# City of Spokane Police Relief and Pension Board

## Your World™

1022520

PREMERA | BLUE CROSS

# INTRODUCTION

This plan is self-funded by City of Spokane Police Relief and Pension Board, which means that City of Spokane Police Relief and Pension Board is financially responsible for the payment of plan benefits. City of Spokane Police Relief and Pension Board ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

City of Spokane Police Relief and Pension Board has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross and Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. City of Spokane Police Relief and Pension Board has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

## HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **How Does Selecting A Provider Affect My Benefits?** — how using providers that we have agreements with will cut your costs
- **What Types Of Expenses Am I Responsible For Paying?**
- **What Are My Benefits?** — what's covered and what you need to pay for covered services.
- **What's Not Covered?** — services that are either limited or not covered under this plan
- **Who Is Eligible For Coverage?** – eligibility requirements for this plan
- **How Do I File A Claim?** — step-by-step instructions for claims submissions
- **What If I Have A Question Or An Appeal?** — processes to follow if you want to file a complaint or an appeal
- **Definitions** — terms that have specific meanings under this plan. Example: "You" and "your" refer to members under this plan. "We," "us" and "our" refer to Premera Blue Cross.

## FOR MORE INFORMATION

You'll find our contact information on the back cover of this booklet. Please call or write Customer Service for help with:

- Questions about benefits or claims
- Questions or complaints about care you receive
- Changes of address or other personal information

You can also get benefit, eligibility and claim information through our Interactive Voice Response system when you call.

### Online information about your plan is at your fingertips whenever you need it

You can use our Web site to:

- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims
- Visit our health information resource to learn about diseases, medications, and more

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| Group Name: | City of Spokane Police Relief and Pension Board |
| Effective Date: | January 1, 2008 |
| Group Number: | 1022520 |
| Plan: | Your World |
| Contract Form Number: | 0730A |

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## HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

To help you manage the cost of health care, the Group has made use of our provider networks and our provider network arrangements with Blue Cross and/or Blue Shield Licensees throughout the country to furnish covered services to you through their provider networks. These networks consist of hospitals and other health care facilities, physicians and professionals. Throughout this section of your booklet, you will find important information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

This plan's benefits are provided for services and supplies furnished by providers that meet both the following requirements:

- **State-licensed or state-certified**
- **Performing services within the scope of their license or certification**

You may be able to lower your out-of-pocket expenses if you use a "network provider." A network provider is any of the following:

- A Washington provider that has an agreement with us
- An Alaska provider that has an agreement with Premera Blue Cross Blue Shield of Alaska
- A provider in Clark County, Washington or outside Washington and Alaska that has a participating provider agreement with the local Blue Cross and/or Blue Shield Licensee.

Participating pharmacies are also available nationwide.

Network providers agree to accept the plan's allowable charge as payment in full. (Please see the "Definitions" section of this booklet for an explanation of the allowable charge.) You're responsible only for amounts in excess of stated benefit maximums and charges for non-covered services and supplies.

If the provider you choose is not a network provider, you're responsible for amounts above the allowable charge (the difference between what the plan allows for the service and the provider's actual charge). These amounts are in addition to applicable deductibles, coinsurance, and copays, if any, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the calendar year deductible, if any, or as coinsurance.

For the most current information on network providers in Washington or Alaska, please refer to our Web site or contact Customer Service. You'll find our Web address and these phone numbers listed on the back cover of this booklet. If you're in Clark County, Washington or are outside Washington and Alaska, please call the BlueCard phone number on the back of this booklet to locate a provider contracted with the local Blue Cross and/or Blue Shield plan.

### EMERGENCY CARE

If you have a "Medical Emergency" (please see the "Definitions section in this booklet), this plan provides worldwide coverage. Benefits for emergency care are provided on the same basis as any other covered service or supply listed under this plan. Please see the "What Types of Expenses Am I Responsible for Paying?" and "What Are My Benefits?" sections for additional benefit information.

## WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your booklet explains the types of expenses you must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for. You'll find the dollar amounts for these expenses and when they apply in the "What Are My Benefits?" section.

## WHAT ARE MY BENEFITS?

This section of your booklet describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury
- It must be, in our judgment, medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this plan is satisfied
- It must be furnished by a "provider" (please see the "Definitions" section in this booklet) who's performing services within the scope of his or her license or certification

Benefits for some types of services and supplies may be limited or excluded under this plan. Please

refer to the actual benefit provisions throughout this section and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

## WHAT'S MY COINSURANCE?

You don't have to pay any coinsurance, unless otherwise stated. Benefits are provided at 100% of allowable charges.

## MEDICAL SERVICES

### This plan provides benefits only to enrolled Subscribers. Dependents are not eligible for coverage under this plan.

### Acupuncture Services

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Benefits are provided for up to 24 visits per member per calendar year.

### Ambulance Services

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation.

### Ambulatory Surgical Center Services

Benefits are provided for services and supplies furnished by an ambulatory surgical center.

### Blood Products and Services

Benefits are provided for blood and blood derivatives.

### Chemical Dependency Treatment

Benefits are provided for inpatient and outpatient chemical dependency treatment and supporting services provided to a member up to a maximum benefit of $14,000 per member, in any 24-consecutive-month period. This period begins on the first day of covered treatment. Covered services must be furnished by a state-approved treatment program.

The current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine is used to determine whether services for chemical dependency treatment are medically necessary.

**Please Note:** Benefits for medically necessary detoxification services are provided under the Emergency Room Services and Hospital Inpatient Care benefits and don't accrue toward the chemical dependency treatment benefit maximum above.

**This benefit doesn't cover:**

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, except as deemed medically necessary
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed substance use disorder or disorders of a member

### Contraceptive Management and Sterilization Services

Benefits are provided for the following:

- Consultations
- Sterilization procedures
- Injectable contraceptives
- Implantable contraceptives (including hormonal implants)
- Emergency contraception methods (oral or injectable), when furnished by your health care provider

**Prescription Contraceptives Dispensed By A Pharmacy**

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug. Please see the Prescription Drugs benefit.

**This benefit doesn't cover:**

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

### Dental Services

This benefit will only be provided for the dental services listed below.

**Care For Injuries**

When services are related to an injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
  - Extensive restoration, veneers, crowns or splints
  - Periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury

**Please Note:** An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets the plan's extension criteria. We must receive extension requests within 12 months of the injury date.

**When Your Condition Requires Hospital Or Ambulatory Surgical Center Care**

General anesthesia and related facility services for dental procedures are covered when medically necessary for one of 2 reasons:

- The member is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

**Please Note:** This benefit will not cover the dentist's services unless the services are to treat a dental injury and meet the requirements described above.

## Diagnostic Services

The Diagnostic Services benefit covers diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Screening tests for prostate, colorectal and cervical cancer
- Diagnostic imaging and scans (including x-rays and EKGs)
- Laboratory services, including routine and preventive
- Pathology tests

**Please Note:**

- Diagnostic surgeries, including scope insertion procedures, such as endoscopies or colonoscopies, can only be covered under the Surgical Services benefit.
- Allergy testing is covered only under the Professional Visits and Services benefit.
- When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.
- When outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

For mammography services, please see the Diagnostic and Screening Mammography benefit.

## Diagnostic and Screening Mammography

The Diagnostic and Screening Mammography benefit covers diagnostic and screening mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

## Emergency Room Services

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services; these services don't accrue toward the Chemical Dependency Treatment benefit maximum. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

## Health Management

These services are provided at 100% of allowable charges, and are covered up to the benefit limits specified.

Benefits are only provided when the following services are furnished by contracted or approved providers. To obtain a list of contracted or approved providers, contact our Customer Service department.

Benefits are provided for outpatient health education services, community wellness classes and programs **and** nicotine dependency programs up to a combined maximum benefit of $250 per member each calendar year. The health education maximum doesn't apply to health education and training to manage diabetes.

**Health Education**

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. Examples of covered health education services are asthma, pain management, childbirth and newborn parenting and lactation.

**Diabetes Health Education**

Benefits are provided for outpatient health education and training services to manage the condition of diabetes. Benefits for these services aren't subject to a calendar year benefit limit.

**Community Wellness**

Community wellness classes and programs that promote positive health and lifestyle choices are also covered. Examples of these classes and programs are adult, child, infant and CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety, and parenting skills. You pay for the cost of the class or program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

**Nicotine Dependency Programs**

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the back cover of this booklet) for a reimbursement form.

Prescription drugs for the treatment of nicotine dependency are also covered under this plan. Please see the Prescription Drugs benefit.

## Home and Hospice Care

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.). In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health or hospice services.

Benefits are provided, up to the maximums shown below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit are medical equipment and supplies provided as part of home health care. (Such equipment and supplies are not subject to the benefit maximums stated in the Medical Equipment and Supplies benefit.)

**Home Health Care**

This benefit provides intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care benefits aren't subject to a calendar year benefit maximum.

**Hospice Care**

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is entering remission. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
- **Inpatient hospice care** This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.

**Insulin and Other Home and Hospice Care Provider Prescribed Drugs**

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

**This benefit doesn't cover:**

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or

injured member

- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

## Hospital Inpatient Care

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services. These services don't accrue toward the Chemical Dependency Treatment benefit maximum

For inpatient hospital chemical dependency treatment, except as stated above for medically necessary detoxification services, please see the Chemical Dependency Treatment benefit.

For inpatient hospital obstetrical care, please see the Obstetrical Care benefit.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

**This benefit doesn't cover:**

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition

## Hospital Outpatient Care

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. This benefit covers outpatient diagnostic services only when they are billed by the hospital and received in combination with other outpatient hospital services.

## Infusion Therapy

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

**This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.**

## Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

## Medical Equipment and Supplies

Covered medical equipment, prosthetics and supplies include:

### Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The plan may also provide benefits

for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

**Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances**

Covered services include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Benefits for medical supplies, orthotics (other than foot orthotics), and orthopedic appliances are not subject to a benefit maximum.

This benefit covers hypodermic needles, lancets, test strips, testing agents and alcohol swabs not provided under the Prescription Drugs benefit.

**Please Note**: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home and Hospice Care benefit for coverage information.

**Prosthetics**

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

**Please Note:** This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see the Mastectomy and Breast Reconstruction Services benefit for coverage information.

Benefits for prosthetics are not subject to a benefit maximum.

**Foot Orthotics and Therapeutic Shoes**

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses up to a combined maximum benefit of $300 per member each calendar year. Items prescribed for the treatment of diabetes are not subject to this limit.

**This benefit doesn't cover:**

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.

## Mental Health Care

Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided as stated below. Benefits are subject to the same calendar year deductible and coinsurance as you would pay for inpatient services and outpatient visits for other covered medical conditions.

Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice as determined by us.

Covered services must be furnished by one of the following types of providers:

- Hospital
- Washington state-licensed community mental health agency
- Licensed Physician (M.D. or D.O.)
- Licensed Psychologist (Ph.D.)
- Any other provider listed under the definition of "provider" (please see the "Definitions" section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her

license.

Covered services may also be furnished by a state hospital operated and maintained by the state of Washington for the care of the mentally ill.

**Inpatient Care**

Benefits are provided for inpatient facility and professional care. As an alternative to inpatient care, this plan covers "psychiatric partial days." These services aren't subject to a calendar year benefit limit.

**Outpatient Therapeutic Visits**

Benefits are provided for outpatient office or home therapeutic visits. Also covered under this benefit are biofeedback services for generalized anxiety disorder when provided by a qualified provider. These services aren't subject to a calendar year benefit limit.

"Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Physicians Current Procedural Terminology**, published by the American Medical Association.

For psychological and neuropsychological testing and evaluation benefit information, please see the Psychological and Neuropsychological Testing benefit.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

**This benefit doesn't cover:**

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment

## Nutritional Therapy

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes is limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes isn't subject to a calendar year benefit limit.

## Obstetrical Care

Obstetrical care benefits include:

Benefits for pregnancy, childbirth and voluntary termination of pregnancy are provided on the same basis as any other condition for the female subscriber.

**Facility Care**

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Plan benefits are also provided for medically necessary supplies related to home births.

**Professional Care**

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

**Please Note:** Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

## Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw

(orthognathic and/or maxillofacial surgery) are provided up to a lifetime maximum benefit of $5,000 per member. These procedures are not covered under other benefits of this plan. The only exception to this benefit maximum is treatment needed to repair a dependent child's congenital anomaly.

## Preventive Medical Care

Benefits are provided for routine and preventive services performed on an outpatient basis and aren't subject to a calendar year benefit limit.

Immunization benefits aren't subject to a calendar year benefit limit.

Covered exam services include:

- Routine physical exams
- Immunizations
- Physical exams related to school, sports, and employment

For outpatient routine or preventive diagnostic services (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, please see the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefit.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive medical benefits of this plan.

**This benefit doesn't cover:**

- Services not named above as covered
- Charges for preventive medical services that exceed what's covered under this benefit
- Inpatient routine newborn exams while the child is in the hospital following birth.
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations

## Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

**Outpatient Professional Exams and Visits**

Benefits are also provided for the following professional services when provided by a qualified provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions")
- Diabetic foot care

**Therapeutic Injections And Allergy Tests**

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

For surgical procedures performed in a provider's office, surgical suite or other facility benefit information, please see the Surgical Services benefit.

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

For home health or hospice care benefit information, please see the Home and Hospice Care benefit.

For benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management and Sterilization Services benefit.

For diagnosis and treatment of psychiatric conditions benefit information, please see the Mental Health Care benefit.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please see the Temporomandibular Joint (TMJ) Disorders benefit.

**This benefit doesn't cover:**

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services

## Psychological and Neuropsychological Testing

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined. Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

## Rehabilitation Therapy and Chronic Pain Care

### Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies.

**Inpatient Care** Benefits are available for inpatient facility and professional care. These benefits aren't subject to a calendar year benefit limit. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

**Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:

- You must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, physical, occupational, or speech therapist, chiropractor, massage practitioner or naturopath.

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 45 visits per member each calendar year. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

### Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

**The Rehabilitation Therapy and Chronic Pain Care benefit doesn't cover:**

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary

## Skilled Nursing Facility Services

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

Benefits for skilled nursing facility services aren't subject to a calendar year benefit limit.

**This benefit doesn't cover:**

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

## Spinal and Other Manipulations

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition.

Non-manipulation services (including diagnostic imaging) are covered as any other medical service.

Available benefits for covered massage and physical therapy services are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

Benefits are limited to 24 visits per member per calendar year.

## Surgical Services

This benefit covers all surgical services (including injections) that are not named as covered under

other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

## Temporomandibular Joint (TMJ) Disorders

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided. Treatment of TMJ disorders is not covered under other benefits of this plan.

This benefit includes coverage for inpatient and outpatient facility and professional care, including professional visits, up to a maximum benefit of $1,000 per member each calendar year. The lifetime maximum for these services is $5,000 per member.

Medical and dental services and supplies are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good medical or dental practice
- Not experimental or investigational, as determined by us according to the criteria stated under "Definitions," or primarily for cosmetic purposes

## Transplants

### Covered Transplants

This benefit covers medical services only if provided by "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Benefits are provided for inpatient and outpatient surgical facility services when you use an approved transplant center, and inpatient and outpatient professional services when you use an approved transplant provider.

The transport and lodging benefits shown below are provided up to the benefit limit of $7,500 per transplant.

Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the "Definitions" section in this booklet for the definition of "experimental/investigational services"). We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet the plan's criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

  The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are:

  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous)

  **Please Note:** For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).
- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us). We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

  Of course, if none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

### Recipient Costs

Benefits are provided for solid organ transplant or bone marrow or stem cell reinfusion.

This benefit also provides coverage for anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

### Donor Costs

Covered services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

### Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, are covered as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- Benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided

**This benefit doesn't cover:**

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the "Definitions" section in this booklet)
- Personal care items

# VISION BENEFIT

## Vision Exams

This benefit provides for one routine vision exam per member each calendar year. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

**Please Note:** For vision exams and testing related to medical conditions of the eye, please see the Professional Visits and Services benefit.

**The Vision Exam benefit doesn't cover** vision hardware or fitting examinations for contact lenses or eyeglasses.

## Vision Hardware

Benefits for vision hardware are provided when all of the requirements listed below are met:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

Benefits are provided for the following vision hardware and related services, up to a maximum benefit of $350 per member per 2 consecutive calendar years:

**What's Covered:**

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Vision hardware benefits are based on the "allowable charge" (please see the "Definitions" section in this booklet) for covered services and supplies. Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

**Please Note:** Copays, deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to vision hardware benefits.

**The Vision Hardware benefit doesn't cover:**

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan

- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
  - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

### Lasik Eye Surgery

Benefits are provided for lasik eye surgery up to a lifetime benefit maximum of $2,600 per member.

## PRESCRIPTION DRUGS

This benefit provides coverage for medically necessary drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are injectable supplies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply.

#### Retail Pharmacy Prescriptions

Benefit for drugs dispensed by a retail pharmacy will be provided at 100% of allowable charges.

##### Dispensing Limit

Benefits are provided for up to a 365-day supply or 365 unit supply of covered medication unless the drug maker's packaging limits the supply in some other way.

#### Medco By Mail / Mail-Order Pharmacy Program

Benefit for drugs dispensed by a participating mail-order pharmacy will be provided at 100% of allowable charges.

##### Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

#### How To Use The Medco By Mail / Mail-Order Pharmacy Program

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to Medco By Mail. Please see the "How Do I File A Claim?" section in this booklet for more information on submitting claims.

To obtain additional details about the mail-order pharmacy program, you may call our Customer Service department. You may also call the Pharmacy Benefit Administrator's Customer Service department or visit their Web site. You'll find the phone numbers and the Web address on the back cover of this booklet.

#### Retail Pharmacy Benefit

- **Participating Retail Pharmacies** The plan will pay the participating pharmacy directly.

  To avoid paying the retail cost for a prescription drug, be sure to present your identification card to the pharmacist for all prescription drug purchases.

  You will need a prescription from your physician to obtain any drug that you would normally purchase over-the-counter. If it cannot be purchased at a participating pharmacy with your identification card, it will not be covered.
- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information.

If you need a list of participating pharmacies, please call us (see the back cover of this booklet). You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross ID card.

#### What's Covered

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the "Definitions" section in this booklet).
- Medically necessary over-the-counter drugs purchased at a participating pharmacy and

prescribed by a physician.

- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription drugs for the treatment of nicotine dependency
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)
- Drugs to treat sexual dysfunction such as Viagra, Lavitra, Cialis, limited to a maximum of 6 pills per member per month

For benefit information concerning therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories, please see the Medical Equipment and Supplies benefit.

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the Preventive Medical Care benefit.

**Specialty Pharmacy** Benefits for certain drugs which require special handling, storage, administration or patient monitoring may be limited to specific participating pharmacies, and to a 30-day supply for initial dispensing. Benefits for up to a 90-day supply of these drugs will be allowed under the Medco By Mail benefit for members who meet specific medical criteria.

**Exclusions**

**This benefit doesn't cover:**

- Prescription vitamins
- Growth Hormones
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagons.) Please see the Infusion Therapy benefit.
- Weight management drugs
- Drugs to treat infertility, including fertility enhancement medications
- Over-the-counter medical supplies, except as specified under "What's Covered."

**Prescription Drug Volume Discount Program**

Premera Blue Cross participates in a program that provides discounts on the costs of certain prescription drugs used by our members on an annual basis. The total net savings generated by the volume discount program is applied toward future rate calculations and/or settlements, on a pro rata basis.

# HEARING BENEFIT

## Routine Hearing Exams and Testing

Benefits are provided for one hearing examination and one hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations

Hearing testing services include the use of calibrated equipment.

## Hearing Hardware

Benefits for hearing hardware are provided up to the lifetime maximum benefit of $3,200 per member after providing evidence of medical necessity.

To receive your hearing hardware benefit:

- In-Area: The officer will submit evidence of medical necessity and an invoice to the City of Spokane, 808 W. Spokane Falls Blvd., Ste 400 Spokane, WA 99201. The City of Spokane will approve the invoice and the officer may then purchase the hearing aid.

  Out-of-Area: If an officer resides outside the greater Spokane area, the officer will submit evidence of medical necessity. Following a review by the City of Spokane, the officer may

then purchase the aid from the provider of his choice and pay any balances over the approved bid.

- You must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA) before obtaining hearing aids
- You must purchase a hearing aid device

Benefits are provided for the following:

- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds
- The hearing aid instruments
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty
- A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

**This benefit doesn't cover:**

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

# WHAT DO I DO IF I'M OUTSIDE WASHINGTON AND ALASKA?

## THE BLUECARD® PROGRAM

Premera Blue Cross, like all Blue Cross and/or Blue Shield Licensees, participates in a program called "BlueCard." Members can take advantage of BlueCard when they receive covered services in Clark County, Washington or outside Washington and Alaska from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. The national BlueCard Program is available throughout the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands.

Your identification card tells contracting providers which independent Blue Cross and/or Blue Shield Licensee covers you. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan. When you use your identification card, you will receive many of the conveniences you're accustomed to from Premera Blue Cross. In most cases, there are no claim forms to submit because contracting providers will handle claim submission for you. In addition, your out-of-pocket costs may be less, as explained below.

**Here's How BlueCard Helps Keep Costs Down**

When you obtain health care services in Clark County, Washington or outside Washington and Alaska through BlueCard (excluding BlueCard Worldwide; see below), the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The "negotiated price" that the Host Blue passes on to Premera Blue Cross for your covered services.

The methods used to determine the negotiated price will vary among Host Blues according to the terms of their provider contracts. Often, the negotiated price will consist of a simple discount, which reflects the actual price allowed as payable by the Host Blue. But, sometimes, it's an estimated price that factors in aggregate payments expected to result from the Host Blue's settlements, withholds, other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects an **average** expected savings with your health care provider or a specified group of providers. The price that reflects average savings may result in greater variation above or below the actual price than will the estimated price. In accordance with national BlueCard policy, these estimated or average prices will also be adjusted from time to time to correct for overestimation or underestimation of past prices. However, the amount on which your and Spokane Firefighters Pension Board's payments is based remains the final price for the covered services billed on your claim.

Some states may mandate a surcharge or a method of calculating what you must pay on a claim that differs from BlueCard's usual method noted above. If such a mandate is in force on the date you received care in that state, the amount you must pay for any covered services will be calculated using the methods required by that mandate. Such methods might not reflect the entire savings expected on a particular claim.

**Clark County Providers**

Some providers in Clark County, Washington do have contracts with Premera Blue Cross. These providers will submit claims directly to us and benefits will be based on our allowable charge for the service or supply.

**Non-BlueCard Claim Submission**

If a hospital, doctor, or other medical care provider does not contract with the Host Blue, that claim might not be filed on your behalf. For instructions on how to file a claim in this situation, refer to the "How Do I File A Claim?" section of this booklet.

**BlueCard Worldwide®**

If you're outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide. BlueCard Worldwide is unlike the national BlueCard Program in certain ways. For instance, although BlueCard Worldwide provides a network of contracting hospitals, it offers only referrals to doctors. When you receive care from doctors, you will have to submit claim forms on your own behalf to obtain reimbursement for the services provided through BlueCard Worldwide.

To access health care services through BlueCard Worldwide and to obtain additional information about providers' charges, please call 1-800-810-BLUE (2583).

**Further Questions?**

If you have questions or need additional information about using your identification card in Clark County, Washington or outside Washington and Alaska, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, call 1-800-810-BLUE (2583).

# CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

The benefits of this plan don't require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions that might benefit from case management.

## CASE MANAGEMENT

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. The decision to provide benefits for these alternatives is within the plan's sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. Your plan benefits may be utilized as specified in the signed agreements, but the agreements are not to be construed as a waiver of the right to administer the plan in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this plan would be available to you at that time.

# WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by our "Care Management" provisions and your eligibility. In addition, some benefits have their own specific limitations.

## LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this book, the plan won't provide benefits for the following:

**Amounts That Exceed The Allowable Charge**

**Benefits From Other Sources**

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage

**Benefits That Have Been Exhausted**

Amounts that exceed the allowable charge or maximum benefit for a covered service.

**Biofeedback Services**

- Biofeedback for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback and neurofeedback services

**Caffeine Or Nicotine Dependency**

Treatment of caffeine or nicotine dependency, except as stated under the Health Management and Prescription Drugs benefits.

**Charges For Records Or Reports**

Separate charges from providers for supplying records or reports, except those we request for utilization review.

**Chemical Dependency Coverage Exceptions**

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

**Cosmetic Services**

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance or shape of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Reconstructive breast surgery in connection with a mastectomy, as specified under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders upon our review and approval

**Counseling, Educational Or Training Services**

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Health Management, Nutritional Therapy and Mental Health Care benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a member.
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

**Court-Ordered Services**

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary by us.

**Custodial Care**

Custodial care, except when provided for hospice care (please see the Home and Hospice Care benefit).

**Dental Care**

Dental services or supplies, except as specified under Dental Services (please see the "Medical Services" section under "What Are My Benefits?").

This exclusion also doesn't apply to dental services covered under the Temporomandibular Joint (TMJ) Disorders benefit.

**Dependent Coverage**

The benefits of this plan are available only to the subscriber. Dependents are not eligible for coverage under this plan.

**Drugs And Food Supplements**

Food and nutritional supplements; herbal, naturopathic, or homeopathic medicines or devices; hair analysis.

**Environmental Therapy**

Therapy designed to provide a changed or controlled environment.

**Experimental Or Investigational Services**

Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "What If I Have A Question Or An Appeal?" section in this booklet for an explanation of the appeals process.

**Please Note:** This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the "Definitions" section in this booklet.

**Family Members Or Volunteers**

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in

your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child.

- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

**Gender Transformations**

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof.

**Governmental Medical Facilities**

Services and supplies furnished by a governmental medical facility, except when:

- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- The plan must provide available benefits for covered services as required by law or regulation

**Hair Loss**

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants

**Hearing Hardware**

- Hearing aids (including batteries and related equipment) that exceed the maximum benefit per member. These expenses are also not eligible for coverage under other benefits of this plan.
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended

**Infertility And Sterilization Reversal**

- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs
- Any assisted fertilization techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

**Medical Equipment And Supplies**

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems
- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Prosthetics, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the Prescription Drugs benefit.

**Military And War-Related Conditions, Including Illegal Acts**

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto. However, this exclusion does not apply to U.S. military personnel (active or retired) or their dependents enrolled in the TRICARE program. The benefits of this plan will be provided on a primary basis to TRICARE beneficiaries consistent with federal law.
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

**No Charge Or You Don't Legally Have To Pay**

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

**Not Covered**

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits
- Services or supplies that aren't listed as covered under this plan
- Services or supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan
- Services or supplies provided to someone other than the ill or injured member, other than

outpatient health education services covered under the Health Education portion of the Health Management benefit

**Not In The Written Plan Of Care**

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home and Hospice Benefit, and Rehabilitation Therapy and Chronic Pain Care benefits.

**Not Medically Necessary**

- Services or supplies that aren't medically necessary, in our judgment, even if they're court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition

**Obesity Services**

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and aftereffects thereof; services and supplies connected with weight loss or weight control, except for health education and wellness classes or programs specified as covered under the Health Management benefit and for services to treat diabetes covered under the Nutritional Therapy benefit. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

**Orthodontia Services**

Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

**Outside The Scope Of A Provider's License Or Certification**

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

**Personal Comfort Or Convenience Items**

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels"

**Private Duty Nursing Services**

Private duty nursing.

**Rehabilitation Services**

Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary.

**Routine Or Preventive Care**

- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability
- Services and supplies that aren't directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn't apply to services and supplies specified as covered under the following benefits:
  - Diagnostic Services
  - Diagnostic and Screening Mammography
  - Preventive Medical Care
  - Diabetes Health Education

**Sexual Dysfunction**

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications (except as specifically stated under the Prescription Drugs Benefit), or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

**Skilled Nursing Facility Coverage Exceptions**

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

**Transplant Coverage Exceptions**

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and

aftereffects thereof, except as specifically stated under the Transplants benefit

- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the "Definitions" section in this booklet)

**Vision Therapy**

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment, except as stated under the Lasik Eye Surgery benefit.

**Work-Related Conditions**

- Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
  - Occupational coverage required of, or voluntarily obtained by, the employer
  - State or federal workers' compensation acts
  - Any legislative act providing compensation for work-related illness or injury

  This exclusion does not apply to subscribers who joined the Washington Law Enforcement Officers and Fire Fighters' retirement system before October 1, 1977. They will be covered under this plan for illnesses or injuries connected with their occupations as law enforcement officers or fire fighters. Coverage is subject to the other terms and limitations of this plan.

# WHAT IF I HAVE OTHER COVERAGE?

**Please Note**: If you participate in a Health Savings Account (HSA) and have other health care coverage that is not a high deductible health plan as defined by IRS regulations, the tax deductibility of the Health Savings Account contributions may not be allowed. Contact your tax advisor or HSA plan administrator for more information.

## COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with each plan at the same time. If you have Medicare, Medicare may submit your claims to your secondary plan.

**Definitions**

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contact or benefit to which COB doesn't apply is treated as a separate plan.
  - "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
  - "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- **This plan** means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.
- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See "Effect On Benefits" later in this section for rules on secondary plan benefits.

- **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by this plan. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that isn't covered by any of your plans isn't an allowable expense.

  An example of an expense that is **not** allowable is any amount over the highest of the expense amounts allowed by either the primary or secondary plan. This is true regardless of what method the plans use to set allowable expenses. However, when Medicare or a Medicare Advantage plan is primary to your other coverage, the allowable expense set by Medicare or the Medicare Advantage plan must be treated as the highest allowable.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

**Primary And Secondary Rules**

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

**Non-LEOFF I Or LEOFF I** A plan that doesn't cover you as a LEOFF I employee or retired LEOFF I employee (see "Who Is Eligibile?" later in this booklet) Such a plan is primary to this plan even if it covers you as a dependent. Please note: If you have Medicare coverage, this rule doesn't apply to that coverage.

**No COB Provision** A plan that doesn't have a COB provision that complies with this plan's rules is primary to this plan unless the rules of both plans make this plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

**Non-Dependent Or Dependent** The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

**Retired Or Laid-Off Employee** The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

**Continuation Coverage** If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that isn't through COBRA or other continuation law.

**Please Note:** The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

**Length Of Coverage** The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally, unless required otherwise by law or regulation applicable to LEOFF I coverage.

**COB's Effect On Benefits**

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. When this plan is secondary, it will reduce its benefits so that its benefits plus those of the primary plan total 100% of the allowable expense for each claim. **However, this plan will never pay more for a claim than what its benefit for that claim would have been in the absence of COB.**

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB.

**Right Of Recovery/Facility Of Payment** If your other plan makes payments that this plan should have made, the plan has the right to remit to the other plan the amount that is needed to comply with COB. To the extent of such payments, the plan is fully discharged from liability. The plan also has the right to recover any payment over the maximum amount required under COB. The plan can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

### SUBROGATION AND REIMBURSEMENT

If the plan makes claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, the plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or the plan. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because the plan excludes coverage for such benefits.

**Definitions** The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the plan, directly from third parties to the extent the plan has paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated to repay any monies advanced by the plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the plan has to the monies advanced under your plan. Because the plan has paid for your illness or injuries, the plan is entitled to recover those expenses.

The plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the plan paid for the condition, whether or not you have been made whole prior to the plan's recovery. The plan's right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

The plan's first priority right of reimbursement will not be reduced due to a member's own negligence; or due to a member not being made whole; or due to attorney's fees and costs.

In recovering benefits provided on behalf of the plan, we may at the Group's election hire an attorney or have the plan be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the plan or the Group or on their behalf. If you retain an attorney or other agent to represent you in the matter, you must require that legal representative to reimburse the plan directly from the settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify us in writing of any terms or conditions offered in a settlement, and you or your legal representative must notify the third party of the plan's interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by the plan on your behalf. If you or your legal representative fail to cooperate fully with us in the recovery of benefits the plan has paid as described above, you are responsible for reimbursing the plan for such benefits.

You or your legal representative must, within 14 business days of receiving a request from the plan, provide all information and sign and return all documents necessary to exercise the plan's right under this provision.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until the plan's subrogation and reimbursement rights are fully determined.

**Agreement To Arbitrate** Any disputes that arise as part of this provision will be resolved by arbitration. Both you and the plan will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington.

This agreement to arbitrate will begin on the effective date of the plan, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

### UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

The plan has the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

## WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. The Group has the discretionary authority to determine your eligibility for benefits.

### SUBSCRIBER ELIGIBILITY

To be a subscriber under this plan, an employee must meet all of the following requirements:

- You must be, a full-time LEOFF I employee who is on the City of Spokane payroll, and must be actively at work full-time on the effective date of coverage; or
- You must be a retired and/or disabled City of Spokane LEOFF I employee who is eligible to receive a retirement benefit under the LEOFF act

**LEOFF I definition: A LEOFF I employee is defined as a full-time active Law Enforcement Officer hired on or before September 30, 1977 who established membership in the LEOFF system as defined in CH131, Law of 1972, 1st Ex. Sess.**

### DEPENDENT ELIGIBILITY

This plan provides benefits only to enrolled subscribers. Any references throughout this booklet to dependent coverage, eligibility or benefits are not applicable. In this plan, the terms "you," "your" or "the member" refer only to the enrolled subscriber.

## WHEN DOES COVERAGE BEGIN?

### ENROLLMENT

You are automatically enrolled on the date of hire provided you meet the eligibility requirements.

### CHANGES IN COVERAGE

No rights are vested under this plan. The Group may change its terms, benefits and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees who become covered under this plan after the date the change becomes effective.

#### Persons Eligible For Medical Assistance

When the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll in this plan, a person who is eligible for state medical assistance and who is also eligible for coverage under this plan, we will enroll the person as a special enrollee. Coverage will start on the first of the month following the date we receive the application for coverage. In order to apply for coverage, you may be required to provide the notice of eligibility you received from DSHS.

## WHEN WILL MY COVERAGE END?

### EVENTS THAT END COVERAGE

Coverage will end without notice on the last day of the month in which one of these events occurs:

- For the subscriber when:
  - The next required monthly charge for coverage isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber

### CERTIFICATE OF HEALTH COVERAGE

When your coverage under this plan terminates, you'll receive a "Certificate of Health Coverage." The certificate will provide information about your coverage period under this plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any waiting period for pre-existing conditions. You'll need a certificate each time you leave a health plan and enroll in a plan that has a waiting period for pre-existing conditions. Therefore, it's important for you to keep the certificate in a safe place.

If you haven't received a certificate, or have misplaced it, you have the right to request one from us or your former employer within 24 months of the date coverage terminated.

When you receive your Certificate of Health Coverage, make sure the information is correct. Contact us or your former employer if any of the information listed isn't accurate.

Documents that may establish creditable coverage in the absence of a certificate include explanations of benefit claims or correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

### PLAN TERMINATION

No rights are vested under this plan. The Group is not required to keep the plan in force for any length of time. The Group reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in "Changes In Coverage" in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

## HOW DO I CONTINUE COVERAGE?

### LEAVE OF ABSENCE

Coverage for a subscriber may be continued for up to 90 days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

### CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who

voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

## CONVERTING TO A NON-GROUP PLAN

You may be entitled to coverage under one of Premera Blue Cross's Conversion plans when your coverage under this plan ends. Conversion plans are individual plans insured by Premera Blue Cross and they differ from this plan. You pay the monthly payment. You must apply and send the first required charge payment to us within 31 days of the date your coverage ends under this plan.

You can apply for a Conversion plan if you live in Washington State and you're not eligible for Medicare coverage, and one of 2 things is true:

- You're not entitled to services or benefits for medical and hospital care under another group plan
- You're entitled to other coverage, but that coverage contains exclusions or waiting periods for any pre-existing conditions you have

For more information about our Conversion plans, contact the Group or our Customer Service department.

**Please Note:** The rates, coverage and eligibility requirements of our Conversion plans differ from those of your current group plan. In addition, enrollment in a Conversion plan may limit your ability to later purchase an individual plan without a pre-existing condition waiting period.

## MEDICARE SUPPLEMENT COVERAGE

If you're enrolled in Parts A and B of Medicare, you **may** be eligible for guaranteed-issue coverage under certain Medicare supplement plans. You must apply within 63 days of losing coverage under this plan.

# HOW DO I FILE A CLAIM?

### Claims Other Than Prescription Drug Claims

Many providers will submit their bills to us directly. However, if you need to submit a claim to us, follow these simple steps:

**Step 1**

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service.

**Step 2**

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or ICD-9 code
- Procedure codes (CPT-4, HCPCS, ADA or UB-92) or descriptive English nomenclature for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

**Step 3**

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

**Step 4**

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

**Step 5**

Sign the Subscriber Claim Form in the space provided.

**Step 6**

Mail your claims to us at the mailing address shown on the back cover of this booklet.

### Prescription Drug Claims

To make a claim for covered prescription drugs, please follow these steps:

**Participating Pharmacies**

For retail pharmacy purchases, you don't have to send us a claim. Just show your Premera Blue Cross ID card to the pharmacist, who will bill us directly. If you don't show your ID card, you'll have to pay the full cost of the prescription and submit the claim yourself.

For mail-order pharmacy purchases, you don't have to send us a claim, but you'll need to follow the instructions on the order form and submit it to the address printed on the form. Please allow up to 14 days for delivery.

**Non-Participating Pharmacies**

You'll have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You'll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

If you need a supply of participating mail-order pharmacy order forms or prescription drug claim forms, contact our Customer Service department at the numbers shown the back cover of this booklet.

### Timely Filing

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

The plan won't provide benefits for claims we receive after the later of these 2 dates, nor will the plan provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

## WHAT IF I HAVE A QUESTION OR AN APPEAL?

### When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service department with any other questions regarding the plan.

### When You Have A Complaint

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you're not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, it will be given to the Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to the Provider Network staff for review. We'll let you know when we've received your complaint. We also may request more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

### When You Have An Appeal

An **appeal** is an oral or written request to reconsider 1) a decision on a complaint, or 2) a decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. This includes admissions to and continued stays in a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you're appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

Although we'll accept an appeal made by phone to our Customer Service department, it's a better idea to put appeals in writing so you can keep copies for your records. Please send all written appeals to the address shown on the back cover of this booklet. We'll let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal.

**Appeals Process**

Please call Customer Service if you have questions or need more information about our complaint or appeal process. The numbers are shown on the back cover of this booklet.

The plan's standard appeals process has 2 levels of review, explained below.

**Level I** The Level I Appeal panel will decide most appeals within 30 calendar days. The Level I Appeal panel will give you its decision within 30 calendar days. This panel will include health care providers as needed. Persons involved in the initial decision will not be on the panel. We can extend our review time up to 15 more calendar days if we need more information. You'll be notified if a delay occurs.

If you don't agree with the decision reached in our

Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. Y**ou must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision.** This time limit may be extended in the event the member needs to obtain additional medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member's control. In no case shall the extension exceed 180 days.

**Level II** Your appeal will be reviewed by a panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. The panel will evaluate all the information within 45 calendar days of the date we receive your Level II request.

**Notice** We'll mail you a written notice of the Level I and Level II decisions within 5 days after the review is complete.

# OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and the Group must follow and other information that must be provided.

### Conformity With The Law

If any provision of the plan or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

### Member Cooperation

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group in the event of a lawsuit.

### Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits under this plan are provided. This proof may be submitted by you, or on your behalf by your health care providers. No benefits will be available if the proof isn't provided or acceptable to the plan.

### Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. Please see the "Right Of Recovery" provision later in this section.

And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, as directed by the Group:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim
- Rescind the member's coverage under this plan (rescind means to cancel coverage back to its effective date, as if it had never existed at all)

### Notice Of Information Use And Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

This information may also be collected, used or disclosed as required or permitted by law

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our Customer Service department and ask a representative to mail a request form to you.

### Notice Of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the plan provides

benefits; and the name and address of that party's insurance carrier

- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

**Notices**

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if it's mailed to the Group or subscriber at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

**Right Of Recovery**

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

**Right To And Payment Of Benefits**

Benefits of this plan are available only to members. Except as required by law, the plan won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only, we have the right to direct the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

**Venue**

All suits or legal proceedings brought against us, the plan, or the Group by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date the rights or benefits claimed under this plan were denied in writing, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by the plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the plan's option, will be in King County, the state of Washington.

# DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

## Allowable Charge

The allowable charge shall mean one of the following:

- **Providers In Washington and Alaska Who Have Agreements With Us**

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

  Your liability for any applicable calendar year deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.
- **Providers Outside Washington and Alaska Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Washington and Alaska, or in Clark County, Washington, allowable charges are determined as stated in the "What Do I Do If I'm Outside Washington And Alaska?" section ("The BlueCard Program") in this booklet.
- **Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

  The allowable charge will be no greater than the maximum allowance that would have been allowed had the medically necessary covered services been furnished by a provider that has an agreement in effect with the local Blue Cross

and/or Blue Shield Licensee (when applicable) or with us (when the provider is in Washington or Alaska or no local Blue Cross and/or Blue Shield allowable charge applies).

When you seek services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, for your normal share of the claims costs (see the "What Are My Benefits?" section for further detail).

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us.

### Ambulatory Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

### Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

### Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

### Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

### Complication Of Pregnancy

A condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix requiring treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma uterine rupture before onset or during labor
  - Ante- or postpartum hemorrhage requiring medical/surgical treatment
  - Placental conditions which require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

### Congenital Anomaly Of A Dependent Child

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

### Custodial Care

Any portion of a service, procedure or supply that, in our judgment, is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel

### Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed

dentist, or other individual performing within the scope of his or her license or certification, as allowed by law. This plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

### Dentally Necessary

Those covered services which are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider
- The least costly of the alternative levels of services which can safely be provided to the member
- Not primarily for research or data accumulation

The fact that the covered services were furnished, prescribed, or approved by a dental care provider does not in itself mean that the services were dentally necessary.

### Effective Date

The date when your coverage under this plan begins.

### Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Oncology Clinical Trials" below in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center (TEC).

### Group

The entity that sponsors this self-funded plan.

### Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A "hospital" will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

### Illness

A sickness, disease, medical condition or pregnancy.

### Injury

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

### Inpatient

Confined in a medical facility as an overnight bed patient.

### Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or injury.

### Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate

medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

### Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

### Medically Necessary

Those covered services and supplies that are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to the diagnosis or the treatment of an illness, injury or condition harmful or threatening to the member's life or health, unless provided for preventive services when specified as covered under this plan
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature
- Medically effective treatment of the diagnosis as demonstrated by:
  - Sufficient evidence exists to draw conclusions about the effect of the health intervention on health outcome
  - Evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
  - Expected beneficial effects of the health intervention on health outcomes outweigh its expected harmful effects
- Cost effective as determined by being the least costly of the alternative supplies or levels of service that's medically effective and can safely be provided to the member. A health intervention is cost effective if no other available health intervention offers a clinically appropriate benefit at a lower cost.
- Not primarily for research or data accumulation
- Not primarily for the convenience of the member, the member's family, the member's physician or another provider

**Health Intervention** is defined as an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical condition. Activities that are primarily custodial, part of normal existence, or undertaken for the convenience of a patient, family, health professional or third party are not health interventions.

**Health Outcome** is defined as the results of medical interventions that directly affect the length or quality of life of the member.

**Sufficient Evidence** is defined as the evidence derived from clinical research that is (1) peer-reviewed, (2) well-controlled, (3) directly or indirectly relates to intervention to health outcomes, and (4) reproducible both within and outside of a research setting.

### Member (also called "You" and "Your")

A person covered under this plan as a subscriber.

### Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum), including voluntary termination of pregnancy, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

### Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

## Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

## Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

## Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

## Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide Prescription Drug benefits.

## Pharmacy Benefits Administrator

An entity that contracts with us to administer Prescription Drug benefits under this plan.

## Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state

## Plan (also called "This Plan")

The Group's self-funded plan described in this booklet.

## Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - **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 or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

## Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

## Psychiatric Condition

A condition listed in the **Diagnostic and Statistical**

**Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

### Skilled Care

Care that's ordered by a physician and, in our judgment, requires the medical knowledge and technical training of a licensed registered nurse.

### Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

### Subscriber

An enrolled employee or retiree of the Group. Coverage under this plan is established in the subscriber's name.

### Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

### We, Us and Our

Means Premera Blue Cross.

# Where To Send Claims

### MAIL YOUR CLAIMS TO

Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

### PRESCRIPTION DRUG CLAIMS

**Mail Your Prescription Drug Claims To**
Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

**Contact Medco Health Solutions, Inc. At**
1-800-391-9701
www.medco.com

# Customer Service

**Mailing Address**
Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

**Physical Address**
3900 East Sprague
Spokane, WA 99202-4895

**Phone Numbers**
Local and toll-free number:
1-800-722-1471

Local and toll-free TDD number
for the hearing impaired:
1-800-842-5357

# When You Have An Appeal

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

# BlueCard

1-800-810-BLUE(2583)

# Visit Our Web Site

www.premera.com