# **Law Enforcement Officers** & Firefighters
# **Health & Welfare Trust**

**911 E Baldwin**
**Spokane, WA 99207**
**Office Phone Numbers: 509-484-5598 or 509-484-2388**
**In Washington toll-free number: 1-800-377-2388**

## HOW TO CONTACT US

Please call or write our office listed above or our contract our Business Associates as follows:

**Eligibility & Claims Payment**

Rehn & Associates
1322 N Post Street
Spokane, WA 99202
www.Rehnonline.com
Office 509-534-0600
Toll-Free Number 1-800-872-8979

**Provider Network & Hospital Pre-Certification**

First Choice Health Network
PO Box 2289
Seattle, WA 98111-2289
1-800-231-6935
www.FCHN.com

**Agent, Benefit Consultant, Customer Service**

BeneFax, Inc.
9 South Washington #315
Spokane, WA 99201
www.benefax.com
Office 509-455-7550/Fax 509-455-7525
Nationwide toll free number 1-800-535-3455

**Prescription Drugs**

Retail Pharmacy
Restat
www.RESTAT.com
1-800-248-1062

Mail Order
IPS Mail Order Services
www.ISPRX.com
1-800-233-3872

**Effective Date: January 1, 2005**

# TABLE OF CONTENTS

# INTRODUCTION

This plan document and benefit booklet is for members of Law Enforcement Officers & Firefighters Health & Welfare Trust. This booklet describes the benefits of the plan and replaces any other benefit booklet you may have received. The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the contract.

## HOW TO USE THIS BOOKLET

We realize that using a health care plan can seem complicated, so we've prepared this booklet to help you understand how to get the most out of your benefits. Please familiarize yourself with the Table of Contents, which lists sections that answer many frequently asked questions. Every section in this booklet contains important information, but the following sections may be particularly useful to you:

- **HOW TO CONTACT US** — phone numbers, mailing addresses and other contact Information conveniently located inside the front cover.

- **HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?** — How using network providers will affect your plan benefits and reduce your out-of-pocket costs

- **WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?** – The types of expenses you must pay for covered services

- **WHAT ARE MY BENEFITS?** — What's covered under your plan. Described within each benefit, you'll find a summary of what you're responsible for paying when you seek covered services from a First Choice Health Network provider

- **WHAT'S NOT COVERED?** — Services that are either limited or not covered under your plan

- **WHO IS ELIGIBLE FOR COVERAGE?** – Eligibility requirements for your plan

- **HOW DO I FILE A CLAIM?** — Step-by-step instructions for claims submissions

- **WHAT IF I HAVE A QUESTION OR AN APPEAL?** — Addresses and processes to follow if you want to share ideas, ask questions, file a complaint or submit an appeal

- **DEFINITIONS** — many terms that have specific meanings under this plan. Example: The terms "you" and "your" refer to members under this plan. The terms "we," "us" and "our" refer to the Law Enforcement Officers & Firefighters Health & Welfare Trust

# HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

To help manage the cost of health care, we've contracted with First Choice Health PPO Network. Your plan benefits and your out -of-pocket expenses depend on the providers you seek care from. Throughout this section you'll find important information on how to control costs and your out -of-pocket expenses, and how the providers you choose can affect your plan benefits.

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services. The First Choice provider networks include hospitals, physicians, and a variety of other types of providers. Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowable charges even though they have an agreement with First Choice. You'll never have to pay more than your share of the allowable charge when you use providers who have an agreement with us.

**Important Note:** You are entitled to receive a provider directory automatically, without charge.

The directory is available on the First Choice Web site at www.FCHN.com or by contacting our Customer Service Department.

## WHEN YOU GET CARE IN WASHINGTON

**You'll always get the highest level of benefits and the lowest out-of-pocket costs when you get covered services and supplies from First Choice Health Network providers**. These providers are also familiar with your plan's features and can help you make informed decisions about the health care services you get.

### Other Providers

If you decide not to use First Choice Health Network providers, you may choose any "provider" (please see the "Definitions" section in this booklet), however, if the provider you choose isn't part of our First Choice Health Network, you'll get the lowest level of benefits under this plan for covered services and supplies, unless otherwise stated below.

**The following services and/or providers will always be covered at the highest applicable in-network benefit applied to the "allowable charge" for covered services and supplies (please see the "Definitions" section of this booklet for the description of "allowable charge"):**

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet), your plan provides worldwide coverage.
- Certain types of providers (including Alcohol Treatment Facilities, Blood Banks and Ambulance companies) with whom First Choice has no agreements. These types of providers aren't included in the First Choice provider directory.
- Services associated with admission by a First Choice provider to a First Choice hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services at any of the First Choice contracted hospitals if you're admitted by a First Choice provider who doesn't have admitting privileges at a First Choice-contracted hospital.

**Important Note:** Please see the "Benefit Level Exceptions For Nonemergent Care" section for more information on requesting the First Choice **provider** level of benefits when you seek covered services and supplies from providers that aren't part of the First Choice network.

**Other Important Information About Selecting Providers**

**If the provider you choose has an agreement with FIRST CHOICE HEALTH NETWORK**, the provider agrees to accept the "Allowable Charge" (please see the "Definitions" section in this booklet) as payment in full. You're responsible only for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non covered services and supplies.

**If the provider you choose doesn't have an agreement with FIRST CHOICE HEALTH NETWORK**, you're responsible for amounts above the "Allowable Charge" (the difference between what we allow for the service and the provider's actual charge), in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non covered services and supplies. Amounts in excess of the Allowable Charge don't accrue toward your calendar year deductible or coinsurance. services you get.

### Other Providers

If you decide not to use a First Choice **participating provider,** you may choose any "provider" (please see the "Definitions" section in this booklet). However, if the provider you choose isn't part of the FIRST CHOICE HEALTH NETWORK preferred or participating provider network, you'll get the lowest level of benefits under this plan for covered services and supplies, unless otherwise stated below.

**The following services and/or providers will always be covered at the highest level of benefits:**

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet), your plan provides worldwide coverage.
- Certain types of providers (including Alcohol Treatment Facilities, Blood Banks and Ambulance Companies) with whom FIRST CHOICE HEALTH NETWORK has no agreements. These types of providers aren't included in the FIRST CHOICE HEALTH NETWORK preferred and participating provider directory.
- Services associated with admission by a FIRST CHOICE HEALTH NETWORK preferred or participating provider to a preferred or participating hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services at any of the FIRST CHOICE HEALTH NETWORK contracted hospitals if you're admitted by a preferred or participating provider who doesn't have admitting privileges at a preferred or participating hospital.

**Important Not**e: Please see the "Benefit Level Exceptions For Nonemergent Care" section for more information on requesting the FIRST CHOICE HEALTH NETWORK **provider** level of benefits when you seek covered services and supplies from providers that aren't part of the FIRST CHOICE HEALTH NETWORK **preferred** or **participating provider** network.

**Other Important Information About Selecting Providers If the provider you choose has an agreement with FIRST CHOICE HEALTH NETWORK**, the provider agrees to accept the "Allowable Charge" (please see the "Definitions" section in this booklet) as payment in full. You're responsible only for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies.

**If the provider you choose doesn't have an agreement with FIRST CHOICE HEALTH NETWORK**, you're responsible for amounts above the "Allowable Charge" (the difference between what we allow for the service and the provider's actual charge), in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies. Amounts in excess of the Allowable Charge don't accrue toward your calendar year deductible or coinsurance.

## WHEN YOU GET CARE OUTSIDE WASHINGTON

### Other Providers

If you are out of the State of Washington, you may choose any "provider" and the plan will pay the usual and customary charges for the service area. The following services and/or providers will always be covered at the highest level of benefits:

- Emergency care. If you have a "medical emergency" (please see the "Definitions" section in this booklet), your plan provides worldwide coverage.
- Services associated with admission by a PPO provider to a PPO hospital that are provided by hospital-based providers.

### Other Important Information About Selecting Providers

Please see the "Benefit Level Exceptions For Nonemergent Care" section for more information on requesting the FIRST CHOICE HEALTH NETWORK provider level of benefits when you seek covered services and supplies that aren't for a medical emergency.

**If the provider you choose has an agreement FIRST CHOICE HEALTH NETWORK**, you're responsible for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums and noncovered services and supplies.

**If the provider you choose doesn't have an agreement with FIRST CHOICE HEALTH NETWORK**, you're responsible for amounts above the "Allowable Charge" (the difference between what the FIRST CHOICE HEALTH NETWORK allows for the service and the provider's actual charge), in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies. Amounts in excess of the Allowable Charge don't accrue toward your calendar year deductible or coinsurance.

# 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.

## COPAYMENTS

Co-payments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service. The copays applicable to the "Medical Services" portion of your plan are located under the "What Are My Benefits?" section. Copays applicable to retail and home delivery pharmacy prescription drug purchases are located under the Prescription Drugs benefit. After your copay, other than Emergency Room services, benefits subject to a copay are provided at 100% of allowable charges and aren't subject to your:

These copays don't apply to your:

- Calendar year deductible
- Coinsurance
- Out-of-pocket maximum

Please refer to the Emergency Room Services benefit under the "What Are My Benefits?" section for more details.

## CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the "Allowable Charge" (please see the "Definitions" section in this booklet).

### Individual Deductible

An "Individual Deductible" is the amount each member must incur and satisfy before certain benefits of this plan are provided.

### Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible. The deductible amounts applicable to the "Medical Services" portion of your plan are located under the "What Are My Benefits?" section. See the "Medical Services" section for which benefits are subject to the calendar year deductible.

### What Doesn't Apply To The Calendar Year Deductible?

Amounts that don't accrue toward your plan January 1, 2005 calendar year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- Coinsurance stated in the Prescription Drugs section

## COINSURANCE

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. It is the percentage you're responsible for, not including copays and calendar year deductible(s), when the plan provides benefits at less than 100% of the allowable charge. The coinsurance percentage applicable to the medical services portion of your plan is located under the "What Are My Benefits?" section. Coinsurance applicable to retail and home delivery pharmacy prescription drug purchases is located under the Prescription Drugs benefit.

### OUT-OF-POCKET MAXIMUM

The “Individual Out-of-pocket maximum” is the maximum amount, made up of the calendar year deductible and coinsurance shown under “medical services,” that each individual could pay each calendar year for covered services and supplies furnished by FIRST CHOICE HEALTH NETWORK providers. There is no out-of-pocket maximum limit for services of providers not in the FIRST CHOICE HEALTH NETWORK network. As with the family deductible, we also keep track of the total deductible and coinsurance amounts applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals a set maximum, called the “Family Out-of-Pocket Maximum,” we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member’s individual out-of-pocket maximum will count toward the family out -of-pocket maximum. Please refer to “What’s My Out-of-Pocket Maximum?” in the “What Are My Benefits?” section for the amount of any out-of-pocket maximums you are responsible for.

**Once this out-of-pocket maximum has been satisfied, the benefits of your plan will be provided at 100% of allowable charges for the remainder of that calendar year for covered services from FIRST CHOICE HEALTH NETWORK providers.**

## 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 accidental injury
- It must be, in our judgment, medically necessary and must be furnished in a medically necessary setting
- 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 benefit 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 ARE MY COPAYS?

Services subject to a copay when received from a FIRST CHOICE HEALTH NETWORK provider are subject to your calendar year deductible and coinsurance when received from providers outside our FIRST CHOICE HEALTH NETWORK.

### Emergency Room Copay

For each emergency room visit, you pay $50. Emergency room visits are also subject to any applicable calendar year deductible and coinsurance. The emergency room copay will be waived if you’re admitted directly to the hospital from the emergency room.

### Professional Visit Copay

For each office or home visit furnished by a FIRST CHOICE HEALTH NETWORK Provider, you pay $5. Certain services don’t require a copay. However, the office visit copay may apply if you consult with a FIRST CHOICE HEALTH NETWORK provider. Separate copays will apply for each separate FIRST CHOICE HEALTH NETWORK provider you receive services from, even if those services are received on the same day.

In addition to office or home visits, this copay also applies to the following services in an office setting: exams, spinal and other manipulations, acupuncture, biofeedback, rehabilitation therapy, neurodevelopment therapy, and nutritional therapy. This copay doesn’t apply to services listed as covered under the Home and Hospice Care.

## WHAT'S MY CALENDAR YEAR DEDUCTIBLE?

**Individual Calendar Year Deductible**

For each member, this amount is $100 for covered services from FIRST CHOICE HEALTH NETWORK providers. For covered services from providers who are not FIRST CHOICE HEALTH NETWORK providers your calendar year deductible is $200. While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowable charges that apply to your individual in-network or out-of-network calendar year deductibles toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to either of your individual calendar year deductibles toward that maximum.

**Family Calendar Year Deductible**

The maximum calendar year deductible for your family is $200 when covered services are received from FIRST CHOICE HEALTH NETWORK providers. When covered services are received from providers who are not FIRST CHOICE HEALTH NETWORK providers, your family calendar year deductible is $400.

**Please Note:** The calendar year deductible accrues toward the out-of-pocket maximum. Expenses you incur for covered services and supplies in the last three months of a calendar year which are used to satisfy all or part of the calendar year deductible will also be used to satisfy all or part of the next year's deductible. This is also true for the family calendar year deductible.

## WHAT'S MY COINSURANCE?

When you choose FIRST CHOICE HEALTH NETWORK providers, your coinsurance is 20% of allowable charges, unless otherwise stated. When you choose providers that aren't part of our FIRST CHOICE HEALTH NETWORK, your coinsurance is 50% of allowable charges, unless otherwise stated.

## WHAT'S MY OUT-OF-POCKET MAXIMUM?

### Individual Maximum

For each member, this amount is $500 per calendar year, for care from FIRST CHOICE HEALTH NETWORK.

### Family Maximum

For each family, this amount is $1,000 per calendar year, for care from FIRST CHOICE HEALTH NETWORK providers.

## DOES MY PLAN HAVE A LIFETIME MAXIMUM?

The lifetime maximum amount of benefit for services described in the medical services section available to any one member is $2,000,000.

**Annual Restoration** Each January 1 of your continuous coverage, we will restore up to $5,000 of your lifetime maximum that has been paid by us and not previously restored. This restoration occurs regardless of the state of your health.
The following benefits don't accrue to your lifetime maximum:

- Benefits described in the Prescription Drugs section
- Benefits for vision hardware described in the Vision Benefit section. It's important to note that certain benefits of this plan are also subject to separate lifetime benefit maximums.

## MEDICAL SERVICES

**Please Note:** Except as specifically stated, the amount you pay for covered services stated in the individual medical benefits refer to services from FIRST CHOICE HEALTH NETWORK providers. Please see "What Are My Benefits?" for a description of the amount you pay for services from providers who are not part of our FIRST CHOICE HEALTH NETWORK.

## Acupuncture Services
You pay a $5 copay per visit in an office setting when you use FIRST CHOICE HEALTH NETWORK provider. When acupuncture isn't done in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay. 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 for acupuncture services aren't subject to a calendar year benefit limit.

## Ambulance Services
The following services are subject to your calendar year deductible and coinsurance. 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. 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
The following services are subject to your calendar year deductible and coinsurance. 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, subject to your calendar year deductible and coinsurance.

## Chemical Dependency Treatment
### Inpatient Facility Services
These services are subject to your calendar year deductible and coinsurance.

### Inpatient Professional Services
These services are subject to your calendar year deductible and coinsurance.

### Outpatient Facility Services
The following services are subject to your calendar year deductible and coinsurance.

### Outpatient Professional Visits
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

Benefits are provided for inpatient and outpatient chemical dependency treatment and supporting services provided to a member up to a maximum benefit of $11,841 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.
In determining whether services for chemical dependency treatment are medically necessary, we'll use the current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine. **Please Not**e: 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 nondependent 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 by us
- 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

### Contraceptive Management and Sterilization Procedures

Benefits are provided for the following:

**Consultations**
You pay a $5 copay per visit when you use a FIRST CHOICE HEALTH NETWORK provider.

**Sterilization Procedures**

**Outpatient Facility Services**
These services are subject to your calendar year deductible and coinsurance.

**Professional Services** These services are subject to your calendar year deductible and coinsurance.

**Injectable Contraceptives**
You pay a $5 copay per visit in an office setting when you use a First Choice Health Network provider. The Injectable Contraceptive copay will be waived if services are provided during an office visit, for which you've already paid a copay.

**Implantable Contraceptives (including hormonal implants)**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. The Implantable Contraceptive copay will be waived if services are provided during an office visit, for which you've already paid a copay.

**Emergency Contraception Methods (oral or injectable) when furnished by your health care provider)**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. The Emergency Contraception copay will be waived if services are provided during an office visit, for which you've already paid a copay. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

**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:**
- Nonprescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including infertility enhancement services, procedures, supplies and drugs

## Dental Services

The Medical Services benefits of this plan will only be provided for the dental services listed below.

**Accidental Injuries**

**Professional Visits**
The professional visit copay applies to dentist visits to examine the damage done in a dental accident and recommend treatment. You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a dental visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

**Dental Treatment**
These services are subject to your calendar year deductible and coinsurance. When services are related to an accidental injury, benefits are provided for the repreparation or repair of the natural tooth structure when such repair is performed within 12 months of the accidental injury. These services are only covered when they're:
- Necessary as a result of an accidental 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 effected 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 accidental 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 accidental injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the accidental injury date.

**When Your Condition Requires Hospital Or Ambulatory Surgical Center Care Inpatient Facility Services**
These services are subject to your calendar year deductible and coinsurance.

**Ambulatory Surgical Center Services**
These services are subject to your calendar year deductible and coinsurance. General anesthesia and related facility services for dental procedures are covered when medically necessary for one of 2 reasons:
- The member is under age 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 Not**e: This benefit will not cover the dentist's services unless the services are to treat a dental accident and meet the requirements described above.

## Diagnostic Imaging And Laboratory Services
Benefits for diagnostic imaging and laboratory services are provided at 100% of allowable charges (your calendar year deductible is waived and you pay no coinsurance) when furnished by a FIRST CHOICE HEALTH NETWORK provider. Benefits are provided for the following imaging and laboratory services, including administration and interpretation:
- Diagnostic and routine imaging (including x-ray).
- Laboratory services, including routine and preventive
- Pathology tests

**This benefit doesn't cover allergy testing.** See the Professional Visits and Services benefit for coverage of allergy testing.

**Please Note:** When covered inpatient imaging and laboratory services are furnished and billed by the hospital, they are only eligible for coverage under the Hospital Inpatient Care benefit.

## Diagnostic And Screening Mammography
Benefits for diagnostic and screening mammography services are provided at 100% of allowable charges (your calendar year deductible is waived and you pay no coinsurance) when furnished by a FIRST CHOICE HEALTH NETWORK provider. Benefits are provided for diagnostic and screening mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

## Emergency Room Services

You pay a $50 copay per visit to the emergency room. These services are also subject to your calendar year deductible and coinsurance.

**Please Not**e: The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room. This benefit is provided for emergency room services, including related services and supplies, such as diagnostic imaging (including x-ray) and laboratory services, surgical dressings and drugs, furnished by and used while at the hospital. Also covered under this benefit are medically necessary detoxification services; these services don't accrue toward the Chemical Dependency Treatment benefit maximum. 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 FIRST CHOICE HEALTH NETWORK providers or approved providers. To obtain a list of FIRST CHOICE HEALTH NETWORK providers or approved providers, contact our . Benefits are provided up to a maximum benefit of $250 per member each calendar year for outpatient health education services. The health education maximum doesn't apply to health education and training to manage diabetes. Benefits are also provided up to a separate combined maximum benefit of $250 per member each calendar year for nicotine dependency programs **and** community wellness services.

### 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. 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, we'll provide benefits as stated in this benefit. Please contact our Customer Service department (see the "How To Contact Us" section inside the front 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, we'll provide benefits as stated herein. Please contact our Customer Service department (see the "How To Contact Us" section inside the front 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.

**Home Health Care**
The following services are subject to your calendar year deductible and coinsurance. This benefit provides up to 130 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 photo therapy, are also covered under this benefit.

**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. These services don't count toward the 130 intermittent home visit limit shown above under Home Healthcare. These services are subject to your calendar year deductible and coinsurance.

- **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. These services are subject to your calendar year deductible and coinsurance.

- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member. These services are subject to your calendar year deductible and coinsurance.

**Insulin and Other Home and Hospice Care Provider Prescribed Drugs**
These services are subject to your calendar year deductible and coinsurance. Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice during a period of covered home health or hospice care. The drugs must be prescribed in the written plan of care.

**This benefit doesn't cover:**
- Charges in excess of the average wholesale price shown in the **Pharmacist's Red Book** for prescription drugs, insulin, and intravenous drugs and solutions
- 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
The following services are subject to your calendar year deductible and coinsurance. 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
- Diagnostic and therapeutic services
- 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 and newborn, please see the Obstetrical Care and Newborn Care benefits.

**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

### Outpatient Surgery Services

These services are subject to your calendar year deductible and coinsurance.

### Other Outpatient Services

These services are subject to your calendar year deductible and coinsurance. This benefit is provided for operating, procedure, and recovery rooms; plus services and supplies, such as diagnostic imaging (including x-ray) and laboratory services, surgical dressings and drugs, furnished by and used while at the hospital.

## Infusion Therapy

The following services are subject to your calendar year deductible and coinsurance. 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:**
- Charges in excess of the average wholesale price shown in the **Pharmacist's Red Book** for drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements

## Jaw Surgery

### Inpatient Facility Services

These services are subject to your calendar year deductible and coinsurance.

### Inpatient Professional Services

These services are subject to your calendar year deductible and coinsurance.

### Outpatient Surgical Facility Services

These services are subject to your calendar year deductible and coinsurance.

### Outpatient Professional Visits

You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When an outpatient professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

### Other Professional Services

These services are subject to your calendar year deductible and coinsurance. When medical necessity criteria are met, benefits for upper and/or lower jaw augmentation or reduction (Orthognathic and/or maxillofacial) surgery are provided up to a lifetime maximum benefit of $5,000 per member.

## Mastectomy and Breast Reconstruction Services

**Inpatient Facility Services**

These services are subject to your calendar year deductible and coinsurance.

**Inpatient Professional and Surgical Services**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Surgical Facility Services**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Professional Visits**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When an outpatient professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please
see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

**Other Outpatient Professional Services**
These services are subject to your calendar year deductible and coinsurance. Benefits are provided for mastectomy necessary due to disease, illness or accidental injury. For a 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 lymph edemas. Services are to be provided in a manner determined in consultation with the attending physician and the patient.

## Medical Equipment and Supplies

The following services are subject to your calendar year deductible and coinsurance. 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. We 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, we'll 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), and Orthopedic Appliances**
Benefits include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses. Benefits for medical supplies, orthotics, and orthopedic appliances are not subject to a benefit maximum. For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

**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. This benefit also provides for the first intraocular lens prescribed to replace the lens of the eye.

**Foot Orthotics and Therapeutic Shoes**
When prescribed for the condition of diabetes, or for corrective purposes, benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses.

**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, weights and whirlpool baths
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses

## Mental Health Care
**Inpatient Facility Services**

These services are subject to your calendar year deductible and coinsurance.

**Inpatient Professional Services**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Therapeutic Visits**
These services are subject to your calendar year deductible and coinsurance. Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided as stated below. 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 generally recognized standards within a relevant health profession 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. Benefits are provided up to the following maximums:

**Inpatient Care**
Up to 7 days per member each calendar year for facility and professional care. As an alternative to inpatient care, your plan covers "psychiatric partial days." Two psychiatric partial days will count as one inpatient day, and you will be responsible for the applicable inpatient cost-share.

**Outpatient Therapeutic Visits**
Up to 20 office or home therapeutic visits per member each calendar year. Also covered under this benefit are biofeedback services for Generalized Anxiety Disorder when provided by a qualified provider. "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 **Physician's 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
- Dementia and sleep disorders
- 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 Services And Your Rights**
Law Enforcement Officers & Firefighters Health & Welfare Trust and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you want a more detailed description of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact Law Enforcement Officers & Firefighters Health & Welfare Trust at one of the following telephone numbers:

Local 509-484-5598 or in Washington toll-free number: 1-800-377-2388

If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 360-236-4010.

## Neurodevelopmental Therapy
Benefits are provided for the treatment of neurodevelopment disabilities for members under age 7. The following inpatient and outpatient neurodevelopment therapy services must be medically necessary to restore and improve function, or to maintain function where, in our judgment, significant physical deterioration would occur without the therapy.

**Inpatient Care**
Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

**Inpatient Facility Care**
These services are subject to your calendar year deductible and coinsurance.

**Inpatient Professional Services**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:
- The enrollee must not be confined in a hospital or other medical facility
- The therapy must be part of a formal written treatment plan prescribed by a physician
- 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, up to a maximum benefit of 45 visits per member each calendar year.

**Outpatient Facility Care**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Professional Services**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

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. We won't provide this benefit and the Rehabilitation Therapy And Chronic Pain Care benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

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

**This 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

## Newborn Care
Newborn children are covered automatically for the first three weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 3-week period, please see the dependent eligibility and enrollment guidelines outlined under "Who Is Eligible For Coverage?" and "When Does Coverage Begin?" If the mother isn't eligible to receive obstetrical care benefits under this plan, the newborn isn't automatically covered for the first three weeks. For newborn enrollment information, please see the sections "Who Is Eligible For Coverage?" and "When Does Coverage Begin?"
.
Plan benefits will apply, subject to the child's own applicable copay, deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

**Hospital Care**
These services are subject to your calendar year deductible and coinsurance. Hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury. 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.

**Professional Care**
- Inpatient newborn care, including newborn exams
- Follow-up care, including newborn exams, consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

**This benefit doesn't cover immunizations. See the Preventive Medical Care benefit for coverage of immunizations and outpatient well-baby care.**

**Inpatient Professional Care**

These services are subject to your calendar year deductible and coinsurance.

**Outpatient Professional Visits**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the
"Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

**Please Not**e: 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.).

## Nutritional Therapy

You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay. Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes are 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

Benefits for pregnancy, childbirth and voluntary termination of pregnancy are provided on the same basis as any other condition for the subscriber or enrolled spouse. Obstetrical care benefits aren't covered for dependent children. However, complications of pregnancy are covered on the same basis as any other illness for the subscriber, enrolled spouse, or enrolled dependent child. Obstetrical care benefits include:

**Facility Care**
**Inpatient Hospital Services**
These services are subject to your calendar year deductible and coinsurance.

**Birthing Center and Short-Stay Hospital Facility Services**
These services are subject to your calendar year deductible and coinsurance. 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.

**Professional Care**
The following obstetrical care services are subject to your calendar year deductible and coinsurance:
- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
- Delivery, including cesarean section
- 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 Not**e: 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 single fee for childbirth that includes prenatal and postpartum services; this plan will cover that fee as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

## Phenylketonuria (PKU) Dietary Formula

Benefits for PKU dietary formula are subject to your calendar year deductible and coinsurance. Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU), not to exceed an order of 5 cases in any calendar month. If more than 5 cases are required for use in any calendar month, benefits will be provided for the additional amount of formula medically necessary to treat the member. This benefit isn't subject to the waiting period for pre-existing conditions, explained in "What's Not Covered?"

## Preventive Medical Care

Benefits for routine and preventive services performed on an outpatient basis are provided up to a combined maximum benefit of $300 per member each calendar year. **This benefit will be provided only when the following covered services are furnished by FIRST CHOICE HEALTH NETWORK providers.**

### Routine or Preventive Exams

You pay a $5 copay per visit when you use a FIRST CHOICE HEALTH NETWORK provider. Covered services include:

- Routine physical exams
- Well-baby exams (beyond the 3-week period specified under the Newborn Care benefit) For outpatient routine or preventive diagnostic imaging (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, please see the Diagnostic Imaging And Laboratory Services and Diagnostic And Screening Mammography benefits. For newborn exams (furnished during the first 3 weeks from birth) benefit information, please see the Newborn Care benefit.

### Immunizations

Benefits for immunizations are provided at 100% of allowable charges (you pay no coinsurance). Immunization benefits are subject to the calendar year limit for preventive care services specified above. 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. These services are covered under the Newborn Care benefit.
- 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

## 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

You pay a $5 copay per visit in a home or office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in a home or office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

Benefits are also provided for the following professional services when provided by a qualified FIRST CHOICE HEALTH NETWORK provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback services for any covered medical diagnosis or treatment plan
- Diabetic foot care
- Surgery performed in a provider's office

### Other Professional Services

Benefits for injections are provided at 100% of allowable charges (you pay no coinsurance) when furnished by a FIRST CHOICE HEALTH NETWORK provider. Benefits are available for the following:

- Therapeutic injections, including allergy injections

- Allergy testing

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

For professional diagnostic imaging and laboratory services benefit information, please see the Diagnostic Imaging And Laboratory 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

The following services are subject to your calendar year deductible and coinsurance. Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined. Covered services include testing related to mental health, rehabilitation and Neurodevelopmental therapy, and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes later re-evaluations to make sure the treatment is achieving the desired medical results.

## 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 accidental injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

**Inpatient Care** Benefits for inpatient facility and professional care are available up to 30 days per enrollee each calendar year. 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 physiatrist (a physician specializing in rehabilitative medicine).

**Inpatient Facility Care**
These services are subject to your calendar year deductible and coinsurance.

**Inpatient Professional Services**
These services are subject to your calendar year deductible and coinsurance.

**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
- The therapy must be part of a formal written treatment plan prescribed by a physician

• 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 enrollee each calendar year.

**Outpatient Facility Care**
These services are subject to your calendar year deductible and coinsurance.

**Outpatient Professional Services**
You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When rehabilitation therapy isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the
"Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay. 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 care. 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. We won't provide this benefit and the Neurodevelopmental Therapy benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

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

**This 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 enrollee's accidental injury or illness or from the date of the enrollee's surgery.

## Skilled Nursing Facility Services
The following services are subject to your calendar year deductible and coinsurance. 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 up to 60 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

**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
You pay a $5 copay per visit when you use a FIRST CHOICE HEALTH NETWORK provider. Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits for spinal manipulations aren't subject to a calendar year benefit limit.

Non-manipulation services (including diagnostic imaging) is 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 and Neurodevelopmental Therapy benefits.

## Surgical Services

The following services are subject to your calendar year deductible and coinsurance. This benefit covers all surgical services when performed on an inpatient or outpatient basis, in such locations as a hospital, surgical suite, or ambulatory surgical facility. Also covered under this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives. For benefits for surgeries performed in a provider office, please see the "Professional Visits and Services" benefit. For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

## Temporomandibular Joint (TMJ) Disorders

### Inpatient Facility Services

These services are subject to your calendar year deductible and coinsurance.

### Inpatient Professional and Surgical Services

These services are subject to your calendar year deductible and coinsurance.

### Outpatient Surgical Facility Services

These services are subject to your calendar year deductible and coinsurance.

### Outpatient Professional Visits

You pay a $5 copay per visit in an office setting when you use a FIRST CHOICE HEALTH NETWORK provider. When a professional visit isn't provided in an office setting, benefits are subject to your calendar year deductible and coinsurance. Please see the "Professional Visit Copay" provision in the "What Are My Benefits?" section of this booklet for details about this copay.

### Other Outpatient Professional Services

These services are subject to your calendar year deductible and coinsurance. Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. 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

### Waiting Period

Your plan doesn't provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization), unless you've been covered under a medical contract with us for 6 consecutive months. However, this waiting period doesn't apply if the transplant is needed as a direct result of:

- An accidental injury that occurs on or after your effective date of coverage under this plan
- A congenital anomaly of a child who's been covered through us since birth

- A congenital anomaly of a child who's been covered through us since placement for adoption with the subscriber

**Please Not**e: Transplant-related services that are covered under other benefits of this plan are subject to the waiting period for pre-existing conditions (please see the "What's Not Covered?" section in this booklet for more information about this waiting period).

**Covered Transplants**
This benefit covers medical services only if provided by First Choice Health Network providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about "Approved Transplant Centers."

**Inpatient Facility Services**
Benefits for services in a FIRST CHOICE HEALTH NETWORK facility or an "Approved Transplant Center," are subject to your calendar year deductible and coinsurance.

**Inpatient Professional and Surgical Services**
Benefits for a FIRST CHOICE HEALTH NETWORK provider or an "Approved Transplant Provider," are subject to your calendar year deductible and coinsurance.

**Outpatient Surgical Facility Services**
Benefits for a FIRST CHOICE HEALTH NETWORK facility or an "Approved Transplant Center," are subject to your calendar year deductible and coinsurance.

**Outpatient Professional Visits**
You pay a $5 copay per visit to a FIRST CHOICE HEALTH NETWORK provider or an "Approved Transplant Provider."

**Other Outpatient Professional Services**
Benefits for a FIRST CHOICE HEALTH NETWORK provider or an "Approved Transplant Provider," are subject to your calendar year deductible and coinsurance.

**Transport and Lodging**
The transport and lodging benefits are subject to your calendar year deductible, but aren't subject to your coinsurance. Benefits 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 our 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 our 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 Not**e: 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).

- You’ve satisfied your waiting period.
- Your medical condition meets our written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (“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.) Please contact First Choice Health Network or Rehn & Associaties for pre authorization and approval.

Whenever medically possible, you’ll be direct to an approved transplant center for transplant services. Of course, if none of our centers or the network centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.
- The $250,000 transplant maximum benefit must not have been reached.

**Transplant Maximum**
This benefit is subject to a lifetime maximum benefit of $250,000 for all covered transplants and transplant-related services combined. Services that accrue to this lifetime maximum benefit are also subject to the 6-month waiting period stated above.

**Recipient Costs**
Benefits for transplant or reinfusion related expenses start accruing to the $250,000 maximum 30 days before the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, 30 days before the date of reinfusion. Benefits stop accruing to the $250,000 maximum 180 days from the date of the transplant or reinfusion. Inpatient stays for episodes of rejection related to a solid organ transplant or bone marrow or stem cell reinfusion beyond the 180-day period will also accrue to the $250,000 maximum. However, the time limits above don’t apply to this benefit’s coverage for transportation and lodging. 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**
Procurement expenses are charged against the recipient’s $250,000 maximum and are limited to $75,000 per transplant. 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, except as stated below, are covered but limited 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
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided at 100% of allowable charges (your coinsurance is 0% of allowable charges), up to a maximum of $125 per day
- When the recipient isn’t a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided at 100% of allowable charges (your coinsurance is 0% of allowable charges), up to a maximum of $80 per day
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) are charged against the recipient’s $250,000 maximum and are limited to $7,500 per transplant

**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
- Nonhuman or mechanical organs, unless we determine they aren't "Experimental or Investigational Services" (please see the "Definitions" section in this booklet)
- Personal care items

## VISION BENEFIT
## Vision Exams

You pay a $5 copay per visit when you use a FIRST CHOICE HEALTH NETWORK provider. If vision testing is done during the same visit as the vision exam, the member will pay only one copay. When you see a provider other than a FIRST CHOICE HEALTH NETWORK provider, services are subject to your deductible and coinsurance. 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.

### Vision Hardware

Benefits for the vision hardware supplies listed below are provided when they meet all of these requirements:
- 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 for the following vision hardware and related services are provided at 100% of allowable charges (your coinsurance is 0% of allowable charges), up to a maximum benefit of $200 per member every 2 consecutive calendar years:
- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- 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.

**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
- Nonprescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses 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

## PRESCRIPTION DRUGS

Your benefit plan provides you with a prescription drug card that is administrated by Restat. Restat is a Prescription Benefit Manager with a nationwide network of more that 54,000 participating pharmacies. It includes most major chain stores, discount stores, grocery stores and independent pharmacies. To learn which pharmacies in your area accept your Restat member ID card, refer to your enrollment materials, visit www.RESTAT.com or call the toll-free number on the back you your membership card.

You will receive the lowest copay through the use of generic drugs. When a generic is not available, there may be more than one brand name drug that may be appropriate for you. The brand name medications are considered preferred and are selected based on their ability to meet your needs at a lower cost. A list of the current Restat Product Formulary is online to www.restat.com. There is also a toll free service line at 1-800-248-1062.

This plan provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagons 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. Each member must pay a “copay” for each separate new prescription or refill. A “copay” is defined as a fixed up-front dollar amount that you’re required to pay the pharmacy for each prescription drug purchased.

### Retail Pharmacy Prescriptions

Generic Drugs .....……. $10 copay
Preferred Brand Name Drugs ..... $20 copay
Non-Preferred Brand Name Drugs..... $40 copay

**Dispensing Limit**
Benefits are provided for up to a 30-day supply of covered medication unless the drug maker’s packaging limits the supply in some other way. You will be charged additional copay for any amount over a 30-day supply.

### Mail Order Pharmacy

Generic Drugs .....…….. $20 copay
Preferred Brand Name Drugs..... $40 copay
Non-Preferred Brand Drugs……..... $80 copay

**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.

### Injectable Supplies

When hypodermic needles and syringes are purchased along with the related injectable prescription medication for insulin dependent diabetics, only the copay for the injectable prescription medication will apply. When hypodermic needles and syringes are purchased for other injectable prescription medication, the Preferred Formulary Brand Name Drug copay will apply for each item purchased, providing you have a written prescription from your health care provider for each item.

.

The Preferred Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets, providing you have a written prescription from your health-care provider for each item. A separate copay will apply to each item purchased.

## How To Use 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 new prescription or refill to the mail order home delivery.

If you are ordering for the first time, you will need to complete a Confidential Patient Profile. There are three (3) options available for you to submit the Profile at no cost to you:

1. Online via IPS website at www.ipsrx.com
2. Contract IPS toll-free at 1-800-233-3872 or
3. Mail completed profile, which will be provided to you at the start of your enrollment. IPS provides a postage paid return envelope for your convenience.

After the initial profile is complete you can order refills via telephone, fax or e-mail 24 hours per day, seven days a week Prescriptions and refills can be ordered via the secured internet at www.ipsrx.com using major credit cards for payment.

**Retail Pharmacy Benefit**

- **Participating Retail Pharmacies**

After you've paid any required copay, we'll pay the participating pharmacy directly. To avoid paying the retail cost for a prescription drug that's reimbursable by us at a lower allowable charge rate, **be sure to present your identification card to the pharmacist for all prescription drug purchases.**

- **Nonparticipating Retail Pharmacies**

If you use a nonparticipating pharmacy, you pay the full price for the drug(s) and submit a claim for reimbursement. Please see the "How Do I File A Claim?" section in this booklet for more information. After you've paid any required deductible and copay or coinsurance, you pay 40% of the allowable charge for the prescription or refill and the difference between the pharmacy's billed charge and our allowable charge. This benefit applies to all prescriptions filled by a nonparticipating pharmacy, including those filled via mail or other home delivery. If you need a list of Participating Pharmacies, please contact Restat at 1-800-248-1062 or the number located on the back of your Law Enforcement Officers & Firefighters Health & Welfare Trust ID card.

**Home Delivery Pharmacy Benefit**

You can often save time and money by filling your prescriptions through our Mail Order program. After you've paid any required copays, we will pay the participating home delivery pharmacy directly. This benefit is limited to prescriptions filled by our participating home delivery pharmacy. For more information on the home delivery pharmacy program, or to obtain order forms, please contact the Restat Customer Service department at 1-800-248-1062.

**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 the prescription benefit of this plan. Copays, deductibles and/or coinsurance required under this benefit don't apply to other benefits of this plan.

**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 and vitamins (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).
- 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.
- Drugs for the treatment of nicotine dependency, up to $250 per member each calendar year
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)

For benefit information concerning therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), 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.

**Exclusions**
**This benefit doesn't cover:**
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but aren't limited to nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- 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 parental administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). Please see the Infusion Therapy benefit.
- Drugs to treat infertility, including fertility enhancement medications

**Your Right To Safe And Effective Pharmacy Services**
State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown inside the front cover of this booklet.

## CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost effective medical care. Your role in the process is simple, but important. The benefits of the plan do not require preauthorization for coverage. You must be eligible on the dates of services and services must be medically necessary. We encourage you to call First Choice Health Network or Rehn & Associates 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 your plan's benefits. The decision to provide benefits for these alternatives is within our sole discretion. Your participation in a treatment plan through Case Management is voluntary. First Choice Health Network Case Management is subject to the terms

set forth in a signed written agreement. We may utilize your contract benefits as specified in the signed agreements, but the agreements are not to be construed as a waiver of our right to administer the Group Contract 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.

### 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.

## WAITING PERIOD FOR PRE-EXISTING CONDITIONS

A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the 3 months before your "Enrollment Date" (please see the "Definitions" section in this booklet). The waiting period for pre-existing conditions is 3 months from your enrollment date. Except as noted below, benefits won't be provided for pre-existing conditions until:

- **After your coverage becomes effective; and your 3-month waiting period for pre-existing conditions has been met. This waiting period may be reduced by prior periods of creditable coverage as explained below.**

### How Creditable Coverage Can Reduce Your Waiting Period For Pre-existing Conditions

This plan's waiting period for pre-existing conditions may be reduced by periods of "creditable" coverage you've accrued under other health care plans prior to your enrollment date for this plan. Most medical health-care coverage is considered "creditable" coverage (see list below). You'll receive credit for prior "creditable" coverage that occurred without a break in coverage of more than 3 months. Any coverage you had before a break in coverage, which exceeds 3 months, isn't credited toward your waiting period for pre-existing conditions. Eligibility waiting periods won't be considered creditable coverage or a break in coverage. Your prior employer or health insurance carrier will provide you with a certificate of health coverage that includes information about your prior health coverage. You may contact Customer Service department if you're unable to obtain a certificate of health coverage from a prior health plan. If you haven't received a certificate, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. "Creditable" coverage shall mean coverage under one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
- Federal or any public health care plan
- Peace Corps Plan
- Any other health insurance coverage

"

Creditable" coverage doesn't include coverage under a limited policy such as an accident only coverage; disability income insurance; workers' compensation; limited scope dental or vision plans; liability insurance;

automobile medical insurance;specified disease coverage; Medicare supplemental policy; or long-term care policy. The waiting period for pre-existing conditions **doesn't apply** to:

- Pregnancy
- Newborn children born after the subscriber's effective date of coverage under this plan, provided they are covered from birth as explained under "When Does Coverage Begin?"
- Newborn children covered under creditable overage as of the last day of the 30-day period beginning with their date of birth. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 3 months.
- Adoptive children who are adopted or placed for adoption after the subscriber's effective date of coverage under this plan, provided they're covered from the date of their adoption or placement for adoption as explained under "When Does Coverage Begin?"
- Adoptive children, who before age 18, were covered under creditable coverage as of the last day of the 30-day period beginning with their date of adoption or placement for adoption. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 3 months.
- Coverage for PKU dietary formula for members with Phenylketonuria.

## WAITING PERIOD FOR TRANSPLANTS

Organ, bone marrow and stem cell transplants are subject to a benefit-specific 6-month waiting period.

Please see the Transplants benefit for details.

## LIMITED AND NONCOVERED SERVICES

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

### 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

### 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 is never covered.

### Caffeine Or Nicotine Dependence

Treatment of caffeine or nicotine dependence, except as stated under the Health Management and

Prescription Drugs benefits.

### Charges For Records Or Reports
Separate charges for records or reports, except those we request for utilization review

### Charges In Excess Of The Average Wholesale Price For Drugs
Charges in excess of the average wholesale price shown in the **Pharmacist's Red Book** for prescription drugs, insulin, and intravenous drugs and solutions, as specified in the Home and Hospice Care and Infusion Therapy benefits.

### Chemical Dependency Services
- Treatment of nondependent 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 accidental injury, providing such repair is started within 12 months of the date of the accident
    - **Repair of a dependent child's congenital anomaly**
- Reconstructive breast surgery in connection with a mastectomy, except 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 therefor. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children under age 7 as stated under the

Neurodevelopmental Therapy benefit.
- Nonmedical 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
Except when provided for hospice care (please see the Home And Hospice Care benefit)

### Dental Care
Dental services, except as specified under Dental Services (please see Medical Services under "What Are My Benefits?").

### Drugs And Food Supplements
Over-the-counter drugs, solutions, supplies, food and nutritional supplements; over-the-counter contraceptive drugs, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription.

### Environmental Therapy
Therapy designed to provide a changed or controlled environment.

### Experimental Or Investigational Services
Any service or supply that Law Enforcement Officers & Firefighters Health & Welfare Trust 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.

### Hair Prosthesis And Hair Loss Treatment
Hair prostheses, such as wigs or hair weaves, transplants, and implants. Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth.

### Hearing Hardware
Hearing aids and devices used to improve hearing sharpness.

### Infertility And Sterilization Reversal
- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs
- Assisted fertilization techniques, 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, weights and whirlpool baths
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- 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
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

### Obesity Services

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and After effects 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. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

### Orthodontia Services

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

### 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", or nutritional guidance, except as specified under the Nutritional Therapy benefit

### Pregnancy of Dependent Children

Any care connected with a dependent child's pregnancy, except care furnished for the treatment of a complication of pregnancy.

### Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental 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.

- Services and supplies that aren't directly related to your illness, accidental 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 Imaging And Laboratory Services
- Diagnostic And Screening Mammography Services
- Newborn Care (including well-newborn care)
- Preventive Medical Care (including well-baby care)
- Health Management

**Services For Which No Charge Is Made 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

**Services And Supplies Furnished By A Governmental Medical Facility**
- Services and supplies furnished by a governmental medical facility, except when:
- We approve your request for a benefit level exception for nonemergent care to the facility (please see the "Benefit Level Exceptions For Nonemergent Care" provision in this booklet)
- You're receiving care for a "Medical Emergency" (please see the "Definitions" section in this booklet)
- We must provide available benefits for covered services as required by law or regulation

**Services Furnished By Family Members Or Volunteers**
- Services 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 provided by volunteers, as specified in the Home and Hospice Care benefit

**Services Furnished When You're Not Covered Under This Plan**
- Services ordered when this plan isn't in effect, or when you're not covered under this plan, except as stated under specific benefits and under "Extended Benefits"
- 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

**Services 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, Neurodevelopmental Therapy and Rehabilitation Therapy and Chronic Pain Care benefits

**Services Not Listed As Covered**
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, service or supply that isn't covered under this plan

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

Services 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 jurisdiction in which the services or supplies were received

**Services That Aren't Medically Necessary**
- Services 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

**Sex Transformations**

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

**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, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

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

**Transplants**
- 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 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 not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Nonhuman or mechanical organs, unless we determine they aren't "Experimental or Investigational Services" (please see the "Definitions" section in this booklet)

**Vision Hardware**
- Nonprescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed
- Services and supplies (including hardware) received after your coverage under this plan 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 plan ended
- You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this plan ended

**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.

**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 1,1997. They will be covered under this plan for illness or accidental 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?
## COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS
You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations. We'll coordinate the benefits of this plan with those of your other plans to make certain that, in each calendar year, the total payments from all medical plans aren't more than the total allowable medical expenses and the total payments from all dental plans aren't more than the total allowable dental expenses.

All of the benefits of this plan are subject to coordination of benefits. However, please note that benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you send your claims to us and the other carriers at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

## Definitions Applicable To Coordination Of Benefits

To understand coordination of benefits, it's important to know the meanings of the following terms:

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health-care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under any of the medical plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.

- Allowable Dental Expense means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under any of the dental plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purpose of this plan, only those dental services to treat an accidental injury to natural teeth will be considered an allowable dental expense.

- **Claim Determination Period** means a calendar year.

- **Medical Plan** means all of the following health-care coverages, even if they don't have their own coordination provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents
- Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation
- Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. It's also important to note that for the purpose of this plan, we'll coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

**Effect On Benefits**

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so that the total benefits from all medical plans aren't more than the allowable medical expenses and the total benefits from all dental plans aren't more than the total allowable dental expenses. Coordination of benefits always considers amounts that **would** be payable under the other plan, whether or not a claim has actually been filed.

Here is the order in which the plans should provide benefits:

**First:** A plan that doesn't provide for coordination of benefits.

**Next:** A plan that covers you as **other than** a dependent.

**Next:** A plan that covers you as a dependent. For dependent children, the following rules apply:

When the Parents **Aren't** Separated or Divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

When the Parents **Are** Separated or Divorced: If a court decree makes one parent responsible for paying the child's health-care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody.

If the rules above don't apply, the plan that has covered you for the longest time will be primary, except that benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. However, this applies only when other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the plan that's covered the employee or subscriber for the longest time will be primary.

Any amount by which a secondary plan's benefits have been reduced in accord with this section shall be used by the secondary plan to pay your allowable medical expenses or allowable dental expenses not otherwise paid, and such reduced amount shall be charged against the applicable plan's benefit limit (medical or dental). However, you must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable medical expenses or allowable dental expenses based on all claims that were submitted up to that time during the claim determination period.

**Right Of Recovery/Facility Of Payment**

We have the right to recover any payments we make that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons we paid or for whom we have paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, we also have the right to pay directly to another plan any amount that should have been paid by us. Our payment will be considered a benefit under this plan and will meet our obligations to the extent of that payment.

### COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law may require this plan to be primary over Medicare. When this plan isn't primary, we'll coordinate benefits with Medicare.

### THIRD-PARTY LIABILITY (SUBROGATION)

If we make 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, we may be 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 us. "Subrogation" means that we may collect directly from that third party to the extent we've paid on your behalf for illness or injury caused by the third party. Because we've paid for your illness or injuries, we may be entitled to recover for those expenses.

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. In recovering benefits provided, we may at our election either hire our own attorney or be represented by your attorney. If we choose to be represented by your attorney, we'll pay, on a contingent basis, a reasonable portion of the attorney fees which are necessary for asserting our right of recovery in the case. This portion usually won't be more than 20% of the amount we seek to recover. We won't pay for any legal costs incurred by you or on your behalf, and you won't be required to pay any portion of the costs incurred by us or on our behalf.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery.

To the maximum extent permitted by law, we're "subrogated" to your rights against any third party who is responsible for the condition, meaning that we have the right to sue any such third party in your name, and have a security interest in, and lien upon, any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. We also may assert our right to recover benefits directly from the third party.

### UNINSURED AND UNDERINSURED MOTORIST COVERAGE

We have 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 or similar type of insurance or contract.

The amount of reimbursement that we're entitled to receive under this provision is the amount in excess

of the amount you receive from all insurance sources that fully compensate you for damages arising from the accidental injury for which such benefits have been paid.

## WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage. We have the discretionary authority to determine your eligibility for benefits.

### SUBSCRIBER ELIGIBILITY

To be a subscriber under this program, you must be, and must continue to be an employee who becomes an active full-time uniformed employee who regularly works a minimum of 20 hours per week and is a member of the Law Enforcement Officers and Fire Fighters Health and Welfare Trust. A uniformed employee is defined as follows:

• LEOFF I Employees - Full-time active law enforcement officers or fire fighters who established membership in the LEOFF system as defined in Sections (3) and (4), CH131, Law of 1972 1st Ex. Sess. prior to October 1, 1977
• LEOFF II Employees - Full-time active law enforcement officers or fire fighters who established membership in the LEOFF System as defined in Sections (3) and (4), CH131, Law of 1972 1st Ex. Sess. on or after October 1, 1977
• Becomes an active full-time support staff employee who regularly works a minimum of 17½ hours a week
• Retired LEOFF I and LEOFF II employees are eligible to continue coverage provided you are an employee who has:

- . Attained age 50 or
- . A minimum of 25 years of credited service with the employer in accordance with rules established in the LEOFF Act or
- . Is eligible to receive a retirement benefit under the LEOFF Act or
- . Transfers directly from active employee status on the employer's group medical program with us to retiree status on the employer's group medical program with us within 31 days of retirement

**DEPENDENT ELIGIBILITY**

To be a dependent under this plan, the family member must be:

• The lawful spouse of the subscriber, unless legally separated or a spouse who is required to be covered by a qualified domestic relations order
• An eligible child under 24 years of age and unmarried. Eligible children other than children placed for adoption or children for whom coverage is mandated by court decree must also be primarily dependent upon the subscriber for support. (Eligibility and enrollment requirements for children placed for adoption and children covered because of a court decree can be found later in this section.) An eligible child is one of the following:
• A natural offspring of either or both the subscriber or spouse
• A legally adopted child of either or both the subscriber or spouse
• A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
• A legally placed ward of the subscriber or spouse living permanently in the home of the subscriber

Foster children aren't eligible for coverage.

# WHEN DOES COVERAGE BEGIN?

## ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an "eligible employee" as defined in the "Who Is Eligible For Coverage?" section.

When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that coincides with or next follows the later of:

• The employee's date of hire
• The date the employee enters a class of employees to whom the Group offers this plan's coverage
• Another date as designated in the Group Contract If we don't receive the enrollment application within 60 days of the date you became eligible, please see the "Open Enrollment" provision later in this section.

## Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the first of the month following the date of marriage. If we don't receive the enrollment application within 60 days of marriage, please see the "Open Enrollment" provision later in this section.

## Natural Newborn Children Born On Or After The Subscriber's Effective Date

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan. To extend the child's coverage beyond the 3-week period, the subscriber should follow the steps below. If the mother isn't eligible for obstetrical care benefits, but the child qualifies as an eligible dependent, the subscriber should follow the steps below to enroll the child from birth.

- An enrollment application isn't required for natural newborn children when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for natural newborn children on the date of birth.

- When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following birth. Coverage becomes effective from the date of birth.

If we don't receive the enrollment application within 60 days of birth, please see the "Open Enrollment" provision later in this section.

## Adoptive Children Acquired On Or After The Subscriber's Effective Date

- An enrollment application isn't required for adoptive children placed with the subscriber when subscription charges being paid already include coverage for dependent children, but we may request additional information if necessary to establish eligibility of the dependent child. Coverage becomes effective for adoptive children on the date of placement with the subscriber.

- When subscription charges being paid don't already include coverage for dependent children, a completed enrollment application and any required subscription charges must be submitted to us within 60 days following the date of placement with the subscriber. Coverage becomes effective from the date of placement. If we don't receive the enrollment application within 60 days of the date of placement with the subscriber, please see the "Open Enrollment" provision later in this section.

## Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the first of the month following the date legal guardianship began. If we don't receive the enrollment application within 60 days of the date legal guardianship began, please see the "Open Enrollment" provision later in this section.

### Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid or the state child support enforcement agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

## SPECIAL ENROLLMENT

**Involuntary Loss of Other Coverage**

If you didn't enroll in this plan when you were first eligible because you weren't required to do so, you may later enroll outside of the annual open enrollment period if each of the following requirements are met:

- You were covered under group health coverage or a health insurance plan at the time coverage under this plan was previously offered
- You stated in writing the reason you declined coverage under this plan at the time this coverage was previously offered

Your coverage under the other group health coverage or health insurance plan was terminated as a result of one of the following:

- Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment)

- Termination of employer contributions toward such coverage

- You were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted

When we receive your completed enrollment application and any required subscription charges from the Group within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment application.

If we don't receive your completed enrollment application within 30 days of the date prior coverage ended, please see the "Open Enrollment" provision later in this section.

**Subscriber And Dependent Special Enrollment**

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Special Enrollment" in the case of marriage, birth or adoption. The eligible employee may also choose to enroll without enrolling any eligible dependents.

## OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under "Special Enrollment" above, you can't be enrolled until the Group's next "Open Enrollment" period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

If the Group offers multiple health care plans and you are enrolled under one of the Group's other health care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

## CHANGES IN COVERAGE

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

The exception is inpatient confinements described in "Extended Benefits"; please see the "How Do I Continue Coverage?" section. Changes to this plan won't apply to inpatient stays that are covered under that provision.

# WHEN WILL MY COVERAGE END?

## EVENTS THAT END COVERAGE

Coverage will end without notice, except as specified under "Extended Benefits," on the last day of the month in which one of these events occurs:

- For the subscriber and dependents when:
    - The Group contract is terminated
    - The next monthly subscription charge isn't paid when due or within the grace period
    - The subscriber dies or is otherwise no longer eligible as a subscriber
    - In the case of an association, the Association Employer's membership in the association ceases
    - In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement

- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber

- For a child when he or she cannot meet the requirements for dependent coverage shown under the "Who Is Eligible For Coverage?"section.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice of a member's termination within 30 days of the date the Group is notified of such event.

### 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.

## HOW DO I CONTINUE COVERAGE?

### CONTINUATION OF GROUP COVERAGE

### Continued Eligibility For A Disabled Child

Coverage may continue beyond the limiting age (shown under "Dependent Eligibility") for an unmarried dependent child who can't support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

The child became disabled before reaching the limiting age The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance The subscriber is covered under this plan The child's subscription charges, if any, continue to be paid

- Within 31 days of the child reaching the limiting age, the subscriber furnishes us with a Request for Certification of Handicapped Dependent form. We must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when we request it. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.

## Leave Of Absence

Coverage for a subscriber and enrolled dependents 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. The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 (Public Law 1033).

## Labor Dispute

A subscriber may pay subscription charges through the Group to keep coverage in effect for up to 6 months in the event of suspension of compensation due to a lockout, strike, or other labor dispute. The 6-month labor dispute period counts toward the maximum COBRA continuation period.

## ((ADD NEW COBRA LANGUAGE)

**Inpatient benefits only if they are enrolled beyond the 3-week period specified in the "Newborn Care" benefit.**
Such continued inpatient coverage will end when the first of the following occurs:

- You're covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this plan did not exist
- You're discharged from that facility or from any other facility to which you were transferred
- Inpatient care is no longer medically necessary
- The maximum benefit for inpatient care in the medical facility has been provided. If the calendar covered inpatient care you receive in the next year. Once it is used up, however, a calendar year maximum benefit will not be renewed
- This plan's lifetime maximum has been provided

**HOW DO I FILE A CLAIM?**
**Medical Claims**
Many providers in Washington have agreements with FIRST CHOICE HEALTH NETWORK and will submit their bills directly. However, if you're outside of Washington and have received medical services from a hospital or other health-care provider, your provider of care must bill Rehn & Associates, our claimspayor. You'll need to submit these claims to Rehn. Please 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 accidental injury, the date, time, location and a brief description of the accident

**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:**
Rehn & Associates
P.O. Box 5433
Spokane , WA 99205

**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 Restat 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 to Rehn & Associates.

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 the copay to the address printed on the form. Please allow up to 14 days for delivery.

**Nonparticipating 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 receipt(s) and submit the information to the address shown on the claim form. If you need a supply of home delivery participating home delivery pharmacy order forms or prescription drug claim forms, contact our Customer Service department at the numbers shown inside the front 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 enrollees who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater We won't provide benefits for claims we receive after the later of these 2 dates, nor will we provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

**Special Notice About Claims Procedure**
We'll make every effort to process your claims as quickly as possible. We'll tell you if your plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to

15 days if it's decided that more time is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision. If your claim was denied, in whole or in part, our written notice will include:

- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information we may need to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of our complaint and appeal processes

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You must notify us in writing and give us the name, address and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this plan, you may file suit in federal court.

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

As a Law Enforcement Officers & Firefighters Health & Welfare Trust enrollee you have the right to offer your ideas, ask questions, voice complaints and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

### When You Have Ideas

We want to hear from you on ways we can continue to improve our service. If you have an idea, suggestion or opinion, please let us know. You can call BeneFax at 1-800-535-3455 or send your comments direct to us at:

Law Enforcement Officers & Firefighters Health & Welfare Trust
P.O. Box 911 E Baldwin
Spokane, WA 99207

### When You Have Questions

Call your provider of care when you have questions about the health-care services you receive. Please call Rehn & Associates with any other questions regarding your Law Enforcement Officers & Firefighters Health & Welfare Trust 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 our benefit consultant 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 our benefit consultant 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 BeneFax. If your complaint is about the quality of care you receive, it will reviewed. If the complaint is of a non-medical nature relating to a provider, it will be given to our 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 that we reconsider

1) our decision on a complaint, or
2) 2) our 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, 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 below. 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. You can also request to review documents relevant to your claim.

You may mail appeals to:

Rehn & Associates
PO Box 5433
Spokane, WA 99205

**Appeals Process**

Our standard appeals process has 2 levels of review. We'll give you our appeal decisions in writing.

**Level I**

The Level I Appeal director will give you a decision within 30 calendar days. This director will be a health-care provider who wasn't involved in the initial decision.

There are 3 exceptions to the 30-day time limit:

- **A decision to change, reduce or end an ongoing service**

We'll mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than an additional 15 calendar days.

- **Denial of an experimental or investigational service**

We'll mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended for up to 10 more calendar days with your informed written consent.

- **Urgent Appeals** (please see the "Urgent Appeals" provision below)

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. **You must make** your request for a Level II review no more than 60 calendar days after the date you receive our

## If you don't agree with the review, you may ask us to perform a Level II decision.

**Level II** Your appeal will be reviewed by The Law Enforcement Officers & Firefighters Health & Welfare Trust appeals board, which is different from the Level I reviewer. You and/or your authorized representative may meet with the panel unless your appeal is deemed urgent (please see the "Urgent Appeals" section below), the panel will give you a decision within 30 calendar days of the date we receive your Level II request.

If you are not satisfied with the outcome of the Level II appeal, you may ask for an independent review (please see the "Independent Review" provision below). You may also ask for an independent review if we don't give you our Level I or II decision within the time limits stated. We must receive your request for independent review within 60 calendar days.

You also have the right to file suit in federal court if you're not satisfied with the outcome of the Level II appeal. .

**Independent Review** Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. The costs of requesting such a review will be the responsibility of the subscriber unless the IRO finds in the subscribers favor.

**Urgent Appeals** We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 72 hours after the appeal is received.

**Appeals Of Ongoing Care** While you're appealing a decision to change, reduce or end coverage because the service or level of service is no longer medically necessary or appropriate, we'll suspend our denial. Our coverage for services received during the appeal period doesn't and shouldn't be construed to reverse our denial. If our initial decision is upheld, you must repay us all **amounts that we've paid for such services.**

### You'll also have to pay providers any difference

between our allowable charge and the provider's billed charge. Please call Customer Service if you have questions or need more information about our complaint or appeal process. The numbers are shown inside the front cover of this booklet.

#### Additional Information About Your Coverage

Your benefit booklet provides you with detailed information about your plan's benefits, limitations and exclusions, how to obtain care and how to appeal our decisions.

You may also ask for the following information:

- •• The preferred drug list, also called a "formulary"
- How we pay providers
- How providers' payment methods help promote good patient care
- A statement of all benefit payments in each year that have been counted toward this plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations
- How to file a complaint and a copy of our process for resolving complaints
- How to access specialists
- Obtaining preauthorization when needed

## OTHER INFORMATION ABOUT MY PLAN

This section tells you how this plan is administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

**Conformity With The Law**
If any provision of this Contract 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 in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

No agent or any other entity is authorized to make any changes of the Law Enforcement Officers & Firefighters Health & Welfare Trust is authorized to make any changes, additions or deletions to the plan or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done over the signature of an officer of the Law Enforcement Officers & Firefighters Health & Welfare Trust.

**Evidence Of Medical Necessity**
We have the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. 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 us.

**Group As The Agent**
Your Group is your agent for all purposes under this plan and not the agent of Law Enforcement Officers & Firefighters Health & Welfare Trust. Any action taken by your Group will be binding on you.

**Intentionally False Or Misleading Statements**
If this plan's benefits are paid in error due to any intentionally false or misleading statements, we'll be entitled to recover these amounts. Please see the "Right Of Recovery" provision later in this section. And, if you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, at our option:

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

Finally, statements that are intentionally false or misleading on any group form required by us, that affect the acceptability of the Group or the risks to be assumed by us, may cause the Group Contract for this plan to be rescinded.

**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 Group Contract 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 we provide 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 other 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 or your Group is required to submit notice to us, it will be considered delivered on the postmark date, or if not postmarked, the date we receive it.

**Right Of Recovery**

We have the right to recover amounts we paid that exceed the amount for which we're 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.

In addition, if the contract for this plan is rescinded as described in "Intentionally False Or Misleading Statements," we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

#### Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we 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 and in accordance with the law, we may pay the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- 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 our obligation as to payment of benefits.

#### Venue

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

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, 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 proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in Spokane County, the state of Washington.

#### Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Group to provide workers' compensation insurance, employer's liability insurance or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the "What's Not Covered?" section in this booklet.

## WHAT ARE MY RIGHTS UNDER ERISA?

This benefit plan is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA Plan" in this section. The LEOFF Health & Welfare Trust plan described in this booklet is a ERISA Plan.

As participants in this plan, subscribers have certain rights and protections. This section explains those rights. ERISA provides that all plan participants shall be entitled to:

- Examine without charge, all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. If the ERISA plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.

- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, (if your plan has such an exclusionary period) when you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The LEOFF Health & Welfare Trust is the plans fiduciary. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Please Note**: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the Summary Plan Description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542.

# DEFINITIONS

The terms listed throughout this section have specific meanings under your plan. We have the discretionary authority to determine the terms used in this plan.

### Accidental Injury

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

### Allowable Charge

The allowable charge shall mean one of the following:

For any given service or supply, the amount the providers have agreed to accept as payment in full pursuant to their applicable agreement between First Choice Health Network and the provider. Your liability for any applicable deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of these allowable charge.

For providers who don't have agreements with First Choice Health Network, the allowable charge will be no greater than the maximum allowance we otherwise would have allowed had the medically necessary covered services been furnished by a provider that had an agreement with them. When you seek services from providers that **don't** have agreements with us, your liability is for any amount above the allowable charge, and for any deductibles, coinsurance, copays, amounts in excess of stated benefit maximums and charges for noncovered services and supplies. We reserve the right to determine the amount allowed for any given service or supply.

### Ambulatory Surgical Center

A facility that is 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

A marked difference, from the normal structure of a body part, that's physically evident at birth.

### Custodial Care

Any portion of a service, procedure or supply that 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

### Effective Date

The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

### Eligibility Waiting Period

The length of time that must pass before an employee or dependent is eligible to be covered under the Group's health-care plan. If an employee or dependent enrolls under the "Special Enrollment" provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

### Enrollment Date

For a subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the later of 2 dates. The 2 dates are the subscriber's date of hire or the date the subscriber enters a class of

employees that the Group offers coverage to under this plan. In all other cases, the enrollment date is the effective date of coverage.

### 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
- 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).

### 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.

### 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 accidental injury. It's of no use in the absence of illness or accidental 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, accidental 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 or dependent.

### 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.

### 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 Home Delivery 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 benefits, terms and limitations set forth by LEOFF Health & Welfare Trust of which this booklet is a part.

### 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
- 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 person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of a person described herein, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law.

Covered licensed or certified categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Acupuncturists (L.Ac.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dental Hygienists (under the supervision of acD.D.S. or D.M.D.)
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T, C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they’re licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:
- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities

- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

### 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 of the Group. Coverage under this plan is established in the subscriber's name

### Subscription Charges
The monthly rates set by us as consideration for the benefits offered in this plan.

### 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 Law Enforcement Officers & Firefighters Health & Welfare Trust in the state of Washington

# where to send claims

**MAIL YOUR CLAIMS TO:**
**Rehn & Associates**
P.O. Box 5433
Spokane, WA 99205

**MAIL PRESCRIPTION DRUG CLAIMS TO:**

**Rehn & Associates**
PO Box 5433
Spokane, WA 99205