chiropractic physician services

See "Spinal and extremity manipulations" on page 59.

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. 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 for more information: **www.hca.wa.gov/employee-retiree-benefits/public-employees/dental-plans-and-benefits**.

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 dental caries (tooth decay); coverage depends on the network status of the medical

provider as described on pages 8–9. Note that health care providers, such as your child's medical primary care provider, may apply fluoride varnish.

For dental services that are covered by the plan, you pay 20% of the allowed amount and the provider may balance bill you (see definition on page 157). **Only the following dental services are covered:**

General anesthesia during a dental procedure

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

- It is provided by an anesthesiologist in a hospital or ambulatory surgery center; and
- The charges for the hospital or ambulatory surgery center are covered by the plan (see below).

Dental procedures performed in a hospital or ambulatory surgery center

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

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

Accidental injuries

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

The actual treatment may extend beyond 30 days if your provider determines 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, 2019, resulting in injuries that are covered by the plan. Your treatment plan must be finalized no later than April 11, 2019. All related treatment must be completed by December 31, 2020 (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 65 for information about TMJ disorder treatment.

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

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate.
- Gum reduction for gingival hyperplasia due to Dilantin® or phenytoin use.

- Services related to cancer and treatment of cancer, including but not limited to jaw reconstruction.
- Treatment of a fracture or dislocation of the jaw or facial bones.
- Treatment related to chronic conditions that result in loss or damage of teeth.

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

Diabetes care supplies

FOR MORE INFORMATION: If a health plan other than UMP Classic is your primary payer, claims for diabetes care supplies may be paid differently. See page 102 for more information.

Diabetic supplies listed below are covered under your plan's prescription drug benefit according to the designated tier in the UMP Preferred Drug List. To be covered, you must get a written prescription for these drugs and supplies and purchase them from a pharmacy. To find out the tier of a product, see the online list or call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

You save money and avoid having to submit your own claims when you purchase these diabetic supplies from a Washington State Rx Services network pharmacy. Find a network pharmacy at **www.hca.wa.gov/ump/find-drugs** or call 1-888-361-1611 (TRS: 711).

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

- Preferred glucose meters
- Preferred test strips
- Insulin syringes
- Lancets

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.

Certain nonpreferred test strips and nonpreferred glucometers may be available through preauthorization (see page 80).

Continuous glucose monitors must be preauthorized and are covered only under the medical benefit. See the definition of medical benefit on page 163.

FOR MEDICARE RETIREES: If Medicare is your primary health coverage, see page 107 for information on how claims for diabetes care supplies are processed.

Diabetes Control Program

TIP: The Diabetes Control Program is exempt from the medical deductible and is free for UMP members ages 18 and older.

For non-Medicare members ages 18 and older with a diagnosis of diabetes, the plan covers 100% for Diabetes Control Program administered by the Case Management Program at Regence. 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 can find out if you qualify for the program at screening events scheduled at your employer worksite, or you can visit your primary care provider for a blood sugar laboratory test. If you see a screening vendor, they will tell you if you meet criteria to participate in the program at the time of the screening. If you see your primary care provider, they will tell you if you meet criteria once the laboratory results are available. If you qualify for the Diabetes Control Program, you can self-refer by calling 866-543-5765.

Diabetes education

The plan covers diabetic self-management training and education, including nutritional therapy by registered dieticians. When diabetes education includes nutritional therapy, the nutritional therapy services are not subject to the three-visit lifetime limit stated under "Nutrition counseling and therapy" on page 53.

Diabetes Prevention Program

For non-Medicare members ages 18 and older, the plan covers 100% for the Diabetes Prevention Program (DPP).

Virtual DPP

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

You can take an online screening questionnaire to see if you meet the program's criteria by visiting **www.omadahealth.com/wapebb** and creating an account. If you meet the criteria, you can 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 can qualify 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.

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

In-person DPP

Members already enrolled in the YMCA's DPP classes who have additional classes remaining, may continue to participate in the in-person classes.

Diagnostic tests, laboratory, and x-rays

This benefit covers tests that are appropriate for your diagnosis or symptoms reported by the ordering provider and must be medically necessary as defined on page 163. If there are alternative diagnostic approaches with different fees, the plan will cover the least expensive, evidence-based diagnostic method. See **www.hca.wa.gov/ump-preauth-classic** or call 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 56 for coverage of preventive or screening colonoscopy.
- Electrocardiograms (EKG, ECG).
- Prostate cancer screening (prostate-specific antigen [PSA] testing): All PSA testing is covered under the medical benefit (subject to the medical deductible and coinsurance), even if billed as preventive.
- Skin allergy testing.

FOR MORE INFORMATION: See page 51 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, you pay:

- 15% for preferred facilities.
- 20% for out-of-network facilities. For dialysis services, amounts paid to out-of-network facilities (including balance-billed amounts; see page 157) will count toward your medical out-of-pocket limit.

Durable medical equipment, supplies, and prostheses

TIP: The plan covers durable medical equipment (DME) at the preferred benefit rate only if you get the equipment or supply from a preferred DME supplier or other preferred medical provider. To find preferred DME providers, see "Finding a preferred DME provider" on page 42.

If you receive a higher-cost durable medical equipment (DME) item when a less expensive, medically appropriate option is available, the plan may not pay for the more expensive item. Some items require preauthorization. See page 88 for how to find the list at **www.hca.wa.gov/ump** or call 1-888-849-3681 (TRS: 711).

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

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Automatic Positive Airway Pressure (APAP) devices and related supplies.
- Bi-level Positive Airway Pressure (BiPAP) devices and related supplies.
- Bone growth (osteogenic) stimulators (requires preauthorization).
- Breast prostheses and bras as required by mastectomy. See "Mastectomy and breast reconstruction" on page 52.
- Breast pumps for pregnant and nursing women (see page 54).
- 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 will be 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; may require preauthorization.)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100. Other wigs and hairpieces are not covered.

The plan limits coverage of DME to one item of a particular type of equipment and the accessories needed to operate the item. The plan also covers the repair or replacement of 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 equipment 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 diabetic 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 **www.hca.wa.gov/ump-providers-classic** and click on the *preferred providers* link.

In the "Search for a doctor, hospital name, or specialty box," begin typing "durable medical"; a drop-down list will appear. Select "Durable Medical Equipment & Supplies Supplier" and click "Search."

Note: You do not have to sign in to the Regence member site to search for a provider, but you will get more relevant results if you do.

You should now have a list of preferred DME suppliers. Note that different DME suppliers carry different types of supplies. You may need to call to confirm that a particular supplier has what you need. These supplies are not available through PPS, the network mail-order pharmacy.

Emergency room

TIP: If you need immediate care but your situation isn't a medical emergency (see page 163), see "Urgent care" on page 66 for how to get treatment at a lower cost than in an emergency room.

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

Charges for professional services 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 163), the plan may not pay for emergency services.

If you are admitted to the hospital directly from the emergency room, the $75 emergency room copay will be waived. However, you must pay the inpatient copay (see page 17).

ALERT! Medical emergencies treated at an out-of-network hospital will be paid at the network rate. However, you may still be balance billed (see definition on page 157). Non-medical emergencies treated at an out-of-network hospital may not be covered by the plan. If the plan does pay, it will be at the out-of-network rate.

End-of-life counseling

End-of-life counseling is the counseling and discussion regarding advanced directives or end-of-life planning and decision making, and discussion of available treatments options. The plan covers end-of-life counseling for all members up to 30 visits per year. There is no requirement to be terminally ill, on hospice, or in the final stages of life to receive end-of-life counseling services. End-of-life counseling associated with hospice services is paid at 100% after you meet your medical deductible. Outside of hospice, these services are paid as a medical benefit (see page 163), subject to the medical deductible and coinsurance.

For more information on hospice care, see page 46.

Family planning services

The plan covers a variety of contraceptive drugs and devices as preventive—you don't pay a deductible (medical or prescription) or coinsurance.

Services related to voluntary and involuntary termination of pregnancy (abortion or miscarriage) are covered under the medical benefit (see definition on page 163).

Education and counseling related to contraception are covered as preventive (see page 56).

If you receive care from an out-of-network provider or non-network pharmacy, you may have to pay upfront and submit a claim for reimbursement (see pages 112–115). However, note that you must get over-the-counter contraceptive supplies from a network pharmacy for these items to be covered (see "Over-the-counter contraceptives" on page 44).

Contraceptives

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

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 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 Washington State Rx Services. Members will need to contact the pharmacy directly for information on prescribing authority.

Barrier devices

All barrier devices requiring a prescription or fitting are covered as preventive 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. Fitting, insertion, and removal of barrier devices that require it are also covered as preventive.

Over-the-counter contraceptives

Only over-the-counter contraceptives that are approved by and registered with the U.S. Food and Drug Administration (FDA) are covered.

For the plan to cover FDA-registered over-the-counter contraceptives, you must present your UMP 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 Washington State Rx Services.

ALERT! To receive plan coverage for an approved over-the-counter contraceptive, you must purchase from a network pharmacy, present your UMP 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 at 100% and are not subject to the medical deductible.

What is not covered under the family planning benefit?

The following services and products are not covered by the plan 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 53. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) with any questions.

Headaches

The treatment for chronic migraine 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 drugs.
- 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% reduction in headache days per month after two treatment cycles).
- The patient has received a maximum of five treatment cycles.

The following treatment is not covered:

- Treatment of chronic tension-type headache with Botox is **not** covered.
- Treatment of chronic migraine or chronic tension-type headache 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 covers treatment for diseases and disorders of the ear or auditory canal not related to routine hearing loss under the medical benefit. Routine hearing care benefit limits (see "Hearing exams and hearing aids" below) do not apply.

Hearing exams and hearing aids

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

Hearing exams (routine)

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

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

Hearing aids

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

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

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

Hearing aid items not covered

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

- Charges incurred after your UMP coverage ends, unless you ordered the hearing aid before that date and it is delivered within 45 days after your coverage ended.
- Extended warranties, or warranties not related to the initial purchase of the hearing aid(s).
- Purchase of replacement batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

Home health care

ALERT! See page 92 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 book 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 (inpatient, outpatient, and respite care)

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.

Medical

Services received from preferred and participating providers are covered at 100% of the allowed amount after you meet your medical deductible. The plan covers hospice care for terminally ill enrollees for 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 prescription drug deductible is met:

- The member pays the normal coinsurance for Value Tier (5%) and Tier 1 (10%) covered prescription drugs, subject to the prescription cost-limit (see page 71).
- The member pays the full cost (allowed amount at a network pharmacy) for covered Tier 2 and Tier 3 drugs.

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

This applies **only to the member in hospice care.** Other members covered under the same account will pay for their covered prescription drugs as described on pages 68–86.

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

ALERT! The member still pays the full cost for noncovered drugs. If the member purchases covered prescription drugs from a non-network pharmacy (see page 76), the plan covers under normal benefits as described on pages 69–73.

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% of the allowed amount after you pay the medical deductible, up to 14 visits per the patient's lifetime.

Hospital services

ALERT! Many services provided in a hospital setting require preauthorization or plan notification, or both. Failure to request or receive preauthorization, or to notify the plan, may result in complete denial of claims. See pages 87–88 for how preauthorization and plan notification work.

This benefit covers hospital accommodations and inpatient, outpatient, and ambulatory care services, supplies, equipment, and prescribed drugs to treat covered conditions. Room and board is limited to the hospital's average semiprivate room rate, except where a private room is determined to be medically necessary (see definition on page 163). Some services require preauthorization. See page 88 for how to find the list of these services or call 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 can't charge you for the difference in cost between the standard and higher-cost item (unless you agreed in writing to pay before receiving the services).

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

Inpatient

Services are considered "inpatient" when you are admitted as inpatient to a hospital. Your provider must notify the plan upon admission. You pay an inpatient copay for facility charges at a preferred facility. See page 17 for details. Professional services—such as lab tests, surgery, or other services—may be billed separately from the facility charges. The plan pays these services according to the network status of the provider, unless your condition is a medical emergency (see "Emergency room" on page 42). All covered professional services are paid based on the allowed amount.

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

Outpatient

Services are considered "outpatient" when you are not admitted to the hospital. Your cost depends on the services provided, such as lab tests, and the network status of the provider(s) involved in your care. You do not pay the inpatient copay for outpatient services. Some services require preauthorization. See page 88 for how to find the list or call 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 will pay 40% of the allowed amount. For out-of-network providers, you may also be balance billed (see definition on page 157). For examples of how much you pay, see "Sample payments to different provider types" on page 10.

To see the network status of anesthesiologists and emergency room doctors in Washington State hospitals, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

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

FOR MEDICARE RETIREES: The COE Program is not available to UMP Classic members who are enrolled in Medicare as their primary coverage (see page 107). Medicare members still have access to covered services related to joint replacement separate from the COE Program. Those services are paid at the standard rate.

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 "What is my travel benefit?" below.
- Hospitalization and surgery.
- Postsurgical check-ups.

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 (see page 15), coinsurance (see page 16), copay (see page 17), or amounts not covered by the plan.

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 can 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 UMP Classic or CDHP member.
- Not enrolled in Medicare as your primary coverage (see page 107).
- Age 18 or older.

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

How do I apply to participate in the COE Program?

If you are interested in participating in the COE Program:

- You may self-refer by calling Premera at 1-855-784-4563.
- Your regular provider may refer you.

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 I'm 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.

What is my travel benefit?

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

To be covered by the program, **all travel must be arranged through Premera**. This travel can be arranged by calling Premera at 1-855-784-4563.

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

FOR MORE INFORMATION: Reimbursement for travel expenses is based on cost or current IRS rates for medical expenses, whichever is less, and may not cover all of your costs. For the IRS rates, visit **www.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's covered and what isn't, 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 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. Call UMP Customer Service if you have questions.

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

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

What happens if I don't 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 will be processed according to the plan's medical policies, benefit structure, and the network status of your provider.

Appeals related to the COE Program

UMP members can 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.

TIP: Deadlines and other rules remain the same. See page 120 for details of how appeals work.

An appeal for services related to the COE Program must be submitted to Premera at the address below (and not to Regence):

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

Knee arthroplasty

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

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

TIP: You may be eligible to have your knee or hip joint replacement surgery covered in full. See "Joint replacement surgery, knees and hips–Centers of Excellence (COE) Program" on page 48.

Mammograms

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

Screening (preventive)

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

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

How much will I pay?

For all women, if you see a:

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

Diagnostic (medical)

The plan pays for medically necessary mammograms to diagnose a medical condition under the "Diagnostic tests, laboratory, and x-rays" benefit, subject to the medical deductible and coinsurance. Coverage of diagnostic mammograms is not related to age.

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

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

Massage therapy

The plan covers up to 16 massage therapy visits per calendar year for covered diagnoses. If you pay for visits before you meet your medical deductible, those visits count toward the 16-visit limit. See the definition of "Limited benefit" on page 162. You must have a prescription for massage therapy treatment from another covered provider type, such as a physician.

ALERT! Only preferred massage therapists are covered. To find a preferred massage therapist, use the Provider Search at **www.hca.wa.gov/ump-providers-classic** or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Mastectomy and breast reconstruction

ALERT! See page 66 for coverage of breast reconstruction or mastectomy services related to transgender services.

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

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

Please note that you must use a covered provider type (see page 10) for services to be covered.

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 on page 62 for details about coverage for substance use disorder treatment. The amount the plan pays depends on the provider's network status (see the table on page 31).

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 87 for details. Contact UMP Customer Service at 1-888-849-3681 (TRS: 711) about preauthorization requirements. See the bullets on page 52 for services that require plan notification.

You pay an inpatient copay for facility charges at a preferred facility (see page 17 for details). Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see page 163). All covered professional services are paid based on the allowed amount.

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

Outpatient

ALERT! See page 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 52 for services requiring plan notification.

Naturopathic physician services

While naturopaths are a covered provider type, naturopaths may recommend services that the plan doesn't cover. You will pay all costs for excluded and non-medically necessary services, even if your naturopathic physician recommends or prescribes them (see definition of medical necessity on page 163).

The plan does not cover herbal, homeopathic, or other dietary supplements (including vitamins and minerals, except as described on page 78), even if prescribed by a covered provider type.

Nutrition counseling and therapy

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

The plan covers up to three visits per lifetime for nutrition counseling and therapy services. Similar services may be covered under other benefits that are not subject to the three-visit limit, including but not limited to "Diabetes Control Program (see page 39), "Diabetes education" (see page 40), and the "Diabetes Prevention Program" (see page 40).

Obstetric and newborn care

Services for pregnancy and its complications are covered. See "Covered provider types" on page 10 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 "When deliveries before 39 weeks gestation may not be covered" on page 54.

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

- Any remaining medical deductible for the mother.
- The mother's inpatient copay (see page 17).
- Coinsurance for professional services for the mother while hospitalized.
- The medical deductible for the newborn; however, if only covered preventive care services (see pages 56–58) are billed for the newborn, you will not pay the newborn's medical deductible, inpatient copay, or coinsurance when you see a preferred provider.

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

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

A newborn dependent of a female enrollee is covered from birth to at least 21 days following birth. Even if the newborn is later enrolled in different coverage, the newborn will still be covered under the mother's UMP coverage for the first 21 days. See "Adding a new dependent to your coverage" on page 55 for what you need to do for continued coverage.

If your obstetric care began while covered under another health plan, and the providers are not part of the plan network, call UMP Customer Service at 1-888-849-3681 (TRS: 711).

When deliveries before 39 weeks gestation may not be covered

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

- Due to a medical emergency (see definition on page 163) 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 163).
- 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 medical 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 78.

See pages 56–58 for more prenatal, newborn, and well-baby services that are covered as preventive. See page 78 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, read the Employee Enrollment Guide or the Retiree Enrollment Guide at **www.hca.wa.gov/erb**.

Office visits

The plan pays for office visits for covered conditions under the medical benefit (see page 163). Preventive care visits to preferred providers as described under "Preventive care" beginning on page 56 are covered in full and are not subject to the medical deductible.

Orthognathic surgery

Orthognathic surgery (see definition on page 166) 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 65 for treatment of temporomandibular joint syndrome (TMJ) disorder.

Physical, occupational, speech, and neurodevelopmental therapy

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

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

You must have a prescription for the above therapies from another covered provider type (see page 10), such as a physician.

Inpatient services

Preauthorization is required for inpatient admissions for physical, occupational, speech, and neurodevelopmental therapy services. The plan covers rehabilitation therapy services provided during inpatient hospitalization up to 60 days per calendar year (see definition of "Limited benefit" on page 162). You must pay the inpatient copay (see page 17) and your coinsurance for inpatient services.

Outpatient services

The plan covers outpatient physical, occupational, speech, and neurodevelopmental therapy services up to 60 visits per calendar year, counting all types of therapies listed here (see definition of "Limited benefit" on page 162).

For the purposes of this benefit, developmental delay (see definition on page 158) means a significant lag in achieving skills such as:

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

Prescription drugs

Please see "Your prescription drug benefit" starting on page 68.

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 will not be covered as preventive. Instead, when medically necessary, they are covered under the standard rate (see page 20).

You don't have to meet your medical deductible before the plan pays for services covered under the preventive care benefit. When you see a preferred provider for these services, you pay nothing. If you see an out-of-network provider, you pay 40% of the allowed amount (see page 156), and the provider may balance bill you. However, if you do not have access to a preferred provider for preventive services, the plan may pay 100% of billed charges. See page 11 for how to request a network waiver.

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

For a list of immunizations covered as preventive, see "Covered immunizations" on page 57.

Examples of services covered under the preventive care benefit include:

- Preventive visits such as well-baby care and annual physical exams.
- Preventive vision acuity screening from birth through 18 years of age.
- Intensive behavioral counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors.
- Screening for hepatitis B for non-pregnant adolescents and adults at high risk.
- Routine screenings for men and women.

- Certain radiology and lab tests such as screening mammograms (see page 51).
- 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" below.
- Hearing tests as part of a newborn screening.
- Fluoride for prevention of caries (dental decay) when prescribed by primary care provider to children age 6 months and older and when water is fluoride deficient. (See page 78 for coverage. See page 37 for coverage of fluoride varnish.)
- Certain screening tests performed during pregnancy. (See page 53 for more on prenatal care.)
- Low to moderate dose of statin prescription drugs to adults ages 40 and over (statin prescription drugs that are designated with a PV in the Tier column on the UMP Preferred Drug List).

You may call UMP Customer Service at 1-888-849-3681 (TRS: 711) to ask if a medical service is covered as preventive. Call Washington State Rx services 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 age 24 years and younger, and for women age 25 and older who are at increased risk for infection.
- Education and counseling regarding contraception.
- Counseling and screening for HIV, counseling and screening for interpersonal and domestic violence, and counseling for sexually transmitted infections.

For additional services covered as preventive for women, see "Family planning services" on pages 43–44, "Mammograms" on page 51, and "Obstetric and newborn care" on page 53.

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

ALERT! Follow-up visits or tests are not covered under the preventive care benefit. If the test or visit is normally covered by the plan and is medically necessary, the plan pays under the medical benefit (see definition on page 163).

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). Visit **www.hca.wa.gov/ump/find-drugs** to find a link to the CDC schedules or call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Note that 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 care benefit are not subject to either the medical or the prescription drug deductibles. Covered immunizations given by the providers listed under "Where can I get immunizations?" on page 58 are paid under the preventive care benefit. If you see an out-of-network provider for covered immunizations, you pay 40% of the allowed amount and may be balance billed.

FOR MORE INFORMATION: For a list of immunizations covered as preventive, find a link to the CDC immunization schedules at **www.hca.wa.gov/ump/find-drugs** or call 1-888-849-3681 (TRS: 711).

Where can I get immunizations?

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

- Preferred provider.
- Network vaccination pharmacy (see page 165 and check at **www.hca.wa.gov/ump/find-drugs** or call Washington State Rx Services 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.

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

Second opinions

This benefit covers:

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

Skilled nursing facility

Services must be preauthorized by the plan before you are admitted to a skilled nursing facility (see page 87). In addition, the facility must notify the plan within 24 hours of your admission (see page 88).

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 163).

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

Skilled nursing care limits for Medicare retirees

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

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

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

Spinal and extremity manipulations

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

Visits that count toward your medical deductible also count toward your 10-visit limit (see "Limited benefit" on page 162).

Spinal injections

Some spinal injections must be preauthorized by the plan (see page 87 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 above may be covered subject to the plan's medical review. Call 1-888-849-3681 (TRS: 711) for more information.

Spine Care–Centers of Excellence (COE) Program

FOR MEDICARE RETIREES: The COE Program is not available to UMP Classic members who are enrolled in Medicare as their primary coverage (see page 107). Medicare members still have access to covered services related to spine care separate from the COE Program. Those services are paid at the standard rate.

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 "What is my travel benefit?" below.
- Hospitalization and surgery, if surgery is determined to be appropriate.
- Postsurgical check-ups.

Patients work with Premera Blue Cross (Premera)—the administrator of the program—and the Centers of Excellence for this procedure—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 15), coinsurance (see page 16), copay (seepage 17), or amounts not covered by the plan.

Centers of Excellence 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 can 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 UMP Classic or CDHP member.
- Not enrolled in Medicare as your primary coverage (see page 107).
- 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 can find these guidelines at **www.breecollaborative.org/wp-content/uploads/4.Lumbar-Fusion-Bundle.pdf**.

How do I apply to participate in the COE Program?

If you are interested in participating in the COE Program:

- You may self-refer by calling Premera at 1-855-784-4563.
- Your regular provider may refer you.

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 I'm 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.

What is my travel benefit?

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

To be covered by the program, *all travel must be arranged through Premera*. This travel can be arranged by calling Premera at 1-855-784-4563.

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

FOR MORE INFORMATION: Reimbursement for travel expenses is based on cost or current IRS rates for medical expenses, whichever is less, and may not cover all of your costs. For a link to the IRS rates, visit **www.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 work with you to help you understand how the COE Program works, what's covered and what isn't, 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 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. Call UMP Customer Service if you have questions.

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

- 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 therapies that are 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.

What happens if I don't 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 will be processed according to the plan's medical policies, benefit structure, and the network status of your provider.

Appeals related to the COE Program

UMP members can 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.

TIP: Appeal deadlines and other rules remain the same. See page 120 for details of how appeals work.

An appeal for services related to the COE Program must be submitted to Premera at 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 87 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 52 for more information on inpatient mental health treatment.

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

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

Inpatient

ALERT! Your provider must notify the plan upon admission when you receive inpatient services for 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 158).

Services are considered "inpatient" when you are admitted to a facility. You pay an inpatient copay for facility charges at a preferred facility (see page 17 for details). Professional services (for example, doctors or lab tests) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency (see definition on page 163).

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

Outpatient

Outpatient 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 in order to determine medical necessity. The plan will review your provider's treatment plan to determine if it meets the following conditions:

- The purpose of the service is to treat or diagnose a medical condition;
- Outpatient services are the appropriate level of services considering the potential benefits of the services;
- The level of service is known to be effective in improving health outcomes; and
- The level of service recommended for your condition is cost-effective compared to alternative interventions including no intervention. See the definition of "Medically necessary services, supplies, drugs, or interventions" on page 163.

Surgery

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

The plan pays for covered surgical services according to the network status of the provider (see page 10 for coinsurance amounts). The surgeon and other professional providers may bill separately from the facility.

Some outpatient procedures require preauthorization (see page 87). In addition, your provider must notify the plan (see page 88) when you receive certain services, including admission as an inpatient. See the list of services that require preauthorization at **www.hca.wa.gov/ump-preauth-classic**. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions.

If services are inpatient (see definition of "Inpatient stay" on page 162), you will also pay an inpatient copay for facility charges at a preferred facility (see page 17).

The plan covers the following services as outpatient:

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

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

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, facsimile, 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, facsimile, or email.

If you see a network provider, telemedicine services will be paid at the network rate. If you see an out-of-network provider, telemedicine services will be 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; and
- The health care services are medically necessary; and
- 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; and
- 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 services are 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 can 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:

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

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, deductibles, and copayment requirements. Services obtained from non-network providers will be reimbursed at the out-of-network rate.

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

- Audio-only telephone, email or facsimile transmissions between doctor and patient.
- Originating sites' professional fees.
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.
- Store and forward technology without an associated office visit between the covered person and the referring health care provider.
- Telemedicine visits originating from a location other than the specified originating sites.
- Services that would not be covered if delivered in person.
- Services that are not medically necessary.
- 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 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.

Temporomandibular joint (TMJ) treatment

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

Tobacco cessation services

ALERT! If you get nicotine replacement therapy or prescription drugs for tobacco cessation at a non-network pharmacy, or purchase at a cash register other than the pharmacy counter, and submit a claim, you may not receive full reimbursement from the plan. See page 74 for how to find a network pharmacy.

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

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

Nicotine replacement therapy

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

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

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

If you get a nicotine replacement therapy product not designated as preventive, you will pay any remaining amount on your prescription drug deductible and Tier 3 coinsurance. To request full coverage of non-preventive nicotine replacement therapy for a medical reason, see "How to request an exception" on page 66.

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 table on pages 20–21) when you see a preferred or participating provider.

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

How to request an exception

To request coverage of a prescription drug or nicotine replacement therapy not usually covered under this benefit, see "Preauthorizing Drugs" on page 80 for how to request an exception. If your exception is approved, you will receive the approved product or drug at no cost.

Quit for Life *program*

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

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

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

FOR MORE INFORMATION: You can only re-attest for an exemption to the PEBB tobacco premium surcharge if you are tobacco-free for two months, enroll in Quit for Life (for members over age 18), or access the information and resources in Smokefree Teen (for members under age 18). Visit the PEBB Program website at **www.hca.wa.gov/pebb** for details about the surcharge.

Transgender health

The following services associated with a diagnosis of gender dysphoria are covered.

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

Visit **www.hca.wa.gov/ump/ump-administration/clinical-policies** to find a link to the clinical criteria for transgender services. Some services and drugs 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 the donor's covered expenses as primary, regardless of any other coverage the donor may have. Covered donor expenses include costs to remove the donor's organ and treat complications directly resulting from the donor's surgery.

Urgent care

See "Emergency room services" on page 42 for care during a medical emergency (definition on page 163).

If you need immediate care or need care when your usual provider is closed, and your situation is not a medical emergency, you may use urgent care facilities to receive care at a lower cost than an emergency room. You don't pay the emergency room copay for urgent care services. These services are paid at the standard rate as described in the table on page 20.

Visit **www.hca.wa.gov/ump-providers-classic** to find preferred urgent care facilities.

Vision care (diseases and disorders of the eye)

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

Following cataract surgery, vision hardware (contact lenses or eyeglasses, including frames and prescription lenses) is covered as durable medical equipment (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 covers one routine eye exam for each enrollee per calendar year, which is exempt from the medical deductible and will be paid at the preventive rate (see page 20).

Vision hardware (eyeglasses and contact lenses)

Adults (over age 18)

The plan pays up to $150 every two calendar years for prescription eyeglass lenses, frames, and contact lenses, including repairs; you do not need to meet your medical deductible. This $150 limit is renewed on January 1 of even years (2018, 2020, 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)" above for vision hardware coverage following cataract surgery.

You can buy your vision hardware anywhere. The maximum benefit of $150 applies no matter where you shop. If you go to a provider that does not bill the plan directly, you can submit a claim for glasses or contacts; see "Billing & payment: filing a claim" starting on page 112 for instructions.

Children ages 18 and under

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

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

The plan will cover one hardware benefit per calendar year for children ages 18 and under as follows:

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

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

FOR MEDICARE RETIREES: If Medicare is your primary coverage, see "How UMP Classic prescription drug coverage works with Medicare" starting on page 110 for important information.

See page 85 for prescription drug contact information.

Your plan's drug benefit is managed by a partnership of companies known as Washington State Rx Services. 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)**—Mail-order pharmacy.
- **Ardon Health**—Specialty drug pharmacy.

When you have questions about your prescription drug coverage or need help finding a network vaccination pharmacy, call Washington State Rx Services 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 Washington State Rx Services with questions about your prescription drug coverage.

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

What drugs are covered? The UMP Preferred Drug List

ALERT! Not all drugs are listed on the UMP Preferred Drug List. If your drug isn't listed, call 1-888-361-1611 (TRS: 711).

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

- If a drug is covered by the plan.
- How much you will pay for a drug based on the drug's tier.
- If the drug must be preauthorized (see "Preauthorizing drugs" on page 80).
- If the drug must be purchased from the plan's specialty pharmacy, Ardon Health (see page 81).
- If there are any limits on a drug's coverage (see page 79).
- If there are less expensive alternatives.

The UMP Preferred Drug List is updated online at least monthly. However, a drug may change tiers at any time, particularly when a generic equivalent becomes available. You can look up your prescription drugs online at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services. New brand-name drugs may not be covered during the first 180 days they are available. To check if a new drug is covered, call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

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

Who decides which drugs are preferred?

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

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

For the plan to approve a drug for you, it must be medically necessary (see page 163) 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 drug may be designated as Tier 3 (nonpreferred) even if no generic equivalent is available. See page 73 for how you may request an exception.

How much will I pay for prescription drugs?

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

- **Preventive Tier**: preventive drugs required under the Affordable Care Act or recommended by the US Preventive Services Task Force.
- **Value Tier**: specific high-value prescription drugs used to treat certain chronic conditions.
- **Tier 1**: primarily low-cost generic drugs.
- **Tier 2**: preferred brand-name drugs and high-cost generic drugs.
- **Tier 3**: nonpreferred drugs.

Preventive tier drugs are covered in full. In general, Value Tier and Tier 1 drugs cost you less money than Tier 3, which are the most expensive. Even though Tier 3 drugs are called "nonpreferred," the plan still covers them, but you pay more. See "What you pay for prescription drugs" below for more information.

You can find a drug's tier by searching the UMP Preferred Drug List at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711). You can purchase up to a 90-day supply for most drugs, except for specialty drugs.

To check your cost, do either of the following:

- Use the Prescription Price Check tool at **www.hca.wa.gov/ump/find-drugs**.
- Call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

See the table on page on page 71 for how much you pay for each of the drug tiers. Using Value Tier and Tier 1 drugs reduces prescription costs for both you and the plan. Generic drugs, follow-on biologics, and biosimilars have the same active ingredient as their brand-name counterparts and are usually less expensive.

Prescription drug deductible

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

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

How does the deductible work?

You pay the prescription drug deductible for Tier 2 and Tier 3 drugs.

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

What counts toward my deductible?

- Amounts paid toward Tier 2 and Tier 3 covered prescription drugs.
- Amounts paid toward supplies designated as Tier 2 or Tier 3 and covered under the prescription drug benefit.

What doesn't count toward my deductible?

- Coinsurance amounts paid for Value Tier or Tier 1 drugs.
- Amounts exceeding the allowed amount (see page 157) paid to non-network pharmacies. *
- Costs for medical services, including drugs covered under the medical benefit.
- Costs for drugs not covered by the plan (see pages 90–97).

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

What will I pay for after reaching my deductible?

- Coinsurance amounts paid for all tiers except preventive.
- Any drugs or other products not covered by the plan. See "Guidelines for drugs UMP does not cover" beginning on page 84 or see pages 90–97 for examples.
- Costs for other enrolled members who have not met their prescription drug deductible (and the family maximum has not been met).

Note: The medical deductible and prescription drug deductible are completely separate.

Where do I pay the deductible?

You pay the prescription drug deductible at any pharmacy.

- If you use a non-network pharmacy (see page 76) you must pay the billed charges for the drug and submit a paper claim. The prescription drug deductible must be met before the plan begins paying benefits for Tier 2 and Tier 3 drugs.
- Network pharmacies will know if you've met your prescription drug deductible, or if it doesn't apply to your prescription. This means that you pay only the amount remaining after the plan pays.

Your coinsurance for prescription drugs

ALERT! See page 46 for special prescription drug coverage while in hospice care.

You pay your coinsurance for all covered prescription drugs, which is a percentage of the drug's cost. You may get up to a 90-day supply for most drugs, except for specialty drugs (see page 81).

Tier	At all network pharmacies (retail and mail-order), you pay	The most you'll pay (prescription cost-limit) Network pharmacies only
Preventive	0% coinsurance *No deductible*	**$0**
Value Tier	5% coinsurance *No deductible*	**$10**—Up to a 30-day supply **$20**—31-60 days' supply **$30**—61-90 days' supply
Tier 1 Select generic drugs	10% coinsurance *No deductible*	**$25**—Up to a 30-day supply **$50**—31-60 days' supply **$75**—61-90 days' supply
Tier 2 Preferred drugs	30% coinsurance *Deductible applies*	**$75**—Up to a 30-day supply **$150**—31-60 days' supply **$225**—61-90 days' supply
Tier 3 Nonpreferred drugs	50% coinsurance *Deductible applies*	Specialty drugs* **only**: $150 No cost-limit for non-specialty drugs

** Specialty drugs must be purchased through the plan's network specialty pharmacy, Ardon Health (see page 81).*

How does the prescription cost-limit work?

ALERT! For annual limits to your prescription drug costs, see "Your prescription drug out-of-pocket limit" on page 72.

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

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

- **Preventive drugs**: No deductible, all network pharmacies.
- **Value Tier drugs:** No deductible, all network pharmacies.
- **Tier 1 drugs:** No deductible, all network pharmacies.
- **Tier 2 drugs:** Must meet your prescription drug deductible first, all network pharmacies.
- **Tier 3 drugs:** Only for specialty drugs. See "Prescription cost-limit for specialty drugs" on page 82. (Non-specialty Tier 3 drugs do not have a cost limit per prescription.)

ALERT! If you get your prescription filled at a non-network pharmacy, the prescription cost-limit does not apply. See "Non-network pharmacies—retail or mail-order" on page 76 for details.

If your normal coinsurance is **less than** the prescription cost-limit, you pay the normal coinsurance. If the normal coinsurance is **more than** the prescription cost-limit, you pay the prescription cost-limit.

See the table below for examples (these examples assume you've met your prescription drug deductible when it applies).

Tier of drug	Allowed amount	Normal coinsurance	The most you'll pay (Prescription cost-limit) *(90-day supply)*	You pay…
Tier 1	$300	10% (10% x $300=**$30**)	$75	$30
Tier 1	$1500	10% (10% x $1500=$150)	$75	$75
Tier 2 *Must meet prescription drug deductible first*	$500	30% (30% x $500=**$150**)	$225	$150
Tier 2 *Must meet prescription drug deductible first*	$2500	30% (30% x $2500=$750)	$225	$225

Your prescription drug out-of-pocket limit

Expenses are counted from January 1, 2019, or your first day of enrollment, whichever is later, and December 31, 2019, or your last day of enrollment, whichever is earlier.

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

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

How does the prescription drug out-of-pocket limit work?

What counts toward my prescription drug out-of-pocket limit?

- Your prescription drug coinsurance up to the prescription cost-limit, when it applies (see table on page on page 71).
- Your prescription drug deductible.

What doesn't count toward my prescription drug out-of-pocket limit?

1. Amounts paid by the plan, including services covered in full.
2. Amounts exceeding the allowed amount for drugs (see page 157) paid to non-network pharmacies. *
3. Drugs and products not covered by the plan. See "Guidelines for drugs not covered" beginning on page 84.

4. Costs for medical services, including drugs covered under the medical benefit. (See page 17 for how the medical out-of-pocket limit works.)
5. Costs paid for other enrolled family members' prescription drugs and products.

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

What will I pay for after reaching my prescription drug out-of-pocket limit?

You will still be responsible for paying numbers 2–5 above after you meet your individual prescription drug out-of-pocket limit.

Requesting an exception to the Tier 3 drug cost-share

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

You or your prescribing provider may request an exception to the cost-share (50% of the allowed amount) for Tier 3 (nonpreferred) brand-name drugs by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711).

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

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

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

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

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

   OR

   (B) Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives (Value Tier, Tier 1, and Tier 2), including the required number of manufacturers of the same generic drug, caused an adverse drug reaction that prevents the patient from taking the prescription drug as directed. If the requested exception is for a brand-name drug that has an FDA-approved generic equivalent, your prescribing provider must document your adverse drug reaction to at least 5 manufacturers of the generic drug, or to all manufacturers of the generic drug if there are fewer than 5 manufacturers, in addition to all other preferred therapeutic alternatives before an exception will be granted.

If you have other medical coverage

If you have primary medical coverage through another plan that covers prescription drugs, some of the limits and restrictions to prescription drug coverage listed on pages 79–83 will apply when UMP pays secondary to another plan. See "Submitting a claim for prescription drugs" beginning on page 114 for how to submit your prescription drug claim.

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

FOR MEDICARE RETIREES: When Medicare is your primary coverage, UMP's network mail-order pharmacy, PPS, cannot bill Medicare for you. You must submit a claim to Washington State Rx Services after Medicare has paid its share. See "Submitting a claim for prescription drugs" beginning on page 112.

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

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail-order pharmacy, then submit a paper claim for payment by UMP. See "Submitting a claim for prescription drugs" beginning on page 114 for how to do this.

Where to purchase your prescription drugs

ALERT! If you use a non-network pharmacy of any type, you will pay the entire cost of the drug upfront and must submit a claim. However, only the allowed amount for covered drugs (see page 157) will count toward your prescription drug deductible or prescription drug out-of-pocket limit.

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

Retail pharmacies

FOR MEDICARE RETIREES: If you are retired and enrolled in Medicare, please see page 110 for more information on how UMP prescription drug coverage works with Medicare.

Washington State Rx Services has a large network of retail pharmacies, which includes many independent and regional pharmacies in Washington State as well as national chains. Search for a network pharmacy at **www.hca.wa.gov/ump/find-drugs** or call 1-888-361-1611 (TRS: 711).

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

Many network retail pharmacies have vaccination pharmacists who are able to administer covered preventive immunizations at no cost to you. Find a list of network vaccination pharmacies (see definition on page 165), at **www.hca.wa.gov/ump/find-drugs**, or call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

TIP: If you take an ongoing prescription drug and purchase between an 84- and 90-day supply you may be able to save money by using a Choice 90 network pharmacy or PPS mail-order pharmacy. Search for a network pharmacy at **www.hca.wa.gov/ump/find-drugs** to find a Choice90 network pharmacy and compare prices.

Mail-order pharmacy

ALERT! PPS cannot ship outside of the United States. See "Travel overrides for prescription drugs" on page 83 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 may not be covered. You may call PPS at 1-800-552-6694 or Washington State Rx Services at 1-888-361-1611 (TRS: 711) for more information about mail order. To get started:

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

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

ALERT! UMP 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 can be ordered through your online pharmacy account at **www.ppsrx.com**, or by calling PPS directly. Prescriptions are usually delivered within 7 to 10 days after the pharmacy receives your prescription.

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

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

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

ALERT! Some durable medical equipment (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 ID card to get the plan discount

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

If you are a Washington State resident and have a prescription UMP does not cover, 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 **www.hca.wa.gov/free-or-low-cost-health-care/prescription-assistance/alternate-help-prescriptions**.

If UMP is your primary insurance coverage, always show your UMP 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 ID cards at the pharmacy and make sure they know which plan pays first so the pharmacy can bill the plans in the correct order. If UMP does not cover your prescription, and you have a 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.

Non-network pharmacies—retail or mail-order

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

- You will need to submit your own claim to Washington State Rx Services for reimbursement (see "Submitting a claim for prescription drugs" starting on page 114).
- You don't get the plan discount.
- You'll pay the difference between the allowed amount (see page 157) and what the pharmacy charges, and it won't count toward your prescription drug deductible or prescription drug out-of-pocket limit.
- The plan pays for prescription drugs covered by the plan, whether from a network or non-network pharmacy, under the coinsurance percentages as shown in the table on page 71.
- The prescription cost-limit (see table on page 71) does not apply to prescriptions filled at non-network pharmacies.
- Non-network pharmacies will not know if a drug must be preauthorized, has a quantity limit, or has other coverage limits. If you purchase a drug from a non-network pharmacy and limits apply, the plan may not cover it.
- Unless noted on the UMP Preferred Drug List, specialty drugs purchased anywhere but through the plan's network specialty drug pharmacy are not covered (see "Specialty drugs" on page 81).

TIP: To submit claims for prescriptions purchased from non-network pharmacies (U.S. retail, internet, or mail-order pharmacies, or foreign retail pharmacies), see "Submitting a claim for prescription drugs" on page 114.

Drugs purchased outside the U.S.

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

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

To submit a claim for a prescription drug purchased outside the U.S., see "Submitting a claim for prescription drugs" beginning on page 114. 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 ordered through mail-order pharmacies located outside the U.S.

Guidelines for drugs UMP covers

UMP 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 and Washington State Rx Services. All prescription drugs, services, or other benefit changes may require approval by the PEB Board at the time of procurement of benefits 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 they will be covered by the Plan.

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

- Has been reviewed by one of the following: the Washington State Pharmacy & Therapeutics (P&T) Committee or Washington State Rx Services (see list on page 68) and has been placed on the UMP Preferred Drug List.
- Be medically necessary (see definition on page 163).
- Can be legally obtained in the United States only with a written prescription.
- Is approved by the Food and Drug Administration (FDA).
- Does **not** have a nonprescription alternative (see definition on page 166), including an over-the-counter alternative with similar safety, efficacy, and ingredients. (See "Exceptions covered" on page on page 78.)
- Is not classified as a vitamin (except as listed below), mineral, dietary supplement, homeopathic drug, or medical food.
- Has been prescribed by a provider with prescribing authority within their scope of license.
- Has been dispensed from a licensed pharmacy employing licensed, registered pharmacists.
- Meets plan coverage criteria.

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

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

Exceptions covered

ALERT! Only select generic prenatal vitamins and generic fluoride supplements are covered. The plan does not cover brand-name prenatal vitamins and fluoride supplements. The plan also does not cover prescriptions that contain DHA (docosahexaenoic acid). DHA is a dietary supplement, and dietary supplements are not covered by the plan.

The plan covers the following prescription drugs as **exceptions** to the above rules when you have a written prescription from your provider:

- Activated vitamin D for patients on renal dialysis or with parathyroidism;
- Select generic fluoride supplements for prevention of dental caries for children ages 6 months to 18 years;
- Select generic prescription prenatal vitamins without docosahexaenoic acid (DHA) for women of childbearing age; and
- Limited products for the treatment of congenital metabolic disorders such as generic phenylketonuria (PKU) detected by newborn screening when specialized formulas are medically necessary.

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

- Insulin and diabetic supplies such as blood glucometers, test strips, lancets, and insulin syringes used in the treatment of diabetes. See "Diabetes care supplies" on page 39 for more information.
- Contraceptive devices and drugs. See pages 43–44.
- Low-dose aspirin for pregnant women. See page 55 for coverage details.
- Select generic over-the-counter prenatal vitamins without DHA for women of childbearing age.
- Certain nicotine replacement therapy products. See page 65.
- FDA approved over-the-counter contraceptives. For the Plan to cover FDA-approved over-the-counter contraceptives, you must present your UMP 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 Washington State Rx Services.
- Other over-the-counter products that are specifically noted in the UMP Preferred Drug List as covered by the plan.

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

- In a standard reference compendium (defined on page 172) as supported by peer-reviewed clinical evidence;
- In most relevant peer-reviewed medical literature (defined on page 168), 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 purchase at a network pharmacy to receive 100% reimbursement. You may not receive full reimbursement for claims from register receipts and non-network pharmacies.

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

- Are recommended by the U.S. Preventive Services Task Force (USPSTF) as described on pages 56–58; and
- Conform to coverage guidelines stated on page 78.

The brand and type of products covered are limited. Call 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 65 for products covered as preventive for tobacco cessation.

Some injectable drugs are covered only under the prescription drug benefit

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

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

Your pharmacy may submit a claim for these drug classes to Washington State Rx Services.

A drug may be approved for use for another condition but is still available only through the prescription drug benefit. Call 1-888-361-1611 (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 drug is unavailable, or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs. Compounded prescription drugs are covered under Tier 3. Compounded drugs costing more than $150 require preauthorization. Claims for compounded drugs require additional information submitted on the claim form. This information is available from the compounding pharmacy.

Limits on your prescription drug coverage

Washington State Rx Services may exclude, discontinue, or limit coverage for any drug manufacturer's version of a drug—or shift a drug to a different tier—for any of the following reasons:

- New drugs are developed.
- Generic, biosimilar, interchangeable biosimilar, or follow-on biologic drugs become available.
- A nonprescription alternative (see definition on page 166), including an over-the-counter alternative (see definition on page 167), becomes available.
- There is a sound medical reason.
- There is lack of scientific evidence a drug is as safe and effective as existing drugs used to treat the same or similar conditions.
- One of the following recommends a change: The Washington State Pharmacy & Therapeutics (P&T) Committee, or Washington State Rx Services (see list on page 68).
- A drug receives Food and Drug Administration (FDA) approval for a new use.

- A drug is found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
- The FDA denies, withdraws, or limits the approval of a product.
- A more cost-effective alternative is available to treat the same condition.

For approval, the drug must be covered by the plan and be medically necessary for your health condition. Your provider may prescribe a drug or drug dose that is not medically necessary (see definition on page 163).

Experimental or Investigational Prescription Drugs are those that involve one or more of the following:

- A prescription drug, device (supply) or biologic product for which the approval of one or more government agencies (such as the FDA) is required, but has not been obtained at the time the treatment is requested or administered.
- A treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established.
- Is only available in the United States as part of a clinical trial or research program for the illness or condition being treated.
- Is the subject of an on-going phase I or phase II clinical trial, or is the research/ experimental/study/investigational arm of an on-going phase III clinical trial.
- Is used within a regimen that may be individually proven, but when utilized in combination, scientific literature does not support the use.
- Is used within a regimen that is proven in combination with other prescription drugs, but when utilized individually, scientific literature does not support the use.

The limits and restrictions described from "Limits on your prescription drug coverage" on page 79 through "Refill too soon" on page 84 help us monitor drug usage, safety, and costs. Drugs may be added to any of these programs at any time. You can find out if your drug falls under any of these limits and restrictions by checking the UMP Preferred Drug List or calling Washington State Rx Services at 1-888-361-1611 (TRS: 711).

Risk Evaluation and Mitigation Strategies (REMS) Program

Risk Evaluation and Mitigation Strategies (REMS) programs make sure drugs are used safely. The Food and Drug Administration (FDA) requires a REMS program for a drug if they determine that safety measures are needed to ensure that the drug's benefits outweigh its risks.

Some REMS programs require the drug to be prescribed, dispensed, and used according to the REMS program guidelines to ensure safe use. If the REMS program is not followed, UMP may not cover the restricted drug.

Preauthorizing drugs

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

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

- Certain injectable drugs when purchased through a retail or network mail-order pharmacy.
- Compounded drugs costing more than $150.

If your drug requires preauthorization, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611 (TRS: 711) to request it.

Note: 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.

ALERT! Preauthorization of drug coverage only means that the plan will cover the drug—it does not change the drug's tier or your coinsurance. You still pay according to the drug's tier as assigned in the UMP Preferred Drug List. See page 73 for how to request an exception for some Tier 3 drugs.

Emergency fill

Emergency fill lets you get a limited quantity of certain 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 **www.hca.wa.gov/ump/ump-classic/what-you-pay-drugs** or by calling 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 coinsurance under the drug's tier.
- The plan will cover an emergency fill of up to a 7-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 drug for any quantity you receive after the emergency fill.

Emergency fill limits

Note that the following limits still apply to emergency fill prescription drugs:

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

Quantity limits

Certain drugs have a quantity limit per prescription (how much or how many you get). If you need more than this limit allows, your pharmacist or prescribing provider must call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

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

Specialty drugs

ALERT! Ardon Health, the plan's network specialty pharmacy, is unable to ship outside the United States. See "Travel overrides for prescription drugs" on page 83 if you will be traveling.

Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs or products that require special handling and storage and are subject to additional rules. You can find out if a drug is a specialty drug by checking the UMP Preferred Drug List at **www.hca.wa.gov/ump/find-drugs**, or by calling Washington State Rx Services. Specialty drugs are covered under the cost-share tier listed on the UMP Preferred Drug List.

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 Time).

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 or a short duration of use, or to ensure that the prescription drug is not causing harmful side effects.

Specialty drugs require preauthorization. See "Preauthorizing drugs" (page 80) on 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 country 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 94).

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

Prescription cost-limit for specialty drugs

ALERT! The prescription cost-limit is the **most** you'll pay for an individual prescription. You may pay less based on normal coinsurance—see on page 71.

See "How does the prescription cost-limit work?" on page 71 for details about the prescription cost-limit. This limit applies to individual prescriptions only. See "Your prescription drug out-of-pocket limit" on page 72 for the annual limit to your prescription drug costs.

Specialty drugs are usually limited to no more than a 30-day supply. The prescription cost-limit for a 30-day (or under) supply corresponds to the "The most you'll pay" column in the table on page 71.

However, some specialty prescription drugs are available only in packages with more than a 30-day supply. In such cases, the prescription cost-limit shown in the table on page 71 will be calculated by multiplying the standard 30-day prescription cost-limit amount as follows:

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

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

Step therapy

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

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

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

To find out if step therapy applies to your drug, check the UMP Preferred Drug List at **www.hca.wa.gov/ump/find-drugs**, or call Washington State Rx Services at 1-888-361-1611 (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 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 isn't available now. That way, when one becomes available, the pharmacist can automatically refill with the generic.

When a brand-name or biological drug has a generic equivalent or interchangeable biosimilar (see definition on page 160), pharmacists in Washington State must substitute the generic equivalent or interchangeable biosimilar drug for the brand-name or biologic drug.

Your provider may write the prescription "dispense as written" if they want you to get only the prescribed brand-name or biologic drug, or you can tell the pharmacist you want the brand-name or biologic drug. You pay according to the drug's tier as assigned in the UMP Preferred Drug List.

Therapeutic Interchange Program (TIP)

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

You can find out if your drug is affected by TIP by checking the UMP Preferred Drug List at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711). Not all nonpreferred drugs are affected by TIP.

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

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

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

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

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

Travel overrides for prescription drugs

You may request a travel override to get an extra supply of prescription drugs for extended travel. All of the conditions listed below 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 United States:
  - **Within the United States,** you may request up to a 90-day supply per prescription, or as allowed under that prescription.
  - **Outside the United States,** you may request up to a 6-month supply per prescription, or as allowed under that prescription.

- Travel overrides will be granted only while you are covered by the plan. If your eligibility is ending, the plan does not cover drugs past the time when your enrollment in the plan ends.
- You will pay applicable charges (deductible and coinsurance) for each extra supply received.

To request a travel override, call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

Refill too soon

The plan will not cover a refill until 84% 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 exigent 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 Washington State Rx Services at 1-888-361-1611 (TRS: 711).

What can I do if coverage is denied?

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

- **Employees**—Your employer's personnel, payroll, or benefits office.
- **All other members**—PEBB Program at 1-800-200-1004 (TRS: 711).

If a network pharmacy (including a mail-order or specialty pharmacy) tells you that preauthorization is required, coverage is denied, or quantities are limited, you, your pharmacist, or your prescribing physician may contact Washington State Rx Services at 1-888-361-1611 (TRS: 711) to request a coverage review or preauthorization.

If Washington State Rx Services denies the coverage request, you have the right to submit an appeal. See instructions for appealing on pages 121–124.

If your provider thinks that 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. Washington State Rx Services will decide regarding coverage of the drug within 72 hours of the request. In this case, you may choose to purchase a three-day supply at your own expense.

Guidelines for drugs UMP does not cover

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

- Drugs that are not medically necessary (see definition on page 163).
- Experimental or investigational drugs.
- Dietary supplements, vitamins, minerals, herbal supplements, and medical foods.
- Homeopathic drugs, including FDA-approved prescription products.
- Dental preparations, such as rinses and pastes.
- Over-the-counter drugs or prescription drugs that have a nonprescription alternative (see page 166), except for the drugs specified under "Guidelines for drugs 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.

- Drugs under a REMS program required by the Food and Drug Administration (FDA) when prescribed outside REMS guidelines (see page 80) for details.
- Drug costs covered by other insurance, including Medicare Part B. See page 110 regarding coordination of benefits with Medicare Part B, and page 102 for coordination with other plans.

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

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

ALERT! 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 age 18 and over. The plan does cover PPIs or nasal sprays for children under age 18 with a prescription.

Prescription drug contact information

Organization or task	Contact information
Washington State Rx Services	1-888-361-1611 (TRS: 711) 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday
Postal Prescription Services (PPS)	1-800-552-6694 Fax: 1-800-723-9023 (providers only) *Mailing a prescription order:* Postal Prescription Services PO Box 2718 Portland, OR 97208-2718
Ardon Health (specialty pharmacy): see page 81.	1-855-425-4085 Fax: 1-855-425-4096 (providers only)
Request preauthorization for prescription drugs (providers only)	1-888-361-1611 (TRS: 711) Fax: 1-800-207-8235
Submit paper claims	Washington State Rx Services Attn: Pharmacy Claims PO Box 40168 Portland, OR 97240-0168 Fax: 1-800-207-8235 Find claim forms at **www.hca.wa.gov/ump-forms**. See instructions for submitting a claim on page 114.

Send appeals/complaints for prescription drugs	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168 Fax: 1-866-923-0412
Online services	**www.hca.wa.gov/ump-drugs-classic** ▪ Find a network pharmacy, including Choice90 or network vaccination pharmacies ▪ Refill mail-order prescriptions ▪ Get estimates of drug costs, retail or mail order ▪ Review the UMP Preferred Drug List tier levels, covered or not, quantity limits, preauthorization coverage criteria, whether subject to TIP ▪ Get drug information and check for interactions

Limits on plan coverage

If you receive a service that is not medically necessary, is experimental or investigational, or is listed as an exclusion in the "What the plan doesn't cover" section on pages 90–97, you are responsible for paying all associated charges.

Preauthorizing medical services

ALERT! This section does not apply to prescription drugs. See page 80 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 in order to be covered. **The fact that a service or supply is prescribed or furnished by a provider does not, by itself, make it a medically necessary covered service (see definition on page 163).**

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 your procedure is a covered benefit, 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 (page 35) and bariatric surgery (page 36)—must be preauthorized before services are received.

- A preferred or participating provider may be required to request preauthorization before performing services.
- An out-of-network provider is not required to obtain preauthorization in advance of some services because they do not have a contract with Regence. A preauthorization may still be required.

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

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

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 doesn't cover" section on pages 90–97).

ALERT! See page 121 for how to appeal denial of a preauthorization request before receiving services.

Where can I find the list of services requiring preauthorization or notification?

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

- Visit **www.hca.wa.gov/ump-preauth-classic**.
- Call UMP Customer Service at 1-888-849-3681 (TRS: 711) to ask questions or request a printed list.

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 **www.hca.wa.gov/ump-preauth-classic** or call UMP Customer Service at 1-888-849-3681 (TRS: 711) to determine if services require preauthorization or notification. The fact that a service doesn't require preauthorization or notification does not guarantee coverage.

Notification for facility admissions

Your provider must notify the plan upon your admission to a facility for services requiring notification as listed at **www.hca.wa.gov/ump-preauth-classic** 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. Notification is usually done by the facility at the time you are admitted. Notification is not the same as preauthorization and many services require both.

What's the difference between preauthorization and notification?

ALERT! Many services, including but not limited to inpatient services, require both preauthorization and notification. Call 1-888-849-3681 (TRS: 711) or talk to your provider if you have questions about services needing preauthorization or notification by the plan.

"Preauthorization" is when your provider sends a request for coverage of a service on the UMP preauthorization list at **www.hca.wa.gov/ump-preauth-classic**, and the plan sends either an approval or denial of coverage.

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

Preauthorization is usually requested by the provider performing the services.

"Notification" means that your provider must contact the plan to let us know when you receive services. Notification is usually done by the facility at the time you receive these 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 does the plan have to make a decision?

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

If additional information is requested:

- You are allowed up to 45 calendar days from the date on the letter to submit the information requested.
- You will be notified in writing of the determination 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 physician believes that waiting for a determination under the standard time frame could place your life, health, or ability to regain maximum function in serious jeopardy, your physician should notify the plan by phone or fax as a shorter time limit may apply.

General information from customer service is not a guarantee that a service is covered

For services not requiring preauthorization, you may call 1-888-849-3681 (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, the plan cannot guarantee that your service will be covered or give an exact amount you will pay out of pocket. This is because when a provider bills for a service, the plan pays for it based on procedure codes developed by independent organizations not affiliated with the plan. Each code describes a particular service in some detail, and there are many codes for similar-sounding services. Your provider, not the plan, determines which of these codes is used on the submitted claim.

Case management

Case management is a free service offered by the plan to help enrollees with serious or complex health care needs coordinate their care. 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 to discuss your options.

This free service helps you:

- Ensure you get the most out of your UMP 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 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 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 (MD or DO) 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 doesn't 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). You may pay all costs associated with a noncovered service.

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

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

1. Air ambulance, if ground ambulance would serve the same purpose.
2. Autologous blood and platelet-rich plasma injections.
3. 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.
4. Bone growth stimulators for:
   - Nonunion of skull, vertebrae or tumor related.
   - Ultrasonic stimulator – delayed fractures and concurrent use with another noninvasive stimulator.
5. Bone morphogenetic protein-7 (rhBMP-7) for use in lumbar fusion.
6. Bronchial thermoplasty for asthma.
7. 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.

8. Carotid artery stenting of intracranial arteries.
9. Carotid intima media thickness testing.
10. Catheter ablation for non-reentrant supraventricular tachycardia.
11. Cervical spinal fusion without evidence of radiculopathy or myelopathy.
12. 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.
13. Computed tomographic colonography (CTC), also called a virtual colonoscopy, for routine colorectal cancer screening.
14. Corneal refractive therapy (CRT), also called orthokeratology.
15. Coronary artery tomographic (CCTA) angiography 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.

16. Coronary or cardiac artery calcium scoring.
17. 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.
18. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
19. Custodial care (see definition on page 158).
20. Deep brain stimulation and transcranial direct current stimulation when used as nonpharmacological treatments for treatment-resistant depression.
21. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 37–39.
22. Dietary or food supplements, including but not limited to:
    - Herbal supplements, dietary supplements, medical foods, and homeopathic drugs.
    - Infant or adult dietary formulas (see "Exceptions covered" by the plan on page 78).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see exceptions on page 78).
23. Dietary programs.
24. Discography for patients with chronic low back pain and lumbar degenerative disc disease. This does not apply to patients with the following conditions:
    - 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
25. Drugs or medicines not covered by the plan as described in the "Your prescription drug benefit" section, on pages 68–86.
26. Drugs or medicines obtained through mail-order pharmacies located outside the U.S.
27. Educational programs, except as described under:
    - "Diabetes Control Program" on page 39.
    - "Diabetes education" on page 40.
    - "Diabetes Prevention Program" on page 40.
    - "Tobacco cessation services" on page 65.
28. Electrical Neural Stimulation (ENS), which includes Transcutaneous Electrical Nerve Stimulation (TENS) Units, outside of medically supervised facility settings (e.g., in home use).
29. Email consultations or e-visits, except as described under the Telemedicine benefit.
30. 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

31. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
32. Experimental or investigational services, supplies, or drugs.
33. Extracorporeal shock wave therapy for musculoskeletal conditions.
34. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
35. Facet neurotomy for the thoracic spine or headache.
36. Fecal microbiota transplantation for treatment of inflammatory bowel disease.
37. Foot care not related to diabetes: cutting of toenails; treatment for diagnosed corns and calluses; or any other maintenance-related foot care.
38. Functional neuroimaging for primary degenerative dementia or mild cognitive impairment.
39. Gene expression profile testing for multiple myeloma or colon cancer.
40. 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.
41. Hip resurfacing.
42. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome.
43. 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.
44. 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 163).
    - Personal or convenience items.
45. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.

46. 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
47. Imaging of the sinus for rhinosinusitis using X-ray or ultrasound.
48. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
49. Implantable drug delivery systems (infusion pumps or IDDS) for chronic, non-cancer pain.
50. Incarceration: Services and supplies provided while confined in a prison or jail.
51. 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.
52. In Vitro Fertilization (IVF) and all related services and supplies, including all procedures involving selection of embryo for implantation.
53. Knee arthroscopy for osteoarthritis of the knee.
54. Knee arthroplasty: Multi-compartmental arthroplasty and partial knee arthroplasty (including bi-compartmental and bi-unicompartmental).
55. Late fees, finance charges, or collections charges.
56. 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 55; or
    - When part of treating a mental health disorder as described on page 52.
57. Lumbar artificial disc replacement.
58. Lumbar fusion for degenerative disc disease.
59. 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.
60. Magnetic resonance imaging, upright (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
61. Maintenance care (see definition on page 162).
62. Manipulations of the spine or extremities, except as described under "Spinal and extremity manipulations" on page 59.
63. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental health, or substance use disorder.
64. Massage therapy services when the massage therapist is not a preferred provider.

65. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see page 109).
66. Microprocessor-controlled lower limb prostheses (MCP) for the feet and ankle.
67. Migraine 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.
68. Missed appointment charges.
69. Negative pressure wound therapy in patients with contraindications referred to by the FDA Safety Communication dated February 24, 2011.
70. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 10).
71. Novocure (i.e., Optune) (tumor treating fields).
72. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
73. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications, except as specified on page 42.
74. Osteochondral allograft/autograft transplantation for joints other than the knee.
75. Out-of-network provider charges that are above the allowed amount.
76. Pharmacogenetic testing for patients being treated with oral anticoagulants.
77. Pharmacogenomics testing for depression, mood disorders, psychosis, anxiety, ADHD, and substance use disorder.
78. Positron Emission Tomography (PET) scans for routine surveillance of lymphoma.
79. Prescription drug charges over the allowed amount, regardless of where purchased.
80. 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.
81. Printing costs for medical records.
82. Proton beam therapy for conditions other than:
    - Ocular cancers.
    - Pediatric cancers (e.g., medulloblastoma, retinoblastoma, Ewing's sarcoma).
    - Central nervous system tumors.
    - Other non-metastatic cancers with the following conditions: patient has had prior radiation in the expected treatment field with contraindication to all other forms of therapy.
83. 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.
84. Recreation therapy.
85. Replacement of lost, stolen, or damaged durable medical equipment.
86. 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

87. 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.
88. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).
89. 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.
90. Routine ultrasounds during pregnancy, except one in week 13 or earlier, one during weeks 16-22, or high-risk pregnancies. See description on page 55.
91. 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.
92. Separate charges for records or reports.
93. Service animals: Any expenses related to a service animal.
94. 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 103 for more about how this works.
95. Services delivered by providers or facilities delivering services outside the scope of their licenses.
96. 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.
97. Services performed during a noncovered service.
98. 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.
99. Services supplemental to digital mammography. When performed supplementary to digital mammography for screening purposes for women 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)

100. Services, supplies, or drugs related to occupational injury or illness (see page 166).
101. 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.
102. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.
103. Sleep apnea diagnosis and treatment as indicated in referenced Medicare national and local coverage determinations.
104. Spinal cord stimulation for chronic neuropathic pain.
105. Spinal injections, therapeutic (except as described under "Spinal injections" on page 59) of the following types:
    - Medial branch nerve block injections
    - Intradiscal injections
    - Facet injections
106. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
107. 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.
108. Telephone or virtual consultations or appointments, except as described under "Telemedicine services" on page 63.
109. 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 Centers of Excellence (COE) Program for single knee and single hip replacement (see page 48) and for spine care (see page on page 59).
110. 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).
111. Upright magnetic resonance imaging (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
112. Vagal nerve stimulation for the treatment of depression.
113. Vitamin D screening and testing as part of routine screening.
114. 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 39)," "Diabetes Prevention Program" (see page 40), "Nutrition counseling and therapy" (see page 53), or "Preventive care" (see page 56).

- **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.

115. 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 medical coverage

FOR MEDICARE RETIREES: Different rules apply to members who have Medicare as their primary payer. See pages 104–111 for how UMP Classic works with Medicare.

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 99 through "What happens with federal and military plans?" on page 100 determine which plan pays first ("primary payer") and which pays second ("secondary payer"). See page 101 for a description of how the plan coordinates benefits when it pays second.

The plan processes claims differently depending on whether it pays first or second. The differences are described in the next several pages.

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

Whom do I inform if I have other coverage?

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

Contact type	Medical services
Phone	Call 1-888-849-3681 (TRS: 711) to request a form.
Online	Go to **www.hca.wa.gov/ump-forms**. Or, sign in to **regence.com:** ▪ In the Search box, type Coordination of Benefits. ▪ Choose "UMP Multiple Coverage Inquiry–Coordination of Benefits." ▪ You may fill out and submit online, or print out and mail or fax in.
Fax	1-877-357-3418
Mail	Regence BlueShield Attn: UMP Claims PO Box 91015 MS BU386 Seattle, WA 98111-9115

Contact type	Prescription drugs
Phone	1-888-361-1611 (TRS: 711)
Online	Go to **www.hca.wa.gov/ump-forms a**nd select "Prescription Drug Multiple Coverage Inquiry Form." Or submit through your pharmacy account at **www.hca.wa.gov/ump/log-your-accounts.**
Fax	503-412-4058
Mail	Washington State Rx Services PO Box 40168 Portland, OR 97240-0168

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

- For medical: UMP Customer Service at 1-888-849-3681 (TRS: 711).
- For prescription drugs: Washington State Rx Services at 1-888-361-1611 (TRS: 711).

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 group 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:

1. Any group plan that does not coordinate benefits.
2. The plan that covers the patient as a subscriber, not a dependent.
3. The plan that covers the patient (or their spouse or state-registered domestic partner) as an active employee pays before a plan that covers the patient as a retired employee.
4. The plan that has covered the patient (or their spouse or state-registered domestic partner) as a subscriber the longest, if there are two plans and numbers 1–3 do not determine which plan pays first.
5. The plan that covers the patient (or their spouse or state-registered domestic partner) as an active employee if the other coverage is Medicare.
6. A plan covering the patient as an employee, subscriber, retiree, or the dependent of such an employee, subscriber, or retiree will pay before a COBRA or a state right of continuation plan.

For dependent children

A group plan is usually primary over Medicaid programs that cover children. However, 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 101), except for Medicare retirees (see page on page 105). When UMP pays second to another group 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 the 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:

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

FOR MEDICARE RETIREES: For more detail on how Medicare and UMP Classic interact when Medicare pays first, and UMP Classic pays second, see pages 104–111.

How much will I pay when UMP pays second?

When you see providers preferred under UMP (see definition on page 169), 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 10 for examples.

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

Situation	Example	Preferred provider charge	UMP allowed amount	UMP normal benefit	Other plan pays	UMP pays	You pay your provider
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 deadlines for filing a claim, called a "timely filing" requirement. 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, the plan will deny it. If your primary plan delays payment on a claim, the claim should be submitted to UMP within the timely 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 in order to provide you with timely processing of your secondary benefit. Adjustments may be made when the primary plan finally pays their portion of your claim. Promptly notifying your providers of any change to your coverage will help avoid errors and delays in processing of claims. See pages 112–115 for how to submit claims.

How are diabetes care supplies covered when UMP Plus pays second?

FOR MEDICARE RETIREES: If your primary coverage is under Medicare, see page 107.

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 don't need to do anything further. If not, you will need to send a claim to Washington State Rx Services for secondary payment. See page 114 for instructions.
- If you get your supplies from a diabetic care supplier, the primary plan may process the claim as medical. In this case, you will need to send your Explanation of Benefits and a claim form to Washington State Rx Services for secondary payment. See pages 112–113 for instructions.

Note: Nonduplication of benefits applies to these claims (see page 101), 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 Washington State Rx Services.

How does coordination of benefits work with prescription drugs?

Some of the limits and restrictions to prescription drug coverage listed on pages 79–83 will apply when UMP pays second to another plan. See "Submitting a claim for prescription drugs" beginning on page 114 for how to submit your prescription drug claim.

Note: If UMP pays second to a plan other than Medicare, nonduplication of benefits applies (see page 101). This means that UMP may pay nothing after your primary plan pays.

ALERT! If UMP pays second, you must still pay your prescription drug deductible before UMP covers Tier 2 and Tier 3 drugs.

Using network pharmacies when UMP is your secondary coverage

If you have primary coverage through another plan that covers prescription drugs, show both plan cards to the pharmacy and make sure they know which plan pays first. 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

FOR MEDICARE RETIREES: See the Tip on page 110 on using PPS when Medicare is your primary coverage.

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

However, if your primary plan uses a different mail-order pharmacy, you will have to use your primary plan's mail order, then submit a paper claim for payment by UMP. See "Submitting a claim for prescription drugs" beginning on page 114 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.

For retirees enrolled in Medicare and UMP Classic

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

Am I a Medicare retiree?

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

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

ALERT! If you are the subscriber (see definition on page 173) and are an employee, see "What happens when UMP Classic pays first and Medicare pays second?" on page 105 for coverage when UMP Classic pays before Medicare. This also applies to retired dependents enrolled in UMP Classic under an employee's account.

If you aren't a Medicare retiree as defined above, UMP Classic pays first and Medicare pays second. You or your provider must bill Medicare after UMP pays. See how to submit a claim on page 112.

How do UMP Classic and Medicare work together?

Because Medicare pays first, a few rules are different for Medicare retirees. This section tells you about these rules, including:

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

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

If you are retired but you or an eligible dependent are not yet eligible to enroll in Medicare Part A and Part B, this section does not apply to you. If you think you might be eligible for Medicare and need information on how to sign up, see the "Medicare entitlement" section on page 137.

Note: Medicare accepts claims **directly** from enrollees only under certain circumstances.

What happens when UMP Classic pays first and Medicare pays second?

If UMP Classic pays first and Medicare pays second, make sure that you tell Medicare about your UMP Classic coverage and that your provider agrees to bill Medicare as secondary to get the maximum benefit from both plans. Medicare generally accepts claims only from providers, so you may not be able to send a claim to Medicare for secondary payment. The provider would need to bill Medicare after UMP Classic has processed the claim.

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

What happens when Medicare pays first and UMP Classic pays second?

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

- Your providers bill Medicare. Medicare pays your claims first. After Medicare processes the claim, Medicare sends the claim to UMP Classic.
- UMP Classic pays your claims second. For most covered services, UMP Classic pays the rest of the Medicare allowed amount and you owe nothing.

Each calendar year, you have to meet the UMP Classic medical deductible ($250 per person) before UMP Classic starts paying benefits. If you incur more covered services during the same calendar year, you may be reimbursed for at least some of your UMP Classic deductible. That reimbursement will come from the coordination of benefits (COB) savings. This savings is the part of your UMP benefit saved because Medicare pays part of your claims.

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

Paying the UMP Classic and Medicare deductibles

If you meet the $250 UMP Classic deductible, you do not pay both the Medicare Part B and the UMP Classic deductible. The $183 Part B deductible is a part of the same total calendar year expenses processed by UMP Classic. Here is an example:

Medicare benefit calculation	
Medicare allowed amount	$600
Medicare deductible	$183
Subtract deductible from allowed amount: $600—$183 =	$417
Medicare pays 80% of this amount (.80 x $417) =	$333.60
Balance remaining after Medicare pays: $600—$333.60 =	$266.40
UMP Classic benefit calculation	
Plan allowed amount	$600
UMP Classic deductible	$250
Subtract deductible from allowed amount: $600—$250 =	$350
Normal UMP Classic benefit (85% of this amount) (.85 x $350) =	$297.50
Since the UMP Classic benefit available (dollar amount) is greater than the balance, UMP pays the balance remaining after Medicare pays:	$266.40
The difference between the normal UMP Classic benefit and the amount UMP paid is: **This amount is considered "COB savings" (see page 110).**	$31.10

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

Example of coordination of benefits when Medicare pays first and UMP Classic pays second

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

In this example, the provider's charge is $300.

Medicare benefit calculation	
Provider's billed charge	$300
Medicare allowed amount	$100
Medicare pays	$80 (80% of $100)
Remaining amount	**$20**
UMP Classic benefit calculation	
Plan allowed amount	$100
UMP Classic normal benefit	$85 (85% of $100)
UMP Classic pays	**$20**
You pay	$0
COB savings accrued	**$65** ($85 - $20 =$65)

The $65 of the normal UMP Classic benefit not paid on this claim is tracked as part of your COB savings. That excess benefit can be used to reimburse you directly for your UMP Classic medical deductible met earlier in the same year or used to pay more on a service covered by UMP Classic, but not covered by Medicare. See "Why did I get a 'COB Savings' check from UMP Classic?" on page 110.

In this example, you owe nothing because the provider accepts Medicare. You may still have to pay coinsurance and deductible amounts when you have not fully met your Medicare deductibles, or when Medicare does not cover a service.

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

If a provider does not bill Medicare for services covered by Medicare, UMP Classic may not cover services. Medicare accepts claims from enrollees only under certain circumstances, and UMP Classic processes claims for services covered by Medicare only after Medicare has processed them. See "What does UMP Classic cover that Medicare doesn't?" on page 108 for exceptions. Ask your provider if they bill Medicare.

Diabetes care supplies when Medicare pays first

Medicare pays claims for some diabetes care supplies under the Part B medical benefit. As a result, UMP Classic pays the claim under the durable medical equipment benefit, not the prescription drug benefit. This means you will have to meet your medical deductible before UMP Classic begins to pay on diabetes care supplies claims, then UMP Classic pays its share based on medical benefit coinsurance (85% of the allowed amount for providers that accept Medicare).

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

What does UMP Classic cover that Medicare doesn't?

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

UMP Classic covers some services that Medicare doesn't cover at all. For these services, it doesn't matter if the provider accepts Medicare, because Medicare doesn't cover the service. You will receive the highest level of benefit if you choose a preferred provider.

For the services listed below, the secondary benefit paid by UMP Classic is the only benefit (plus any COB savings accrued earlier in the year). Out-of-network providers may balance bill you (see definition on page 157).

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

- Acupuncture (see page 35).
- Hearing aids.
- Hearing exams for the purpose of getting a hearing aid (see page 45).
- Massage therapy (a massage therapist **must** be a preferred provider).
- Medical coverage outside the country; Medicare doesn't cover services outside of the U.S. (see pages 12–14 for details).
- Naturopathic medicine (see page 53).
- Prescription drugs (see "Use network pharmacies that bill Medicare Part B directly" on page 110 for exceptions).
- Routine vision exams and hardware (see page 67). (Medicare covers medical vision exams and vision hardware following cataract surgery.)
- Wigs for cancer patients (see page 42).

If you see a preferred provider, they will submit the claim for you. For out-of-network providers, check if the provider will submit the claim. If not, you will need to send a claim to UMP Classic. See "Billing & payment: filing a claim" starting on page 112.

What UMP Classic covers more than Medicare

UMP Classic covers some services after the Medicare benefit ends. These services include:

- Substance use disorder services (Medicare covers some substance abuse services under mental health).
- Inpatient hospital services.
- Mental health, both outpatient and inpatient services.
- Covered preventive care: Medicare covers some preventive services. See pages 56–58 for what UMP Classic covers.
- Skilled nursing facility services. See page 58 for what UMP Classic covers.

When Medicare does not cover these services, you may receive the highest benefit level when you see a preferred provider. Call UMP Customer Service at 1-888-849-3681 (TRS: 711) for more information.

ALERT! Preferred providers do not necessarily accept Medicare—you should always ask.

Should I see a preferred provider?

To find preferred providers outside the U.S., see pages 12–14.

Type of service	Higher benefits with a preferred provider?	Important information
Services covered by Medicare	No	You should see a provider who accepts Medicare. See "When providers don't accept Medicare: opt-out providers" below to learn why this is important.
Services covered by UMP Classic but not by Medicare *(Exception: See massage therapy below.)*	Yes	See "What does UMP Classic cover that Medicare doesn't?" starting on page 108 to see which services apply. Use the provider search at **www.hca.wa.gov/ump**, at **regence.com**, or call 1-888-849-3681 (TRS: 711), to find a preferred provider.
Massage therapy	Yes	UMP Classic pays for massage therapy services only when the provider is preferred.
Prescription drugs	Yes	You must also choose pharmacies that participate in and can bill Medicare Part B directly because Medicare Part B covers a few drugs. See "Use network pharmacies that bill Medicare Part B directly" on page 110 for more information.

When providers don't accept Medicare: opt-out providers

When services are covered by Medicare, you must see providers who accept Medicare for the services to be covered by Medicare and UMP Classic. If your provider is not contracted with Medicare or has chosen to "opt out" of participating in Medicare, UMP Classic will not cover services by that provider, even if the provider is in the Regence or Blue Card network (preferred) for UMP Classic members (see page 8). Providers that "opt out" of Medicare are supposed to have you sign a "private contract" before providing services, but you are responsible for all costs even if you did not sign a contract.

When do I pay? How billing works

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

1. Your provider bills Medicare.
2. Medicare processes the claim and sends you an Explanation of Medicare Benefits (EOMB). The EOMB tells you how much Medicare paid on your claim.
3. Medicare then sends the claim to UMP Classic for processing. You do not need to submit a claim form or other paperwork to UMP Classic.
4. UMP Classic processes the claim and sends you an Explanation of Benefits (EOB). The EOB tells you how much UMP Classic and Medicare paid, plus how much you owe the provider.
5. You receive a bill from your provider for any remaining amount due. To confirm that the provider has credited your account with both Medicare and UMP Classic payments:
   - Note the allowed amount on the Medicare EOMB.
   - Subtract both Medicare's and UMP Classic's payments from that amount; this should match the bill from your provider.

6. You pay your provider the amount due, if any. After you've met both your Medicare and UMP Classic deductibles, you won't pay anything for most claims.

If you haven't received any paperwork on a health care service within three months, call your provider's billing office and ask if they've sent the claim. Neither Medicare nor UMP Classic can process a claim they haven't received. While you are welcome to call UMP Classic and ask, if we haven't received the claim, we won't have any record of the service.

Why did I get a "COB Savings" check from UMP Classic?

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

UMP Classic keeps track of how much you've paid out of pocket during the year. If your Medicare coverage generates COB savings, we may send you a "COB savings check" to pay you back for the out-of-pocket expenses you paid earlier in the year. UMP Classic does not reimburse you for more than you paid out of pocket. See "How do UMP Classic and Medicare work together?" starting on page 104 for examples.

How UMP Classic prescription drug coverage works with Medicare

FOR MORE INFORMATION: See "Your prescription drug benefit" on pages 68–86 for complete information about your prescription drug coverage.

Use network pharmacies that bill Medicare Part B directly

ALERT! UMP's network mail-order pharmacy, PPS, cannot bill Medicare for you when Medicare is your primary coverage. You must submit a claim to Washington State Rx Services only after Medicare has paid its share. See "Submitting a claim for prescription drugs" on page 114.

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

For those drugs and medical supplies covered under your prescription drug benefit, we recommend that you choose a network pharmacy that can bill Medicare Part B directly to get the most from your prescription drug coverage. Medicare Part B does cover a few drugs and supplies for specific purposes. These drugs and supplies are identified on the UMP Preferred Drug List. **Note:** Medicare Part B quantity restrictions may apply.

Medicare accepts claims only from pharmacies, not from individuals. If Medicare covers a drug or supply and the pharmacy doesn't send the claim to Medicare first for payment, UMP Classic will reject the claim. To find a network retail pharmacy, see the pharmacy locator at **www.hca.wa.gov/ump/find-drugs** or call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

Can I have UMP Classic and Medicare Part D?

No, you can't enroll in both UMP Classic and a Medicare Part D prescription drug plan. UMP Classic provides your prescription drug coverage and you may not have both. Medicare will notify the PEBB Program if you enroll in a Part D plan while enrolled in UMP Classic. You could lose your eligibility for PEBB coverage if you do this. If you think you want a Part D prescription drug plan, you must change your medical plan from UMP Classic to Medicare Supplement Plan F. See "Medicare Part D" on page 149 for more information. Contact the PEBB Program at 1-800-200-1004 (TRS: 711) to ask when and how you can change your PEBB medical plan.

Where do I go for more information?

Types of questions	Contact information
▪ What Medicare covers ▪ Your Medicare deductibles and coinsurance amounts ▪ Medicare premiums ▪ Whether your claim has been processed by Medicare	Medicare: 1-800-MEDICARE (1-800-633-4227) **www.medicare.gov** **www.MyMedicare.gov**
▪ What UMP Classic covers ▪ Your UMP Classic copays, coinsurance, and deductible amounts	UMP Customer Service: 1-888-849-3681 (TRS: 711) **www.hca.wa.gov/ump**
▪ Your claim after it has been processed by Medicare	UMP Customer Service: 1-888-849-3681 (TRS: 711) Sign in at **regence.com**
▪ Prescription drugs	Washington State Rx Services 1-888-361-1611 (TRS: 711)
▪ UMP Classic premiums ▪ Address changes ▪ Adding or removing dependents on your account ▪ Changing your PEBB medical coverage	PEBB Program: 1-800-200-1004 (TRS: 711) **www.hca.wa.gov/erb**
▪ Whether your claim has been submitted to Medicare ▪ If the Patient Responsibility dollar amount on your UMP Classic Explanation of Benefits doesn't match your doctor's bill	Your doctor's billing office

Billing & payment: filing a claim

FOR MEDICARE RETIREES: Read "For Retirees Enrolled in Medicare" starting on page 104.

Submitting a claim for medical services

When UMP is your primary insurance and your provider is preferred, you don't need to submit claims. The provider will do it for you. If you have a question about whether your provider's office has submitted a claim, 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 for UMP Classic. Medical claims are handled by Regence BlueShield, and claims involving prescription drugs are handled by Washington State Rx Services.

When do I need to submit a claim?

You may need to submit a claim to Uniform Medical Plan for payment if:

- You receive services from an out-of-network provider.
- You have other insurance that pays first and UMP is secondary. (**See also:** Medicare retirees, pages 104–111. All other members: with other coverage, pages 98–102.)

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

How do I submit a claim?

TIP: If you purchase contact lenses or eyeglasses from an out-of-network provider that doesn't bill your plan, you must submit a claim for reimbursement. You can download the *Medical Claim Form* at **www.hca.wa.gov/ump-forms** or call UMP Customer Service for a copy.

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

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

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

- Patient's name and plan ID number, including the alpha prefix (three letters before ID number).
- Description of the injury or illness.
- Date and type of service.
- Provider's name, address, and phone number.
- For ambulance claims, please also include 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 have to request additional information, the processing of your claim may be delayed.

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

Be sure to make copies of your documents for your records.

Mail both the claim form and the provider's claim document (or bill) to:

Regence BlueShield
PO Box 1106
Lewiston, ID 83501-1106

Call 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 102 for how this works when you have other coverage that pays first.

For information about submitting claims for services outside of the United States, see instructions at **www.hca.wa.gov/ump/ump-administration/access-coverage-while-traveling**, or 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 98–103 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 136) the plan may pay the custodial parent or legal guardian of the child.

Claims determinations

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

- Circumstances beyond the plan's control. Notification will include an explanation why an extension is necessary and when the plan expects to take action on the claim.
- Lack of information. The plan will notify you within the 30-day period that an extension is necessary, with a description of the information needed as well as why it is needed.

If the plan asks you for more information, you will be allowed at least 45 days to provide it. If the plan doesn't receive the information requested within the time allowed, the claim will be denied.

Submitting a claim for prescription drugs

ALERT! See "Products covered under the preventive care benefit" on page 78 for coverage of products such as contraceptive drugs, tobacco cessation drugs, nicotine replacement, or over-the-counter products covered as preventive.

You may need to submit your own prescription drug claim to Washington State Rx Services for reimbursement if you:

- Purchase drugs at a non-network pharmacy.
- Fail to show your ID card at a network pharmacy.
- 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 112). Member-submitted vaccine claims sent to Washington State Rx Services will be denied.

Prescription drug claim forms are available online at **www.hca.wa.gov/ump-forms** or by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711). Send the completed claim form, along with your pharmacy receipt(s), to:

Washington State Rx Services
Attn: Pharmacy Claims
PO Box 40168
Portland, OR 97240-0168
Fax 1-800-207-8235

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

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

- The plan pays based on the allowed amount. If the pharmacy charges you more than the allowed amount, you will pay your usual coinsurance (and prescription drug deductible if applicable), plus the difference between what the plan paid and the pharmacy's charge.
- The plan pays all prescription drug claims, including non-network, based on coinsurance (as shown in the table on page 71).
- If your claim exceeds the quantity limit allowed by the plan or the maximum days' supply, the plan will pay only for the amount of the drug up to the quantity limit or maximum days' supply.
- If you receive a refill before 84% of the last supply you received should have been taken, the plan will not pay for it. This is called a "refill too soon" (see page 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 plan ID card when purchasing a prescription at a Washington State Rx Services' network pharmacy, you will have to pay the full cash price and submit a Prescription Drug Claim Form. You won't receive the plan discount.

False claims or statements

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

In addition, neither you nor any person acting for you may make any false or incomplete statements on any document for your plan coverage.

The plan may recover any payments or overpayments made as a result of a false claim or false statement by withholding future claim payments, by suing you, or by other means. False claims may also be crimes.

If you represent yourself as being enrolled in this plan when you are not, the plan will deny all claims.

What you need to know: 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. See page 102.
- On request, receive information from the plan about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - Technologies and treatments currently under review by the Health Technology Clinical Committee (HTCC).
  - Services and treatments that have completed HTCC review and how that affects coverage by 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 *Notice of Privacy Practices,* available online at **www.hca.wa.gov/ump**.
- Get a second opinion about your provider's care recommendations.
- Make decisions with your providers about your health care.
- Make recommendations about member rights and responsibilities.
- Have a translator's assistance, if required, when calling the plan.
- Complain about or appeal plan services or decisions, or the care you receive.
- Receive:
  - All covered services and supplies determined to be medically necessary as described in this certificate of coverage, subject to the maximums, limits, exclusions, deductibles, coinsurance, and copayments.
  - Courteous, prompt answers from the plan.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, color, national origin, age, disability, or religion.
  - Written explanation from the plan about any request to refund an overpayment.

As a plan member, you have the responsibility to:

- Understand your plan benefits, including what's covered, preauthorization and notification requirements, and other information described in this certificate of coverage.
- Understand how to contact the plan for additional information and assistance about any covered benefit or information described in this certificate of coverage.
- Contact the plan as soon as possible if you do not understand what is covered, if you have any questions, or if you need information.
- 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 copayments, coinsurance, and deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to the plan any outside sources of health care coverage or payment.
- Return your completed Multiple Coverage Inquiry questionnaire you receive from the plan in a timely manner to prevent delay in claims payment.
- Use preferred providers when available.

Information available to you

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. You can find the following information in this certificate of coverage:

- List of covered expenses (pages 22–67).
- Benefit exclusions, reductions, and maximums or limits (pages 90–97).
- Clear explanation of complaint and appeal procedures (pages 120–on page 126).
- Preventive health care benefits that are covered (pages 56–58, page 78).
- Definition of terms (pages 156–174).
- Process for preauthorization, notification, or review (page 80 and pages 87–88).
- Policies regarding drug coverage and how the plan adds and removes drugs from the UMP Preferred Drug List (pages 69 and 84).

You can find the following at **www.hca.wa.gov/ump**, or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711):

- Online directory of preferred providers, including both primary care providers and specialists.
- The Summary of Benefits and Coverage (SBC) and Uniform Glossary of Terms (UGT).
- Notice of privacy practices (includes plan policy for protecting the confidentiality of health information; see "Confidentiality of Your Health Information" on page 118).
- Clinical coverage criteria applicable to health care services and supplies that require preauthorization.
- When the plan may retroactively deny coverage for preauthorized medical services.
- Information on the plan's care management programs.

- Procedures to follow for consulting with providers.
- General reimbursement or payment arrangements between the plan and preferred providers.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Accreditation information, including measures used to report the plan's performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.

The following are available through your medical online account at **regence.com** or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711):

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

The following are available at **www.hca.wa.gov/ump** or by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711):

- The UMP Preferred Drug List.
- Prescription drug claims history and prescription drug deductible status (through your online prescription drug account).
- Clinical coverage criteria applicable to prescription drugs that require preauthorization.

You may also call 1-888-849-3681 (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 Washington State Rx Services 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 **www.hca.wa.gov/ump** or by calling Customer Service. The plan will release member health information only as described in that notice or as required or permitted by law or court order.

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, Uniform Medical Plan must have written authorization to communicate with anyone but the member (patient). However, a parent or legal guardian may act as a representative for a member under age 13 without written authorization, except for issues involving contraceptive use. For members age 13 to 17, a parent or legal guardian may usually act as a representative, except for certain specially protected types of information, for which the plan must receive written authorization as described below.

You may choose to authorize a representative to:

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

To authorize release of protected health information, you must complete an *Authorization to Disclose Protected Health Information* form. 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 Washington State Rx Services at 1-888-361-1611 (TRS: 711) or download the form at **www.hca.wa.gov/ump-forms**.

Send the form to the address on the form. Uniform Medical Plan cannot share information until we receive the completed form. On the form, you must specify:

- What information may be disclosed;
- The purpose of the disclosure (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 don't provide the information when requested.

Complaint and appeal procedures

TIP: In the following section, Uniform Medical Plan refers to the administrative functions for appeals for UMP Classic. Medical appeals are handled by Regence BlueShield, appeals involving prescription drugs are handled by Washington State Rx Services, 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 **medical services**:

1-888-849-3681 (TRS: 711)

Uniform Medical Plan
Attn: Correspondence, Intake, and Appeals
PO Box 2998
Tacoma, WA 98401-2998

For questions about **prescription drugs**:

1-888-361-1611 (TRS: 711)

Washington State Rx Services
Attn: Appeals
PO Box 40168
Portland, OR 97240-0168

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

What is a complaint or grievance?

A complaint (also known as a grievance) is an oral or written complaint submitted by or on behalf of a member regarding:

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

Note: If your issue is regarding denial of payment or nonprovision of medical services, it is an appeal (see "How to file an appeal" on page 121).

How to file a complaint or grievance

For all complaints or grievances, we recommend calling Customer Service first. Many issues can be resolved with a phone call. If an initial phone call does not resolve your grievance, you may submit your complaint or grievance:

- Over the phone: If you want a written response, you must request one.
- By mail, fax, or email (see contact information on page 123).

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

What is an appeal?

An appeal is an oral or written request made by you or your authorized representative to Regence BlueShield or Washington State Rx Services to reconsider a previous decision about:

- Claims payment, processing, or reimbursement for health care services or supplies.
- A decision to deny, modify, reduce, or terminate payment, coverage, certification, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility.
- A retroactive decision to deny coverage based on eligibility; see "Appeals related to eligibility" on page 126.
- A preauthorization.

The appeals process

ALERT! If your appeal is for an urgent or life-threatening condition, see "Expedited appeals" on page 123.

You, your treating provider, or an authorized representative (see "How to designate an authorized representative" on page 118) may request an appeal for you. There are three parts 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 particular treatment, drug, or other item is experimental, investigational, or not medically necessary. In this case, the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved.

You may send written comments, documents, and any other information when you request an appeal. You may also request copies of documents the plan has that are relevant to your appeal, which the plan will provide at no cost. Our review will consider any information submitted to us.

How to file an appeal

You can send an appeal by telephone, mail, fax, or email (see contact information on page 123). The plan will send confirmation upon receipt of your appeal. You will also receive notice of the action on your appeal within 30 calendar days. We will ask your permission if we need more time to respond.

Information to provide with an appeal

Your appeal will be handled more quickly if you provide all the necessary information when you file it. Please include the following information when requesting an appeal:

- The subscriber's full name (the name of the employee or retiree covered by the plan).

- The patient's full name (the name of the employee, retiree, or dependent covered by the plan).
- The subscriber's ID number (starting with a "W" on your ID card).
- The name(s) of any providers involved in the issue you are appealing.
- The dates when services were provided.
- Your mailing address.
- Your daytime phone number(s).
- A statement of what the issue is and what you are asking for.
- A copy of the Explanation of Benefits, if applicable.
- Medical records from your provider, if applicable. For cases in which the denial of coverage is based on medical necessity or other clinical reasons, your provider should supply clinically relevant information such as medical records or any other relevant information along with your appeal. Because of the time limits on deciding appeals, getting this information in advance will help us make the most accurate decision on your case.

First-level appeals

You may request a first-level appeal orally or in writing no more than 180 days after you receive notice of the action being appealed. Although you may request an appeal by phone or in person, putting your appeal in writing will help lead to more informed decisions. If you don't request an appeal within this time period, your appeal will not be reviewed, and you will not be able to continue further appeals (second-level and independent review).

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

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

Second-level appeals

If you disagree with the 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 don't request an appeal within this time period, your appeal will not be reviewed, and you will not be able to continue further appeals (independent review).

Second-level appeals for medical services are reviewed by Regence BlueShield employees, and second-level appeals for prescription drugs are handled by Washington State Rx Services. Employees from Regence BlueShield and Washington State Rx Services handling the appeals will not have been involved in, or subordinate to anyone involved in, the first-level decision. You, or your authorized representative (see page 118), will be given a reasonable opportunity to provide written testimony for the Regence BlueShield panel or Washington State Rx Services to consider.

Expedited appeals

For medical service claims involving urgent care

If the plan denies coverage for services and your provider determines that taking the usual time allowed could seriously affect your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the disputed care or treatment, ask your provider to request an expedited appeal. An expedited appeal replaces the first- and second-level appeals. Regence BlueShield will decide on your expedited appeal within 72 hours of the request. Your provider must submit all clinically relevant information to the plan by phone or fax at:

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

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

For prescription drugs

If you or your provider thinks that 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. Washington State Rx Services will decide regarding coverage of the drug within 72 hours of the request.

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

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

Where to send complaints or appeals

ALERT! See page 51 and 62 for appeals related to the Centers of Excellence (COE) Program.

We recommend calling first with a complaint or appeal about prescription drugs, since many problems can be resolved quickly over the phone.

Contact type	Medical services: Regence
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 Time
Mail	Uniform Medical Plan Attn: Correspondence, Intake, and Appeals PO Box 2998 Tacoma, WA 98401-2998
Email	Secure email through your account at **regence.com**
Fax	1-877-663-7526

Contact type	Prescription drugs: Washington State Rx Services
Phone	1-888-361-1611 (TRS: 711) Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Time
Mail	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168
Email	n/a
Fax	1-866-923-0412

Time limits for the plan to decide appeals

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

The time limits below apply to both first- and second-level appeals and are calculated from when the plan receives the appeal.

- The plan will decide on your appeal within 14 days of receipt but may take up to 30 days unless a different time limit applies as explained below. We will request written permission from you or your authorized representative (see page 118) when we need an extension to the 30-day timeline, to get medical records or a second opinion.

The time limits below apply to expedited appeals:

- When your provider determines a delay could seriously jeopardize your life, health, or ability to regain maximum function, or that delay would cause severe pain that could not be adequately managed without the care or treatment you are appealing, we will decide as soon as possible but always within 72 hours. We will notify you (or your authorized representative) of our decision verbally within 72 hours and will mail a written notification within 72 hours of the decision.

External (or independent) 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 external or independent review.

You may request an external or independent review when the denial is based on the plan's decision to:

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

You may also immediately request external 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 118) can request an independent review. You may authorize a representative to submit the appeal on your behalf in writing or verbally by contacting UMP Customer Service.

TIP: An Independent Review Organization (IRO) will conduct the external review. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not related to the plan, Regence BlueShield, Washington State Rx Services, or the Health Care Authority. An IRO is intended to provide unbiased, independent clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. The IRO reviews your appeal to determine if the plan's decision is consistent with state law and the UMP Classic Certificate of Coverage. The plan will pay the IRO's charges.

Requesting an independent review

To request an independent review, contact the plan at:

Contact type	For medical services
Mail	Uniform Medical Plan Attn: Correspondence, Intake, and Appeals PO Box 2998 Tacoma, WA 98401-2998
Phone	1-888-849-3681 (TRS: 711)
Fax	1-877-663-7526

Contact type	For prescription drugs
Mail	Washington State Rx Services Attn: Appeals PO Box 40168 Portland, OR 97240-0168
Phone	1-888-361-1611 (TRS: 711)
Fax	1-866-923-0412

The plan—Regence BlueShield for medical services, and Washington State Rx Services for prescription drugs—will send the relevant information and correspondence to the Independent Review Organization.

Additional legal options

You are required to have exercised the opportunity to seek IRO review (see page 124) of the plan's decision before you are authorized to bring a cause of action in court against the plan or the Health Care Authority. The IRO decision is binding on both the plan and you except to the extent that other remedies are available under state or federal law.

If you prevail at the IRO level, the plan must provide benefits (including by making payment on the claim) following the IRO's decision without delay, regardless of whether the plan intends to seek judicial review of the IRO's decision and unless and until there is a judicial decision otherwise.

Complaints about quality of care

For complaints or concerns about the quality of care you received from preferred providers only, 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.
- Email **HSQAComplaintIntake@doh.wa.gov**.
- Visit **www.doh.wa.gov/AboutUs/DepartmentofHealth/Fileacomplaint**.

Appeals related to eligibility

Appeals related to eligibility and enrollment are handled by the Public Employees Benefits Board (PEBB) Program and governed by Chapter 182-16 Washington Administrative Code (WAC).

Information on how to file an appeal is available:

- On the PEBB website at **www.hca.wa.gov/erb**.
- By contacting the PEBB Appeals Unit at 1-800-351-6827 or **pebappeals@hca.wa.gov**.

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 don't, coverage may be denied. You may call UMP Customer Service at 1-888-849-3681 (TRS: 711) if you have questions.

What are my and the plan's legal rights and responsibilities?

Coverage under the plan is not provided for medical, dental, 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; or
- Any other source, including no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no-fault coverage, commercial premises no-fault medical coverage, sports policies including excess or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to you, whether or not you make a claim under such coverage; or
- Services or supplies for work-related injury or illness, even when the service or supply is not a covered workers' compensation benefit under the workers' compensation plan.

ALERT! You must respond to any communication sent to you about other sources of benefits, or claims may be denied.

However, after expiration or exhaustion of the above no fault benefits, if you also have a potential right of recovery for illnesses or injuries from a third party who may have legal responsibility or from any other source, benefits may be advanced by the plan pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, you agree that the plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This includes any arbitration award, judgment, settlement, disputed claim settlement, underinsured or uninsured motorist payment or any other recovery related to the injury or illness for which benefits under the plan have been provided.
- The plan may choose to recover expenses through subrogation to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. The plan is authorized, but not obligated, to recover any benefits to the extent that they were paid under the plan directly from any party liable to you, upon mailing of a written notice to the potential payer, to you or to your representative.
- The plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration, award, or judgment; or other characterization of the recovery by the claimant or any third party or the recovery source. The plan is entitled to reimbursement from the first dollars received from any recovery to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained. This applies regardless of whether:
  - The third party or third party's insurer admits liability;
  - The health care expenses are itemized or expressly excluded in the recovery; or
  - The recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the plan.

- You may be required to sign and deliver all legal papers and take any other actions requested to secure the plan's rights (including an assignment of rights to pursue your claim if you fail to pursue your claim of recovery from the third party or other source). If you are asked to sign a trust/reimbursement agreement or other document to reimburse the plan from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits. If you or your agent or attorney fail to comply during the course of the case, we may request refunds from the providers or offset future benefits.
- You must agree that nothing will be done to prejudice the plan's rights and that you will cooperate fully with the plan, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the plan of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
  - The filing of a lawsuit;
  - The making of a claim against any third party;
  - Scheduling of settlement negotiations in accordance with the plan (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
  - Intent of a third party to make payment of any kind to your benefit or on your behalf and that in any manner relates to the injury or illness that gives rise to the plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to your benefit that in any manner relates to the injury or illness giving rise to the plan's right of reimbursement or subrogation, until the plan's right is satisfied or released.
- In the event you or your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any illness or injury may be recovered through legal action to the extent that the settlement or recovery exceeds full compensation to you for the injury or illness that you sustained.
- Any benefits provided or advanced under the plan are provided solely to assist you. By paying such benefits, the plan is not waiving any right to reimbursement or subrogation.

Services covered by other insurance

The plan does not cover services that are covered by other insurance, including but not limited to no fault automobile medical payments ("Med-Pay"), no fault automobile personal injury protection ("PIP"), homeowner's no-fault coverage, commercial premises no fault medical coverage, sports policies including excess, underinsured or uninsured motorist coverage or similar contract or insurance. You are responsible for any cost-sharing required under the other coverage as allowed by state law. Once you have exhausted benefits (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.

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.

Future medical expenses

Benefits for otherwise covered services may be excluded as follows:

- When you have received a recovery from another source relating to an illness or injury for services for which we normally would provide benefits. The amount of any exclusions under this provision, however, will not exceed the amount of your recovery.
- Until the total amount excluded under this subrogation provision equals the third-party recovery.

Eligibility and enrollment for active employees

Eligibility

Eligible employees

In these sections, we may refer to employees as "subscribers" or "enrollees." The employee's employing agency will inform the employee whether or not 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 120 of this certificate of coverage.

Eligible dependents

To enroll in a health plan, a dependent must be eligible, and the employee must follow the procedural requirements for enrolling the dependent. The PEBB Program or employing agency verifies the eligibility of all dependents and requires employees to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. 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 occurred except as described in subsection (h) of this section. Children are defined as the subscriber's:
   - Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
   - Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
   - Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;
   - Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
   - Children of the subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
   - Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
   - Extended 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

- 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 26. The following requirements apply to dependents 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 agree to notify the PEBB Program in writing no later than 60 days after the date that 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 (h) of this subsection if they later become incapable of self-support.
  - The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability, 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.

Alert! Don't forget to notify your employing agency of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents of the subscriber.
   - 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.
   - Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Enrollment

TIP: If you are a retiring employee, an elected or full-time appointed official leaving public office, or a dependent becoming eligible as a survivor, you may be eligible to enroll or defer enrollment in PEBB retiree insurance coverage. You must meet eligibility and procedural requirements and enroll or defer enrollment in PEBB retiree insurance coverage within the PEBB Program's time limits. If you do not enroll or formally defer, you will not be able to enroll in PEBB retiree insurance coverage later.

An employee 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 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 another 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

ALERT! Subscribers may change health plans at the following times:

- **During annual open enrollment:** Subscribers may change health plans during the PEBB Program's annual open enrollment; see page 133.
- **During a special open enrollment:** Subscribers may change health plans outside of the annual open enrollment if a special open enrollment event occurs; see page 133.

Employees must submit an *Employee Enrollment/Change* 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. 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. If the employee does not return the *Employee Enrollment/Change* form by the deadline, the employee will be enrolled in UMP 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.

An employee or their dependents may also enroll during the PEBB Program's annual open enrollment (see "Annual Open Enrollment" on page 133) or during a special open enrollment (see "Special Open Enrollment" beginning on page 133). The employee must provide proof of the event that created the special open enrollment.

ALERT! Failure to notify your employing agency of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

Employees must notify their employing agency to remove dependents within 60 days from the last day of the month when dependents no longer meet the eligibility criteria described under "Eligible Dependents" on page 130. Consequences for not submitting notice within 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 138;
- 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.

TIP: Keeping your address and other personal information up-to-date helps ensure that you receive important notices about your benefits. If your address or name changes:

- Employees should notify their personnel, payroll, or benefits office as soon as possible.
- Retirees and PEBB continuation coverage subscribers should contact the PEBB Program at 1-800-200-1004 (TRS: 711).

When medical coverage begins

For an employee and the employee's eligible dependent, **enrolling when the employee is newly eligible,** medical coverage will begin the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

For an employee or an employee's eligible dependent **enrolling during the PEBB Program's annual open enrollment,** medical coverage will begin on January 1 of the following year.

For an employee or an employee's eligible dependent **enrolling during a special open enrollment,** medical coverage will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:
   - For the newly born child, medical coverage will begin the date of birth;
   - For a newly adopted child, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;
   - For a spouse or state registered domestic partner of a subscriber, medical coverage will begin the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, medical coverage will begin on the first day of the month following eligibility certification.

Annual open enrollment

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

- Enroll in or waive their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change their medical plan.

The employee must submit the required enrollment/change form to their employing agency. The form must be received no later than the last day of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

TIP: You may be eligible to change medical plans if you move during the calendar year. See the list of special open enrollment events below for details.

Special open enrollment

Employees may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both. The special open enrollment may allow an employee to:

- Enroll in or change 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, the employee must submit the required form(s) to their employing agency. Form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program or employing agency will require the employee to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

ALERT! See "Adding a new dependent to your coverage" on page 55.

Exception: If an employee wants to enroll a newborn or child whom the employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the employee should notify their employing agency by submitting an enrollment/change form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Employees should contact their personnel, payroll, or benefits office for the required forms. See "Adding a New Dependent to Your Coverage" on page 55.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee 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. Also, if an employee transfers from one employing agency to another during the year, the employee cannot change medical plans, except as outlined in this Enrollment section beginning on page 131.

When can an employee change their health plan?

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

1. Employee gains a new dependent due to:
   - Marriage or registering a domestic partnership;
   - Birth, adoption or when the employee assumes a legal obligation for total or partial support in anticipation of adoption; or
   - A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
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 health plan;
5. Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee moves and their current health plan is not available in the new location, the employee must select a new health plan;
6. A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent);
7. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or the employee's dependent loses eligibility for coverage under Medicaid or CHIP;

8. Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP;
9. Employee or an employee's dependent becomes entitled to coverage under Medicare, or the employee or an employee's dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or an employee's dependent's entitlement to Medicare, the employee must select a new health plan;
10. Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Employee or an employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    - Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
    - Transplant within the last 12 months; or
    - Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for this continuity of care); or
    - Recent major surgery still within the postoperative period of up to 8 weeks; or
    - Third trimester of pregnancy.

Note: If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee 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 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:
    - Marriage or registering a state-domestic partnership;
    - Birth, adoption or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects 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;
5. Employee or an employee's dependent has a change in enrollment under an employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

6. Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
7. A court order 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 an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Employee or an employee's eligible dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.
10. Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;
11. Employee becomes eligible and enrolls in Medicare or loses eligibility for Medicare.

When can an employee enroll or remove eligible dependents?

To enroll a dependent, the employee must include the dependent's enrollment information and provide any required document(s) as 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. Employee gains a new dependent due to:
   - Marriage or registering a state domestic partnership;
   - Birth, adoption or when an employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
   - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
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 health plan;
5. Employee or an employee's dependent has a change in enrollment under an employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
6. Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
7. A court order requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

National Medical Support Notice (NMSN)

When an NMSN requires an employee to provide health plan coverage for a dependent child the following provisions apply:

1. The employee may enroll their dependent child and request changes to their health plan coverage as described under subsection (3) of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB Program.
2. If the employee fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:
   - The child's other parent; or
   - Child support enforcement program.
3. Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
   - The dependent will be enrolled under the employee's health plan coverage as directed by the NMSN;
   - An employee who has waived PEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;
   - The employee's selected health plan will be changed if directed by the NMSN;
   - 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;
   - If the employee 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 employee's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.
5. The employee may be eligible to make changes to their health plan enrollment and salary reduction elections related to the NMSN.

Medicare entitlement

FOR MEDICARE RETIREES OR SURVIVORS: Retirees, permanently disabled employees, survivors, and their eligible dependents must enroll in Medicare Part A and Part B if entitled.

If an enrollee 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 employees 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, employees 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 again enroll in PEBB medical during a special open enrollment or annual open enrollment.

In most situations, employees 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 enrollee must contact Medicare about deferral of premiums. Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan becomes secondary.

When medical coverage ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. On the last day of the month when any enrollee ceases to be eligible.
2. On the date a plan terminates. If that should occur, any enrollee losing coverage 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 an enrollee dies or asks to terminate their medical plan before the end of the month.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollees may be eligible for continuation coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

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 surcharge remains 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 surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If the subscriber's premium balance or applicable premium surcharge remains 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 premium and any applicable premium surcharge was paid.

An employee who needs the required forms for an enrollment or benefit change may contact their employing agency.

TIP: When your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended, and your provider bills the plan for services you receive, the plan will deny all claims.

Options for continuing PEBB medical coverage

Employees and their dependents covered by this medical plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are three continuation coverage options for PEBB medical plan enrollees:

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)
3. PEBB retiree insurance coverage

The first two options temporarily extend group insurance coverage when the employee or dependent'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 enrollees 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. Enrollees who qualify for both PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

The third option, PEBB retiree insurance coverage is available only to retiring employees, eligible elected or full-time appointed officials leaving public office, and dependents becoming eligible as a survivor who meet eligibility and procedural requirements.

The PEBB Program administers all three continuation coverage options. Refer to the *PEBB Continuation Coverage Election Notice* booklet or the *PEBB Retiree Enrollment Guide* for details.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The employee's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the 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 surcharge during this period to maintain eligibility. If the employee's monthly premium or applicable premium surcharge remains 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 surcharge was 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 surcharge set by the HCA, with no contribution from the employer while on approved leave. For additional information on continuation coverage, see the section titled "Options for Continuing PEBB Medical Coverage."

Payment of premium during a labor dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to 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, the employee shall be notified immediately by the HCA by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due.

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

Enrollees (including spouses and dependents 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. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call UMP Customer Service at 1-888-849-2681 (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 surcharge when due;
4. Misconduct. Examples of such termination include, but are not limited to the following:

    - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
    - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

The PEBB Program will enroll the employee and their eligible dependents in another 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 enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Any enrollee may appeal a decision regarding administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment 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.

Eligibility and enrollment for retirees and survivors

Eligibility

In these sections, we may refer to retirees and survivors as "subscribers" or "enrollees." The term "retiree" or "retiring employee" as used in these sections includes elected and full-time appointed officials of the legislative and executive branch of state government eligible to continue enrollment in PEBB retiree insurance coverage.

The Public Employee's Benefits Board (PEBB) Program determines if a retiring employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a completed *Retiree Coverage Election* form. If the retiring 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 the retiring employee of their right to an appeal. Information about appealing a decision made by the PEBB Program can be found on page 120 of this certificate of coverage.

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 *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 the survivor of their right to an appeal. Information about appealing a decision made by the PEBB Program can be found on page 120 of this certificate of coverage.

Retirees, survivors, and their enrolled dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B. This is a condition of their enrollment in a PEBB retiree health plan. Enrollees must provide a copy of their Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B dates to the PEBB Program as proof of enrollment in Medicare. If an enrollee is not entitled to either Medicare Part A or Part B on their 65th birthday, the enrollee must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for employees who retired on or before July 1, 1991.

Eligible dependents

To be enrolled in a medical plan, a dependent must be eligible, and the subscriber must follow the procedural requirements described in the "Enrollment" section beginning on page 143.

The PEBB Program verifies the eligibility of all dependents and requires documents from subscribers that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection (h) of this section. Children are defined as the subscriber's:
    - Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    - Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

- Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;
- Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
- Children of the subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
- Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
- Extended 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
- 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 26. The following requirements apply to dependents 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 agree to notify the PEBB Program in writing no later than 60 days after the date that 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 (h) of this subsection if they later become incapable of self-support.
  - The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability, 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.

ALERT! Notify the PEBB Program at 1-800-200-1004 (TRS: 711) as soon as possible of changes in dependent status. You may be required to pay for services received by ineligible dependents.

4. Parents of the subscriber.
   - 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.
     - 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

Retiring employees and dependents becoming eligible as a survivor who want to defer enrollment must submit a *Retiree Coverage Election* form to the PEBB Program. If a retiree or a survivor defers enrollment in a PEBB health plan, they also defer enrollment for all eligible dependents, except as described below. Retiring employees and dependents becoming eligible as a survivor that do not enroll in a PEBB health plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, 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 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. You may cover eligible dependents who are not enrolled in Medicaid coverage that includes payment of medical and hospital benefits.
- 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 as a retiree or the dependent of a retiree in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

To defer enrollment in a PEBB health plan, the retiree or survivor must submit a Retiree Coverage Election form to the PEBB Program. The form must be received within the required enrollment time limits. Exception: A retiree may defer enrollment in a PEBB health plan during the period of time they are enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State school district, a Washington State educational service district, or a Washington State charter school including such coverage under COBRA or continuation coverage. They do not need to submit a Retiree Coverage Election form.

If a retiree or a survivor defers enrollment in PEBB medical, enrollment must also be deferred for PEBB dental.

Enrollees can enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers.

Note: PEBB retiree health plan enrollment is deferred if a retiree or a survivor becomes newly eligible for PEBB benefits as a new employee and enrolls in a PEBB health plan.

How to enroll

Retiring employees and dependents becoming eligible as a survivor must submit a *Retiree Coverage Election* form along with any other required forms to the PEBB Program to enroll in PEBB retiree insurance coverage. The form(s) must be received within the required enrollment time limits listed under "When Medical Coverage Begins".

Survivors of emergency service personnel killed in the line of duty must submit a *Retiree Coverage Election* form along with any other required forms to the PEBB Program. The completed form(s) must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor; or

- 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.

A retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB health plan must do so in writing to the PEBB Program. 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. Retirees or survivors who deferred coverage may later enroll in a PEBB health plan if they provide proof of continuous enrollment (see *Enrollment Following Deferral* section).

Retiring employees and dependents becoming eligible as a survivor who request 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 or reenroll dependents if the PEBB Program is unable to verify a dependent's eligibility.

Retirees and survivors may also enroll eligible dependents during the PEBB Program's annual open enrollment (see "Annual Open Enrollment" on page 146) or during a special open enrollment (see "Special Open Enrollment" on page 146). 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 as the retiree or surviving dependent.

Exception: If a retiree or a survivor selects a Medicare Supplement Plan, non-Medicare enrollees will be enrolled in UMP Classic.

ALERT! Failure to notify the PEBB Program of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

Subscribers are required to remove dependents within 60 days from the last day of the month when dependents no longer meet the eligibility criteria described under "Eligible Dependents" on page 141--142. Consequences for not submitting the notice within 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 150;
- 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

ALERT! See "Adding a new dependent to your coverage" on page 55.

For retiring employees and their dependents enrolling **no later than 60 days after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends,** PEBB retiree insurance 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 enrolling **no later than 60 days after the official leaves public office,** PEBB retiree insurance 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 enrolling **no later than 60 days after the death of the retiree,** PEBB retiree insurance coverage will be continued without a gap subject to payment of premiums and any applicable premium surcharges.

For an eligible survivor of an employee (not including emergency service personnel killed in the line of duty) and their dependents enrolling **no later than 60 days after the later of the date of the employee's death or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends,** PEBB retiree insurance coverage begins the first day of the month following the later of the date of the employee's death or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB health plan **no later than 60 days after a loss of other qualifying coverage,** PEBB health plan coverage begins the first day of the month after the loss of the other qualifying coverage.

For a retiree's or a survivor's dependent enrolling **during the PEBB Program's annual open enrollment,** medical coverage will begin on January 1 of the following year.

For a retiree's or a survivor's dependent enrolling **during a special open enrollment,** medical coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exceptions:

- If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:
  - For the newly born child, medical coverage will begin the date of birth;
  - For a newly adopted child, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;
  - For a spouse or state registered domestic partner of a subscriber, medical coverage will begin the first day of the month in which the event occurs.
- If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, medical coverage will begin on the first day of the month following eligibility certification.

TIP: Retirees or survivors should notify the PEBB Program at 1-800-200-1004 (TRS: 711) of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your benefits and helps us serve you better.

Enrollment following deferral

Retirees or survivors who defer enrollment **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.

Retirees or survivors who defer enrollment **while enrolled in a federal retiree medical plan as a retiree or dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.

Retirees or survivors who defer enrollment **while enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB 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.

Retirees or survivors who defer enrollment **while enrolled in coverage through a health care exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after exchange coverage ends.

Retirees or survivors who defer enrollment **while enrolled in CHAMPVA 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 CHAMPVA medical plan ends.

Retirees or survivors who defer enrollment **while enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State school district, a Washington State educational service district, or a Washington State charter school, 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 school district, a Washington State educational service district, or Washington State charter school ends, or such coverage under COBRA or continuation coverage ends.

Retirees or survivors who defer enrollment 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 retiree or survivor must send a *Retiree Coverage Election* form along with any other required forms and proof of continuous enrollment in one or more qualifying coverages to the PEBB Program.

Retirees and survivors should contact the PEBB Program or visit **www.hca.wa.gov/pebb-retirees** to get the required forms, information on premiums, and available medical plans.

Annual open enrollment

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

- Enroll in a medical plan following a deferral or defer their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change their medical plan.

The subscriber must submit the required form(s) and any other required documents to the PEBB Program. The forms must be received no later than the last day of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

Special open enrollment

TIP: You may be eligible to change medical plans if you move during the calendar year. See "When may a subscriber change their plan?" on page 147 for a list of special open enrollment events.

Subscribers may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must 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, the subscriber's dependent, or both.

Exception: A retiree or a survivor may defer or terminate enrollment in a PEBB health plan or terminate a dependent's enrollment at any time by providing written notice to the PEBB Program.

Retirees or survivors who have deferred their enrollment in a PEBB health plan may only enroll as described in the "Enrollment Following Deferral" section.

To make an enrollment change, the subscriber must submit the required form(s) to the PEBB Program. Forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program will require the subscriber to 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 forms no later than six months after the enrollment in Medicare Part B for either the subscriber or the subscriber's 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 an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

When may a subscriber change their health plan?

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

1. Subscriber gains a new dependent due to:
   - Marriage or registering a domestic partnership;
   - Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
   - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward 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;
5. Subscriber or a subscriber's 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;
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 a subscriber's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
8. Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP;

9. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare the subscriber must select a new health plan;
10. Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Subscriber or a subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent for a specific condition or ongoing course of treatment. The subscriber may not change 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:
    - Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
    - Transplant within the last 12 months; or
    - Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for continuity of care); or
    - Recent major surgery still within the postoperative period of up to 8 weeks; or
    - Third trimester of pregnancy.

ALERT! If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the 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?

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

1. Subscriber gains a new dependent due to:
    - Marriage or registering for a state domestic partnership;
    - Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for 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;
5. Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health insurance 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;

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 a subscriber's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

Medicare entitlement

Medicare Part A and Medicare Part B

If an enrollee becomes entitled to Medicare, they should contact the nearest Social Security Administration Office to ask about Medicare enrollment. Unless retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage, the enrollee must enroll and maintain enrollment in Medicare Part A and Medicare Part B. Medicare will become the primary insurance coverage, in most cases, and the PEBB retiree medical plan will become the secondary insurance coverage.

FOR MEDICARE RETIREES: PEBB rules do not require you to enroll in Medicare's prescription drug coverage, Medicare Part D. You cannot have both this plan and Medicare Part D. If you sign up for Medicare Part D, you will need to select a Medicare supplement plan offered through PEBB. If you do not sign up with a PEBB Medicare supplement plan, you cannot keep your PEBB health plan coverage.

Medicare Part D

PEBB has determined that this 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, you cannot enroll in Medicare Part D and remain in this plan. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in the PEBB-sponsored Medicare supplement plan.

FOR MEDICARE RETIREES: PEBB includes an "annual notice of creditable prescription drug coverage" in the October *For Your Benefit* newsletter sent to each retiree subscriber. If you or your covered dependent(s) decide to terminate this plan, you may contact the PEBB Program to request a certificate of creditable coverage. If you do not show that you had creditable prescription drug coverage, you may have to pay higher premiums for Medicare Part D prescription drug coverage.

When medical coverage ends

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

Medical plan enrollment ends on the following dates:

1. On the last day of the month when any enrollee ceases to be eligible.
2. On the date a plan terminates. If that should occur, any enrollee losing coverage will be given the opportunity to enroll in another PEBB medical plan.

3. For an enrollee who declines the opportunity or is ineligible to continue enrollment under one of the options described in the "Options for Continuing PEBB Medical Coverage" below, coverage ends for the enrollee on the last day of the month in which they cease to be eligible.
4. The subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains 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 surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If the subscriber's premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, coverage will be terminated for the subscriber and enrolled dependents retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

   A full month's premium is charged for each calendar month of coverage. 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 an enrollee dies or if the subscriber requests to terminate their medical plan before the end of a month.

The subscriber is responsible for timely payment of premiums and applicable premium surcharges, and reporting changes in eligibility or address. The subscriber and their covered dependent(s) or beneficiary is responsible for reporting changes no later than 60 days after the event, such as divorce, termination of a state-registered domestic partnership, death, or when a dependent no longer meets the eligibility criteria described under "Eligible Dependents."

Failure to report changes can result in loss of premiums and loss of the subscriber and their dependent's right to continue coverage under one of the continuation coverage options described in the "Options for Continuing PEBB Medical Coverage" below of this certificate of coverage. To find forms, retirees and survivors can visit **www.hca.wa.gov/pebb-retirees** or can call the PEBB Program at 1-800-200-1004 (TRS: 711).

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care" (see on page 53), is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends and the enrollee is not immediately covered by other health care coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from a skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollees may be eligible for continuation coverage or conversion to other health care coverage if application is made within the time limits explained in the following sections.

TIP: If your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended, and your provider bills this plan for services you receive, the plan will deny all claims.

Options for continuing PEBB medical coverage

Subscribers and their dependents covered by this medical plan may be eligible to continue enrollment if they lose eligibility and are eligible under one of the following options for continuing coverage:

1. PEBB Continuation Coverage (COBRA)
2. PEBB retiree insurance coverage

The first option above temporarily extends group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements in federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

The second option above is available only to dependents becoming eligible as a survivor who meet eligibility and procedural requirements.

The PEBB Program administers both options. Contact the PEBB Program at 1-800-200-1004 (TRS: 711) or refer to the PEBB *Continuation Coverage Election Notice* booklet or the *Retiree Enrollment Guide* for details.

Conversion of coverage

Enrollees (including spouses and dependents 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. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion plan differ from those of the enrollee's current group 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 surcharge 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:
   - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
   - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of 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 enrollee 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.

Any enrollee may appeal a decision regarding the administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment 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

If you have questions about your PEBB retiree eligibility and benefit information, please contact the PEBB Program at 1-800-200-1004 (TRS: 711) or visit **www.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 **www.medicare.gov**.

General provisions

UMP is administered by a third-party vendor under contract with the Washington State Health Care Authority.

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.

Out-of-area services

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

BlueCard Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Negotiated national account arrangements

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

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

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

- **Member Liability Calculation.** When covered services are provided outside of Regence's service area by out-of-network providers, the amount you pay for such services will generally be based on either the Host Blue's out-of-network provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.
- **Exceptions.** In certain situations, Regence may use other payment bases, such as billed covered charges, the payment Regence would make if the health care services had been obtained within Regence's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Regence will pay for services rendered by out-of-network providers. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment Regence will make for the covered services as set forth in this paragraph.

Right to receive and release needed information

Regence may need certain facts about your health care coverage or services provided in order to process your claims correctly. Regence may get these facts from or give them to other organizations or persons without your consent. You must give Regence any facts necessary for processing of claims to get benefits under UMP. See page 118 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 can be held liable for any claim or damages connected with injuries you may suffer while receiving health services or supplies provided by professionals who are neither

employees nor agents of 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 Uniform Medical Plan (the plan) will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Washington without regard to its conflict of law rules. The Washington State Health Care Authority delegates discretion to Regence BlueShield for the purposes of paying benefits under this coverage only if it is determined that you are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when you seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. Regence BlueShield is not the plan administrator, but does provide claims administration under the plan, and the court will determine the level of discretion that it will accord determinations.

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 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 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 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 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 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 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 will remain responsible for fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Regence uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Regence would then calculate your liability for any covered services according to applicable law.

Charges in excess of the allowed amount are not reimbursable. For questions regarding the basis for determination of the allowed amount, please call UMP Customer Service at 1-888-849-3681 (TRS: 711).

Allowed amount, prescription drugs

The **allowed amount for prescription** drugs is based on Washington State Rx Services' contractually agreed reimbursement, unless other contractual arrangements or terms apply. All covered prescription drug claims are paid based on this allowed amount.

Ambulatory surgery center (ASC)

An **ambulatory surgery center** (ASC) is a health care facility that specializes in providing surgery, pain management, and certain diagnostic services in an outpatient setting. ASC-qualified procedures are typically more complex than those done in a doctor's office but not so complex as to require an overnight stay. Procedures commonly performed in these centers include colonoscopies, endoscopies, cataract surgery, orthopedic, and ENT (ear, nose, and throat) procedures. An ASC may also be known as an outpatient surgery center or same-day surgery center.

Annual open enrollment

Open enrollment is a period defined by the HCA when you have the opportunity to change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Appeal

See pages 121–124 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 118 for how this works.

Balance billing

Balance billing is a provider billing you for the difference between the provider's or facility's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Preferred and participating providers may not balance bill you for covered services above the allowed amount. See an example of how this works on page 10.

Brand-name drug

A **brand-name drug** is a drug sold under the proprietary name or trade name selected by the manufacturer.

Business day

Business days are Mondays through Fridays, except for holidays observed by Washington State.

Calendar day

A **calendar day** is any day of the week regardless of whether it is observed as a holiday by Washington State.

Calendar year

A **calendar year** is January 1 through December 31.

Clinical review

Clinical review is when a plan clinical professional reviews medical records related to inpatient treatment in order to determine if inpatient treatment is medically necessary.

Coinsurance

Coinsurance is the percentage of the allowed amount you must pay the provider on claims for which the plan pays less than 100% of the allowed amount. This includes most medical services and prescription drugs.

Coordination of benefits

For members covered by more than one group health plan, **coordination of benefits** is the method the plan uses to determine which plan pays first, which pays second, and the amount paid by each plan. Please see description and examples in "If you have other medical coverage" on page 98.

Copayment

Copayment (or copay) is a set dollar amount you pay when receiving specific services, treatments, or supplies, such as inpatient hospitalization or emergency room visits.

Cost share

Cost share means the amount you pay for a service, supply, or drug. This may be a deductible (see page 15), coinsurance (see page 16), copay (see page 17), 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

See the definitions of "Medical deductible" and "Prescription drug deductible."

Dependent

A **dependent** is a spouse, state-registered domestic partner, child, or other eligible family member covered by the plan under the subscriber's account (see "Eligible dependents" on pages 130–131 and pages 141–142).

Developmental delay

Developmental delay is a significant lag in reaching developmental milestones as expected during infancy and early childhood. The cause may be present at birth or acquired after birth from a disease or disorder of the body, an injury, a disorder of the mind or emotions, or harmful effects of the surrounding environment. Only a physician or other provider can diagnose a developmental delay.

Durable medical equipment

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 on page 94 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, retiree, 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 a service, supply, intervention, or drug that the plan has classified as experimental or investigational and therefore, is not covered, even if the service, supply, intervention, or drug is considered medically necessary. The plan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the service, supply, intervention, or drug to determine if it is experimental or investigational. A service, supply, or drug not meeting all of the following criteria is, in the plan's judgment, investigational:

- If a prescription drug or device, the health intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a prescription drug is prescribed for other than its FDA-approved use(s) and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a prescription drug must be so recognized in one of the standard reference compendia (see definition on page 172) or, if not, then in a majority of relevant peer-reviewed medical literature (see definition on page 168); or by the United States Secretary of Health and Human Services. See on page 79 for more information on experimental or investigational drugs.
- The scientific evidence must permit conclusions concerning the effect of the service, supply, intervention, or drug on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.
- The service, supply, intervention, or drug must improve net health outcome.
- The scientific evidence must show that the service, supply, intervention, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

- The service, supply, intervention, or drug is provided by a provider that has demonstrated medical proficiency in the provision of the service, supply, or drug. The service, supply, intervention, or drug is recognized by the medical community in the service area in which they are received.
- The service, supply, intervention, or drug is not considered to be experimental or investigational by U.S. standards.

When the plan receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 20 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call UMP Customer Service at 1-888-849-3681 (TRS: 711). You may be liable for all charges if you receive services that are determined to be experimental or investigational (see "What the plan doesn't cover" section on pages 90–97). You may have the right to an expedited appeal; see page 123 for that process.

Explanation of benefits (EOB)

An **Explanation of Benefits** (EOB) is a detailed account of each medical claim processed by the plan, which is sent to you to notify you of claim payment or denial. You can also get this online on your account at **regence.com** or call UMP Customer Service to request a copy of an EOB (you will need to provide identifying information).

Family

Family is defined as all eligible family members (subscriber and dependents) who are enrolled on a single account.

Fee schedule

A **fee schedule** is a list of the plan's maximum payment amounts for specific services or supplies. Preferred providers have agreed to accept these fees as payment in full for services to enrollees. See "Allowed amount, medical services" on page 156 for more details.

Formulary

See "What drugs are covered? The UMP Preferred Drug List" on page 68.

Generic drug

A **generic drug** is a drug with the same active ingredient(s), but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent. A generic drug is therapeutically equivalent to the brand-name drug, which means it works like the brand-name drug in dosage, strength, performance, and use. All generic drugs sold in the United States must be reviewed and approved by the U.S. Food and Drug Administration (FDA), and meet the same quality and safety standards as brand-name drugs.

Generic equivalent

A **generic equivalent** is a generic drug that has the same active ingredients as its brand-name counterpart. For a generic drug to be considered "equivalent," it has to be approved by the FDA as being interchangeable with that brand-name drug. Under Washington State law, the pharmacist is required to dispense a generic equivalent in place of a brand-name drug, unless your provider objects. See "Substitution under Washington State Law" on page 83 for how this works.

Grievance

A **grievance** is also called a complaint. See page 120 for details on how these are handled.

Health Care Authority (HCA)

The **Health Care Authority** is the Washington State agency that administers the Uniform Medical Plan (UMP Classic, the UMP Consumer-Directed Health Plan, and the UMP Plus Plans: UMP Plus–UW Medicine Accountable Care Network and UMP Plus–Puget Sound High Value Network) in addition to the following health care programs: Washington Prescription Drug Program, Public Employees Benefits Board (PEBB) Program, and Apple Health, formerly called 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 considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

High-cost generic drugs

High-cost generic drugs are generic drugs (see "Generic drug" on page 160) that the plan covers under Tier 2 (see table on page 71).

Home

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's located. Any exception to this must be approved by the plan.

The term hospital **does not** include a convalescent nursing home or institution (or a part of one) that:

- Furnishes primarily domiciliary or custodial care (see definition on page 158).

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

Inpatient copay

The **inpatient copay** is what you pay for inpatient services at a preferred facility—hospital, skilled nursing, mental health, substance use disorder: $200 per day for facility charges. Employees, retirees, and dependents not enrolled in Medicare pay up to $600 maximum per person per calendar year; retirees enrolled in Medicare pay up to a $600 maximum per admission up to the medical out-of-pocket limit. The inpatient copay does not count toward your medical deductible but does count toward the medical out-of-pocket limit.

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

Inpatient stay

From when you are admitted to a hospital or other medical facility, until you are discharged from that facility.

IRO

Independent Review Organization (see page 124).

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 163–165) or preauthorization of services (see page 87).

A **limited benefit** is a benefit that is limited to a certain number of visits or a maximum dollar amount. The limit applies to these benefits even if the provider prescribes additional visits and even if the visits are medically necessary. The plan does not make exceptions to benefit limits.

For benefits limited to a certain number of visits, any visits that are applied to your medical deductible (see pages 15–16) also count against your annual visit or dollar limit. In addition, visits that are paid by another health plan that is primary apply to the plan limit. For example, if your primary plan applies your first six massage therapy sessions to your medical deductible, you may receive coverage for 10 more sessions in that calendar year, for a total of 16 visits (the visit maximum for massage therapy). **Note:** These limits apply *per enrollee*.

Services are counted against a limited benefit according to the type of service, not the provider type. When a provider practicing within the scope of his/her license provides services coded under a limited benefit (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 of the limited benefits. For example, if both manipulation and physical therapy codes are billed for a visit, that visit will count against both the spinal and extremity manipulation and physical therapy benefits.

Maintenance care

Maintenance care is a health intervention after the patient has reached maximum rehabilitation potential or functional level and has shown no significant improvement for one to two weeks, and instruction in the maintenance program has been completed.

Maintenance care may apply to a number of different services, including but not limited to physical therapy, speech therapy, neurodevelopmental therapy, home health care, and skilled nursing care.

Medical

Medical generally refers to all plan benefits and services other than those covered under preventive care and prescription drug benefits (except as the term is used in the eligibility sections of this certificate of coverage).

Medical benefit

Medical benefit refers to services subject to the medical deductible, and copayment or coinsurance. See pages on page 15–18 for a description of how this works.

Medical deductible

The **medical deductible** is a dollar amount you must pay each calendar year for health care expenses before the plan starts paying for services. You pay the first $250 per person in medical expenses to your providers ($750 maximum if you have a family of three or more on one account). Only expenses covered by the plan count toward your deductible. For example, if you receive LASIK surgery (see exclusion on page 92), the plan does not apply this payment to your medical deductible. Some services are exempt from this deductible (see the "Summary of benefits" on pages 26–34). See pages 15–16 for details on how the medical deductible works.

The medical and prescription drug deductibles are separate: Medical services do **not** count toward your prescription drug deductible. Prescription drug purchases do **not** count toward your medical deductible. See "Prescription drug deductible" starting on page 70.

Medical emergency

A **medical emergency** means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the person's health, or with respect to a pregnant female, her health or the health of her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically necessary services, supplies, drugs, or interventions

ALERT! The provider or patient must provide documentation demonstrating medical necessity when requested by the plan, or services may be denied as not medically necessary. Some services that are medically necessary may not be covered by the plan. All benefits or services that are medically necessary are subject to the coverage limitations, exclusions, and provisions of the plan. It is important to review this certificate of coverage or verify coverage with Customer Service at 1-888-849-3681 (TRS: 711) before receiving services.

Medically necessary or **medical necessity** means health care services, drugs, supplies, or interventions that a treating licensed health care provider recommends, and all of the following conditions are met:

1. The purpose of the service, supply, intervention, or drug is to treat or diagnose a medical condition.
2. It is the appropriate level of service, supply, or intervention, or drug dose considering the potential benefits and harm to the patient.
3. The level of service, supply, intervention, or drug dose is known to be effective in improving health outcomes.
4. The level of service, supply, intervention, or drug recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary.

The plan may require proof that services, interventions, supplies, or drugs (including court-ordered care) are medically necessary. No benefits will be provided if the proof isn't received or isn't acceptable, or if the service, supply, drug, or drug dose is not medically necessary. Claims processing may be delayed if proof of medical necessity is required but not provided by the health service provider.

The plan uses scientific evidence from peer-reviewed medical literature to determine effectiveness for services and intervention not yet in widespread use for the medical condition and patient indications being considered. State law requires that UMP determine whether a service or intervention is covered based on decisions made by the Health Technology Clinical Committee (HTCC) (see page 23); these decisions may be referenced at **www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews**. If the HTCC determines that a health technology will be covered only under certain conditions, the plan is required by law to use the HTCC coverage criteria when evaluating whether the technology is medically necessary. If the HTCC determines that a health technology will not be covered, then the health technology is considered to be not medically necessary by the plan.

For other services, interventions, or supplies the plan first uses scientific evidence, then professional standards, then expert opinion to determine effectiveness. "Effective" means that the drug, drug dose, intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. The scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determining medical necessity. If no scientific evidence is available, professional United States (U.S.) standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that the plan should deny coverage of interventions in the absence of conclusive scientific evidence. Interventions can meet the plan's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, drug, or intervention is considered "cost effective" if the benefits and harms relative to the costs represent an economically efficient use of resources for the patients with this condition. The plan applies this criterion based on the characteristics of the individual patient. Cost-effective does not necessarily mean the lowest price.

Preventive services not covered by the plan's preventive care benefit will still be covered under the medical benefit if medically necessary.

A "health intervention" is an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, or palliate a medical condition (such as a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity" the plan does not consider a health intervention separately from the medical condition and patient indications it is applied to.

"Treating provider" means a licensed health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

Interventions for which clinical trials have not been conducted because of epidemiological reasons (that is, rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

Medical out-of-pocket limit

See "Out-of-pocket limit, medical" on page 167.

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 Washington State Rx Services to provide prescription drug coverage to UMP members at the contracted rate (allowed amount). See pages 74–76 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 Washington State Rx Services to give covered immunizations to plan enrollees at the network rate. You can find out which pharmacies are contracted at **www.hca.wa.gov/ump/find-drugs** or by calling Washington State Rx Services at 1-888-361-1611 (TRS: 711).

Noncovered services

Noncovered services refers to any service that is not covered by the plan. Some services may be medically necessary, yet still are not covered. See "What the plan doesn't cover" on pages 90–97 and "Guidelines for drugs not covered" on page 84 for details.

Nonduplication of benefits

Nonduplication of benefits is how UMP coordinates benefits when UMP is your secondary coverage (see definition on page 172). When another plan (other than Medicare) 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 101.

Non-network pharmacy

A **non-network pharmacy** does not contract with Washington State Rx Services. See page 76 for what happens if you use a non-network pharmacy to purchase covered prescription drugs.

Nonpreferred drug

A **nonpreferred drug** is a prescription drug designated as Tier 3 (nonpreferred) in the UMP Preferred Drug List (see page 68).

Nonprescription alternative

A **nonprescription alternative** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you can buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Nonprescription drug

A **nonprescription drug** includes an over-the-counter drug, dietary supplement, herbal supplement, vitamin, mineral, medical food, or medical device that you can buy without a prescription.

Normal benefit

The plan's **normal benefit** is the dollar amount of the benefit the plan would normally pay if no other 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 service area, but is not contracted as part of Regence BlueShield's preferred provider organization network; or
- Outside the Regence service area but is not contracted with another Blue Cross or Blue Shield organization in the BlueCard® program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to plan members.

Out-of-pocket limit, medical

The **medical out-of-pocket limit** is the most you pay during a calendar year before the plan pays 100% of the allowed amount. This limit doesn't include your premium, balance-billed charges, or services the plan doesn't cover; see also page 18 for other costs that do not count toward this limit. For more information on how this works, see page 17 under "Your medical out-of-pocket limit."

Out-of-pocket limit, prescription drugs

The **prescription drug out-of-pocket limit** is the maximum you pay for covered prescription drugs and products during a calendar year. Once the $2,000 limit per enrolled member is met, the plan pays 100% of the allowed amount for covered prescription drugs and products for that member. See page 72 for a list of services that don't count toward this limit and that you pay even after you have met it.

Over-the-counter alternative

An **over-the-counter alternative** drug is a drug that you can buy without a prescription that has similar safety, efficacy, and ingredients as a prescription drug.

Over-the-counter drugs

Over-the-counter drugs are medications you can get without a prescription.

Over-the-counter equivalent

An **over-the-counter equivalent** is a drug you can buy without a prescription that has identical active ingredients and strengths as a prescription drug or product in a comparable dosage form.

P&T Committee

See "Pharmacy & Therapeutics Committee."

Participating provider

A **participating provider** is contracted but is in another network. The plan pays these providers at the out-of-network rate (most covered services are paid at 60%), but the provider may not balance bill you. Coinsurance paid to a participating provider applies to the medical out-of-pocket limit. Covered preventive services from participating providers will be paid by the plan at 100% of the allowed amount. Covered mental health or substance use disorder services from participating providers will be considered network.

PEBB

The **Public Employees Benefits Board** is a group of representatives, appointed by the governor, that approves insurance benefit plans for employees and establishes eligibility criteria for participation in insurance benefit plans.

PEBB plan

A **PEBB plan** is one of several health benefit plans, including the Uniform Medical Plan (UMP Classic, the UMP Consumer-Directed Health Plan, and the UMP Plus Plans: UMP Plus–UW Medicine Accountable Care Network and UMP Plus–Puget Sound High Value Network), offered through the Public Employees Benefits Board (PEBB) Program to public eligible employees, former employees, retirees, survivors, and their 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.

PEBB Program

The **PEBB Program** is the Washington State Health Care Authority program that administers PEBB benefit eligibility and enrollment.

Peer-reviewed medical literature

Peer-reviewed medical literature is scientific studies printed in journals or other publications in which original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related websites or in-house publications of pharmaceutical manufacturers.

Pharmacy & Therapeutics (P&T) Committee

Pharmacy & Therapeutics Committee: A group of providers and other health care professionals who review prescription drugs and make recommendations on the preferred status of prescription drugs on the Preferred Drug List (see page 69).

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 **www.hca.wa.gov/ump-providers-classic**.

Plan

Plan as referred to in this document means the Uniform Medical Plan Classic (UMP Classic), a self-funded PPO plan offered by the PEBB Program. In the eligibility sections (see pages 130–152), "plan" refers to any PEBB-sponsored plan. In the "If you have other medical coverage" section on page 98, "plan" may mean any health insurance coverage.

PPO

A **Preferred Provider Organization (PPO)** is a health plan that has a network of providers who have agreed to provide services for the plan's enrollees at discounted rates. Enrollees may self-refer to most specialists. UMP Classic is a PPO.

Preauthorization

Preauthorization is approval by the plan for coverage of specific services, supplies, or drugs before they are provided to the member. Preauthorization is not a guarantee of coverage. If you or your provider do not receive preauthorization for certain medical services or drugs, the claim may be denied. See "Preauthorizing medical services" on page 87 for how this works. A list of medical services that require preauthorization is available at **www.hca.wa.gov/ump-preauth-classic** or by calling UMP Customer Service at 1-888-849-3681 (TRS: 711). See page 80 for information on prescription drugs that must be preauthorized.

Preferred drug

A **preferred drug** is a prescription drug that is listed on the UMP Preferred Drug List and covered under the Value Tier, Tier 1, or Tier 2.

Preferred Drug List

The **UMP Preferred Drug List** is a list available online that specifies how prescription drugs are covered by the plan. By using this list, you can find out if a drug is covered, how much you'll pay, if the drug must be ordered through the plan's specialty drug pharmacy, and whether the drug has any limitations (such as needing preauthorization or quantity limits; see pages 79–83).

Drugs are designated by "tiers": Value Tier are cost-effective drugs for treatment of certain chronic conditions; Tier 1 are primarily generic drugs; Tier 2 are preferred brand-name drugs and some high-cost generic drugs; and Tier 3 are nonpreferred brand-name drugs.

"NC" designates a drug not covered under the prescription drug benefit; however, some drugs—such as IV drugs that require administration by a physician—may be covered under the medical benefit. Call Washington State Rx Services at 1-888-361-1611 (TRS: 711) for more information about drugs listed as NC.

The UMP Preferred Drug List is based on the Washington Preferred Drug List and recommendations by one of the Pharmacy & Therapeutics Committees that partner with Washington State Rx Services (see "Who decides which drugs are preferred?" on page 69 for more information).

If your drug is not listed, call Washington State Rx Services 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 cost-limit

The **prescription cost-limit** is the most you pay for a Value Tier drug, Tier 1 drug, Tier 2 drug, and Tier 3 specialty drug at a network pharmacy; non-specialty Tier 3 drugs do not have a cost limit per prescription. See page 71 for how this works. See "Your prescription drug out-of-pocket limit" on page 72 for annual limits to covered prescription drug costs.

Prescription drug deductible

The **prescription drug deductible** is a dollar amount you must pay each calendar year for Tier 2 and Tier 3 prescription drugs before the plan starts paying benefits for these drugs. You pay the first $100 per individual in prescription drug charges ($300 maximum if you have a family of three or more on one account). Only expenses for Tier 2 and Tier 3 drugs covered by the plan count toward your deductible. For example, if you receive a

prescription for a drug for cosmetic purposes (see exclusion on page 91), the plan does not apply the cost of a noncovered drug to your deductible.

See "Your prescription drug out-of-pocket limit" on page 72 for annual limits to your cost for prescription drugs.

The prescription drug and medical deductibles are separate: Prescription drug purchases do not count toward your medical deductible. Medical services do not count toward your prescription drug deductible. See "Your deductibles" on page 15.

Note: What you pay (coinsurance) for Value Tier and Tier 1 drugs does not count toward your prescription drug deductible.

Prescription drug out-of-pocket limit

See "Your prescription drug out-of-pocket limit" on page 72.

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).

Primary care provider

A **primary care provider** is a physician (see "Physician services" on page 168), nurse practitioner, or physician assistant who provides, coordinates, or helps a patient access a range of health care services. See page 10 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(s)

A **provider network** is a network of providers who are contracted to provide health care services to plan members. These providers have agreed to see members under certain rules, including billing at contracted rates (see "Allowed amount, medical services" on page 156). Preferred providers for UMP Classic members in 2019 consist of Regence BlueShield preferred providers and Blue Cross and Blue Shield plan providers in the BlueCard® program designated as preferred providers.

Quantity limit

A **quantity limit** is a limit on how much of a particular drug you can get for a specific time period (days' supply).

Reconstructive surgery

Reconstructive surgery is surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Regence service area

The **Regence service area** means the Washington counties of Clallam, Columbia, Cowlitz, Grays Harbor, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Yakima, Wahkiakum, Walla Walla, Whatcom, and any other areas designated by Regence. Please check the website **regence.com** for up-to-date information.

Residential treatment facility

A **residential treatment facility** is a 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 as a result 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 57).

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 98 for more information on how this plan coordinates benefits.

Skilled nursing care

Skilled nursing care is services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled nursing facility

A **skilled nursing facility** is an institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Medicaid-eligible, long-term care facilities are not necessarily skilled nursing facilities.

SmartHealth

SmartHealth is a wellness program offered by the PEBB Program. SmartHealth offers a $125 wellness incentive in 2019 to eligible non-Medicare subscribers who met eligibility requirements. More details on eligibility and program requirements are at **www.hca.wa.gov/pebb-smarthealth.**

Specialty drugs

Specialty drugs are high-cost injectable, infused, oral, or inhaled 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 81 for information on how specialty drug prescriptions are handled.

Standard reference compendium

Standard reference compendium refers to any of these sources:

- *The American Hospital Formulary Service Drug Information*
- *The American Medical Association Drug Evaluation*
- *The United States Pharmacopoeia Drug Information*
- Other authoritative compendia as identified from time to time by the U.S. Secretary of Health and Human Services

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, retiree, 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 service area (see page 171), contracted with the local BlueCard network.

Therapeutic alternative

A **therapeutic alternative** is a drug that isn't chemically identical to a nonpreferred drug but has similar effects when given in therapeutically equivalent doses.

Therapeutic equivalent

A **therapeutic equivalent** is a drug that is chemically identical to a nonpreferred drug and is expected to have the same efficacy and toxicity when given in the same doses.

Therapeutic interchange

Therapeutic interchange is substitution of a nonpreferred drug by a pharmacist with a preferred drug that is a therapeutic alternative or equivalent, with the endorsing provider's permission (see page 83).

Tier

Tier is a term that tells you how much you will have to pay for a covered prescription drug. UMP Classic's prescription drug benefit categorizes covered prescription drugs into four tiers. See page 71 for details on the prescription drug tiers.

Tobacco cessation services

Tobacco cessation services are provided for the purpose of quitting tobacco use, usually cigarette smoking. UMP members under age 18 who use tobacco may participate in the online Smokefree Teen program. See page 65 for more information.

Uniform Medical Plan Classic (UMP Classic)

Uniform Medical Plan Classic (UMP Classic) is a self-funded health plan offered through the Public Employees Benefits Board (PEBB) Program and managed by the Health Care Authority.

Value Tier

Value Tier refers to cost-effective drugs that are used to treat certain chronic conditions. See the table on page 71 for details. For a list of Value Tier drugs, go to **www.hca.wa.gov/ump-drugs-classic**, or call 1-888-361-1611 (TRS: 711).

Uniform
Medical Plan