2007

Uniform Medical Plan
Preferred Provider Organization (PPO)

Certificate of Coverage

Uniform Medical Plan

Your health. Your plan. Your choice.

Self-insured by the State of Washington
Effective January 1, 2007

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

HCA 54-550 (10/06)

To Learn More About . . .

See the Index at the back of this booklet.

This booklet explains benefit provisions specific to UMP PPO and is the certificate of coverage for UMP PPO enrollees. (This certificate of coverage supersedes previous certificates.)

If provisions in this booklet are inconsistent with any controlling federal or state statute or rule, the language of the statute or rule will govern.

This booklet was compiled by the Washington State Health Care Authority/Uniform Medical Plan, PO Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact UMP PPO (see the Directory).

To Learn More About . . .

Welcome to UMP PPO!

The Uniform Medical Plan Preferred Provider Organization (UMP PPO) is a self-insured plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). UMP PPO is available only to people eligible for PEBB coverage, 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 PEBB programs.

This plan is designed to keep you and your family healthy as well as provide benefits in case of illness or injury. Please review this booklet carefully so you can take advantage of all this plan has to offer. In addition, you can visit the UMP Web site at **www.ump.hca.wa.gov** to find the following:

- Online accounts, where you can look at your medical and pharmacy claims information through secure Web sites.
- *Health Counts*, UMP's wellness program that rewards you for healthy behaviors.
- Secure e-mail to send questions to Customer Service (through your online account).
- UMP's preferred drug list.
- Provider and pharmacy network directories.
- UMP publications and forms.
- The "Info Center"—A knowledge base of frequently asked questions about UMP coverage.

How Preferred Provider Organizations Work

UMP PPO is a preferred provider organization. That means you can choose your own providers. You don't have to choose a primary care provider who acts as a "gatekeeper" to manage your care, and you don't need to get a referral from UMP to see a specialist. You will receive the highest level of benefit and pay the lowest amount out of your pocket if you see network providers.

With choice comes responsibility! To get the most out of your benefits, you need to know what services UMP PPO covers and whether your provider is in our network. Please consult this *Certificate of Coverage* before getting services. If you're not sure if a service, supply, or provider will be covered, call Customer Service for help.

Your Choices For Health Care Providers

Why Choose a Network Provider?

While you may receive coverage for services performed by any approved provider type (see list on pages 5-6), there are a lot of good reasons to use a network provider. These reasons are:

- UMP PPO pays a higher amount (90% of UMP's allowed charge in most cases) when you see a network provider.
- Network providers can't bill you more than the UMP allowed charge for covered services. Allowed charge refers to the amount that network providers have agreed to charge for covered services.
- UMP PPO pays 100% for covered preventive care services when you see a network provider. You don't have to pay a deductible or coinsurance. Please see the lists on pages 28-33 for specific services covered.
- You won't have to file a claim if UMP is your primary coverage.

Note: In addition to any applicable deductible and your enrollee cost-share for covered services, you will have to pay for services or supplies that exceed UMP's benefit limits or are not covered by UMP.

Using Non-Network Providers Costs You Money

You should avoid seeing non-network providers whenever possible because:

- UMP PPO pays only 60% of allowed charges to non-network providers. Non-network providers can charge more than the UMP allowed charge. You will pay 40% of the allowed charge **plus** the amount above our allowed charge.
- Any money you pay to a non-network provider won't count toward your annual medical out-of-pocket limit.
- You may have to pay up front and send your own claims to be paid by UMP.

Plus, you will still have to pay a deductible (if it applies), coinsurance, or copayments.

For Medicare Retirees

Provider Options for Medicare Retirees

If you have Medicare as your primary coverage, you can see any provider who accepts Medicare assignment and the services will be paid at UMP's network level. So you are not limited to the UMP network. You'll receive the highest benefit by seeing providers who accept Medicare assignment.

If you receive services in Washington State, it's still a good idea to select UMP network providers whenever possible. For certain services (such as inpatient hospitalization), UMP PPO covers more than Medicare does. For those services, you will receive the highest level of benefit when you see a UMP network provider in Washington.

If you need care from providers in other states, you can select any provider who accepts Medicare assignment. There is no added benefit for Medicare retirees to use the Beech Street network.

If you see a provider who has "opted out" of Medicare, UMP will not pay anything toward the cost of services normally covered by Medicare. Ask your provider if he or she has opted out of Medicare before you receive services, or you may have to pay the entire bill.

When You Don't Have Access To a Network Provider

Out-of-Area Payment

If you receive covered services in the United States where there is no access to a network provider, or if you receive services outside the U.S., UMP may pay at the "out-of-area" rate. The out-of-area payment is 80% of UMP allowed charge, after you pay your annual medical deductible. In these situations, your enrollee coinsurance (20% of UMP's allowed charge) *does* apply to your annual medical out-of-pocket limit. Because these providers are not in the UMP network, they can charge more than UMP allows. They can also bill you for the entire amount over UMP's allowed charge, in addition to your enrollee coinsurance.

If you live in a rural area and do not have access to network providers within 50 miles of your home's ZIP Code, UMP may pay for services from approved provider types at the out-of-area rate. If you live in an urban area and do not have access to a network specialist within 50 miles, or 30 miles for a primary care provider, UMP may pay at the out-of-area rate. Mileage is as measured on a map with a ruler, ***not*** road mileage; see definition of "Out-of-Area Services" on pages 93-94.

Comparing Network, Non-Network, and Out-of-Area Payments

The chart below shows how UMP PPO pays benefits for professional services when UMP PPO is your primary insurance. For these examples, assume you have paid your annual deductible, and you haven't reached your annual medical out-of-pocket limit.

Network provider				
Billed Charge	**UMP Allowed Charge**	**Must Provider Accept UMP Allowed Charge?**	**UMP PPO Pays**	**You Owe Provider**
$1,000	$900	Yes Provider discount = $100	$810 (90% x $900)	$90 ($900 - $810)
Non-network provider				
Billed Charge	**UMP Allowed Charge**	**Must Provider Accept UMP Allowed Charge?**	**UMP PPO Pays**	**You Owe Provider**
$1,000	$900	No	$540 (60% x $900)	$460* ($1,000-$540)
No access to network providers, or outside the U.S.				
Billed Charge	**UMP Allowed Charge**	**Must Provider Accept UMP Allowed Charge?**	**UMP PPO Pays**	**You Owe Provider**
$1,000	$900	No	$720 (80% x $900)	$280** ($1,000-$720)

Please note that these are examples only, and may not apply in a specific situation.

*Your payment does not apply to your annual medical out-of-pocket limit.

**Your coinsurance (20% of $900, or $180) counts toward your annual medical out-of-pocket limit, but the part of the billed charge over UMP's allowed charge ($100) does not.

How To Find a Network Provider

In Washington State

UMP's network includes most acute care hospitals, nearly every major multispecialty clinic in the state, more than 11,000 physicians, and over 7,000 nonphysician health care professionals such as advanced registered nurse practitioners and physical, occupational, and speech therapists. We also include alternative care providers (naturopaths, acupuncturists, and massage therapists) in the Axia WholeHealth Networks as network providers.

To locate a network provider in Washington State, you will get the most up-to-date information by checking the online provider directory (updated twice a month) on the UMP Web site at **www.ump.hca.wa.gov**, or by calling UMP Customer Service at 1-800-762-6004 (or 425-670-3000 in the Seattle area). You may also get a printed copy of the directory from Customer Service. However, please note that provider network status may change after the directory is printed.

In the Idaho Border Counties

In Bonner, Kootenai, Latah, and Nez Perce counties, UMP contracts directly with some providers. UMP PPO pays non-network providers in these counties at the out-of-area rate (80% of UMP's allowed charge).

Outside Washington State, Inside the U.S.

For care elsewhere in the United States (other than Washington and the four Idaho counties above)—You will receive network-level benefits when you receive services from a Beech Street network provider outside of Washington. The Beech Street network includes more than 400,000 providers in the U.S. To find a Beech Street provider or to nominate a provider to join the Beech Street network, visit their Web site at **www.beechstreet.com** or call Customer Service at 1-800-762-6004.

For Medicare Retirees

If Medicare is your primary coverage and you see a provider who accepts Medicare assignment, UMP will pay for covered services at the highest level, even if the provider is not in Beech Street's network. UMP coordinates with Medicare to cover most services in full (up to Medicare's allowed charge), even if the provider is not in UMP's or Beech Street's network. See "Provider Options For Medicare Retirees" on page 2 for more information.

Note: UMP does not use the Beech Street network in Washington State. To get the highest benefits while in Washington or the Idaho border counties, use UMP network providers.

Services Received Outside the U.S.

UMP PPO may cover health care services outside of the U.S. if:

- Provided by an approved provider type (see pages 5-6).
- Medically necessary (see definition on pages 92-93).
- Appropriate for the condition being treated.
- Not considered to be experimental or investigational by United States standards.
- Otherwise covered by UMP PPO.

These services are covered at the out-of-area benefit level.

If you seek nonemergency services abroad, contact UMP to help you determine whether these services will be covered. Our toll-free numbers don't work outside the U.S. You may use your secure e-mail through your UMP online account or the Question/Feedback form on UMP's Web site at **www.ump.hca.wa.gov**. You may also call us at 425-670-3000 write to us at:

Uniform Medical Plan
P.O. Box 34578
Seattle, WA 98124-1578

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the

currency exchange rate. UMP does not pay for that translation and documentation.

Approved Provider Types

UMP PPO pays for covered services only when performed by an approved provider type. All UMP network providers are approved provider types. However, if you see a non-network provider that is not one of the approved provider types listed below, UMP will not pay for those services. The list of approved provider types includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To receive payment under UMP PPO benefits, the provider must:

- Be of a type or specialty listed in this section.
- Have a current license, registration, or certificate to deliver services at his or her location.
- Perform only services within the provider's scope of practice, as defined by the licensing agency.
- Provide services within UMP PPO's benefit limits.
- Comply with UMP billing practices.

Note: **A provider can be an "approved provider type" without being in the UMP network.**

Approved provider types include:

- Acupuncturists, licensed (LAc).
- Alcohol/Chemical Dependency Centers and Substance Abuse Treatment Facilities, licensed with Department of Social and Health Services (DSHS) certification (must be approved by UMP); non-PhD psychologists and mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility ***and*** the facility bills for their services.
- Ambulances, licensed ground or air service.
- Ambulatory Surgical Centers (ASC), licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations or other recognized national accreditation).
- Audiologists, certified.
- Biofeedback technicians, certified (covered only when employed by and delivering services within a hospital or other UMP-approved facility ***and*** the employing organization bills for their services).
- Birthing centers, licensed.
- Chiropractors, licensed (Doctors of Chiropractic [DC]).
- Community mental health agencies, licensed; non-PhD psychologists and counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency ***and*** the agency bills for their services.
- Counselors, licensed, including Licensed Marriage and Family Therapists (LMFT), Licensed Masters of Social Work (LMSW), and Licensed Mental Health Counselors (LMHC).
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (UMP does not cover most dental services. See pages 17-18 and page 39 for limits on dental services covered).
- Diabetes education programs (including Medical Nutrition Therapy), Medicare-approved or otherwise approved by UMP.
- Dieticians providing services as part of an approved diabetes education program (see above).
- Durable medical equipment (DME), orthotics, and prosthetics suppliers.
- *Free & Clear* tobacco cessation program.
- Hearing aid fitters and dispensers, licensed.
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency ***and*** that agency bills for their services).
- Home health or hospice agencies, licensed (Medicare-certified or accredited by the Joint Commission on Accreditation of Healthcare Organizations).
- Hospitals, licensed.
- Massage practitioners, licensed (LMP); only massage practitioners in the UMP provider network are considered approved providers.

- Medical nutrition therapists (MNT), Medicare-approved or approved by UMP for the treatment of diabetes mellitus (see diabetes education programs) or chronic renal insufficiency, end-stage renal disease when dialysis is not received, or medical conditions up to 36 months after kidney transplant. MNTs are covered only when employed by and delivering services within a hospital or other UMP-approved facility ***and*** the employing organization bills for their services.
- Midwives, licensed (LM).
- Naturopaths, licensed (Naturopathic Doctors [ND]).
- Nurses (all types must be licensed) as listed below:
  - Advanced Registered Nurse Practitioners (ARNP)
  - Certified Nurse Midwives (CNM)
  - Practical Nurses (LPN)*
  - Registered Nurses (RN)*; UMP does ***not*** cover RNs to assist at surgery, unless they are credentialed as a CRNFA.
  - Registered Nurse First Assistants, certified; ***only*** Certified Registered Nurse First Assistants (CRNFA) are covered (covered only when providing services under the supervision of a physician ***and*** the employing physician or physician clinic/group bills for their services).

  ** Covered **only** when employed by and delivering services within a hospital, skilled nursing facility, hospice, or home health agency, or under the direction of a physician or ARNP **and** the employing organization or clinician bills for their services.*
- Occupational therapists, licensed (OT).
- Optometrists, licensed (Doctors of Optometry [OD]).
- Pharmacists, licensed and registered (RPh) or Doctors of Pharmacy (PharmD).
- Pharmacies, licensed.
- Physical therapists, registered and licensed (RPT).
- Physicians, licensed (Doctors of Medicine [MD], or Doctors of Osteopathic Medicine [DO]).
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a physician ***and*** the employing physician or physician clinic/group bills for their services).
- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM]).
- Psychologists, licensed (PhD).
- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, or home health agency, or under the direction of a physician or ARNP ***and*** the employing organization or clinician bills for their services).
- Skilled nursing facilities, licensed (Medicare-certified).
- Speech pathologists, licensed and certified by the American Speech, Language and Hearing Association.

Exception: Your UMP vision hardware benefit covers prescription eyeglasses, frames, and contact lenses purchased anywhere; you don't have to use an approved provider type.

What You Pay For Medical Services

Annual Medical Deductible

A deductible is a fixed dollar amount you pay before UMP begins paying most benefits. You pay the deductible to your providers—not to UMP.

The annual medical deductible applies for most covered medical services. (You also have a separate annual prescription drug deductible.) Your annual medical deductible is $200 per person (up to $600 for three or more covered family members) and is calculated from January 1 to December 31, even if you're enrolled for only part of the year. For example, if you enroll in July you would still have to pay the entire annual medical deductible for that year before the plan would reimburse for medical benefits. You would then have to pay a new medical deductible starting each January 1.

For families of three or more covered people, the $200 per person deductible still applies. If any one person spends $200, UMP will begin paying benefits for that person. Once three or more persons spend a combined total of $600, UMP will begin paying benefits for all family members. Coinsurance paid by one member of the family does *not* apply toward the deductible of other family members. For information about the annual prescription drug deductible, see pages 45 and 88.

Please note: If you pay toward your deductible for services with a benefit limit (such as chiropractic, massage therapy, or physical therapy), those visits will count toward the benefit limit. For example, if you pay out-of-pocket for a chiropractor visit because you haven't met your deductible, that visit will count toward the maximum of 10 visits per calendar year. See definition of "Limited Benefit" on page 91 for more information. Your deductible costs do not count toward your annual medical out-of-pocket limit.

Benefits Not Subject to the Annual Medical Deductible

You do not have to pay toward the deductible for these services. UMP will pay them based on their own reimbursement schedules, even if you have not paid your annual medical deductible in full.

- Preventive care benefits listed on pages 28-33.
- Required second opinions.
- Routine eye exams and vision hardware.
- Routine hearing exams and hearing aids.
- Services received under the *Free & Clear* tobacco cessation program.

Note: Only the UMP allowed charge (see definition on page 87) applies to the deductible or the medical out-of-pocket limit. Charges over UMP's allowed charge are not counted.

Enrollee Coinsurance

Enrollee coinsurance is the percentage you must pay when UMP PPO pays less than 100% of the allowed charge. For most covered services, you pay 10% of the allowed charge for network providers and 40% of the allowed charge for non-network providers. Where there is no access to a network provider, your coinsurance is 20% of the allowed charge. When you see a non-network provider, the provider can bill you for any amounts over UMP's allowed charge. For prescription drugs purchased through a retail pharmacy, you pay a percentage depending on the drug's tier level (see page 45).

Coinsurance does not apply to some services, such as preventive care. See the "Summary of Benefits" charts on pages 9-15 for coinsurance levels for specific services. See "Your Choices For Health Care Providers" on pages 2-6 for a description of your costs when seeing a network or non-network provider.

Copayments

A copayment is a flat dollar amount you pay when you receive specific services, treatments, or supplies, such as inpatient hospitalization in a network facility, emergency room care, or a prescription filled through our mail-order pharmacy. See the "Summary of Benefits" charts on pages 9-15 for specific copayment amounts.

Annual Medical Out-of-Pocket Limit

The medical out-of-pocket limit is the maximum total amount of enrollee coinsurance and copayments you may have to pay for medical services during a calendar year. The limit is $1,500 per person or $3,000 per family (all family members combined under one subscriber's account). Once you have reached this limit, UMP PPO pays 100% of allowed charges for covered medical services from network providers for the rest of the calendar year.

The following costs are *not* counted towards your annual medical out-of-pocket limit:

- Annual medical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review or preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance, copayments, and ancillary charges for prescriptions filled at retail and mail-order pharmacies.
- Enrollee coinsurance or copayments for services for non-network providers, except when UMP pays the out-of-area rate.

The medical out-of-pocket limit does not apply to services from non-network providers, unless the claim is processed as out-of-area. In many cases, a provider's billed charge is higher than the UMP's allowed charge. Even if you have met your annual medical out-of-pocket limit, your costs when using non-network providers are the combination of your 40% enrollee coinsurance plus the difference between the provider's billed and UMP's allowed charges.

***Exception:* Out-of-area services from non-network providers will be paid at 100% of allowed charges when you have met your annual medical out-of-pocket limit. If the provider bills more than UMP's allowed charge, you will still be responsible for paying the difference, however.**

Maximum Plan Payment

The total UMP PPO will pay for all benefits is limited to a lifetime maximum of $2,000,000 per enrollee. UMP restores up to $10,000 of the lifetime maximum automatically each January 1 for benefits paid by UMP PPO during the prior calendar year. Some services also have specific calendar year or other benefit limits, as detailed in the "Summary of Benefits" starting on page 9.

Summary of Benefits

Even if a provider orders a test or prescribes a treatment, UMP PPO may not cover it. Please review this *Certificate of Coverage*, or call UMP Customer Service at 1-800-762-6004 if you have questions about whether a service or supply is covered.

On the next several pages, you'll find a table summarizing your UMP benefits. Only the most common benefits are shown; see "Benefits: What UMP PPO Covers" starting on page 16 for a detailed list. In addition, see the section "What UMP PPO Doesn't Cover" starting on page 39 for information about some services that are not covered by UMP PPO. UMP PPO covers only medically necessary services and supplies; see the definition on pages 92-93.

You must pay your annual medical deductible for most benefits before UMP PPO begins to pay (except for those benefits exempt from this deductible; see page 7).

Some benefits are also subject to limits or maximums. The percentage in the table refers to the amount UMP PPO pays after your deductible has been paid. These percentages are based on UMP's allowed charge; see definition on page 87. The remaining percentage is your enrollee coinsurance (see pages 7 and 90).

UMP PPO pays only up to the allowed charge (see definition on page 87). If you use non-network providers, you must pay the provider's charges over UMP's allowed charge, in addition to your enrollee coinsurance and other costs. Network providers agree to accept UMP's allowed charge as payment in full; non-network providers do not. See pages 2-6 for more information on your provider options.

UMP PPO has no waiting period for coverage of pre-existing health conditions.

For Medicare Retirees

If you also have Medicare coverage, see "Provider Options For Medicare Retirees" on page 2.

Summary of Benefits

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	60%	No	16, 39
Ambulance				16-17, 39
Air and ground	Not applicable (no network providers)	80%	No	
Biofeedback (if for mental health diagnosis, see "Mental Health Treatment" on page 24)	90%	60%	No	17, 24
Blood and Blood Derivatives	90%	60%	Only for stem cell harvesting for transplant purposes	17, 37-38
Bone, Eye, and Skin Bank Services	90%	60%	No	17
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	17, 37, 41
Chemical Dependency Treatment $13,500 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient treatment combined ($13,500 limit excludes detox unless you have been admitted to a chemical dependency program when you receive those services)				17, 42, 89
• Inpatient Facility services *Doctors and other professionals may bill separately for their services*	100% after $200 copay/day; $600 max copay/ person/year	60%	No	
Professional services	90%	60%	No	
• Outpatient	90%	60%	No	

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Diabetes Education See pages 18-19.	90%	60%	Only for more than10 hours per calendar year	18-19, 20, 35, 37
Diagnostic Tests, Laboratory, and X-Rays (outpatient)	90%	60%	Certain services	19, 38, 39, 40
Dialysis	90%	60%	No	19, 20, 35, 47
Durable Medical Equipment, Supplies, and Prostheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max; other wigs and hairpieces are not covered	90%	60%	Yes, for rentals over 3 months and rentals or purchases over $1,000	19-20, 37, 39, 89
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical deductible or medical out-of-pocket limit.			No	20-21, 91
• Facility	90% after $75** copay/visit	60% after $75** copay/visit		
• Professional *When you see non-network emergency room doctors at a network facility, UMP PPO pays at the out-of-area rate.*	90%	60%		
Hearing Exams & Hearing Aids (Routine)*	$400 max plan payment every 3 calendar years	$400 max plan payment every 3 calendar years	No	21, 35
Home Health Care	90%	60%	Yes, except for infusion therapy	21-22, 35, 37, 39, 40, 91

(continued on next page)

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

Summary of Benefits, continued

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Hospice Care Six months maximum benefit				22, 37, 40, 91, 96
• **Inpatient**				
When preauthorized	100%	60%	Yes	
When NOT preauthorized	90%	60%	No	
• **Respite care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				22-23, 40, 91, 94
Facility services *Doctors and other professionals may bill separately for their services*	100% after $200 copay/day; $600 max copay/person/year	60%	Some services; see "Physical, Occupational, and Speech Therapy"	
Professional services *See page 23 for important information*	90%	60%	No	23
• **Outpatient**	90%	60%	No	23, 91
Mammograms				
• **Screening mammograms*** (beginning at age 40, every one or two years)	100%	60%	No	19, 33
• **Diagnostic mammograms**	90%	60%	No	19
Massage Therapy 16 visits max/year	90%	Not applicable; massage therapists must be network providers to be covered.	No, but treatment plan required on file. **Exception:** Preauthorization required for services exceeding one hour per session.	23, 37, 41, 91

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Mastectomy and Breast Reconstruction	90%	60%	No	20, 23
Mental Health Treatment				24, 37, 41, 42
• **Inpatient:** 10 days max/year Facility services *Doctors and other professionals may bill separately for their services*	100% after $200 copay/day; $600 max copay/ person/year	60%	Only for partial hospitalization services	
Professional services	90%	60%	No	
• **Outpatient:** 20 visits max/year	90%	60%	No	
Naturopathic Physician Services	90%	60%	No	24-25, 39, 50
Neurodevelopmental Therapy (Covered for ages 6 years and under only)				25, 41
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/ person/year	60%	No	
• **Outpatient:** 60 visits max/year for all types of therapy combined	90%	60%	No, but treatment plan required on file	
Obstetric and Newborn Care				
• **Inpatient**				26
Facility charges	100% after $200 copay/day; $600 max copay/ person/year *(routine newborn nursery care is not subject to copay)*	60%	No	
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	23

(continued on next page)

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

Summary of Benefits, continued

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Organ Transplants				26-27, 37-38, 41, 44
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/ person/year	60%	Yes	
Professional services	90%	60%	Yes	
• **Outpatient**				
Donor searches (bone marrow, stem cell, umbilical cord) are limited to 15 searches per transplant	90%	60%	Yes	
Out-of-Area Care Includes care obtained in locations without access to network providers, including the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce (see definition on pages 93-94)	Not applicable	80%	Varies by service/supply	3, 4, 8, 41, 88
Outpatient Surgery or Ambulatory Surgical Center	90%	60%	No	27, 88
Phenylketonuria (PKU) Supplements	90%	60%	No	27
Physical, Occupational, and Speech Therapy				
• **Inpatient:** 60 days max/year for all types of therapy combined	100% after $200 copay/day; $600 max copay/ person/year	60%	Yes	22, 27, 37
• **Outpatient:** 60 visits max/year for all types of therapy combined	90%	60%	No, but treatment plan required on file	23, 27

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

All covered benefits are subject to the annual medical deductible unless noted. **Percentages shown in chart apply to UMP's allowed charge, which is the fee accepted by UMP network providers.**

Benefits	Plan payment for network providers *(percentage of UMP allowed charge)*	Plan payment** for non-network providers *(percentage of UMP allowed charge)*	Preauthorization required?	See page***
Prescription Drugs* See pages 43-50 for information on prescription drug coverage				39, 41, 42, 43-50
Preventive Care* Only certain services are covered under the preventive care benefit. See lists of covered services on pages 28-33.	100%	60%	No	28-33, 41, 95
Skilled Nursing Facility 150 days max/year (see page 34 for important information regarding Medicare coverage)	100% after $200 copay/day; $600 max copay/ person/year	60%	Yes	34, 38
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No, but treatment plan required on file	34, 41
Tobacco Cessation Program* *Free & Clear* program only	100%	Not covered	No	35, 42, 96
Vision Care*				36, 40, 41
• **Eye exams** (routine) One exam per calendar year	90%	60%	No	
• **Vision hardware** Including frames, lenses, contact lenses, and fitting fees combined	$150 max plan payment every two calendar years	$150 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services* *See specific services covered under "Preventive Care"*	100%	60%	No	26, 29-31

** Not subject to the annual medical deductible.*

*** Your enrollee coinsurance for services from non-network providers does not count towards your annual medical out-of-pocket limit, unless UMP PPO pays the claim at the out-of-area rate. You must pay the provider's charges over UMP's allowed amount.*

**** Several exclusions listed in "What UMP PPO Doesn't Cover" may apply to all benefits. Please review that section (pages 39-42) carefully.*

Benefits: What UMP PPO Covers

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not make it medically necessary (see pages 92-93).

Benefits covered by UMP PPO must:

- Be medically necessary; definition on pages 92-93.
- Conform to UMP medical review and preauthorization requirements; see pages 37-38.
- Be received from an approved provider type (except as noted); see pages 5-6.

Except when coverage is required by law, you must pay the costs of any services or supplies received after your UMP PPO coverage ends.

UMP will cover—or not cover—"health technology" according to the decisions of a statewide "health technology clinical committee." The term "health technology" is defined in state law (RCW 70.14.080), but generally means medical services or equipment. This committee will also determine how UMP decides whether the service or equipment is medically necessary (see definition on pages 92-93). UMP is required by Washington State law to comply with the committee's decisions.

UMP follows Medicare coverage guidelines in most cases, unless another specific provision applies. All benefits may be affected by one or more limits or exclusions; see both the benefit description and "What UMP PPO Doesn't Cover," starting on page 39.

UMP strives to maintain a full provider network in each geographic region. However, the fact that services or supplies are listed as covered does not necessarily mean that network providers are available.

For most services, you must pay toward your medical deductible before UMP PPO pays. See "What You Pay For Medical Services" starting on page 7 for more information on the deductible and the medical out-of-pocket limit, as well as other amounts you have to pay, such as enrollee coinsurance. Also see the "Definitions" section starting on page 87 for a description of terms used in this *Certificate of Coverage*.

UMP PPO covers these benefits :

Acupuncture

Acupuncture is covered only when used as an anesthetic or to reduce pain. Acupuncture is not covered instead of surgery, or for maintenance of health. This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 visits per calendar year. See definition of "Limited Benefit" on page 91.

Ambulance

When other transportation is not appropriate, this benefit covers ambulance services for transportation 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 91).
- From one facility to the nearest other facility equipped to give further treatment.
- Home (if determined medically necessary; see definition on pages 92-93).

If you travel outside the U.S. a lot, consider getting special insurance for air ambulance services. UMP PPO covers air ambulance only to the nearest facility (such as a hospital) that can provide the care you need. Even though you or your doctor would rather that you be sent to a facility closer to home, UMP PPO will not cover it.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

If your medical condition requires that you travel by regularly scheduled air or rail transportation for treatment, please call UMP to request preauthorization.

Ambulance services are reimbursed at 80% of the UMP allowed charge.

Emergency air ambulance services will be covered ***only*** when:

- Ground ambulance is not appropriate.
- The situation is a medical emergency (see definition on page 91).
- Transport is to the nearest facility able to provide the care you need.
- Air ambulance is the only appropriate means of transport, based on UMP's decision regarding medical necessity (see definition on pages 92-93).

Biofeedback Therapy

If used to treat a physical medical condition such as hypertension (high blood pressure), biofeedback therapy is covered at normal plan payment levels. If used for mental health treatment, UMP PPO covers biofeedback therapy under the mental health benefit.

Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance therapy; see definition on page 91) are covered when preauthorized.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum plan payment of $13,500 every 24 consecutive calendar month period. Chemical dependency is defined as an illness characterized by a physiological or psychological dependency on a controlled substance or on alcohol. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 1996 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment.
- Inpatient treatment based on a prescribed treatment plan at a hospital or substance abuse treatment facility.
- Outpatient substance abuse diagnosis and treatment.

If you are not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum under the chemical dependency treatment benefit.

Prescriptions filled through retail or mail-order pharmacies are covered under the UMP pharmacy benefit. See details under "How the UMP PPO Pharmacy Benefit Works" starting on page 43.

Chiropractic Physician Services

For information on the "Spinal and Extremity Manipulations" benefit, see page 34.

Dental Services

UMP PPO does not cover most dental services. For example, dental implants, orthodontic services, and treatment for damage to teeth or gums caused by biting, chewing, grinding, or any combination of these

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

are not covered by UMP PPO. However, they may be covered by your PEBB dental plan.

Dental services covered by UMP PPO are limited to:

1. General anesthesia, but only when:
   - It is provided by an anesthesiologist in a hospital or ambulatory surgical center.
   - The charges for the hospital or ambulatory surgical center are covered by UMP PPO.
2. Specific dental procedures performed in a hospital or ambulatory surgical center, but only if the services are medically necessary because the enrollee:
   - Is under the age of 7 with a dental condition that cannot be safely and effectively treated in a dental office.
   - Has a dental condition that cannot be safely and effectively treated in a dental office because of a physical or developmental disability.
   - Has a medical condition that would put the enrollee at undue risk if the procedure was performed in a dental office.
3. Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan. UMP PPO covers these repairs only if they are based on an evaluation and treatment plan completed within 30 days of the injury. Treatment may extend beyond 30 days if your provider determines treatment should start later or continue longer.
4. The following oral surgery procedures, whether performed by a dentist or a medical professional (other oral surgical procedures are not covered):
   - 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.
   - Jaw reconstruction due to cancer.
   - Reduction of a fracture or dislocation of the jaw or facial bones.

Diabetes Care Supplies

To be covered by UMP, you must get a written prescription from an approved provider type for the medications and supplies listed below. Note that you can buy some supplies through either a pharmacy or a durable medical equipment supplier; check with your provider to see which works better for you.

The diabetic supplies listed below are covered under Tier 1 of the prescription drug benefit; see page 45.

- All insulin.
- Diabetic supplies such as glucometers, test strips, lancets, and insulin syringes purchased at a retail pharmacy or UMP's mail-order pharmacy.

The diabetic supplies listed below are covered under the medical benefit as durable medical equipment (DME):

- Nondisposable equipment such as glucometers, sharps containers, and insulin syringes.
- Insulin pumps and related supplies.
- Disposable diabetic supplies purchased somewhere other than a retail pharmacy or through our mail-order pharmacy (such as a medical supply store).

When you purchase diabetic supplies covered as durable medical equipment (DME) from a pharmacy, make sure that the pharmacy is in UMP's network as a DME supplier as well as a pharmacy. Many network pharmacies are *not* network DME suppliers, and you will pay more if you get your DME diabetic supplies there.

Diabetes Education

This benefit covers a diabetes education program approved by Medicare or UMP. The benefit follows Medicare criteria and includes services for:

- Newly diagnosed diabetics.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

- Diabetics whose treatment changes from diet control to oral diabetes medication, or from oral diabetes medication to injectable diabetes medication.
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive laboratory results three or more months apart during a 12-month period.
- Persons identified by their provider as being at high risk for complications from inadequate glycemic control.

Diabetes education services must be prescribed by an approved provider type. To find an approved diabetes education program, visit the Web site **www.diabetes.org/education/edustate2.asp**. When working with an approved diabetes education program, services provided by dieticians are covered. Coverage is limited to 10 hours per calendar year; you must receive preauthorization from UMP for diabetes education services in excess of 10 hours.

Diagnostic Tests, Laboratory, and X-Rays

Screening mammograms that are inconsistent with UMP PPO's preventive care benefit on page 33 are not covered even if they are recommended by your provider. However, UMP PPO covers mammograms under the medical benefit if they are related to treatment for an existing medical condition and determined by UMP to be medically necessary (see definition on pages 92-93).

This benefit covers tests that must be appropriate to the diagnosis or symptoms reported by the ordering provider. Where there are alternative diagnostic approaches with different fees, UMP PPO will cover the least expensive, evidence-based diagnostic method. Covered services include:

- Colonoscopies for enrollees ages 50 or over (these are covered under the preventive care benefit regardless of diagnosis; see page 33 for details and limits on coverage).
- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Electroencephalograms (EEG) and similar tests.
- Pathology exams.
- Positron Emission Tomography (PET) scans, which require preauthorization (except for cancer diagnosis or staging).
- Prostate cancer screening as recommended by your provider.
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is ***not*** covered.

See "Genetic Testing" on page 21 for UMP coverage information.

Dialysis

Professional and facility services necessary to perform dialysis are covered when prescribed by an approved provider type for a condition covered by UMP PPO.

Independent dialysis facilities are paid at 80% of the UMP allowed charge.

For dialysis performed in a hospital or skilled nursing facility (SNF), payment is based on whether the hospital or SNF is network or non-network (90% of allowed for network; 60% of allowed for non-network).

Durable Medical Equipment, Supplies, and Prostheses

You must receive preauthorization from UMP for durable medical equipment rentals of more than three months, and rentals or purchases over $1,000.

Durable medical equipment is covered at the network benefit rate only if you get the equipment or supply from a UMP PPO network durable medical equipment supplier or other network provider.

Equipment charges that exceed the charge for less costly equipment that serves the same medical purpose

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

are not covered. To speed claims processing and ensure coverage, it's a good idea to call UMP to preauthorize durable medical equipment items. This benefit covers services and supplies that are prescribed by an approved provider type, 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).
- Breast prostheses and bras as required by mastectomy, including replacements as needed due to normal wear, a change in your medical condition, or additional surgery (see "Mastectomy and Breast Reconstruction" on page 23).
- Breast pump, but only for a medical condition of the mother or infant.
- Casts, splints, crutches, trusses, and braces.
- Contraceptive supplies that require a prescription, such as diaphragms.
- Foot care appliances, but only for diabetics.
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when other accepted treatment has been unsuccessful and the impotence:
  - Is caused by a covered medical condition (not psychological).
  - Is a complication directly resulting from a covered surgery.
  - Is a result of an injury to the genitalia or spinal cord.
- Rental or purchase (at UMP's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price).
- 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.

Educational Programs

Only the following services are covered under this benefit:

- Medical nutrition therapy for:
  - Treatment of diabetes mellitus.
  - Chronic renal insufficiency.
  - End-stage renal disease when dialysis is not received.
  - Medical conditions up to 36 months after a kidney transplant.

See also "Diabetes Education" on pages 18-19.

Emergency Room

Facility charges for emergency room treatment are covered for diagnosis and treatment of an illness or injury covered by UMP PPO. Charges for professional services (provided by doctors and other provider types) may be billed separately from facility charges. UMP PPO pays these professional services based on the provider's network status, payment rules, and service provided.

You must pay a separate $75 copayment for each emergency room visit, in addition to any enrollee coinsurance or amount owed towards your medical deductible.

Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be UMP network providers. If a non-network provider bills separately from the hospital and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference.

If you are admitted to the hospital as an inpatient directly from the emergency room, you won't have to pay the $75 emergency room copayment. However, you must pay the inpatient hospital copayment (see page 12).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

If UMP determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, UMP will not pay for emergency room services.

Family Planning Services

Family planning services (including contraceptive supplies requiring a prescription or fitting, or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered under the "Durable Medical Equipment, Supplies, and Prostheses" benefit.

Contraceptive drugs (such as the "pill") are covered under the prescription drug benefit (see pages 45-47).

Services related to voluntary and involuntary termination of pregnancy are covered under the medical benefit. Direct complications of infertility treatments (including selective fetal reduction) are not covered.

Genetic Testing

Except for genetic screening and counseling done during pregnancy, you must receive preauthorization from UMP for genetic testing services. To be covered, UMP may require that genetic testing be performed by a plan-designated specialist center or provider.

UMP does not cover genetic testing for family planning purposes.

Hearing Exams and Hearing Aids

This benefit is limited to $400 per enrollee every three calendar years, and you don't pay toward your medical deductible. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid.
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of an exam, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty and 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.

UMP is now offering reduced-cost hearing aids and hearing care services through the EPIC Program. To find out more about this voluntary program that may save you money, call 1-866-956-5400.

If you prefer, you can continue to see your UMP provider for hearing care services.

The following items are ***not*** covered:

- Charges incurred after your UMP PPO coverage ends, unless you ordered the hearing aid before that date and it is delivered within 45 days after UMP PPO coverage ends.
- Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

Hearing (Related To Diseases and Disorders of the Ear)

UMP PPO covers treatment for diseases and disorders of the ear or auditory canal (not related to a routine hearing loss) under the medical benefit. In this case, hearing care benefit limits do not apply.

Home Health Care

You must receive preauthorization from UMP for home health care in which:

- Visits are daily.
- Visits are expected to exceed two hours a day.
- Treatment is expected to last more than three weeks.

You must receive reauthorization every two weeks unless otherwise approved by UMP. Please call UMP

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

at 1-888-759-4855 before the start of home health services in these cases.

UMP PPO covers services provided and billed by a licensed home health agency for 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 ARNP). The provider must certify that you are homebound and that you would require hospital or skilled nursing facility care if you did not receive home health care. Covered expenses include:

- 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 an RN, LPN, or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs provided by the home health agency.
- Home infusion therapy.

Hospice Care (Including Respite Care)

When you receive preauthorization from UMP, hospice care received from network providers is covered at 100% of the UMP allowed charge. If not preauthorized, UMP PPO pays for services at the normal UMP PPO benefit levels (90% of allowed charges for network providers; 60% of allowed charges for non-network providers).

UMP PPO covers hospice care for terminally ill enrollees for up to six months. UMP may approve hospice services for longer than that when necessary, but these services must be preauthorized. Services must be part of a written plan of care developed by a state-licensed or Medicare-approved hospice.

UMP PPO covers:

- Inpatient services and supplies such as: prescription drugs, medical supplies usually used for inpatient care, and rental of durable medical equipment, when ordered by an attending provider.
- Respite care for a homebound hospice patient. Respite care is continuous care of more than four hours a day to give family members temporary relief from caring for the patient. Respite care is covered up to a $5,000 lifetime maximum.

Hospital Inpatient Services

This benefit covers hospital accommodations and the following inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions:

- Blood and blood derivatives.
- Bone, skin, and eye bank services.
- Diagnostic tests and exams.
- General nursing care.
- Prescription drugs administered during an inpatient stay.
- Radiation and X-ray therapy.
- Surgery—see box on page 23; providers may not be in UMP's network, even if the hospital is.
- Take-home prescription drugs dispensed and billed by the hospital upon discharge.

You must receive preauthorization from UMP for inpatient physical, occupational, and speech therapy.

If you receive a service or device at a hospital that costs more than the standard service or device to treat the same condition, you may have to pay the difference between the higher-cost service or device and the standard service or device. An example is the use of metal-on-metal or ceramic hip prostheses, rather than the standard, less expensive alternative. However, network facilities cannot bill you for the extra cost for the high-cost service or device, unless you have agreed in writing to pay before services. Please remember that all services must meet UMP criteria for medical necessity; in particular, see #4 on page 92 under the definition of "Medically Necessary Services, Supplies, and Interventions." For services that do not meet medical necessity criteria, you may be responsible for part or all of the charges.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Some hospital-based physicians (such as anesthesiologists, radiologists, pathologists, emergency room doctors, etc.) who work in a network hospital or other facility may not be UMP network providers. If a non-network provider bills separately from the hospital and his or her billed charges exceed the UMP allowed charge, you owe the provider the difference.

When a hospital has only private rooms available and your medical condition does not require a private room, UMP PPO pays based on semi-private room rates. This applies even if the hospital only has private rooms. Network facilities cannot bill you for the difference in cost between the private and semi-private rooms, unless you specifically requested a private room.

In some cases, special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, may be covered based on the facility's special-care room rates.

Hospital Outpatient Services

UMP PPO covers the following outpatient services provided through a hospital:

- Surgery.
- Short-stay obstetrical (childbirth) services (released from the hospital within 24 hours of admission).
- Observation services of less than 24 hours.

UMP PPO also covers ancillary services such as:

- Laboratory services.
- X-rays.
- Radiation therapy.
- Intravenous (IV) infusion therapy.
- Physical, occupational, and speech therapy.

Massage Therapy

To be covered by UMP PPO, a massage therapist *must* be a UMP network provider.

UMP PPO covers a maximum of 16 visits per calendar year. You must receive preauthorization from UMP for massage therapy exceeding one hour per session.

This benefit covers massage therapy ***only*** to improve or restore function lost due to:

- An acute musculoskeletal illness or injury.
- An exacerbation of a chronic musculoskeletal injury.

UMP PPO covers massage therapy services ***only*** when prescribed for a diagnosed condition by an approved provider type and based on a written treatment plan. Massage therapy is ***not*** covered for maintenance of health.

Please note that any visits applied to your deductible also apply to the annual visit maximum. See definition of "Limited Benefit" on page 91.

Mastectomy and Breast Reconstruction

UMP PPO 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 the mastectomy.

UMP PPO may cover the services listed above even when not associated with a mastectomy. However, if these services are related to a procedure (such as a cosmetic procedure) that UMP PPO does not cover, then UMP PPO would not cover the above services.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Mental Health

This benefit covers hospital inpatient and outpatient services as well as professional services to treat neuropsychiatric, mental, or personality disorders, including eating disorders. UMP PPO covers services from mental health providers for a mental health disorder only under the mental health benefit, regardless of the cause of the disorder (such as postpartum depression).

UMP PPO limits coverage for inpatient mental health treatment to 10 days per calendar year. UMP PPO limits coverage for outpatient mental health treatment to 20 visits per calendar year. See definition of "Limited Benefit" on page 91. Visits for the sole purpose of medication management do not count toward the outpatient visit limit; UMP PPO covers these visits under the medical benefit.

UMP may cover partial hospitalization services in place of inpatient care. You ***must*** receive preauthorization from UMP for partial hospitalization services before services are received. When preauthorized, you can get up to 20 days of partial hospitalization care in place of your 10-day inpatient care limit. If you do not get services preauthorized, each partial hospitalization day will count as one visit toward your 20-visit outpatient limit.

UMP PPO covers services of a licensed marriage and family counselor only when provided to treat neuropsychiatric, mental, or personality disorders.

UMP PPO covers biofeedback therapy under this benefit when prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency.
- Licensed nurse practitioner (ARNP) with training in psychology and counseling.
- Licensed physician.
- Licensed psychologist.
- Licensed Master of Social Work, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist.
- Licensed state hospital.

UMP PPO covers services from non-PhD psychologists under this benefit only when they are employed by and deliver services within a licensed community mental health agency ***and*** that agency bills for the services.

Mental Health Services and Your Rights

UMP and state law have established standards to:

- **Help ensure the competence and professional conduct of mental health service providers.**
- **Support your right to receive treatment only after informed consent.**
- **Protect the privacy of your medical information.**
- **Help you understand which services UMP PPO covers, and the limits on your coverage.**

For more information about covered mental health services, or if you have a question or concern about your mental health benefits, please contact UMP.

If you think any mental health benefit you have received from UMP PPO may not conform to the terms of your coverage contract or your rights under the law, contact UMP at 206-521-2000. If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

Naturopathic Physician Services

UMP PPO covers services provided by a naturopathic physician the same as for other providers. Naturopaths may recommend services that are not covered by UMP PPO. All services must be medically necessary (see definition on pages 92-93) to be covered. If you receive

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

services that UMP PPO doesn't cover, you may have to pay the full cost of the services.

UMP PPO does not cover herbs and other nonprescription drugs, lotions, vitamins, or minerals even if your provider prescribes them. Also see the list of exclusions on pages 39-42 for other services and items not covered by UMP PPO.

Neurodevelopmental Therapy for Children Ages 6 and Younger

UMP PPO covers neurodevelopmental therapy for:

- Children ages 6 and younger only, up until his or her seventh birthday.
- Therapy to assist with motor or sensory skills, such as:
  - Speech therapy for developmental disorders of articulation (problems speaking clearly).
  - Language therapy for developmental delay in language skills.
  - Diagnosis or treatment of learning disabilities.

UMP PPO covers the above services only when the child's condition would get significantly worse without the services, or to restore and improve the child's function. The problem must be diagnosed by a qualified physician and follow a written treatment plan to be covered.

UMP PPO covers ***only*** services meeting the following conditions:

- Provided by a UMP approved provider type qualified to perform the therapy.
- Part of a written treatment plan developed in consultation with the provider who diagnosed the developmental delay.

For the purposes of this benefit, developmental delay (see definition on page 89) means a significant lag in achieving skills, in areas such as:

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

You must pay the hospital inpatient copayment and enrollee coinsurance for therapy received during an inpatient stay. UMP PPO limits coverage for **inpatient** neurodevelopmental therapy to a maximum of 60 days per calendar year. UMP PPO limits coverage for **outpatient** neurodevelopmental therapy services to a maximum of 60 visits per calendar year (counting all therapies involved in treatment). See definition of "Limited Benefit" on page 91.

This benefit cannot be used at the same time as the "Physical, Occupational, and Speech Therapy" (see page 27) benefit for the same condition in the same calendar year. When a child receiving services under this benefit turns 7 years of age, he or she may qualify for neurodevelopmental services under the "Physical Therapy, Occupational, and Speech Therapy" benefit. We recommend enrollment in case management to ensure coverage and coordination of care.

Obesity Surgery

Obesity (bariatric) surgery is covered only in very specific clinical circumstances, including co-morbid conditions, and only for those enrollees who participate in UMP's case management program (see page 38). The surgery will be covered only if the patient meets all case management requirements, including those for before and after surgery. The final decision as to whether the surgery will be covered is made by the UMP Medical Director ***after*** presurgical requirements are met. Approval will not be granted to patients who had previous bariatric surgery within the last ten years or any prior bariatric surgery covered by a PEBB health plan. The enrollee will be required to use providers and facilities designated by UMP.

UMP will cover only the Roux-en-Y gastric bypass procedure. No other procedure will be considered for coverage.

UMP will cover related services (such as surgical removal of excessive tissue following weight loss) only if those services are medically necessary and meet all other coverage criteria. Services covered are limited to those preapproved by UMP.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Obstetric and Newborn Care

For information on adding a new dependent to your coverage, see pages 73-74 (employees) or page 83 (retirees), or call PEBB Benefit Services at 1-800-200-1004. You must call PEBB Benefit Services within 60 days of birth or adoption.

UMP PPO covers services for pregnancy and its complications when provided and billed by any one of the following:

- A licensed physician.
- A nurse practitioner.
- A licensed midwife or certified nurse midwife.
- A hospital.
- A birthing center.

UMP PPO covers only services performed by providers able to provide the full scope of obstetric services (prenatal, delivery, and postnatal care) , except in geographic areas where provider access is limited. You pay the inpatient hospital copayment, enrollee coinsurance, and any medical deductible owed for the year for these services.

Professional services covered include:

- Prenatal and postnatal care.
- Amniocentesis and related genetic counseling and testing during pregnancy.
- Prenatal testing (in accordance with the standards set forth in WAC 246-680-020).
- Vaginal or cesarean delivery.
- Care of complications resulting from pregnancy.

UMP PPO covers routine newborn nursery care during hospitalization of the mother receiving maternity benefits under UMP PPO, and you do not pay a separate copayment.

UMP PPO covers other hospitalization for a newborn for the first 21 days after birth, if UMP PPO also covers the mother. You must first pay any deductible, copayment, and coinsurance requirements. After 21 days from birth, UMP PPO will cover the child if you enroll him or her and pay your premium in full.

Organ Transplants

You must receive preauthorization from UMP for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. UMP PPO covers donor expenses as defined below. UMP PPO may cover related services such as outpatient prescription drugs, and outpatient laboratory and X-rays under other UMP PPO benefits.

UMP PPO covers organ transplants only when you receive preauthorization. Transplants must be performed in a plan-designated facility, and services must meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is from published peer-reviewed medical literature (see definition on page 94), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The expected benefits on length or quality of life outweigh the harmful risks and effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee that is more conservative or substantially less costly.

In addition, the treating facility's transplant program must accept you, and you must follow that program's protocol.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

UMP PPO covers costs to remove the donor's organ and treat complications directly resulting from the donor's surgery if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program.
- Organ recipient is enrolled in UMP PPO.
- Organ transplant meets the above coverage criteria.

Benefit Limits: Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on page 94). UMP PPO covers direct medical costs for bone marrow, stem cell, and umbilical cord donor searches up to a combined total of 15 donor searches per transplant. No other benefits are provided for services related to locating a transplant donor.

Outpatient Surgery or Ambulatory Surgical Center

UMP PPO covers the following services under this benefit:

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

For some procedures, UMP does not pay separately for surgical suite or facility charges. If you use a network facility, you don't have to pay these charges. However, if the facility is non-network, you must pay these charges if billed by the provider.

Even if your doctor is in the UMP network, the facility might not be. Make sure you confirm that both the doctor and the facility are in UMP's network before you receive services.

Phenylketonuria (PKU) Supplements

UMP PPO covers phenylketonuria (PKU) supplements when prescribed and used to treat PKU.

Physical, Occupational, and Speech Therapy

You must receive preauthorization from UMP for inpatient physical, occupational, and speech therapy.

UMP PPO covers inpatient and outpatient services to improve or restore function lost due to:

- An acute illness or injury.
- Worsening or aggravation of a chronic injury.
- A congenital anomaly (inborn defect, such as cleft lip or palate) in a dependent child covered by UMP PPO.

These services must be part of a formal written treatment plan developed with the provider who diagnosed your condition and prescribed the therapy.

UMP PPO limits coverage of rehabilitation therapy services provided during inpatient hospitalization to a maximum of 60 days per calendar year. You must pay the hospital inpatient copayment and enrollee coinsurance for inpatient services. If UMP decides that inpatient care is not medically necessary or that you could receive outpatient treatment with equal effectiveness, UMP will not pay for inpatient therapy services.

UMP PPO limits coverage of outpatient physical, occupational, and speech therapy services to a maximum of 60 visits per calendar year, counting all types of therapies listed here. See definition of "Limited Benefit" on page 91.

UMP PPO will not cover similar services for the same condition in a single calendar year under both this benefit and the "Neurodevelopmental Therapy" benefit (see page 25).

Prescription Drugs

Please see the section "How the UMP Pharmacy Benefit Works" on pages 43-50 for a detailed description of this benefit. For coverage of supplies and medications specific to diabetes, see "Diabetes Care Supplies" on page 18.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Preventive Care

This benefit is not subject to the annual medical deductible. It covers only the services in the tables that follow. If you receive additional services that exceed those listed here, they will not be reimbursed as preventive care. Instead, when medically necessary, they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays) and will be subject to your annual medical deductible. If your provider bills your visit as treatment for a medical condition instead of a routine physical exam, the services are not considered preventive.

You don't have to pay toward your annual medical deductible for services covered under the preventive care benefit. When you see a network provider for these services, UMP PPO pays 100%; you don't owe a copayment or enrollee coinsurance. If you see a non-network provider, UMP PPO pays the non-network rate (60% of the UMP allowed charge; see page 87).

UMP PPO's preventive care benefit is based on guidelines from the U.S. Preventive Services Task Force, recommendations of the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature (see page 94) on preventive care.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Preventive Care: Covered Services

UMP PPO covers only *one* routine exam under the preventive care benefit per calendar year. If you have two visits for preventive care in a calendar year, UMP PPO may deny payment for the second claim received even if the visit would otherwise have been covered. If your provider bills your visit as treatment for a medical condition instead of a routine physical exam, the services are not considered preventive and may be paid under the medical benefit (subject to coinsurance and any deductible owed).

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once each calendar year. You may request preauthorization to waive this requirement by describing your individual circumstances to UMP in writing.

Preventive Care Services, Ages Newborn to 18 years

Infants and Toddlers (Newborn to 2 years)
Well child visits covered
Newborn, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months *See CDC graph on next 2* pages *for immunizations covered.*

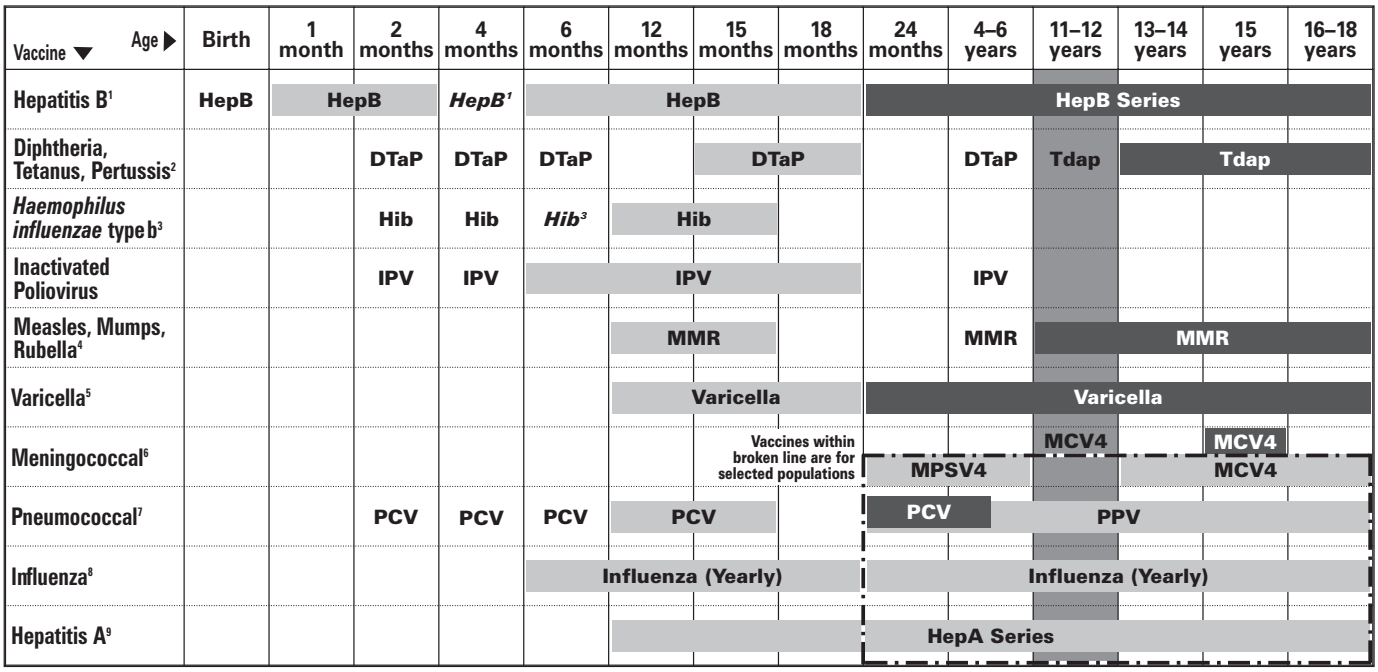
Children (Ages 2 to 18 years)
Preventive visit covered annually (up to once each calendar year)
See CDC graph on next 2 pages *for immunizations covered.*

Additional services covered	
Service covered	**Age**
Oral fluoride supplements for children, if primary water source is deficient in fluoride.	6 months and older
Meningococcal vaccine, if not administered previously.	11 years or older
HIV screening of adolescents at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually.	8-18 years
Females: Pap smear and screening for chlamydia and gonorrhea	18 years (younger if sexually active).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ■ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

Range of recommended ages **Catch-up immunization** **11–12 year old assessment**

1. **Hepatitis B vaccine (HepB).** ***AT BIRTH:*** **All newborns** should receive monovalent HepB soon after birth and before hospital discharge. **Infants born to mothers who are HBsAg-positive** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. **Infants born to mothers whose HBsAg status is unknown** should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **For infants born to HBsAg-negative mothers,** the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. ***FOLLOWING THE BIRTHDOSE:*** The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. **Infants born to HBsAg-positive mothers** should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9–18 months (generally at the next well-child visit after completion of the vaccine series).
2. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years.

   Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap – adolescent preparation) is recommended at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13–18 years who missed the 11–12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent **tetanus and diphtheria toxoids (Td)** are recommended every 10 years.
3. ***Haemophilus influenzae* type b conjugate vaccine (Hib).** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.
4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.
5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.
6. **Meningococcal vaccine (MCV4).** Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although **meningococcal polysaccharide vaccine (MPSV4)** is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.
7. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000; 49(RR-9):1-35.
8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54[RR-8]:1-55). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
9. **Hepatitis A vaccine (HepA).** HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2–18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see *MMWR* 1999; 48[RR-12]1-37).

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2006

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	**4 weeks**	**4 weeks**	**6 months**	**6 months**[1]
Inactivated Poliovirus	6 wks	**4 weeks**	**4 weeks**	**4 weeks**[2]	
Hepatitis B[3]	Birth	**4 weeks**	**8 weeks** (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	**4 weeks**[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	**4 weeks** if first dose given at age <12 months **8 weeks (as final dose)** if first dose given at age 12-14 months **No further doses needed** if first dose given at age ≥15 months	**4 weeks**[6] if current age <12 months **8 weeks (as final dose)**[6] if current age ≥12 months and second dose given at age <15 months **No further doses needed** if previous dose given at age ≥15 mo	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	**4 weeks** if first dose given at age <12 months and current age <24 months **8 weeks (as final dose)** if first dose given at age ≥12 months or current age 24–59 months **No further doses needed** for healthy children if first dose given at age ≥24 months	**4 weeks** if current age <12 months **8 weeks (as final dose)** if current age ≥12 months **No further doses needed** for healthy children if previous dose given at age ≥24 months	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria[8]	**4 weeks**	**6 months**	**6 months** if first dose given at age <12 months and current age <11 years; otherwise **5 years**
Inactivated Poliovirus[9]	**4 weeks**	**4 weeks**	**IPV**[2,9]
Hepatitis B	**4 weeks**	**8 weeks** (and 16 weeks after first dose)	
Measles, Mumps, Rubella	**4 weeks**		
Varicella[10]	**4 weeks**		

1. **DTaP.** The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.
2. **IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. **HepB.** Administer the 3-dose series to all children and adolescents <19 years of age if they were not previously vaccinated.
4. **MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
5. **Hib.** Vaccine is not generally recommended for children aged ≥5 years.
6. **Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
7. **PCV.** Vaccine is not generally recommended for children aged ≥5 years.
8. **Td.** Adolescent tetanus, diphtheria, and pertussis vaccine (Tdap) may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. See ACIP recommendations for further information.
9. **IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella.** Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.hhs.gov or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or contact 800-CDC-INFO (800-232-4636) (In English, En Español — 24/7)

Preventive Care Services, Men and Women, Ages 19 and Over

UMP PPO covers only *one* routine exam under the preventive care benefit per calendar year. If you have two visits for preventive care in a calendar year, UMP PPO may deny payment for the second claim received even if the visit would otherwise have been covered. If your provider bills your visit as treatment for a medical condition instead of a routine physical exam, the services are not considered preventive and may be paid under the medical benefit (subject to coinsurance and any deductible owed).

Services for Adults, Men and Women Ages 19 and Over	
Preventive visit covered annually (up to once each calendar year)	Ages 19+ years

Immunizations covered	Ages 19+ years
Influenza vaccine, annually	
Meningococcal vaccine—For college students, post-splenectomy patients, or as indicated for patients with chronic illness	
Tetanus/Diphtheria (Td) booster once every 10 years (or more frequently if injured)	
Varicella (if no history of chickenpox and not previously immunized)	

Immunizations covered	Age or other indications
Measles/Mumps/Rubella (MMR)—Second dose, if not administered previously	**Men:** 40 years **Women:** Childbearing age, but not during pregnancy (discuss with your provider)
Pneumococcal vaccine—Once, plus revaccination five years later for patients with chronic illness or post-splenectomy patients	**Men and women:** 65+ years (or younger if you are chronically ill)

Screening exams for both men and women ages 19 and over	
Service	**Age(s) covered**
HIV screening of young adults at increased risk per U.S. Preventive Services Task Force guidelines, up to two tests annually	19-21 years

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Screening exams for both men and women ages 19 and over	
Service	**Age(s) covered**
Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia	19+ years
Blood cholesterol/lipids screening every 5 years	Men: 35-65 years Women: 45-65 years. ***For both men and women:*** After age 65, at physician discretion based on risk factors.
Fecal occult blood test for colorectal cancer at each preventive health visit	Both men and women: 50+ years
Flexible sigmoidoscopy once every 48 months Colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy	Both men and women: 50+ years (or younger if at risk)
Services specific to men	
One-time screening ultrasound for abdominal aortic aneurysm, for current or prior tobacco users	65-75 years
Services specific to women	
Pap smear and pelvic exam annually or every 1-3 years as recommended by your provider *(See note at top of* page 32. *Only* ***one*** *preventive care visit is covered per calendar year.)*	19-64 years
Annual chlamydia and gonorrhea screening (at the same time as your Pap smear and pelvic exam)	19-24 years
Mammogram every 1-2 years depending on risk factors	40+ years

Screening mammograms that are inconsistent with UMP PPO's preventive care benefit are not covered even if they are recommended by your provider. Mammograms are covered under the medical benefit if they are related to treatment for an existing medical condition and determined by UMP to be medically necessary (see definition on pages 92-93).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Second Opinions

This benefit covers:

- **Second opinions you choose to have.** These are covered under the medical benefit, based on the network status of the provider (network or non-network).
- **Second opinions that are required by UMP**. These are paid at 100% of the UMP allowed charge (you don't pay toward your deductible and don't owe enrollee coinsurance). If you don't get a second opinion when required by UMP, your claims for services may be denied.

Skilled Nursing Facility

You must receive preauthorization and enroll in UMP's case management program to receive inpatient skilled nursing facility benefits.

UMP PPO covers services and care only if the enrollee meets Medicare guidelines for skilled level nursing care, and only when provided by a facility that is licensed by the state where it is located, and is certified by Medicare.

Services are covered only if you require continued care from skilled medical or rehabilitation professionals that cannot be provided on an outpatient basis. UMP PPO limits benefits to 150 days per calendar year.

For Medicare Retirees

Medicare limits treatment in a skilled nursing facility to 100 days per year. If Medicare is your primary coverage, UMP PPO covers your first 100 days in a skilled nursing facility as your secondary insurer. Those 100 days count against the 150-day maximum allowed by UMP.

After you have reached your Medicare maximum of 100 days, UMP PPO covers an additional 50 days if services are medically necessary. For UMP to cover the additional 50 days, before you reach the 100th day covered by Medicare, you must:

- **Get skilled nursing services preauthorized by UMP.**
- **Enroll in UMP case management (see page 38).**

UMP PPO does not cover skilled nursing facility confinement primarily for treatment of mental health conditions or mental retardation, or for care that is primarily convalescent or custodial in nature.

Spinal and Extremity Manipulations

Manipulations (adjustments) of the spine and extremities (arms and legs) may be performed by a chiropractor, an osteopathic physician, or another approved provider type.

UMP PPO limits this benefit to 10 visits per calendar year. When you have reached your 10-visit limit, UMP PPO will deny claims for any services covered under this benefit. Visits that count toward your annual medical deductible also count toward your 10-visit limit (see "Limited Benefit" on page 91).

UMP PPO also covers services related to spinal and extremity manipulation under this benefit. When performed during a single visit, these services also count as one visit toward your 10-visit limit, regardless of whether a manipulation is also performed at that time.

- Diagnostic tests
- Office visits
- Spinal and extremity manipulation
- X-rays

UMP PPO does ***not*** separately pay for complementary or preparatory services performed during a visit. They are considered included in the office visit charges. These include (but are not limited to):

- Application of heat or cold, before or after manipulation.
- Exercises performed before manipulation.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Telemedicine Services

UMP PPO covers certain limited services provided through telehealth communications technology. Such services must be provided by a provider who is:

- A specialist in UMP's network.
- Located at a site (location) other than where the patient is located.
- Of a physician specialty not available in the community where the patient lives, *or* is a psychologist or speech pathologist.

Interactive audio and video telecommunications must be used, with real-time communication between the specialist and patient.

UMP PPO limits covered services to consultations, outpatient visits, certain mental health services and assessments, diabetes self-management training through an approved program, monitoring of dialysis patients, and some speech and hearing services.

A referral from an approved provider type is required for covered consultation services.

The site where the patient is located must be in a rural area where there is a shortage of specialists and can be:

- A provider's office.
- A community mental health center.
- A hospital.
- A rural health clinic.
- A federally qualified health center.

This benefit does not include:

- E-mail, telephone, and facsimile transmissions.
- "Store and forward" technology (transmission of medical information reviewed at a later time by physician or practitioner at distant site).
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.
- Online medical evaluations using Internet or similar communications network.

TMJ (Temporomandibular Joint) Treatment

When preauthorized, UMP PPO may cover surgical treatment for TMJ (temporomandibular joint) disorders. UMP PPO does ***not*** cover medical, dental, or other types of treatment for TMJ disorders.

Tobacco Cessation Program

UMP PPO covers **only** services provided by the *Free & Clear* tobacco cessation program; no other stop smoking services are covered. *Free & Clear* provides phone counseling and educational materials to help you quit using tobacco.

UMP PPO covers these services in full. You do not have to pay toward your annual medical deductible.

If your *Free & Clear* counselor recommends nicotine replacement therapy, UMP PPO covers medications like Zyban, nicotine patches, lozenges, or gum in full (the prescription drug deductible, coinsurance, or copayment do not apply).

For UMP to cover any of the nicotine replacements for tobacco cessation, you must:

- Get a recommendation from your *Free & Clear* counselor.
- Get a prescription from your doctor.

For more details or to enroll in the program, call 1-866-Quit4Life (1-866-784-4845) or visit the Web site at **www.freeclear.com/ump**.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Vision Care (Related To Diseases and Disorders of the Eye)

UMP PPO covers treatment for diseases and disorders of the eye (not part of a routine vision exam) under the medical benefit. The routine vision care benefit limits stated below do not apply.

Vision Care (Routine)

You don't pay toward your annual medical deductible for this benefit.

Eye Exams

UMP PPO covers one routine eye exam (including refractions, the fitting of corrective lenses) per calendar year. UMP PPO pays these services based on the UMP allowed charge and the network status of the provider (see the "Summary of Benefits" on pages 9-15 for percentages).

Hardware (Eyeglasses and Contact Lenses)

For prescription eyeglass lenses, frames, contact lenses, and contact lens fitting fees, UMP PPO allows $150 every two calendar years. UMP PPO will not pay more than your actual cost for these items and services. When UMP PPO payments since the beginning of last calendar year total $150, you pay your provider any additional costs.

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 UMP, it is easy to submit a claim for glasses or contacts; see pages 51-52 for instructions.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "What UMP PPO Doesn't Cover."

Limits on UMP PPO Coverage

Preauthorizing Services

UMP PPO has clinical staff to review and approve some medical services and supplies before, during, or after they're received. This medical review team evaluates the appropriate treatment setting, whether the service or supply is medically necessary, whether the service or supply has been accurately billed, and whether the charge is appropriate. (The fact a service or supply is prescribed or furnished by an approved provider type does not, by itself, make it medically necessary; see definition on pages 92-93).

This program discourages unnecessary care, saves money for you and UMP, and helps ensure treatment is consistent with standards of good medical practice. Medical reviewers may approve a proposed service, deny it, suggest alternative methods, require that you participate in case management, or require a second opinion from another specialist. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

You must receive preauthorization from UMP for the following services. If you don't, UMP PPO may not cover it. To ensure you receive UMP PPO benefits, call 1-800-762-6004 (or 425-670-3000 in the Seattle area) for preauthorization before receiving these services. You may fax preauthorization requests directly to the Medical Review Department at 425-670-3197.

- Cardiac and pulmonary rehabilitation (see page 17).
- Certain injectable drugs that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP's mail-order pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).
- Cochlear implants.
- Diabetes education services exceeding 10 hours in a calendar year (see pages 18-19).
- Durable medical equipment, supplies, and prostheses. You must receive preauthorization for rentals beyond three months, or for rentals or purchases over $1,000.

It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.

- Genetic testing, except when associated with pregnancy. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP.
- Home health care: You must receive preauthorization for cases in which:
  - Visits are daily.
  - Visits are expected to exceed two hours a day.
  - Treatment is expected to last more than three weeks.

  You must receive reauthorization every two weeks unless UMP tells you otherwise. Call 1-888-759-4855 before starting home health services; otherwise, UMP may deny your claims.

  When ***only*** infusion therapy services are provided, home health services do ***not*** require preauthorization.
- Hospice care, including respite care: UMP PPO covers hospice care from UMP network providers in full for up to six months when preauthorized. Respite care has a $5,000 lifetime maximum limit.
- Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services (see page 24).
- Negative Pressure Wound Therapy Pumps and related services.
- Organ transplants: You must receive preauthorization from UMP for all organ transplants (including bone marrow, umbilical cord, and stem cell trans-

plants). The treating facility's transplant program must also accept you, and you must follow the program's protocol.

- Positron Emission Tomography (PET) scans, except for diagnosis or staging of cancer.
- Skilled nursing facility admissions.
- Temporomandibular joint (TMJ) surgery.

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions, and Limitations" contain more information on all services and supplies that require preauthorization.

Confirming Coverage With Customer Service

For services not requiring preauthorization, you may call UMP Customer Service to ask if those services are generally covered by UMP PPO. However, until a claim for services is actually submitted to UMP, UMP is unable to provide an accurate estimate of payment.

Second Opinions

The UMP's medical reviewers may require a second opinion before approving an admission or procedure. When UMP requests a second opinion, UMP PPO will cover it at 100% and you will not have to pay toward your annual medical deductible. If you don't get a required second opinion, UMP may deny your benefits.

For more information on second opinions you choose to get, see page 34.

Medical Review During Claim Processing

When claims are processed, UMP will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP may review all claims for hospital admissions retrospectively. UMP makes the final determination of the amount payable for any service or supply.

Case Management Services

Optional Case Management

UMP offers optional case management to enrollees with complex health care needs. This ***free*** service helps you:

- Keep your health care costs down.
- Find network providers.
- Get the most from your health care benefits.

You, or any provider or facility (such as a hospital) involved in your treatment, may call UMP to request case management services. UMP case managers work with you and your providers to coordinate your medical care, to ensure you get the most from your benefits.

Certain services, such as care in a skilled nursing facility, require preauthorization and are available only to participants in case management.

If you need help coordinating your health care, call UMP Case Management at 1-888-759-4855.

Required Case Management

The UMP 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, UMP may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP may deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You may appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" starting on page 61.

What UMP PPO Doesn't Cover

Expenses Not Covered, Exclusions, and Limitations

UMP PPO 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. If you have questions, call Customer Service at 1-800-762-6004.

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.

1. Acupuncture, except as described under "Acupuncture" on page 16.
2. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
3. Circumcision, unless determined medically necessary for a medical condition.
4. Complications directly arising from services that are not covered.
5. Conditions caused by or arising from acts of war.
6. Cosmetic services or supplies, including drugs, pharmaceuticals, removal of excess tissue and similar procedures. However, UMP PPO does cover:
   - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
   - Reconstructive surgery of a congenital anomaly in a covered dependent child.
7. Court-ordered care, unless determined by UMP to be medically necessary and otherwise covered.
8. Custodial care; see definition on page 89.
9. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 17-18.
10. Dietary or food supplements, including:
    - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs.
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment.
    - Minerals.
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
11. Dietary programs designed for weight control or weight loss.
12. Drugs or medicines not covered by UMP as described in the "How the UMP PPO Pharmacy Benefit Works" section, pages 43-50.
13. Educational programs, except those listed under "Diabetes Education" (pages 18-19), "Educational Programs" (page 20), and "Tobacco Cessation Program" (page 35).
14. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
15. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Convenience items and options.
    - Exercise equipment.
    - Sanitary supplies.
16. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
17. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.

18. Extracorporeal Shockwave Therapy; low-energy shock waves focused on a source of pain (soft tissue).
19. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
20. Foot care treatment for complaints such as corns and calluses, or fallen arches; and supplies for correction or treatment of such complaints, for example corrective shoes, orthotics, or related prescriptions. However, see "Durable Medical Equipment, Supplies, and Prostheses" on pages 19-20 for coverage related to diabetes.
21. Genetic testing or counseling for family planning, or any other genetic testing or counseling that is not preauthorized. See "Genetic Testing" on page 21 for more information on what's covered.
22. Home health care except as provided on pages 21-22. For example, the following are not covered:
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Home Health Care" on pages 21-22.
    - Unless preauthorized:
        - Daily visits.
        - Visits exceeding two hours per day.
        - Visits continuing for more than three weeks.
        - 24-hour or full-time care in the home.
    - Dietary assistance.
    - Expenses for normal necessities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
23. Hospice care except as provided on page 22. For example, the following are not covered:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" on page 22, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
24. Hospital inpatient charges such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples include metal-on-metal or ceramic hip prostheses. See additional information under "Hospital Inpatient Services" on pages 22-23.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and preauthorized by UMP.

25. Immunizations, except as described under "Preventive Care" starting on page 28. Immunizations for the purpose of travel or employment, or required because of where you reside, or any others not listed, are not covered.
26. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.
27. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
28. Learning disabilities treatment after diagnosis, except as described under "Neurodevelopmental Therapy" on page 25, or when treatment is part of a mental health disorder and covered under the "Mental Health Treatment" benefit.
29. Maintenance therapy (see definition on page 91).
30. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 34.
31. Massage therapy, unless services meet the criteria in "Massage Therapy" on page 23. Also, services from massage therapists who are not UMP network providers, and services not preauthorized that exceed one hour per session, are not covered.
32. Medicare-covered services or supplies delivered under a "private contract" with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see page 65 for more information).
33. Mental health—UMP does not cover marital, family, or other counseling or training services, except when provided to treat neuropsychiatric, mental, or personality disorders (coverage is described on page 24). Services from non-PhD psychologists are covered only when they are employed by and deliver services within a licensed community mental health agency and that agency bills for the services. Wilderness training programs are not covered.
34. Missed appointments.
35. Non-approved provider types—Services delivered by types of providers not listed as approved on pages 5-6, or by providers delivering services outside of the scope of their licenses, are not covered.
36. Non-network provider charges that are above the UMP allowed charge, even when the provider is paid at the out-of-area rate.
37. Organ donor coverage for anyone who is not a UMP PPO enrollee, or costs of locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" on pages 26-27.
38. Organ transplant expenses not preauthorized by UMP.
39. Orthognathic surgery, or surgery to straighten or correct the jaw, except for a congenital anomaly in covered dependent child.
40. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" on page 36.
41. Other insurance coverage—services or supplies are not covered if benefits are available under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (When we say "available," we mean that you could get services paid under another policy by applying for coverage.) However, UMP PPO may advance payments to you with the expectation that UMP will be reimbursed from any settlement.
42. Physical exam—Any additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 28), even if required for employment, travel, immigration, licensing, or insurance and related reports.
43. Prescription drug charges over the UMP allowed charge, regardless of where purchased.

44. Provider administrative fees—Any charges for completing forms or copying records, except for records requested by UMP to perform retrospective utilization review.
45. Recreation therapy.
46. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient care treatment (such as schools, wilderness programs, and behavioral programs for teenagers).
47. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" on page 22).
    - For which you are not obligated to pay.
48. Sexual dysfunction or disorder diagnosis, counseling or treatment.
49. Sexual reassignment surgery, services, counseling, or supplies.
50. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or mental retardation.
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial (see "Custodial Care" on page 89).
51. Sterilization (the ***reversal*** of voluntary vasectomy or tubal ligation is excluded).
52. TMJ (temporomandibular joint) disorder treatment, except as described on page 35.
53. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program" on page 35.
54. Weight control, weight loss, and obesity treatment as follows:
    - **Non-surgical:** Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. UMP PPO does not cover exercise programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services. Such treatment is not covered even if prescribed by a provider.
    - **Surgical:** Any surgery for obesity or morbid obesity, including any related medical services, drugs, or supplies. UMP PPO does not cover gastroplasty, gastric stapling, gastric wrapping or banding, gastric bubble or balloon, intestinal bypass, or any other bariatric surgery, except under case management as described under "Obesity Surgery" on page 25. Removal of excess skin is not covered. Bariatric surgery will not be covered if you have had bariatric surgery within the last ten years, or if you have ever had this surgery covered under a PEBB plan.
55. Workers' compensation—UMP PPO does not cover services or supplies if benefits are available under any workers' compensation or other similar type of program, insurance, or contract. (When we say "available," we mean that you could get services paid for under another policy by applying for coverage.)

If you have questions about whether a certain service or supply is covered, call UMP at 1-800-762-6004 (or 425-670-3000 in the Seattle area).

How the UMP PPO Pharmacy Benefit Works

Your Prescription Drug Provider Options

Retail Pharmacies

UMP contracts with an extensive network of pharmacies through Express Scripts, Inc. The UMP pharmacy network includes most pharmacies in Washington State as well as national chains. To see if your pharmacy is in the UMP network, check the online provider directory or call Express Scripts Member Services.

Although you may use any pharmacy, a UMP network pharmacy will save you time and money. Network pharmacies agree to sell prescription drugs at a discounted rate. When you use a network pharmacy, you pay only your coinsurance and any applicable deductible. Network pharmacies submit your claims for you. In addition, when you use a network pharmacy, there is a limit on what you have to pay for Tier 1 and Tier 2 drugs (see page 46).

Be sure to show your UMP I.D. card to a network pharmacy when you get a prescription filled. If you don't, you will likely pay more for your drugs. You'll have to submit your own claims and UMP will treat the claim as if you used a non-network pharmacy.

It is your responsibility to show your UMP I.D. card when purchasing prescription drugs at a network pharmacy so that you receive the UMP discounted price. If the pharmacist doesn't know you are a UMP enrollee, you may be charged more than the UMP allowed charge, and UMP will not reimburse you for the excess charges. Also, the Tier 1 and Tier 2 cost-share limit will not apply to claims you submit, even if you purchased the drugs at a network pharmacy.

Transferring to a network pharmacy is easy. Just contact the network pharmacy of your choice, tell them you have UMP coverage and would like them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages.

Mail-Order Pharmacy

If you have primary coverage other than UMP PPO that covers prescription drugs, you can't use UMP's mail-order pharmacy. Use the pharmacy options available through your primary plan. After your primary plan processes your prescription, you may submit a paper claim form to UMP for secondary payment.

UMP also offers prescription drugs through Express Scripts' mail-order pharmacy. To order a prescription or refill by mail, you may visit the UMP Web site at **www.ump.hca.wa.gov**, or call Express Scripts Member Services at 1-866-576-3862. When using the mail-order pharmacy, the same annual prescription drug deductible, preauthorization requirements, and limits on coverage apply as for retail prescription drugs. Prescriptions are usually delivered 10 to 14 business days after the Express Scripts mail-order pharmacy receives the prescription.

If there is a manufacturer shortage of a specific drug (or other shortage that our mail-order pharmacy cannot control), and the quantity available is less than the quantity you ordered, you will pay the same copayment; it will not be prorated.

Prescriptions mailed or orders placed in December but not filled until January 1 or after will be subject

to the annual prescription drug deductible applicable on the date the prescription is processed. Because of increased volume at the end of the year, prescriptions submitted to our mail-order pharmacy in December may not be processed during the current benefit year.

Prescriptions being faxed to the Express Scripts mail-order pharmacy *must*:

- Be faxed from the PROVIDER'S office fax machine.
- Be on the provider's letterhead.
- Include the patient's name, address, UMP I.D. number, and date of birth.

Remember, *only* your provider can fax in a prescription. The fax number is 1-800-396-2171. Not following these instructions may cause a delay in filling your prescription.

Specialty Pharmacy

UMP has selected "CuraScript," a subsidiary of Express Scripts, as its exclusive vendor for specialty medications. Specialty medications are high-cost injectable, infused, oral, or inhaled drugs that generally require close monitoring of the patient's drug therapy.

All specialty medications will be limited to a 30-day maximum supply per prescription or refill. You may get your first prescription filled either at a retail pharmacy or through CuraScript, but all subsequent refills will need to be ordered through CuraScript.

You may order your specialty medications from CuraScript by calling 1-866-413-4135 (Monday-Friday 5 a.m.—6 p.m. Pacific Time; Saturday 6 a.m.—10 a.m. Pacific Time). A Patient Care Coordinator will contact your physician to get your prescription. The Patient Care Coordinator will work with you to schedule a delivery time for the medication. If you are unable to be present for the delivery, CuraScript will deliver your medications anywhere you choose, such as to your workplace or to a neighbor. Specialty medications often require special handling and storage so someone must be present to sign for them.

Non-Network Pharmacies—Retail or Mail-Order

If you get your prescriptions filled at a non-network pharmacy, whether a retail, Internet, or mail-order pharmacy other than Express Scripts, the following applies:

- You will need to pay up front for your prescriptions and submit a claim to UMP for reimbursement (see pages 52-53).
- UMP PPO pays its percentage based on the UMP allowed charge; if the non-network pharmacy charges more than the UMP allowed charge, you will pay the difference, plus your enrollee coinsurance.
- For non-network mail-order pharmacies, reimbursement is the same as for a non-network retail pharmacy.
- The maximum cost-share at retail for Tier 1 and Tier 2 drugs does not apply.
- Specialty drugs purchased at a non-network pharmacy are not covered (see "Specialty Pharmacy").

To submit claims for prescriptions purchased from non-network pharmacies (either U.S. or foreign), see pages 52-53 under "Submitting a Claim for Prescription Drugs."

For Medicare Retirees

Using Pharmacies That Bill Medicare Directly

Medicare Part B covers a few drugs for certain conditions, including certain oral chemotherapy drugs, and immunosuppressant drugs for organ transplants. These drugs are identified on the *UMP Preferred Drug List*. If Medicare is your primary insurance and you need to purchase one of these drugs, you must use a pharmacy that agrees to bill Medicare directly to receive any benefits.

Medicare accepts claims only from providers, not from members. So if you use a pharmacy that won't bill Medicare for you, Medicare will not reimburse you for your drug purchase. UMP can't process your claim for these drugs

For Medicare Retirees

without an explanation of benefits from Medicare saying how the claim was paid.

While not required, it's best to choose a pharmacy that can bill Medicare electronically, because you'll get reimbursed much faster. Medicare takes 4-6 weeks to process paper claims. Depending on the pharmacy, electronic claims can be processed while you wait or within 2 business days.

What You Pay For Prescription Drugs

Annual Prescription Drug Deductible

You do not have to pay towards the prescription drug deductible for Tier 1 (generic and other drugs; see table below) prescription drugs.

You must pay an annual prescription drug deductible for purchases of brand-name (Tier 2 and Tier 3) prescription drugs before UMP PPO pays benefits. This deductible is $100 per person, or a maximum of $300 for a family (three or more people covered under the same account). You must pay towards this deductible no matter where you get your prescriptions.

Drug Tier Levels

The amount you pay for a prescription depends on the tier level the drug falls in. This is shown in the table below. Using generic and preferred drugs reduces costs both for you and for UMP. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive.

	How Much Will I Pay?	
Tier	**At a UMP Network Retail Pharmacy (for *up to* a 90-day supply per prescription or refill)**	**At UMP's Mail-Order Pharmacy (for *up to* a 90-day supply per prescription or refill)**
Tier 1 Generic drugs, all insulin, most disposable diabetic supplies, and preferred specialty drugs (see page 96)	Lesser of 10% coinsurance or cost-share limit (see page 46) *Annual prescription drug deductible does not apply*	$10 copay *Annual prescription drug deductible does not apply*
Tier 2 Preferred brand-name drugs	Lesser of 30% coinsurance or cost-share limit (see page 46)	$50 copay
Tier 3 Nonpreferred brand-name drugs, compounded prescriptions, and nonpreferred specialty drugs (see page 96)	50% coinsurance, ***plus*** the ancillary charge for drugs with a generic equivalent—see page 46	$100 copay, ***plus*** the ancillary charge for drugs with a generic equivalent—see page 46)

Prescription Drug Payment Is Based On The UMP Allowed Charge

UMP PPO bases its payment for prescription drugs on the UMP allowed charge (see definition on page 87). If you use a non-network pharmacy or do not give a network pharmacy your UMP I.D. card, and the amount charged is more than the UMP allowed charge, you will pay the difference, in addition to your enrollee coinsurance.

Minimum Mail-Order Cost

The minimum mail-order cost is $8.99. If the medication costs less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater.

Tier 1 and Tier 2 Enrollee Cost-Share Limit At Network Retail Pharmacies

The cost-share limit refers to the most you have to pay out of your pocket for Tier 1 or Tier 2 drugs purchased at a ***network*** retail pharmacy. For:

- Up to a 30-day supply, your cost-share limit is $75.
- A 31- to 60-day supply, the limit is $150.
- A 61- to 90-day supply, the limit is $225.

The maximum enrollee cost-share limit ***does not apply*** to Tier 3 drugs or drugs purchased at non-network pharmacies.

Higher Cost for Tier 3 Drugs With a Generic Equivalent: Ancillary Charge

If you get a Tier 3 drug that has a generic equivalent (multi-source drug), you will pay more than you would for other Tier 3 drugs.

Once you've met your annual prescription drug deductible, if you get a multi-source Tier 3 drug rather than its generic equivalent, UMP PPO pays the same amount for the Tier 3 drug as it would have paid for the generic equivalent. You pay the rest of the cost of the Tier 3 drug.

The amount that you pay above the standard copay or coinsurance is called the "ancillary charge."

The examples below assume that you have paid your prescription drug deductible. You may get up to a 90-day supply of a drug per prescription or refill (except for specialty drugs, which are limited to a 30-day supply).

At a UMP Network Retail Pharmacy

	Generic Drug	Multi-source Tier 3 Drug
Drug Cost	$15.22	$133.60
What UMP PPO pays	$13.70	$13.70
Enrollee Coinsurance	$1.52 (lesser of 10% or cost-share limit)	$66.80 (50% coinsurance)
Ancillary Charge	Not applicable	$53.10 ($66.80 – $13.70)
What You Pay	*$1.52*	*$119.90*

At the UMP Mail-Order Pharmacy

	Generic Drug	Multi-source Tier 3 Drug
Drug Cost	$15.22	$133.60
What UMP PPO pays	$5.22	$5.22
Enrollee Copay	$10.00	$100.00
Ancillary charge	Not applicable	$28.38 ($133.60 – $5.22, minus your $100 copay)
What You Pay	*$10.00*	*$128.38*

In the example above, you pay less at retail than for mail-order, but that will not always be the case. Express Scripts Member Services can tell you if you will have to pay the ancillary charge for your Tier 3 drug and which purchasing method (retail or mail-order) would be less expensive.

Drugs Covered by UMP PPO

Guidelines For Coverage

The UMP pharmacy benefit covers drugs that meet all of the following criteria:

- Can be legally obtained only with a written prescription.
- ***Do not*** have an over-the-counter equivalent (see exceptions below).
- Are not classified as vitamins (except as listed below), minerals, or dietary supplements.
- Are approved by the Food and Drug Administration (FDA).

The following prescription drugs are covered as exceptions to the above rules:

- Fluoride supplements for prevention of dental caries (see page 29).
- Prescription prenatal vitamins (during pregnancy).
- Vitamin D for patients on renal dialysis.

UMP PPO covers certain nonprescription drugs and supplies , including:

- All insulin and diabetic supplies such as blood glucose meters, test strips, lancets, and insulin syringes used in the treatment of diabetes (see "Diabetes Care Supplies" on page 18 for more information).
- Over-the-counter prenatal vitamins (during pregnancy).
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free & Clear* tobacco cessation program (see page 35).
- Other over-the-counter products and prescription drugs with over-the-counter equivalents that are specifically noted in the *UMP Preferred Drug List* (UMP PDL) as covered under Tier 1, Tier 2, or Tier 3.

To be covered, the above-listed prescription and nonprescription drugs and supplies must be prescribed by an approved provider type, and must be medically necessary. Services must be received from a licensed pharmacy employing licensed registered pharmacists.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 96).
- In most relevant peer-reviewed medical literature (defined on page 94), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

UMP PPO will not cover any drug when the FDA has determined its use to be contraindicated.

The *UMP Preferred Drug List* (UMP PDL)

The *UMP Preferred Drug List (PDL)* is a list of all prescription drugs that are covered by UMP PPO. The UMP PDL identifies the drug's tier, whether preauthorization or coverage limits apply, and if there are less expensive alternatives available. The list is updated about every three months and is available on the UMP Web site. You also can call Express Scripts Member Services for a printed copy or to ask about particular drugs.

The UMP PDL includes drugs from both the Washington Preferred Drug List (Washington PDL) and the Express Scripts National Formulary. State law requires that UMP conform to the Washington PDL, which is developed by the Washington State Pharmacy & Therapeutics Committee (P&T Committee), an independent group of practicing health care providers. The P&T Committee meets quarterly to review specific drug classes. Once these reviews are completed, the UMP PDL may change based on the P&T Committee's recommendations. UMP uses the Express Scripts National Formulary for drug classes not yet reviewed by the Washington State P&T Committee.

UMP retains the right to update the UMP PDL or shift medications to different tiers during the year if generic or over-the-counter alternatives become available,

or if the Washington PDL or Express Scripts National Formulary changes. The fact that a drug is preferred at one time does not necessarily mean it will be preferred through the end of the year. UMP will notify you in writing when changes occur that will cause you to pay more for your medications. UMP posts all changes to the UMP Web site on a quarterly basis.

Limits on Drug Coverage

UMP may exclude, discontinue, or limit coverage for any drug when:

- New drugs are developed.
- Generic drugs become available.
- There is a sound medical reason.
- There is evidence, or a lack of evidence, regarding the cost-effectiveness of a drug.
- The State Pharmacy & Therapeutics (P&T) Committee or the Express Scripts Pharmacy & Therapeutics Committee recommends a change.
- A drug receives FDA approval for a new use.

Changes can occur at any time. UMP will let you know when the rules change for a drug you are taking.

UMP encourages you to use generic drugs whenever possible. The programs described below help us monitor drug usage, safety, and costs. Drugs may be added to any of these programs at any time.

Preauthorization Program

UMP will not pay for medications that require preauthorization unless authorized by UMP.

If your drug requires preauthorization, we will let your pharmacist know when filling your prescription. Your pharmacist or prescribing provider must call Express Scripts at 1-800-417-8164 to request authorization.

If the request is denied, you can appeal (see "Complaint and Appeal Procedures" starting on page 61).

This program helps ensure you use drugs based on accepted medical standards. You can find out if your drug requires preauthorization by calling Express Scripts Member Services, or checking the *UMP Preferred Drug List* on the UMP Web site.

Limits to How Much You Can Get: Quantity Limit Program

Some drugs have limits to how much you can get per prescription or refill. When you fill a prescription, if your prescription is for more of a drug than is covered by UMP, your pharmacist will get a message that it needs to be authorized. To request an increased quantity of a drug, your pharmacist or prescribing provider must call Express Scripts at 1-800-417-8164.

You can appeal (see pages 61-64) if your request is denied.

If your request is denied or authorization not completed, UMP will cover the drug only up to the quantity limit amount; you will pay for any extra amount.

How UMP PPO Covers Specialty Drugs

Specialty drugs (see definition on page 96) are subject to special rules. You can find out if a drug is a specialty drug by checking the *UMP Preferred Drug List* on the UMP Web site, or by calling Express Scripts Member Services.

You can get up to a 30-day supply of a specialty drug per prescription or refill. You can fill your first prescription at a network retail pharmacy. After that, you must order through UMP's specialty pharmacy, CuraScript. Most specialty drugs are covered under Tier 1; however, some brand-name specialty drugs are covered under Tier 3. You will also have to pay the ancillary charge (see page 46) for multi-source Tier 3 specialty drugs.

For details on how to order specialty drugs, see "Specialty Pharmacy" on page 44.

When You Have to Try Other Drugs First: Step Therapy

Step Therapy programs may require you to try other drugs first, before UMP will cover a particular medication. When filling your prescription, your pharmacist will be notified if a Step Therapy program applies. If they feel you need the prescription filled as originally written, your pharmacist or prescribing provider can call Express Scripts at 1-800-417-8164 and request

coverage. To find out if a Step Therapy program applies to your drug, you can check the *UMP Preferred Drug List* on the UMP Web site, or call Express Scripts Member Services at 1-866-576-3862.

If coverage is denied, you can appeal (see pages 61-64).

If UMP doesn't authorize coverage before you get the drug, UMP will not cover it, and you will have to pay the entire cost of the drug.

When The Pharmacist Substitutes One Drug For Another: Therapeutic Interchange Program (TIP)

TIP does not apply to refills on antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drugs, or drugs to treat Hepatitis C. For these drugs, your prescription will be filled as written.

The Therapeutic Interchange Program (TIP) allows a pharmacist to substitute a "therapeutic equivalent" drug (see page 96) for a nonpreferred brand-name drug in certain cases.

You can find out if your drug is affected by TIP by checking the *UMP Preferred Drug List* on the UMP Web site, or by calling Express Scripts at 1-866-576-3862. Not all nonpreferred drugs are affected by TIP.

Your drug may be substituted when your prescribing provider has "endorsed" the Washington State Preferred Drug List, ***and***:

- You are filling your prescription in Washington State (or you sent your prescription to UMP's mail-order pharmacy, and your prescribing provider approves the substitution).
- Your prescribing provider did ***not*** write your prescription "dispense as written."

If you do not want your drug to be substituted, you can either:

- Ask your prescribing provider to write the prescription "dispense as written."
- Tell the pharmacist to fill the prescription "dispense as written."

In either case, you will pay the higher copay or coinsurance if you get the nonpreferred drug, including the ancillary charge (see page 46) if the drug has a generic equivalent.

Travel Overrides For Prescription Drugs

You may request a travel override when you will not have access to network pharmacies during extended business or vacation travel. All of the conditions listed below apply.

- Travel overrides will be granted no more than twice per calendar year, for as many covered drugs as you wish to request.
- You can get up to a 90-day supply in addition to your normal 90-day supply.
- If you are going to be outside the U.S. for an extended period, coverage may be granted for up to one year.
- You will pay applicable charges (deductible, copayment, or coinsurance) to each individual supply received.

To request a travel override, call Express Scripts Member Services at 1-866-576-3862.

Note: As specialty drugs are limited to a 30-day supply (see page 44), travel overrides are also limited to an additional 30-day supply.

Refill Too Soon

When you fill a prescription, UMP expects you will use a predictable amount within a certain period of time, based on the doctor's instructions. If you try to fill a prescription before 70% of the prescription should be used up, UMP will deny the claim. Claims

for therapeutic equivalents of the drug will also be denied.

As an example, say you get 180 pills for a 90-day supply, with instructions to take 2 pills a day. If you try to refill this prescription before 63 days have passed (70% of 180=126 pills, or 63 days), UMP will not cover the prescription.

Drugs Not Covered Under the UMP PPO Pharmacy Benefit

- Experimental or investigational drugs.
- Dietary supplements (vitamins, minerals, herbal supplements).
- Homeopathic drugs, including FDA-approved prescription products.
- Over-the-counter drugs or prescription drugs that have an over-the-counter equivalent, except for the drugs specified under "Guidelines for Coverage" on page 47.
- Drugs covered by Medicare Part B (see page 65-67 regarding coordination of benefits with Medicare).
- Drug costs covered by other insurance (see page 68 regarding coordination of benefits).

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

- Drugs to treat sexual dysfunction.
- Drugs to treat infertility.
- Drugs used for cosmetic purposes.
- Drugs to treat obesity or to lose weight.

What To Do If Coverage Is Denied

If a network pharmacy (including mail-order and CuraScript for specialty drugs) tells you that coverage is denied, preauthorization is required, quantities are limited, or the prescription is otherwise not covered in full, your pharmacist or prescribing physician may contact Express Scripts at 1-800-417-8164 to request a coverage review.

If coverage is denied, Express Scripts will send you a written notice of its decision within two business days after receiving all necessary information from your provider. If you are dissatisfied with the decision, you may request an appeal (see pages 61-64).

If you need the medication immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Express Scripts at 1-800-417-8164 for approval of a temporary supply.

Filing a Claim

For Medicare Retirees

Medicare-enrolled retirees: Be sure to read "If You Are Retired And Enrolled In Medicare" on pages 65-66.

Submitting a Claim for Medical Services

When UMP is your primary insurance and your provider is in the UMP network, the provider will submit claims for you. So even if you get a bill from a network provider, don't send in a claim. If you have a question about whether a claim has been submitted, you may call UMP Customer Service at 1-800-762-6004.

When Do I Need To Submit a Claim?

You may need to submit a claim to UMP for payment if you receive services from a non-network provider, or if you have other insurance that should pay first and UMP is secondary.

How Do I Submit a Claim?

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

1. The Uniform Medical Plan Claim Form—the form is on pages 54-55, and is also available on the UMP Web site at **www.ump.hca.wa.gov**. You may also request a form by calling UMP Customer Service. You must fill out Sections 1, 2, 3, and 6 completely for the claim to be processed. Fill out Section 4 if the services were for a work-related illness or injury; fill out Section 5 if the patient has other insurance coverage.
2. An itemized bill from your provider that describes the services you received and the charges. This document could be a standard claim form ("CMS 1500" claim form for individual providers or a "UB-92" form for facilities), or it could be in the form of a bill or an invoice. If you submit a standard form, your claim will be paid more quickly.

If your provider uses a non-standard claim form, the following information must appear on the provider's itemized bill for the claim to be considered for payment:

- Patient's name and UMP I.D. number.
- Description of the illness or injury.
- Date and type of service.
- Provider's name and credentials (such as MD), address, and phone number.

If you have a claim form or an itemized bill from the provider, proof of payment (such as a receipt) is not required. However, if the only documentation you have is a receipt, send it in along with your completed claim form. Please note that if UMP has to request additional information, processing of the claim may be delayed.

Section 6 on the UMP claim form asks you whether or not you have paid the provider. If you check "Yes," UMP will send payment to you. If you check "No," UMP will send payment to the provider. For hospital claims, payment is almost always sent directly to the hospital, whether it is in the UMP network or not.

Make copies of your documents. It is a good idea to keep a copy (or keep the original and send UMP a copy) of any documents.

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

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

How Long Does It Take To Process A Claim?

Most claims are processed within four weeks. If you have a question about the status of a claim and haven't heard anything, we suggest waiting four weeks before calling Customer Service. You can also check on the status of a claim through your online medical account on the UMP Web site.

UMP may delay paying your claim for a variety of causes, including insufficient information on the claim form, or not having up-to-date information on other insurance you or family members may have. Also, UMP may need to ask your provider for more information, which can take additional time.

When UMP processes your claim, you will receive a document called an "Explanation of Benefits." This statement explains how UMP processed your claim, including: procedure code(s) for services provided, date of service, patient name, billed charges, UMP allowed charge, percentage paid by UMP, amount paid by UMP, amount you need to pay, and any amount applied to your deductible. Keep your original Explanation of Benefits and always make a copy if it needs to be sent elsewhere. UMP claims are calculated based on the benefits in this *Certificate of Coverage*.

Important Information About Submitting Claims

You or your provider must submit claims within 12 months of the date you received health care services. UMP will not pay claims submitted by you or your provider more than 12 months after the date of service.

For additional instructions for services outside of the United States, see "Services Received Outside the U.S." on pages 4-5.

If you or a family member has other health care coverage, see "If You Have Other Medical Coverage" on pages 65-69 for information on how UMP coordinates benefits with other plans.

Who Gets the Money When Claims Are Paid?

If you see a network provider, UMP sends payment directly to the provider. In most cases, you shouldn't pay a network provider until after UMP has processed the claim and determined what you owe.

If you see a non-network provider, ask if he or she is going to submit the claim for you, or if you need to do it. Depending on the type of provider and your answers to questions on the claim form, payment may be sent to either you or the provider.

When UMP sends payment to the provider, UMP sends both you and the provider an Explanation of Benefits detailing how the claim was processed, how much UMP paid, and how much you are responsible for.

When UMP sends payment to you , a check will be attached to your Explanation of Benefits.

Submitting a Claim for Prescription Drugs

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

- Purchase drugs at a non-network pharmacy.
- Fail to show your I.D. card at a network pharmacy.
- Get a prescription from a mail-order or Internet pharmacy other than Express Scripts' mail-order pharmacy.

The prescription drug claim form is shown on pages 56-57. Claim forms are also available on the UMP Web site or by calling Express Scripts Member Services. The form lists what you need to send in along with it. Send the completed claim form, along with necessary items, to:

Express Scripts Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
Attn: Claims Dept

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

Foreign claims for prescription drugs must be translated into English with specific services, charges, drugs and dosage documented, and you must tell us the currency exchange rate. UMP does not pay for this documentation.

If you submit a prescription drug claim to UMP, UMP will pay for it at the non-network rate, including when you use a mail-order or Internet-based service (other than Express Scripts). This means that:

- UMP PPO pays based on the UMP allowed charge. If the billed charge was more than the UMP allowed charge, you will have to pay the difference, in addition to your enrollee coinsurance.
- If the claim you submit exceeds the quantity level limit allowed by UMP or the maximum days' supply, UMP will pay only for the amount of the drug up to the quantity level limit or maximum days' supply.
- If you submit a prescription drug claim and the prescription was ordered before it was eligible to be refilled, UMP will not pay for the prescription. (This is called a "refill too soon.")
- You must submit prescription drug claims within 12 months of purchase.

If you do not show your UMP I.D. card when purchasing a prescription at a UMP network retail pharmacy, you will have to pay the full cash price and submit a Prescription Drug Claim Form. In addition, the enrollee cost-share limit on Tier 1 and Tier 2 drugs does not apply to any claims that you submit using the Prescription Drug Claim Form.

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 UMP PPO coverage.

UMP 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 UMP when you are not, UMP will deny all claims.

Do not staple in this area.

Uniform Medical Plan
Your health. Your plan. Your choice.

Claim Form

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were received from a Uniform Medical Plan PPO (UMP PPO) or UMP Neighborhood network provider and either plan is primary (pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. This is the correct form to submit a claim for prescription eyeglasses or contact lenses.
7. Do not use this form for prescription drug or dental claims.

Questions? Uniform Medical Plan PPO enrollees: 1-800-762-6004; or 425-670-3000 (Seattle)
UMP Neighborhood enrollees: 1-888-380-2822; or 425-686-1218 (Seattle)

Section 1 Subscriber Information

A. Uniform Medical Plan Subscriber ID No. _____

B. Subscriber Name _____ (Last Name / First Name / M.I.) Birth Date _____/_____/_____ (Mo. / Day / Yr.)

C. Subscriber Home Address _____ (Street Address)

_____ (City / State / ZIP Code + 4 / Work Phone Number / Home Phone Number)

D. Has your address changed since your last claim? ❑ Yes ❑ No

Section 2 Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name _____ (Last Name / First Name / M.I.) Birth Date _____/_____/_____ (Mo. / Day / Yr.)

B. Relationship to subscriber

- ❑ Spouse
- ❑ Dependent child under age 20
- ❑ Dependent stepchild under age 20
- ❑ Qualified same-sex domestic partner
- ❑ Registered student dependent age 20-23
- ❑ Other Specify _____

C. Is patient employed? ❑ Yes, full-time ❑ Yes, part-time ❑ No

If yes: _____ (Name of Employer)

_____ (City / State / ZIP Code + 4 / Employer's Phone Number)

Section 3 Provider Information

Complete this section if the provider information is not included on the bill.

Provider Name	Provider Name
Specialty	Specialty
Address	Address
City / State / ZIP Code + 4	City / State / ZIP Code + 4
Tax I.D. Number (if known)	Tax I.D. Number (if known)

PLEASE COMPLETE REVERSE SIDE

Section 4 Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? ❑ Yes ❑ No

B. Is this claim due to any accident or injury? ❑ Yes ❑ No
If you answered no to both questions, go to Section 5.

C. Was illness or injury due to ❑ Auto accident ❑ Other Specify _____

D. Date accident occurred _____/_____/_____
Mo. Day Yr.

E. Was a police report filed? ❑ Yes ❑ No ***If yes, you must submit a copy of the police report with this claim.***

F. Explain where and how the illness or injury occurred _____

_____

G. Your auto or homeowner's insurance company _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

H. Insurance company of another party involved with this loss _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

I. Do you intend to seek repayment of medical expenses or work time lost for you or your dependent?
❑ Yes ❑ No ❑ Uncertain at this time

J. Will you file for any disability benefits? ❑ Yes ❑ No ❑ Uncertain at this time

K. Will you contact an attorney in this matter? ❑ Yes ❑ No ❑ Uncertain at this time

L. If yes _____
Name of Attorney Phone Number

Section 5 Other Coverage

A. Are patient's medical expenses covered by another employer's group health insurance, welfare, or government plan? ❑ Yes ❑ No
If yes, and the other plan is primary, attach a copy of the Explanation of Benefits from the other plan to expedite processing.

If yes, name of policyholder on other coverage _____
Name

_____
Street Address City State ZIP Code + 4

_____
Name of Plan Group Number

B. Is patient covered by Medicare? ❑ Yes ❑ No
If no, go to Section 6. If yes, please submit a copy of the Explanation of Medicare Benefits.

C. What type of Medicare coverage does patient have? ❑ Part A (Hospital) ❑ Part B (Physician)

If patient is under age 65:

D. Is Medicare coverage due to kidney disease? ❑ Yes ❑ No

E. Is Medicare coverage due to disability? ❑ Yes ❑ No

Section 6 Authorization to Pay

Have you paid for these charges? ❑ Yes ❑ No ***UMP pays network providers directly.***

I certify this information is correct and authorize its release as required for administration of this claim.
Please note that personal information you may be required to submit to the Uniform Medical Plan, including medical records, will be disclosed only according to guidelines in the UMP *Notice of Privacy Practices*, which is available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling customer service (see page 1).

_____ _____
Signature of Subscriber/Patient (Parent, if minor) Date

EXPRESS SCRIPTS
Charting the Future of Pharmacy

PRESCRIPTION DRUG CLAIM FORM

DIV WA5

Cardholder's Name (last, first, MI)	Date Of Birth	Gender M F	Cardholder ID Number

☐ Check if new address

Address Street_____

City/State_____ Zip Code_____ Daytime Telephone (___)_____

Employer	Insurance Carrier	Group Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor.

Cardholder's Signature **Date**

Patient Information (please list information for each patient submitting claims)

	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	How many prescriptions attached?
1					
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	How many prescriptions attached?
2					
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	How many prescriptions attached?
3					
Pharmacy Name and Address			Physician Name (name of prescribing Doctor) and DEA#:		

Is claim for Diabetic Supply? ☐ yes ☐no. If **Yes**, Patient's name_____

Type of supply (lancets, syringe, etc.)_____ Quantity_____ Days Supply_____

Does the patient reside in an assisted living facility? ☐ yes ☐no Is this claim for allergy serum? ☐ yes ☐no

Does the patient have primary prescription drug coverage through another insurance carrier? ☐yes ☐no

Did the patient submit this claim to the other carrier? ☐ yes ☐no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

➔ **IMPORTANT** ← **All prescription claims must have prescriptions receipts/labels which include:**

• Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price •Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

☒**Please tape receipts to separate piece of paper**

☒**Patient history print outs from the pharmacy are also acceptable but MUST be signed by the Pharmacist.**

☒**CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
(With the exception of diabetic supplies)

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)

1. Print Cardholder's name (last, first, middle initial)
2. Print Cardholder's date of birth
3. Circle the correct letter to indicate if Cardholder is male or female
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card)
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card)

IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED

Patient Information (Complete a section for <u>each</u> family member who is submitting prescriptions.)

1. Print Patient's name
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:
Prescription receipts/labels **<u>or</u>** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the following information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple or glue.

Reason for claim submission or special notes
This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-866-576-3862.

Please return this claim to:
Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
ATTN: Claims Department

What You Need to Know As a UMP PPO Enrollee

Your Rights and Responsibilities

To ensure UMP PPO offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must know your rights and responsibilities.

As a UMP PPO enrollee, you have the right to:

- Be treated with respect.
- Be informed by your providers or UMP about all appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How providers are reimbursed by UMP PPO.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - UMP and our network of providers.
  - Your covered expenses, exclusions, and maximums or limits.
- Keep your medical records and personal information confidential.
- Get a second opinion about your provider's care recommendations.
- Make decisions with your providers about your health care.
- Make recommendations about enrollee rights and responsibilities.
- Have a translator's assistance, if required, when calling UMP.
- Complain about or appeal UMP PPO services or decisions, or the care you receive.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums, limits, exclusions, deductibles, enrollee coinsurance, and copayments.
  - Clear information from your provider about illness or treatment before services and supplies are provided.
  - Courteous, prompt answers from UMP.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from UMP about any request to refund an overpayment.

As a UMP PPO enrollee, you have the responsibility to:

- Confirm your provider's network status before *every* visit.
- Enroll in Medicare Parts A and B as soon as you are entitled.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with UMP or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, or deductibles promptly.

- Refund promptly any overpayment made to you or for you.
- Report to UMP any outside sources of health care coverage or payment.
- Return your completed annual coordination of benefits questionnaire you receive from UMP in a timely manner to prevent delay in claims payment.
- Show the same respect to your providers and UMP as you expect from them.
- Understand your UMP PPO benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage*.
- Use UMP network providers when available to help ensure quality care at the lowest cost.

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. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 16-36).
- Benefit exclusions, reductions, and maximums or limits (see pages 39-42).
- Clear explanation of complaint and appeal procedures (see pages 61-64).
- Preventive health care benefits that are covered (see pages 28-33).
- Definition of terms (see pages 87-96).
- Process for preauthorization or review (pages 37-38).
- Policies regarding drug coverage and how drugs are added to or removed from the *UMP Preferred Drug List* (pages 47-48).

You can get the following information on the UMP Web site, or by calling UMP Customer Service:

- Directory of network providers, including both primary care providers and specialists.
- Preferred drug list.
- Claims history and deductible status through your personal medical account.
- Information on UMP PPO's care management programs.
- When UMP PPO may retrospectively deny coverage for preauthorized care.
- Notice of privacy practices (includes UMP policy for protecting the confidentiality of health information; see page 60.)
- Procedures to follow for consulting with providers.
- General reimbursement or payment arrangements between UMP PPO and network providers.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- How you can be involved in decisions about benefits.
- Accreditation information, including measures used to report UMP's performance such as consumer satisfaction survey results or Health Plan Employer Data and Information Set (HEDIS) measures.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage*.

You may call UMP Customer Service for an annual accounting of all payments made by UMP PPO that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage. UMP will provide a written summary of payments within 30 calendar days of your request. You may also get this information by starting your personal online medical account on the UMP Web site.

UMP does not prevent or discourage providers from telling you of the care you require, including various treatment options and whether the provider thinks that care is consistent with UMP PPO's coverage criteria. You may, at any time, get health care outside of UMP PPO coverage for any reason; however, you must pay for those services and supplies. In addition, UMP does not prevent or discourage you from talking about other health plans with your provider.

Confidentiality of Your Health Information

UMP follows our *Notice of Privacy Practices*, available online at **www.ump.hca.wa.gov** or by calling Customer Service at 1-800-762-6004. UMP will release enrollee health information only as described in that Notice or as required or permitted by law or court order.

Release of Information

The UMP or 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. UMP could deny coverage if you don't provide the information when requested.

Complaint and Appeal Procedures

What Is a Complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee about:

- Denial of coverage or payment for health care services or prescription drugs.
- Delays in service or conflicts with UMP or providers.
- UMP practices or actions unrelated to health care services or prescription drugs.

What Is an Appeal?

An appeal is an oral or written request sent by you or your authorized representative to UMP to reconsider a previous decision about:

- UMP's resolution of your complaint.
- Claims payment, processing, or reimbursement for health care services.
- UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

Filing a Complaint or First-Level Appeal

You can send a complaint or appeal **by telephone, mail, fax, or e-mail.** If you send a written complaint or appeal, UMP will send confirmation within five business days of receiving it. You will also receive notice of the action on your complaint or appeal within 30 calendar days. UMP will notify you if it needs more time to respond.

Express Scripts handles complaints or first-level appeals for prescription drugs. UMP handles all other complaints and appeals.

Complaints or First-Level Appeals About Prescription Drugs

For complaints or appeals about prescription drug coverage or service, call Express Scripts at 1-866-576-3862. Express Scripts can resolve many issues at this level.

If UMP PPO does not cover your prescription for one of the reasons listed below, your pharmacist or prescriber may call Express Scripts at 1-800-417-8164 to request a coverage review.

- Preauthorization (see page 48)
- Quantity Limit (see page 48)
- Refill Too Soon (see pages 49-50)
- Step Therapy (see pages 48-49)

You may be able to get a temporary supply while the review is in process. However, if UMP denies coverage, you will have to pay the full cost of any medication received outside UMP rules.

You also may file a first-level appeal for prescription drug coverage in writing to:

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
6625 West 78th Street
Mail Route BLO390
Bloomington, MN 55439

Fax: 1-877-852-4070

Express Scripts Member Services:
1-866-576-3862

Preauthorization Line (for Providers only):
1-800-417-8164

Complaints or First-Level Appeals Not Related to Prescription Drugs

If you have a complaint about or want to appeal issues other than prescription drugs, call 1-800-762-6004 or 425-670-3000 in the Seattle area from 8 a.m. to 6 p.m.

Monday through Friday (except holidays), or write UMP at:

Uniform Medical Plan
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 425-670-3197

You can send your complaint or appeal using secure email through your online medical account at **www.ump.hca.wa.gov**. Please include the documentation described under "Information To Provide With An Appeal," pages 62-63, to the extent you can. You also may e-mail complaints or appeals to UMP at **umpappeals@hca.wa.gov**, but be aware that this method is not secure. Health information and other private information should not be sent to that e-mail address.

Complaints Regarding Provider Conduct or Quality of Care

If you have a complaint or concern about the quality of care received from a health care provider (such as a complaint related to a provider's conduct or ability to practice medicine safely), please contact the Department of Health by e-mail at **hpqa.csc@doh.wa.gov** or 360-236-4700, or visit its Web site (**https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm**) for more information.

Appeals Related to Eligibility

You can also request an appeal for decisions related to eligibility. Those include decisions where UMP's benefit decision is based on your not being eligible for coverage or not having paid premiums. Those appeals are handled by the Public Employees Benefits Board. If your appeal involves those issues, call PEBB Benefit Services at 1-800-200-1004 or write to:

Health Care Authority
PEBB Appeals Manager
P.O. Box 42699
Olympia, WA 98504-2699

The Appeals Process

You may request an appeal yourself or your provider may request an appeal for you. If your request involves a decision to change, reduce, or terminate coverage for services already being provided, UMP is required to continue coverage for these services during your appeal. However, if UMP upholds the decision to change, reduce, or terminate coverage, you will be responsible for any payments made by UMP PPO during that period. If you request payment for denied claims or approval of services not yet initiated, UMP PPO does not have to cover these services while the appeal is under consideration.

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

You may send written comments, documents, and any other information to UMP when you request an appeal. You may also request copies of documents UMP has that are relevant to your appeal, which UMP will provide at no cost. Our review will consider the information you submit to us, and any other information that we did not consider in the earlier decision or appeal.

There can be up to three levels of appeals. UMP handles first- and second-level appeals; an independent review organization handles third-level appeals. UMP will include different reviewers at each level of review from those involved in the earlier decision. Reviewers conduct their own research into a case and do not assume the earlier decision was correct.

Information To Provide With An Appeal

UMP will handle your appeal 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 patient's full name.
- The UMP I.D. number (the one starting with a "W" on your I.D. 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).
- Your e-mail address, if you have one.
- *Release of Information* form (available on the UMP Web site or by calling Customer Service). This form allows UMP to request additional records from your provider or share information with someone else who is handling your appeal, if applicable.
- Relevant medical records from your provider, if applicable. In cases involving denial of coverage based on medical necessity or other clinical reasons, your provider should supply clinically relevant information such as a letter of medical necessity, medical records, etc. along with your appeal. Because of the time limits on deciding appeals, getting this information up front will help us take better-informed actions on your case.
- Copy of Explanation of Benefits sent by UMP, if applicable.

Time Limits For UMP to Decide Appeals

The time limits below apply to both first- and second-level appeals, based on when UMP receives the appeal.

- UMP will send written confirmation of your appeal to you within five business days of receiving it.
- UMP will decide on your appeal within 30 calendar days unless a shorter time limit applies as explained below. UMP will request written permission from you or your representative when we need an extension to the 30-day timeline, to get medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, UMP will decide within 14 days.
- When a delay could seriously jeopardize your life, health, or ability to regain maximum function, or if a physician who knows your condition tells UMP that delay would cause severe pain that could not be adequately managed without the care or treatment you are appealing, UMP will decide as soon as possible but always within 72 hours (see "Expedited Appeals" below).
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 calendar days. If UMP must decide sooner than 20 days, the shorter time limit applies.

Expedited Appeals

If UMP denies your coverage and your provider determines this would seriously affect your life, health, or ability to regain maximum function, ask your provider to request an expedited appeal. Your provider must submit all clinically relevant information to UMP by phone or fax at:

Phone: 206-521-2000
Fax: 206-521-2001

First-Level Appeals

You may request a first-level appeal orally or in writing, no more than 180 calendar days after you receive notice of the action leading to the appeal. Although you may request an appeal by phone or in person, putting your appeal in writing with all of the necessary information (see pages 62-63 for list) will speed up the process and help UMP make more informed decisions.

Due to privacy laws, UMP usually cannot share information on appeals or complaints with family members or other persons unless the patient is a minor, or UMP has received written authorization to release personal health information to the other person. If you would like someone else to handle your appeal, a *Release of Information* form may be downloaded from UMP's Web site, or requested from Customer Service. If you request information about claims or appeals for a spouse, domestic partner, or child over the age of 13, we must receive the patient's written authorization before we can release the information to you.

Claim processing disputes will be reviewed by an experienced claims examiner who did not process the original claim. Appeals about covering, authorizing, or providing health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical review nurse upholds UMP's denial of coverage, or decides not to authorize services because they are found experimental, investigational, or not medically necessary, the UMP medical director or associate medical director will review and decide on the appeal

Second-Level Appeals

If you disagree with the decision made at the first level, you may request a second-level appeal. Second-level appeals must be submitted within 180 calendar days of UMP's decision regarding the first-level appeal. Send any additional information you have to support your appeal with your request.

Send second-level appeals (***not related to prescription drug coverage***) to:

Uniform Medical Plan
Second-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 425-670-3197

E-mail: Secure e-mail via your online medical account at www.ump.hca.wa.gov

Send second-level ***prescription drug appeals*** to:

Uniform Medical Plan
Prescription Drug Appeal
P.O. Box 91118
Seattle, WA 98111-9218

Phone: 206-521-2000

Fax: 206-521-2001

E-mail: Secure e-mail via your online medical account at www.ump.hca.wa.gov

The UMP Appeals Committee will conduct the second-level review. This committee includes the UMP executive director, UMP medical director, and deputy program manager for compliance, or designees.

Third-Level Appeals: Independent Review

You may request an external or "independent" review in two situations:

- If you have appealed a decision to deny, modify, reduce, or terminate coverage of or payment for a health care service and UMP exceeds the timelines for response to your appeal without good cause and without reaching a decision.
- If UMP has met all timelines, but you are dissatisfied with the decision of your second-level appeal.

You must request an independent review within 180 days of the date of the letter responding to your second-level appeal.

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 UMP in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP will pay the IRO's charges.

To request an independent review, contact UMP at:

Uniform Medical Plan
Independent Review Process
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001
Phone: 206-521-2000

E-mail: Secure e-mail via your online medical account at www.ump.hca.wa.gov

If You Have Other Medical Coverage

UMP PPO coordinates benefits with any other group health coverage you have so your UMP PPO and other coverage combined will pay up to 100% of allowed charges (but not more than 100%) in a calendar year. **Note:** This means you may receive one or more checks for "coordination of benefits (COB) adjustments" during the year. You receive this benefit adjustment because UMP PPO did not need to pay benefits paid by your primary plan. Those saved UMP PPO benefit dollars are later used to reimburse you for cost-share expenses (such as deductibles or coinsurance) that you paid for services earlier in that calendar year.

UMP PPO coordinates benefits with these types of plans:

1. Group or blanket disability insurance policies, and 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) and coverage required or provided by any statute.

Benefits are not coordinated with any individual health coverage, only with group plans.

The group insurance plan that is "primary" will process the claim first for all covered expenses. The primary plan will pay its normal plan benefit. The other plan(s) that cover you will be considered secondary and may pay less than their normal benefit, since total payments combined cannot exceed 100% of the allowed charges.

For Medicare Retirees

For retirees enrolled in Medicare, UMP PPO is always secondary to Medicare for services covered by Medicare.

When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first. If you enroll in Medicare and are still an active employee, your Medicare coverage is secondary to UMP PPO; Medicare becomes primary when you retire.

If You Are Retired and Enrolled in Medicare

Make sure that your provider accepts "Medicare assignment." If a provider does not accept Medicare assignment, UMP PPO does not cover services normally covered by Medicare.

For Medicare Retirees

Retirees who are entitled to Medicare must enroll in Parts A and B.

If Medicare is your primary coverage, ask your providers if they accept Medicare assignment. If you see any provider who doesn't accept Medicare assignment (this is known as "opting out"), UMP will not pay toward the cost of your care and you'll have to pay the entire bill. Providers who don't accept Medicare assignment must give you a written notice to sign before accepting services. This is known as a "private contract" for care. UMP does not cover any services or supplies that are normally covered by Medicare and obtained through a "private contract" with a physician or practitioner.

Retirees enrolled in Medicare pay lower premiums because Medicare is the primary payer for most services. UMP assumes the primary payer role for services and supplies not covered by Medicare, such as routine vision care and certain preventive care services.

If you have Medicare as your primary coverage and receive services from a provider who

For Medicare Retirees

accepts Medicare assignment, the claim will be processed at the network benefit level. This applies throughout the U.S.; Beech Street discounts do not apply for out-of-state claims. UMP coordinates benefits for most services in full (up to the Medicare allowed charge) regardless of network affiliation, when you use providers who accept Medicare assignment.

It's still a good idea for Medicare retirees to select UMP network providers when receiving services in Washington State. For certain services (including inpatient hospitalization), UMP PPO covers more than Medicare does. For those services, you will receive the highest benefit when you see a UMP network provider in Washington.

Who Pays First?

When UMP coordinates benefits with plans other than Medicare, the following rules determine which plan is the primary payer. These rules apply in order, so the first rule below that applies to your situation will determine which plan is your primary coverage (subsequent rules ***do not*** apply):

The following plan will be your primary payer:

1. The other plan, if its contract or certificate of coverage says it does not coordinate benefits.
2. The plan that covers you as a subscriber, not a dependent.
3. The plan that covers you as an active employee pays before a plan that covers you as a retired employee.
4. The plan that has covered you as a subscriber the longest, if there are two plans and 1–3 in the list above do not determine who pays first.
5. The plan that covers you as an active employee if your other coverage is Medicare.

For a Spouse or Same-Sex Domestic Partner Covered by a UMP PPO Subscriber

- If the spouse or same-sex domestic partner has other group health coverage, the other group plan pays first.
- If the spouse or same-sex domestic partner is also covered by Medicare and the subscriber is an ***active employee***, UMP PPO pays first on the spouse's or same-sex domestic partner's claims.
- If the spouse or same-sex domestic partner is also covered by Medicare and the subscriber is a ***retiree***, Medicare pays first on the spouse's or same-sex domestic partner's claims.

For Dependent Children Covered By a UMP PPO Subscriber

- If a dependent child has coverage through his or her employment, the child's coverage pays before the parent's.
- UMP PPO will usually be primary over certain government programs that cover children.

Dependent children of married parents:

- The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August 21).
- There is an exception to this "birthday rule" for newborn children. Washington law says that the mother's health plan must cover the newborn for the first 21 days of life, so the mother's plan pays first for all covered charges for the first 21 days of life. After that date, standard coordination rules as stated here apply to covered charges.

Dependent children of legally separated or divorced parents:

- Court decrees may require a non-custodial parent to provide coverage in which the standard rules for coordination of benefits apply, or may require a non-custodial parent to assume full financial responsibility for health care costs or coverage, in which case the standard rules may not apply. These cases will follow the orders of the court.

- In the absence of a specific court decree the following order of payment applies:
  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.

Other Types of Plans

Group plans (including UMP PPO) are usually primary over certain federal government or military programs available to veterans, and certain federal retirees.

If UMP PPO is the primary payer, the UMP PPO payment will be your normal UMP PPO benefit.

When UMP PPO Is the Secondary Payer

When UMP PPO is secondary to another group health plan or Medicare, standard coordination of benefits applies.

For Medicare Retirees

Coordination of Benefits: Medicare and UMP PPO

Benefits are coordinated with Medicare in the same way as they are coordinated with other coverage.

When Medicare is primary, Medicare pays first and UMP PPO pays second. Here's how the reimbursement process for medical claims works under UMP PPO's coordination of benefits:

- Medicare pays a portion of the bill. Then Medicare sends an electronic copy of each claim to UMP to process your secondary benefit. You do not need to send a paper claim to UMP.
- UMP identifies the difference between the Medicare allowed amount and the Medicare payment (the "remaining amount").
- UMP determines what your normal UMP PPO benefit would be.

For Medicare Retirees

- UMP PPO pays the difference between the Medicare allowed amount and the amount Medicare paid (the "remaining amount") or the normal UMP PPO benefit amount, whichever is less.

Here's an example to illustrate how this process works, assuming you have paid your deductible, and you received care in Washington from a network provider or anywhere in the U.S. from a provider who accepts Medicare assignment.

Provider's charge	**$300**
Medicare Benefit Calculation	
Medicare allowed charge:	$100
Medicare pays:	$80 (80% of $100)
Remaining amount:	$20
UMP PPO Benefit Calculation	
UMP PPO allowed charge:	$100
UMP PPO normal benefit:	$90 (90% of $100)
UMP PPO pays:	$20
Enrollee Owes:	**$0**

In the example above, you owe nothing because the provider accepts Medicare assignment. This means the provider must write off the remaining amount of the bill that exceeds the Medicare allowed amount.

In some cases, UMP PPO will pay primary for retirees enrolled in Medicare when the service or supply is covered by UMP PPO but not by Medicare, such as routine vision care, or services outside the United States. Medicare-enrolled UMP PPO enrollees may still be required to pay coinsurance and deductible amounts when you have not fully paid your

Medicare deductibles, or when Medicare does not cover a service.

If a provider does not bill Medicare, UMP may not cover services. Medicare will not accept bills from you and UMP PPO will only process claims after Medicare has processed them. Ask your provider if he or she bills Medicare.

Coordination of Benefits: Another Primary Plan and UMP PPO

If you have primary coverage other than UMP PPO that covers prescription drugs, you can't use UMP's mail-order pharmacy. Use the pharmacy options available through your primary plan. After your primary plan has processed your prescription, you may submit a paper claim form to UMP for secondary payment.

When you fill prescriptions at a retail pharmacy, your pharmacist will bill your primary plan first. Again, after your primary plan has processed your prescription, you may submit a paper claim form to UMP for secondary payment.

Here's how it works:

- Your primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP PPO.
- UMP PPO reviews the primary plan's benefit calculation, and the primary plan payment.
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer.
- UMP PPO compares allowed charges and determines which is the highest allowed charge.
- UMP PPO pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP PPO benefit amount.

Please contact UMP Customer Service at 1-800-762-6004 or 425-670-3000 in the Seattle area for help with any questions when you are covered by more than one plan.

Here's an example to show the process on page 68. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible, and that the patient has not paid anything toward the deductible.

Provider's original billed charge	**$1,200**	
Primary Plan Benefit Calculation		
Primary plan's allowed charge:	$1,000	
Your deductible:	$500	
Primary plan pays:	$400	($1,000 allowed charge – $500 deductible = $500 balance x 80% = $400)
UMP PPO Benefit Calculation (if UMP were the primary payer)		
UMP's allowed charge:	$900	
Your medical deductible:	$200	
UMP PPO normal benefit:	$630	($900 allowed charge – $200 deductible = $700 balance x 90% = $630)
Actual Payment by UMP PPO (as secondary payer)		
Highest allowed charge:	$1,000	(primary plan)
Primary plan's payment:	$400	
UMP PPO pays:	**$600**	**UMP paid the balance of the highest allowed amount, but no more, after the primary plan paid $400.**

In the example above, you owe nothing if the provider is contracted as a network provider with either UMP or your other plan. A non-network provider can bill you for the difference between their billed charge ($1,200) and the higher of the two plans' allowed charges ($1,000).

Coordination of Benefits Questionnaire

Please call UMP Customer Service to tell us of changes involving other coverage. You may receive a Coordination of Benefits questionnaire from UMP. This gives UMP information about other health care coverage. If you don't complete the form and return it to UMP, UMP may delay paying your claims. Please complete and return the form quickly.

When Another Party Is Responsible for Injury or Illness

How UMP Handles Payment

If you get injured or sick because of something someone else did, or didn't do, UMP PPO covers benefits as it usually does. But if you get money back from someone else, you have to repay UMP for expenses we covered for you. Even if you don't choose to file a claim against the responsible party, UMP can do so and you must help us by giving us whatever information we need. You must not do anything to prevent UMP from recovering its money.

For example, if you are hurt in a car accident and need medical treatment, UMP will pay for covered services. But if it turns out that either you or the other driver has auto insurance that could pay for your medical expenses, UMP can legally pursue getting money back from either or both of those insurance companies. In such a case, the auto insurance company generally has the first responsibility for those costs, not UMP. UMP PPO pays so that you don't have to wait for auto insurance companies to settle legal questions, which can take some time.

Recovery of Expenses Initially Paid by UMP

If you file a lawsuit or other legal action against someone responsible for your injury or illness and get money back, UMP can ask for its share, up to the amount UMP paid on your behalf. You must give UMP information on any such action, including letting UMP know when you file a claim or lawsuit. You must also tell us about any proposed settlement with another party.

If you do file a lawsuit, you must include a claim for expenses UMP paid on your behalf, and allow UMP to participate in the lawsuit. As stated above, if you don't file to get money from the other party, UMP can still do so. You are required to help us in the process.

UMP uses a company that asks for information on your injury or illness and follows up on third-party settlements. You must complete and return any requested forms to help UMP pursue its share of any money. If you are concerned about privacy and have a question about whether someone asking you for information on UMP's behalf is legitimate, please call UMP Customer Service at 1-800-762-6004.

How Much Money Does UMP Get?

UMP recovers the amount it paid, up to the amount you recover.

If UMP itself sues the third party, then UMP should recover the whole amount it paid.

Legal Statement Regarding Subrogation

UMP's right of recovery shall be a prior lien against any proceeds you recover. UMP's rights shall not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," or any other such doctrine purporting to defeat UMP's recovery rights by allocating the proceeds exclusively to non-medical damages or by making UMP's right subject to your having been made whole.

You must not incur any expenses on behalf of UMP in pursuit of UMP's rights. No court costs or attorney's fees may be deducted from UMP's recovery unless UMP agrees in advance, in writing. UMP's recovery shall not be reduced by applying any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any similar doctrine or approach.

UMP shall recover the full amount of benefits it paid without regard to any claim or fault on the part of any beneficiary, whether under comparative negligence or otherwise.

Eligibility and Enrollment for Active Employees

Eligibility

(See "When Coverage Begins" on pages 74-75 to determine when coverage for eligible enrollees begins.)

Eligible Employees

Employees (referred to in this book as "employees," "subscribers" or, in some cases, "enrollees") of state government, higher education, participating K-12 school districts, educational service districts, and employer groups are eligible to apply for coverage by Public Employees Benefits Board (PEBB) plans in accordance with PEBB eligibility rules in Chapter 182-12 of the Washington Administrative Code (WAC). An employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating employer groups may follow either PEBB rules or rules determined by collective bargaining agreement, if approved by PEBB in accordance with Chapter 182-12 WAC.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. For example, a dependent child who is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one.

The following dependents are eligible:

1. The subscriber's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. Dependent children through age 19. The term "children" includes the subscriber's biological children, stepchildren, legally adopted children, 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 qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and additional legal dependents approved by the PEBB program are included. Dependent children beyond the age of 19 are eligible under the following conditions:
   a. Students ages 20 through 23 are eligible if they are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter/semester for which the student is registered begins, and ends the last day of the month in which the student stops attending or in which the quarter/semester ends.

      To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to PEBB Benefit Services for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. Misrepresentation or failure to notify the PEBB program of changes in status resulting in loss of eligibility, including changes in student status, may result in the subscriber being responsible for payment of services received. Dependent student coverage continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months

following graduation as long as the subscriber is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

Don't forget! Notify PEBB Benefit Services at 1-800-200-1004 as soon as possible of changes in student status. You may be required to pay for services received.

b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurs before age 20, or during the time they met the criteria for student coverage under PEBB rules. The subscriber must complete an application with proof that such disability occurred either (a) before the dependent became 20 years old or (b) during the time the dependent met the criteria for student coverage as described above. The subscriber must submit the application to PEBB Benefit Services for approval by UMP. The PEBB program will, on behalf of UMP, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber, (c) the subscriber who claimed the parent as a dependent continues enrollment in a PEBB plan, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.
4. Dependents of an active employee who were previously covered under a K-12 or employer group medical plan, and who are not otherwise eligible for PEBB coverage, may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 or employer group medical plan with no lapse in coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the PEBB program or UMP.

Medicare Entitlement

Retirees, permanently disabled employees, and eligible dependents must enroll in Medicare Parts A and B if entitled.

If an employee or the employee's spouse or dependent becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified same-sex domestic partners ages 65 and older, the PEBB-sponsored medical plan will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to re-enroll in a PEBB medical plan offered to active employees. However, the employee will remain enrolled in PEBB-sponsored dental, life, and long-term disability coverage.

In most situations, employees and their spouses or qualified same-sex domestic partners can elect to defer Medicare Part B enrollment without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer and the PEBB-sponsored medical plan becomes secondary.

Please contact PEBB Benefit Services for information about retiree eligibility and benefit information.

Enrollment

(See "When Coverage Begins" on pages 74-75 to determine when coverage for eligible enrollees begins.)

Employees and their eligible dependents may enroll in this plan within 31 days of the date the employee first becomes eligible to apply for PEBB coverage as described in the "Eligibility" section. Enrollment forms are furnished by the employee's payroll, personnel, or insurance office and should be returned to that office within 31 days of the date of eligibility.

Eligible dependents who are not enrolled when they are initially eligible may be enrolled in the subscriber's PEBB medical plan if they lose coverage under another medical plan. Dependents losing other medical coverage must be enrolled within 60 days after termination of the other coverage, and provide proof of continuous coverage to the PEBB program to establish enrollment eligibility.

Eligible employees and dependents may also enroll in PEBB coverage during any PEBB open enrollment period or if the employee acquires a new dependent as a result of marriage, qualified same-sex domestic partnership, birth, adoption, or placement for adoption. Eligible employees and dependents may enroll in these situations without proof of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Waiver of Coverage

Employees eligible for PEBB medical coverage have the option of waiving health plan coverage if they are covered by other health plan coverage. To waive coverage, the employee must complete an *Employee Enrollment/Change* form that identifies the individuals for whom coverage is being waived. If an employee waives coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive coverage for any or all dependents.

An employee may waive only the medical portion of health plan coverage. The employee must remain enrolled in the dental, life, and long-term disability insurance coverages. The appropriate form to waive health plan coverage must be received before the date coverage is to be waived.

If PEBB medical coverage is waived, an otherwise eligible person may enroll in a PEBB plan only during the next open enrollment period, or within 60 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less.

The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 60 days after the date of marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption.

Enrolling a Dependent Acquired After the Subscriber's Effective Date of Coverage

Subscribers may enroll dependents who become eligible after the subscriber's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify his or her personnel, payroll, or insurance office of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.
3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Subscribers should contact their personnel, payroll, or insurance office, or PEBB Benefit Services for an *Employee Enrollment/Change* form.

Disenrolling a Dependent

Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

Employees should contact their payroll, personnel, or insurance office for forms and information on how to update their records. A dependent may be deleted from coverage by submitting an *Employee Enrollment/Change* form to the employee's personnel, payroll, or insurance office.

Please refer to the "Options for Continuing PEBB Benefits" section for more information.

Enrollment changes should be made as soon as possible. If an event occurs that would change your premium or cause a loss of eligibility, you must report the event within 60 days. If you don't, you may not get back money paid toward premiums in error, and may lose your right to continued coverage.

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 payroll office as soon as possible.**
- **Retirees (and other self-pay enrollees) should contact PEBB Benefit Services at 1-800-200-1004.**

When Coverage Begins

Coverage will begin for employees and their dependents as follows:

For Employees

1. ***Permanent Employees, Career Seasonal Employees, and Instructional Year Employees:*** Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.
2. ***Nonpermanent Employees:*** Coverage for nonpermanent employees who work half-time or more for six consecutive months begins on the first day of the seventh calendar month following the date of employment.
3. ***Part-Time Faculty and Part-Time Academic Employees:*** Coverage for part-time faculty and part-time academic employees begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.
4. ***Appointed and Elected Officials, Judges:*** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

   Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government, and

judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

5. ***Employees of Participating Employer Groups:*** The effective date of coverage for eligible employees may be determined by the terms of employment or collective bargaining agreement if the terms relating to the effective date are approved by HCA. Participation of the bargaining unit or non-represented employees is subject to approval by HCA.

For Dependents

Coverage for eligible dependents begins on the day the subscriber's coverage begins if the subscriber lists the dependents on the enrollment form for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition or declaration. If the date of acquisition or declaration is the first day of a month, coverage will begin on the first day of the month of acquisition or declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the subscriber assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the PEBB program. If the condition of dependency is established and approved as of the first day of a month, coverage will begin on the date dependency is established.

Special Enrollment for Employees and Their Dependents Who Previously Waived Coverage

Coverage for eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll to enroll dependents.

1. Coverage for eligible employees and dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The enrollment form must be received by the employee's payroll, personnel, or insurance office within 60 days after termination of other medical coverage, and proof of other continuous comprehensive group medical coverage must be provided.
2. Coverage for eligible employees and dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.
3. Coverage for eligible employees and dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days of the birth or date of placement.

Changing Medical Plans

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 60 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan

available in his or her new locality, or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.

3. If a court order requires a subscriber to provide medical coverage for an eligible spouse or child, the subscriber may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the dependent's effective date of coverage, whichever is later.
4. If a subscriber retires for any reason, the subscriber may change plans at the time of application for retiree coverage. The change will become effective on the first day of the month following the retirement date.
5. Seasonal employees whose off-season occurs during open enrollment may change plans within 60 days of returning to work.
6. If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 60 days after notification by the PEBB program. Anyone who does not choose another medical plan within this time period will be enrolled in the medical carrier's successor plan if one is available, or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment.
7. If an enrollee incurs a claim that would meet or exceed the lifetime limit on all benefits.
8. If an enrollee exercises the special enrollment right to add newly acquired dependents due to marriage, a qualified same-sex domestic partnership, birth, adoption, or placement for adoption. The enrollment application must be submitted to the employee's personnel, payroll, or benefits office within 60 days after:
   - The marriage or qualification of same-sex domestic partnership; or
   - Birth, adoption, or placement for adoption of a child.
9. If the enrollee's physician stops participation with the enrollee's medical plan and the PEBB appeals manager determines that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

When you retire, be sure to enroll in PEBB retiree coverage within 60 days of your retirement date. Retirees may defer medical coverage if they have other employment that provides comprehensive medical coverage. If you do not enroll or formally defer PEBB coverage within 60 days of retirement, you will not be able to return to PEBB coverage later.

To change plans, subscribers must fill out an *Employee Enrollment/Change* form. Subscribers should contact their payroll, personnel, or insurance office for forms and information on how to update their records.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP PPO, the enrollee may not change health plans until the next PEBB open enrollment period, except as provided in WAC 182-08-198(2)(f). UMP PPO cannot guarantee that any one physician, hospital, or other provider will be available in UMP's network. Also, if an employee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change health plans, except as outlined above.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage) at midnight on the last day of

the month in which the employee or dependent is eligible.

3. Premium payments are not prorated if an enrollee dies or terminates coverage 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 coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- 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 and 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.
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

As a PEBB enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated at the end of the month for which the last full premium was received. If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

When your UMP coverage ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your UMP enrollment has ended and he or she bills UMP for services you receive, UMP will deny all claims.

Options for Continuing PEBB Benefits

Employees and their dependents covered by UMP PPO have options for continuing coverage during temporary or permanent loss of eligibility. There are four continuation of coverage options you may be eligible for as a PEBB enrollee:

- Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) coverage
- PEBB-sponsored retiree coverage

The first three options above temporarily extend health coverage in a PEBB plan if certain circumstances occur that would otherwise end your or your dependents' eligibility for PEBB medical or dental coverage. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is available only to individuals who meet eligibility criteria defined in Washington Administrative Code (WAC) 182-12-171, or surviving dependents who meet eligibility criteria defined in WAC 182-12-250 or 182-12-265.

All four options are administered by the PEBB program. Refer to your *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* for specific details, or call PEBB Benefit Services at 1-800-200-1004.

Employees also have the right to convert to individual medical coverage when their eligibility for PEBB group coverage ends. Dependents also have this option for continuing coverage. See "Conversion of Coverage" on page 78.

Family and Medical Leave Act of 1993

Employer contributions toward PEBB plan coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this

period to maintain eligibility. After that, coverage may be continued as explained in "Options for Continuing PEBB Benefits" above.

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to PEBB 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.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by HCA in writing, by mail addressed to the last address of record with HCA, that the employee may pay the fees as they become due as provided in this section.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group (including COBRA) coverage, and are not entitled to Medicare or other group coverage which provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group (including COBRA) coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements for our conversion plans differ from those of other UMP coverage. Enrollment in a conversion plan may limit your ability to later purchase individual coverage through carriers available in this state without going through health screening and a preexisting condition waiting period. To obtain detailed information on conversion plan options offered by UMP, call PEBB Benefit Services at 1-800-200-1004.

Eligibility and Enrollment for Retirees and Surviving Dependents

Eligibility

(See "When Coverage Begins" on page 84 to determine when coverage for eligible enrollees begins.)

Eligible Retirees

Retired or permanently disabled employees (referred to in this book as "retirees," "subscribers," or in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, and participating employer groups are eligible for coverage by PEBB plans on a self-pay basis in accordance with Washington Administrative Code (WAC) 182-12-171 and WAC 182-12-211. A retired or permanently disabled employee under WAC 182-12-171 or WAC 182-12-211 is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

To be eligible, the following conditions must be met:

1. a. Under the following state of Washington retirement systems, individuals must immediately begin receiving a monthly retirement allowance, or have taken a lump-sum payment because their monthly benefit would be less than the minimum amount established by the Department of Retirement Systems:
    i. Public Employees Retirement System (PERS) 1, 2, or 3 (with the exception noted below in section 1.b.i.).
    ii. Public Safety Employees Retirement System (PSERS).
    iii. Teachers Retirement System (TRS) 1, 2, or 3 (with the exception noted below in section 1.b.i.).
    iv. School Employees Retirement System (SERS) 2 or 3 (with the exception noted below in section 1.b.i).
    v. Higher Education Retirement Plan (e.g., TIAA-CREF) (with the exception noted below in section 1.b.ii.).
    vi. Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2.
    vii. State Judges/Judicial Retirement System.
    viii. Washington State Patrol Retirement System (WSPRS) 1 or 2.
   b. Individuals in the following state of Washington retirement systems are not required to begin receiving a monthly retirement allowance, but may instead meet these conditions:
    i. Public Employees Retirement System (PERS) 3, Teachers Retirement System (TRS) 3, and School Employees Retirement System (SERS) 3 not receiving a monthly retirement allowance (defined benefit), must be at least age 55 with at least 10 years of service credit at the time of separation.
    ii. Higher Education Retirement Plan (e.g., TIAA-CREF), must be at least age 55 with at least 10 years of service, or at least age 62.
   c. Employees who are approved a disability retirement must apply for coverage within 60 days after the date of the approval notice from the Department of Retirement Systems or their higher-education retirement system.
   d. Appointed and elected officials of the legislative and executive branches of state government who leave public office may continue their PEBB medical coverage on a self-pay basis whether or not they receive a

retirement benefit from a state retirement system, provided they apply no later than 60 days after the end of their term.

2. All eligible retirees must submit an election form to enroll or defer medical coverage **no later than 60 days** after their employer-paid or continuous COBRA coverage ends.
3. **Retirees and their covered dependents who are entitled to enroll in Medicare must enroll in Medicare Parts A and B.** A copy of their Medicare card must be provided to the PEBB program as proof of enrollment. Enrollees not entitled to either Medicare Part A or B must provide PEBB Benefit Services with a copy of the appropriate documentation from the Social Security Administration.

Eligible Surviving Dependents

Eligible widows, widowers, and surviving dependent children (referred to in this book as "surviving dependents," "subscribers," or in some cases, "enrollees") who meet eligibility criteria in Washington Administrative Code (WAC) may enroll in or defer PEBB retiree coverage. Surviving dependents will lose their right to enroll in PEBB coverage if they do not apply to enroll in or defer coverage within the timelines stated in WAC or do not maintain continuous comprehensive employer-sponsored medical coverage during the deferral period.

- Eligibility criteria for surviving dependents of an eligible employee are outlined in WAC 182-12-265.
- Eligibility criteria for surviving dependents of an eligible PEBB retiree are outlined in WAC 182-12-265.
- Eligibility criteria for surviving dependents of emergency service personnel who are killed in the line of duty are outlined in WAC 182-12-250.

Deferring PEBB Retiree Coverage

If the eligible retiree or surviving dependent elects not to enroll in PEBB retiree coverage within the timelines stated in WAC, or cancels his or her PEBB retiree coverage, the enrollee is not eligible for PEBB coverage unless he or she defers PEBB retiree coverage as outlined below.

For retirees: Beginning January 1, 2001, a retiree may defer enrollment in PEBB medical coverage pursuant to WAC 182-12-205 if the following conditions are met. The retiree must be continually covered under another comprehensive, employer-sponsored medical plan as an employee or the spouse or qualified same-sex domestic partner of an employee, or as a retiree or the spouse or same-sex domestic partner in a federal retiree plan. Coverage for the retiree's dependents will automatically be waived if the retiree defers coverage pursuant to WAC 182-12-205.

Pursuant to WAC 182-12-200, a retiree whose spouse is enrolled as an eligible employee in a PEBB or Washington State K-12 school district-sponsored health plan may defer enrollment in PEBB retiree medical plans and enroll in the spouse's PEBB or school district-sponsored health plan. Coverage for the retiree's dependents will automatically be waived if the retiree defers coverage pursuant to WAC 182-12-200.

Retirees may defer enrollment in PEBB medical coverage while they are continually covered under a Medicaid program that provides creditable coverage. Coverage for the retiree's dependents will automatically be waived, unless the dependents are not eligible for Medicaid coverage.

For surviving dependents: Surviving dependents may defer enrollment in PEBB retiree coverage pursuant to WAC 182-12-250 and WAC 182-12-265 while enrolled in comprehensive medical coverage through an employer. Surviving dependents may also defer enrollment in PEBB coverage if they are covered under a Medicaid program that provides creditable coverage.

To defer medical and dental coverage, the retiree or surviving dependent must submit a PEBB election form to PEBB Benefit Services indicating his or her desire to defer coverage. If a retiree or surviving dependent defers enrollment in PEBB retiree medical, he or she must also defer enrollment for PEBB dental.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below (except that surviving dependents of emergency service personnel may not add newly acquired dependents). A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. The following dependents are eligible:

1. The retiree's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. The retiree's dependent children through age 19. The term "children" includes the retiree's biological children, stepchildren, legally adopted children, children for whom the retiree has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the retiree's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the retiree under the Internal Revenue Code and additional legal dependents approved by the PEBB program are included. Dependent children who are registered students or who are developmentally or physically disabled are eligible beyond the age of 19 under the following conditions:
   a. Students ages 20 through 23 are eligible if they are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter or semester for which the dependent is registered begins and ends the last day of the month in which the student stops attending or in which the quarter or semester ends.

      To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to PEBB Benefit Services for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. Misrepresentation or failure to notify PEBB of changes in status resulting in loss of eligibility, including changes in student status, may result in the subscriber being responsible for payment of services received. Coverage of dependent students continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the retiree is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.
   b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred prior to age 20, or during the time they met the criteria for student coverage under PEBB rules. The subscriber must complete an application with proof that such disability occurred either (a) before the dependent became 20 years old; or (b) during the time the dependent met the criteria for student coverage as described above. The subscriber must submit the application to PEBB Benefit Services for approval by UMP. The PEBB program will, on behalf of UMP PPO, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.
3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible retiree, (c) the retiree who claimed the parent as a dependent continues

enrollment in a PEBB plan, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible retiree; however, dependent parents may not add additional family members to their coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the PEBB program or UMP PPO.

Notify PEBB Benefit Services at 1-800-200-1004 as soon as possible of changes in student status. You may be required to pay for services received.

Medicare Entitlement

Medicare Part A and Medicare Part B

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about Medicare enrollment. Unless you retired before July 1, 1991, or are a dependent of an active PEBB member, you must enroll in Medicare Parts A and B to continue PEBB retiree coverage. In most cases, Medicare will be your primary coverage, and UMP PPO becomes the secondary 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 UMP and Medicare Part D. If you drop your UMP PPO coverage and sign up for Medicare Part D, you will need to select a Medicare supplement plan offered through PEBB. If you do not sign up with a PEBB Medicare supplement plan, you won't be able to come back to a PEBB plan in the future.

Medicare Part D

PEBB has determined that UMP PPO has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, you **cannot** enroll in Medicare Part D and remain in UMP PPO. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in one of the PEBB-sponsored Medicare supplement plans, Plan E or Plan J.

For Medicare Retirees

PEBB sends out a "certificate of creditable prescription drug coverage" each year. If sometime in the future you or your covered family member(s) decide to drop your UMP PPO coverage, you will need to show this as proof that you had "creditable coverage" if you apply for Part D. If you do not show that you had creditable coverage, you may have to pay higher Medicare premiums.

Customer Service

If you have questions about your PEBB retiree eligibility and benefit information, please contact Benefits Services at 1-800-200-1004 or online at **www.pebb.hca.wa.gov**. For questions about Medicare, please contact the Center for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or online at **www.medicare.gov**.

Enrollment

Eligible retirees must submit an election form to enroll in or defer PEBB coverage within 60 days from the date that their employment or continuous COBRA coverage ends.

Retirees or surviving dependents who defer PEBB medical coverage while enrolled in other comprehensive, employer-sponsored coverage may enroll in UMP PPO within 60 days of the date other employer-sponsored coverage ends or during a PEBB open enrollment period. Proof of continuous enrollment in comprehensive, employer-sponsored coverage is required with the election form. Contact PEBB Benefit Services for information on the premiums and coverage available.

Retirees or surviving dependents who defer PEBB medical and dental coverage while enrolled as a retiree or dependent in a federal retiree plan will have a one-time opportunity to re-enroll in PEBB medical and dental coverage. To re-enroll in PEBB medical and dental coverage, retirees or their surviving dependents must submit a *PEBB-Sponsored Retiree Coverage Election Form* and proof of continuous enrollment in a federal retiree

medical plan to PEBB Benefit Services either (a) during any PEBB open enrollment period; or (b) within 60 days after the date their other coverage ends.

Retirees or surviving dependents who defer enrollment in PEBB medical coverage while they are continually covered under a Medicaid program that provides creditable coverage may enroll in this plan if they lose their Medicaid coverage. To re-enroll in PEBB medical and dental coverage, they must submit a *PEBB-Sponsored Retiree Coverage Election Form* and proof of continuous enrollment in Medicaid coverage to PEBB Benefit Services either (a) during any PEBB open enrollment period; or (b) within 60 days after the date their Medicaid coverage ends.

Enrolling a Dependent Acquired After the Retiree's Effective Date of Coverage

Eligible subscribers may enroll dependents who become eligible after their effective date (except that surviving dependents of emergency service personnel may not add newly acquired dependents). Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify PEBB Benefit Services of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Contact PEBB Benefit Services for an election form.

Special Enrollment Period for Dependents

Coverage for eligible dependents whose medical coverage was previously waived will be effective as described below.

1. Eligible dependents who were waived **while the retiree or surviving dependent maintained enrollment in a PEBB medical plan** may be enrolled during any PEBB open enrollment period, or within 60 days of loss of other medical coverage. Outside of enrollment during a designated open enrollment, proof of other medical coverage is required to demonstrate that: 1) coverage was continuous; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less. Coverage for eligible dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The election form must be received by PEBB Benefit Services within 60 days after termination of other medical coverage. Coverage for eligible dependents enrolling during a PEBB open enrollment period will begin January 1 of the following year.

2. Marriage or qualified same-sex domestic partnership: Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by PEBB Benefit Services within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.

3. Birth or adoption: Coverage for eligible dependents enrolling following a birth or

placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by PEBB Benefit Services within 60 days of the birth or date of placement.

Disenrolling a Dependent

Subscribers should contact PEBB Benefit Services to update their records. To remove a dependent, you must submit a *PEBB-Sponsored Retiree Coverage Election Form* to PEBB Benefit Services. Failure to notify PEBB of changes in status resulting in loss of eligibility may result in termination of coverage and the subscriber being responsible for payment of services received. Please refer to the "Options for Continuing Benefits" section for more information.

Enrollment changes must be submitted to PEBB Benefit Services within 60 days after the event that created the change.

Medicare Retirees

Retirees should notify PEBB Benefit Services at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP PPO benefits and helps us serve you better.

When Coverage Begins

Coverage for eligible retirees begins on the day following loss of other coverage provided application for retiree coverage is made in accordance with PEBB rules. Coverage for eligible surviving dependents begins as outlined in WAC.

Coverage for eligible dependents begins on the day the retiree's or surviving dependent's coverage begins if the retiree or surviving dependent lists the dependents on the enrollment form for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition/declaration. If the date of acquisition/declaration is the first day of a month, coverage will begin on the first day of the month of acquisition/declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the PEBB program. If the condition of dependency is established and approved on the first day of a month, coverage will begin on the date dependency is established.

Changing Medical Plans

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 60 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality; or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a retiree to provide medical coverage for an eligible spouse or child, the retiree may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the dependent's effective date of coverage, whichever is later.
4. If a retiree or surviving dependent becomes entitled to Medicare Part A and Part B, they may enroll in a medical plan that is newly available to them within sixty days of their enrollment in Medicare Part A and Part B.

5. If an enrollee is covered under Medicare Part A and Medicare Part B, and during a Medicare-approved enrollment period elects to enroll in Medicare Part D, the enrollee must make a plan change and select either Medicare Supplement Plan E or Plan J.
6. If a medical plan becomes unavailable, the retiree or surviving dependent may choose another medical plan within 60 days after notification by the PEBB program. Anyone that does not choose another medical plan within this time period will be enrolled in the medical carrier's successor plan if one is available or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment.
7. If an enrollee incurs a claim that would meet or exceed a lifetime limit on all benefits.
8. If the enrollee exercises the special enrollment right to add newly acquired dependents due to marriage, qualification of a same-sex domestic partnership, birth, adoption, or placement for adoption. The enrollment application must be submitted to PEBB Benefit Services within 60 days after:
   - The marriage or qualification of same-sex domestic partnership.
   - Birth, adoption, or placement for adoption of a child.
9. The enrollee's physician stops participation with the enrollee's medical plan and it is determined by the PEBB appeals manager that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

To change plans, the subscriber must fill out a *PEBB-Sponsored Retiree Coverage Election Form*. Enrollees should contact PEBB Benefit Services to update their records.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP PPO, the enrollee may not change health plans until the next open enrollment period, except as provided in WAC 182-08-198(2)(f). UMP PPO cannot guarantee that any one physician, hospital, or other provider will be available or remain offered under the plan.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. If the retiree or surviving dependent stops paying monthly premiums, coverage ends for the retiree and dependents on the last day of the month for which the last **full premium** was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or terminates prior to the end of a month.
3. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20, or a spouse when a final decree of divorce is entered).

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- 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 and 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.
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums and reporting of changes in eligibility or address.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated the end of the month in which the last full premium was received. If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

The enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes within 60 days after the event, such as divorce, death, or when no longer a dependent as defined in WAC 182-12-260.

If an event occurs that would change your premium or cause a loss of eligibility, you must report the event within 60 days. If you don't, you or your dependents may not get back money paid toward premiums in error, and may lose your right to continued coverage under the federal COBRA law or PEBB rules. For help, call PEBB Benefit Services at 1-800-200-1004.

Options for Continuing PEBB Benefits

Some enrollees and their dependents covered by this plan who lose eligibility have options for continuing coverage: (1) PEBB rules allow for continued retiree coverage of dependents of a deceased subscriber, (2) the federal COBRA law gives enrollees the right to continue group coverage for a period of 18 to 36 months. Refer to the *Summary Plan Description of Continuation of Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

Retirees and their dependents also have the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of retirees also have options for continuing coverage for themselves following loss of eligibility.

Retirees and permanently disabled employees of employer groups whose participation in a PEBB plan ends may be eligible to continue PEBB coverage. Refer to the *Summary Plan Description of Continuation of Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Benefit Services at 1-800-200-1004.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage (including COBRA) to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group coverage, and are not entitled to Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group coverage (including COBRA) ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of our conversion plans differ from those of other UMP coverage. Enrollment in a conversion plan may limit your ability to later purchase an individual plan without going through health screening and a preexisting condition waiting period. To obtain detailed information on conversion options offered by UMP, call PEBB Benefit Services at 1-800-200-1004.

Definitions

Allowed Charge(s)

The maximum amount UMP PPO pays for a specific covered service or supply. See the table below for how UMP determines the allowed charge for specific services and provider types.

UMP reserves the right to determine the amount payable for any service or supply.

Type of Provider/Service	Network Status	Location of Provider	Allowed Charge
Professional services, durable medical equipment, supplies, and prostheses	UMP network provider	***Inside*** Washington State	Lesser of billed charge or UMP contracted fee schedule amount
	Non-network provider	***Inside*** Washington State and the border counties of Oregon	Lesser of billed charge or the UMP fee schedule amount*
	Non-network provider	***Outside*** Washington State and the border counties of Oregon	Lesser of billed charge or a regionally adjusted charge (see page 95)*
Hospitals and other facilities	UMP network hospital/ facility	***Inside and outside*** Washington State	As contracted between the provider and UMP
	Non-network hospital/ facility	***Inside*** Washington State	Based on allowed charges for network facilities
		Outside Washington State	Percentage of billed charges, or rates negotiated with the facility
Prescription drugs**	All prescription drug providers	Everywhere, including outside the U.S.	Express Scripts' standard reimbursement, unless other contractual arrangements or terms apply

**This includes cases in which the provider is paid at the out-of-area rate.*

***When medications not normally self-administered are received in a provider's office, the UMP fee schedule amount is based on a percentage of the Average Wholesale Price (AWP) or a percentage of the Average Sales Price (ASP) determined by the Centers for Medicare & Medicaid Services.*

Note: The UMP fee schedule identifies certain services and procedures that are reimbursed on a case-specific (by report) basis. The allowed charge for those services or procedures may be based on UMP's fee schedule amounts for comparable services or procedures, billed charges (or percentage of billed charges), Medicare's fee schedules, rates negotiated by case managers, or other method(s) at UMP's discretion.

Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by an accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations), that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are certain biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

Ancillary Charge

The amount that you pay above the standard copay or coinsurance for a multi-source Tier 3 drug is called the "ancillary charge"; see page 46 for more information.

Annual Medical Deductible

A dollar amount you must pay each calendar year before UMP PPO pays medical benefits. Except for services specifically exempted in the "Summary of Benefits," the first $200 per individual in allowed charges for medical services (or $600 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual medical deductible and are your responsibility.

Annual Medical Out-of-Pocket Limit

The annual medical out-of-pocket limit is the maximum total amount of enrollee coinsurance and copayments that you may have to pay for medical services during a calendar year. The limit is $1,500 per person or $3,000 per family (all family members combined under one subscriber's account). Once you have reached that limit, claims for covered medical services from network providers are paid at 100% of allowed charges for the rest of the calendar year.

Regardless of whether you have met your medical out-of-pocket limit, you still pay coinsurance of 40% of allowed charges when you see non-network providers. The only exceptions are out-of-area claims for covered medical services, which are paid at 100% of allowed charges for the rest of the calendar year after you have reached your annual medical out-of-pocket limit.

Whenever you see any non-network provider, you will still be responsible for paying any billed amounts that exceed the UMP allowed charge, even if the provider was paid at the out-of-area rate.

The following services and charges do not count towards your or your family's annual medical out-of-pocket limit:

- Annual medical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review or preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance or copayments for retail and our mail-order prescription drugs.
- Enrollee coinsurance or copayments for services from non-network providers (unless your claim is processed as "out-of-area").

For more information on how this works, see page 8 under "What You Pay For Medical Services."

Annual Prescription Drug Deductible

A dollar amount you must pay each calendar year for prescription drugs before UMP PPO pays prescription drug benefits. The first $100 per individual in allowed charges for prescription drugs (or $300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility. For more information on how this works, see page 45 under "What You Pay For Prescription Drugs."

Appeal

See pages 61-64 for an explanation of appeals and how the process works.

Approved Provider Types (or Approved Provider)

See list on pages 5-6. A category of health care provider approved to deliver services under UMP PPO. Being an "approved" provider type does not mean the provider is a network provider; an approved provider

may be a network or non-network provider. Some approved provider types, such as massage therapists, must be network providers to be covered by UMP PPO.

Brand-Name Drug

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

January 1 through December 31.

Chemical Dependency

An illness characterized by a physiological or psychological dependency on a controlled substance or on alcohol.

Coinsurance

The percentage of allowed charges that UMP PPO pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percentage you pay or "enrollee cost-share").

Coordination of Benefits

For enrollees covered by more than one health plan, the method UMP uses to determine which plan pays first, which pays second, and the amount paid by each plan. Please see description and examples in "If You Have Other Medical Coverage" on pages 65-69.

Copayment

A flat dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization, emergency room care, or a prescription filled through our mail-order pharmacy.

Custodial Care

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. UMP PPO reserves the right to determine which services are custodial care.

Deductible

See definitions of "Annual Medical Deductible" (page 88) and "Annual Prescription Drug Deductible" (page 88). For a description of how these work, see pages 7 and 45.

Dependent

A spouse, qualified same-sex domestic partner, child, or other family member of a UMP PPO subscriber (see "Eligible Dependents" on pages 71 and 81).

Developmental Delay

Developmental delay is when an individual is significantly behind schedule in the appearance of normal developmental milestones achieved during infancy and early childhood. The cause may be present at time of birth or acquired after birth from a disease or disorder of the body, a disorder of the mind or emotions, or harmful effects of the surrounding environment. Only a qualified physician can diagnose a developmental delay.

Domestic Partner

A qualified same-sex domestic partner who meets the requirements described on the *Declaration of Marriage or Same-Sex Domestic Partnership* form available from PEBB or your agency's personnel, payroll, or insurance office.

Durable Medical Equipment

Equipment that is:

- Designed for prolonged use.
- For a specific therapeutic purpose in treating your illness or injury.
- Medically necessary.
- Prescribed by the attending approved provider.
- Primarily and customarily used only for a medical purpose.

Emergency

See "Medical Emergency."

Endorsing Prescriber

A provider who has "endorsed" the Washington Preferred Drug List. He or she has agreed to allow "therapeutic interchange" (see page 96) of a preferred drug for a nonpreferred one in the same drug class.

Enrollee

An employee, retiree, former employee, or dependent enrolled in UMP PPO.

Enrollee Coinsurance

The percentage you are required to pay the provider on claims for which UMP PPO pays less than 100% of allowed charges. This includes prescription drugs purchased from a retail pharmacy.

Experimental or Investigational

A service or supply is experimental or investigational if any one or more of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted.
- Is the subject of a current new drug or new device application on file with the FDA.
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy.
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives.
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy.
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy.
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting.

In determining whether a service or supply is experimental or investigational, UMP relies exclusively on the following sources of information:

- The enrollee's medical records.
- Written protocol(s) or other document(s) under which the service is provided.
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service.
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service is provided, and other information concerning the authority or actions of the IRB or similar body.
- Up-to-date, published peer-reviewed medical literature (as defined on page 94) regarding the service, as applied to the enrollee's illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the U.S. Food and Drug Administration (FDA), Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
- Information that your provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.
- Expert opinion, at UMP's discretion.

Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to notify you of claim payment or denial.

Family

All eligible family members (subscriber and dependents) enrolled in a single account.

Fee Schedule

UMP's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP PPO enrollees. See "Allowed Charge(s)" on page 87 for more details.

Formulary

See "Preferred Drug List" on pages 94-95.

Generic Drug

A drug with the same active ingredient, but not necessarily the same inactive ingredients, as a brand-name drug that is no longer protected by a commercial patent.

Generic Equivalent

A drug that has the same active ingredients as its brand-name counterpart, and has been approved by the FDA as being interchangeable with that brand-name drug as approved by your provider.

Health Care Authority (HCA)

The Washington State agency that administers the following health care programs: Basic Health, Community Health Services, Prescription Drug Program, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan PPO as a medical plan option for PEBB enrollees.

Home Health Agency

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or a UMP PPO network provider.

Hospice

Pain relief care and support services that address the physical, emotional, social, and economic needs of terminally ill patients and their families without intent to cure. Services may be provided in the home or in a hospice facility, and must be provided through a state-licensed hospice program.

Hospital

An institution accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations and licensed by the state where it's located. Any exception to this must be approved by UMP.

The term hospital ***does not*** include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care.
- Is operated as a school.
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Limited Benefit

A benefit that is limited to a certain number of visits or a maximum dollar amount. For benefits limited to a certain number of visits, any visits that are applied to your annual medical deductible (see page 7) also count against your annual limit. In addition, visits that are paid by another health plan that is primary apply to your UMP PPO limit. For example, if your first 6 massage therapy sessions are applied to the deductible, you are entitled to a maximum of 10 more sessions for the rest of that calendar year, for a total of 16 visits (the maximum for massage therapy).

Maintenance Therapy

Medical services designed to preserve or retain a current level of activity or health. UMP reserves the right to determine which services constitute maintenance therapy.

Medical

As used in this document, benefits and services other than prescription drug benefits.

Medical Emergency

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention.
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

UMP reserves the right to determine whether the symptoms indicate a medical emergency.

Medically Necessary Services, Supplies, or Interventions

UMP provides coverage for services, supplies, or interventions that are:

- Included as a covered service as described in the "Benefits: What UMP PPO Covers" section.
- Not excluded (see pages 39-42).
- Medically necessary.

Except as provided under "Chemical Dependency Treatment" on page 17, or as decided by the statewide health technology clinical committee described on page 16, a service is "medically necessary" if your treating provider recommends it ***and*** all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a medical condition.
2. It is the appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient.
3. The level of service, supply, or intervention is known to be effective in improving health outcomes.
4. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. "Effective" means that the 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.

A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., 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," a health intervention is not considered separately from the medical condition and patient indications for which it is being applied.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." UMP may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity"; however, UMP is not required to do so.

"Treating provider" means a 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.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

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.

New 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.

For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving

priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet UMP'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, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for the patients with this condition. The application of this criterion to an individual case will be based on the characteristics of the individual patient. Cost-effective does not necessarily mean lowest price.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Preventive services not covered by the UMP PPO preventive care benefit will still be covered under the medical benefit if medically necessary.

UMP may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP PPO benefits will be provided if that proof isn't received or isn't acceptable—or if UMP determines the service or supply is not medically necessary.

Multi-Source Drug

A prescription drug that has one or more generic equivalents.

Network Provider(s)

Health care providers who have contracted with UMP (or are part of a group or provider network that has contracted with UMP, such as the Beech Street and Axia WholeHealth networks) to provide services to UMP enrollees at a reduced rate. When you use network providers, you cannot be billed for the difference between the provider's billed charge and the UMP allowed charge in most situations.

- For services received in Washington and Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, UMP contracts directly with network providers (except for naturopathic physicians, acupuncturists, and massage therapists who contract through Axia WholeHealth Networks).
- For services elsewhere in the U.S., UMP PPO enrollees have access to network providers through the Beech Street Network. **Exception:** Retirees with Medicare coverage do not have access to Beech Street Network discounts. If Medicare is your primary coverage, and you see a provider who accepts Medicare, UMP will reimburse the provider at the network rate, regardless of network affiliation.

Non-Network Provider(s)

Health care providers who practice within the service area of a network provider but are not contracted with UMP PPO or another UMP-contracted network (Axia WholeHealth Networks or Beech Street). See pages 2-3 for more information on how UMP PPO pays non-network providers.

Nonpreferred Drug

A prescription drug designated nonpreferred in the *UMP Preferred Drug List* (see pages 47-48) and covered under Tier 3.

Normal Benefit

The dollar amount of the benefit UMP PPO would normally pay if no other health plan had the primary responsibility to pay the claim.

Open Enrollment Period

A period defined by the HCA when you have the opportunity to change to another health plan offered by PEBB for an effective date beginning January 1 of the following year.

Out-of-Area Services

Health care services by providers located outside of the U.S. or in geographic areas where there is no access to a network provider, as determined by UMP.

Where there is no access to a network provider, UMP may pay a non-network provider at the "out-of-area" rate (80% of allowed charges, after your annual

deductible). Non-network providers, even when paid by UMP at the out-of-area rate, can bill you for charges that are more than UMP's allowed charge.

In the following cases, UMP may pay a non-network provider as out-of-area:

For primary care services	For specialist services
Urban: If network provider is not available within 30 miles* of the center point of the ZIP Code of the enrollee's residence.	**Urban and Rural:** If a network provider is not available within 50 miles* of the center point of the ZIP Code of the enrollee's residence.
Rural: If a network provider is not available within 50 miles* of the center point of the ZIP Code of the enrollee's residence.	

** Mileage refers to direct mileage as measured on a map with a ruler, **not** road mileage.*

Out-of-Pocket Limit

See definition of "Annual Medical Out-of-Pocket Limit" on page 88. For more information on how this works, see page 8 under "What You Pay For Medical Services."

Over-the-Counter Drugs

Medications that can be obtained without a prescription.

Over-the-Counter Equivalent

An over-the-counter drug that has identical active ingredients and strengths as a prescription drug or product in a comparable dosage form

Partial Hospitalization

Ambulatory services provided in a hospital setting which permit the patient to return to his or her residence at night.

PEBB Plan

One of several health insurance plans, including the state's own self-funded preferred provider plan, UMP PPO, offered through the Public Employees Benefits Board (PEBB) program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive benefits package.

Peer-Reviewed Medical Literature

Scientific studies printed in journals or other publications where 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 Web sites or in-house publications of pharmaceutical manufacturers.

Plan-Designated Facility

A facility, such as a hospital, that UMP designates for the performance of a particular service(s) for an enrollee. Some services are covered only if the designated facility is used. Such a designation will be made by UMP Medical Review, Case Manager, or the UMP Medical Director.

Preauthorization

Approval by UMP PPO for certain services and drugs before they are provided to the enrollee. Preauthorization is not a guarantee of coverage. If you don't receive preauthorization for certain medical services or drugs, UMP could deny the claim. Please see "Preauthorizing Services" starting on page 37 for medical services that require preauthorization, and "Preauthorization Program" on page 48 for information on drugs that require preauthorization.

Preferred Drug

A prescription drug that is listed on the *UMP Preferred Drug List* (see pages 47-48) and covered under either Tier 2 (for preferred brand-name prescription drugs) or Tier 1 (for generic drugs, insulin, disposable diabetic supplies, and most specialty drugs).

Preferred Drug List

A list of selected prescription medicines that are covered by UMP PPO. Covered drugs on the list are designated by "tiers": Tier 1 drugs are generic drugs, insulin, disposable diabetic supplies, and most spe-

cialty drugs; Tier 2 are preferred brand-name drugs; and Tier 3 drugs are nonpreferred brand-name drugs, some specialty drugs, and compounded prescriptions. The *UMP Preferred Drug List* is based on a combination of the Washington Preferred Drug List and the Express Scripts National Formulary.

Prenatal

During pregnancy.

Preventive Services

UMP PPO covers ***only*** certain services as preventive; see lists on pages 29-33 for specific services covered.

Primary Care Services

Medical care from nonspecialist providers including general practitioners, family practitioners, pediatricians, and internists.

Primary Payer

The insurance plan that processes the claim first when an enrollee has more than one group insurance plan that covers the services.

Professional Services

Non-facility medical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

The Certificate of Creditable Coverage provided to the enrollee by the enrollee's prior health plan; or a letter from the enrollee's employer, on the employer's letterhead, providing the time period the enrollee and his or her dependent(s) were covered by health insurance.

Provider

An individual medical professional, 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 list of providers who are contracted to provide health care services to enrollees. These providers have agreed to see UMP enrollees under certain rules, including billing at reduced rates (see "Allowed Charge(s)" on page 87). UMP maintains its own provider network, contracting with Axia WholeHealth Networks for naturopaths, acupuncturists, and massage therapists, and with the Beech Street network for services outside of Washington State.

Quantity Limitation

A limit on how much of a particular drug you can get for a specific time period (days' supply).

Regionally Adjusted Charge

The maximum charge allowed by UMP for a specific service or supply when performed by non-network providers (including when paid at the out-of-area rate) outside of Washington State and Oregon border counties. UMP establishes and updates regionally adjusted charges as needed, based on the geographic area where the service is performed, and the specific service using one of the following methods:

- Medicare's allowable charge in the geographic region, which may be increased by a percentage determined by UMP.
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider's geographic area (based on the 75th percentile of charge data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System).
- Most consistent charge made by the non-network provider for a particular service.
- The provider's actual charge after any discounts or reductions.
- The UMP, Beech Street, or Axia WholeHealth networks' fee schedule or payment system methodology.

UMP reserves the right to determine the amount payable for any service or supply on a case-by-case basis.

Reimbursement Level

How much UMP PPO pays for a particular service or provider type (see pages 7-8 under "What You Pay For Medical Services" for specific details). For example, the network provider "reimbursement level" is usually 90% of the allowed charge (see page 87).

Respite Care

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.

Secondary Coverage

When you are covered by more than one health plan, you have "secondary coverage" that may pay a part or the rest of a provider's bill after your primary payer has paid (see page 95). See "If You Have Other Medical Coverage" on pages 65-69 for details.

Skilled Nursing Facility

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.

Specialty Drugs

Specialty medications are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Most specialty drugs are used to treat chronic diseases. Specialty drugs are identified on the *UMP Preferred Drug List*. See pages 44 and 48 for information on how specialty drug prescriptions are handled.

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 federal Secretary of Health and Human Services

Subscriber

The individual or family member who is the primary certificate holder and UMP PPO enrollee.

Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that 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.

Therapeutic Alternative

A drug that isn't chemically identical to a nonpreferred drug, but has similar effects when given in therapeutically equivalent doses.

Therapeutic Equivalent

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

When a pharmacist substitutes a preferred drug (therapeutic alternative or equivalent) for the prescribed nonpreferred drug, with the endorsing provider's permission (see page 90).

Tier

A term that tells you how much you will have to pay for a covered prescription drug. UMP's prescription drug benefit categorizes covered medications into three tiers. See page 45 for details on the prescription drug tiers.

Tobacco Cessation Services

Services provided for the purpose of quitting tobacco use, usually cigarette smoking. Only the *Free & Clear* program is covered by UMP (see page 35 for details). When recommended by *Free & Clear* counselors, nicotine replacements and other drugs prescribed are also covered at no cost to the enrollee. *Free & Clear* is offered at no charge to enrollees, and there is no limit to how many times you may enroll.

Index

For some common terms, not every occurrence is listed. Where a specific exclusion not covered under the benefit applies, you will see it listed as [41, ***28***]. This means that the exclusion is on page 41, under exclusion 28. As not all exclusions and limitations are listed, it is important that you read "What UMP PPO Doesn't Cover" (pages 39-42) and "Benefits: What UMP PPO Covers" (pages 16-36).

Note: *This partial index does not include all terms in this* Certificate of Coverage. *It is a selective list intended to help you find information. If you don't see what you're looking for here, try the "Definitions" section (pages 87-96), check the Table of Contents, or call UMP Customer Service at 1-800-762-6004.*

Note: *This partial index does not include all terms in this* Certificate of Coverage. *It is a selective list intended to help you find information. If you don't see what you're looking for here, try the "Definitions" section (pages 87-96), check the Table of Contents, or call UMP Customer Service at 1-800-762-6004.*

Note: *This partial index does not include all terms in this* Certificate of Coverage. *It is a selective list intended to help you find information. If you don't see what you're looking for here, try the "Definitions" section (pages 87-96), check the Table of Contents, or call UMP Customer Service at 1-800-762-6004.*

Note: *This partial index does not include all terms in this* Certificate of Coverage. *It is a selective list intended to help you find information. If you don't see what you're looking for here, try the "Definitions" section (pages 87-96), check the Table of Contents, or call UMP Customer Service at 1-800-762-6004.*

Note: *This partial index does not include all terms in this* Certificate of Coverage. *It is a selective list intended to help you find information. If you don't see what you're looking for here, try the "Definitions" section (pages 87-96), check the Table of Contents, or call UMP Customer Service at 1-800-762-6004.*

Directory

If you have questions about…	Contact…	
Customer Service **Monday-Friday, 8 a.m. to 6 p.m.**	**Active employees: 1-800-762-6004 or 425-670-3000 (Seattle area)** **Retirees: 1-800-352-3968 or 425-686-1350 (Seattle area)**	
Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review	Uniform Medical Plan P.O. Box 34578 Seattle, WA 98124-1578	Call Customer Service Fax: 425-670-3197
Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status	Uniform Medical Plan P.O. Box 34850 Seattle, WA 98124-1850	**www.ump.hca.wa.gov** or call Customer Service
Finding a Network Provider	For services in: **Washington and Idaho border counties** of Bonner, Kootenai, Latah, and Nez Perce: Call Customer Service or **www.ump.hca.wa.gov** **Other U.S. locations (Beech Street):** 1-800-432-1776 or **www.beechstreet.com**	
Prescription Drugs **Member Services, Network Pharmacies, Preferred Drugs Questions, Complaints**	Express Scripts, Inc. 1-866-576-3862 Available 24 hours a day, 7 days a week	**www.express-scripts.com**
First-Level Appeals, Correspondence	Express Scripts, Inc. Attn: Pharmacy Appeals: WA5 Mail Route BLO390 6625 West 78th Street Bloomington, MN 55439	Fax: 1-877-852-4070 Enrollee phone: 1-866-576-3862 Provider phone: 1-800-417-8164
Drug Coverage Management and Preauthorization	Have your provider or pharmacist call for you Phone: 1-800-417-8164 Fax: 1-877-697-7192 (can take 3-5 business days)	
Mail-Order Pharmacy ***First prescription, order by mail:*** *Note: Use Web site for refills only*.	Express Scripts, Inc. P.O. Box 52166 Phoenix, AZ 85072-9886 Provider fax: 1-800-396-2171 *(prescription must be faxed by provider on clinic letterhead)*	
Refills:	Express Scripts, Inc. 1-866-576-3862 **www.express-scripts.com**	
Claims from Non-Network Pharmacies	Express Scripts, Inc. WA5A P.O. Box 390873 Bloomington, MN 55439-0873	
Case Management See page 38 for more information.	1-888-759-4855	
Eligibility and Enrollment	PEBB Benefit Services 1-800-200-1004 or 360-412-4200 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m.	**www.pebb.hca.wa.gov**
Preventive Care Guidelines	**www.ahcpr.gov/clinic/gcpspu.htm** **www.cdc.gov/nip/publications/ACIP-list.htm**	
Tobacco Cessation	*Free & Clear* 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m.	**www.freeclear.com/ump**
Address Changes	**Active employees:** Contact your personnel, payroll, or insurance office	**Retirees:** Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684

To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.