

Spokane Firefighters Pension Board

Your World™

1022518

INTRODUCTION

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

Spokane Firefighters Pension Board has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Spokane Firefighters Pension Board has delegated to Premera Blue Cross the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent stated in our administrative services contract with the Group. Premera Blue Cross does not insure the benefits of this plan.

Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the "Claims Administrator." This booklet replaces any other benefit booklet you may have.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see *Definitions*). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

Spokane Firefighters Pension Board believes this plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of the plan lifetime maximum.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to lose its grandfathered health plan status, can be directed to the Group's plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Group Name: Spokane Firefighters Pension Board

Effective Date: January 1, 2023

Group Number: 1022518

Plan: Your World (Grandfathered)

Certificate Form Number: 10225180123A

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃសម្រាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች: በነጻ ሊያገዝዎት ተዘጋጅተዋል: ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث انكر اللغة، فان خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਪਿਆਰ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຄຳບອກ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

HOW TO USE THIS BOOKLET

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

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

FOR MORE INFORMATION

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

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

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

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

You can use our Web site to:

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

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HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

Global Network Providers

This plan provides you benefits for covered services from providers of your choice.

It uses our Global network in Washington, which is our broadest network. It is made up of all providers contracted with us in Washington. In Alaska, this plan gives you access to all providers who have contracts with Premera Blue Cross Blue Shield of Alaska. For care outside our service area, this plan also gives you access to providers contracted with the Traditional (participating) provider networks of local Blue Cross and/or Blue Shield Licensees ("Host Blues").

This plan's cost-shares for the above contracted providers are the same as they are for other covered providers.

However, the contracted providers provide medical care to members at negotiated fees. These fees are the allowable charges for these providers. Contracted providers will not charge you more than the allowable charge for covered services. For this reason, your portion of the charges for covered services is lower. Global providers are also familiar with this plan's features and can help you make informed decisions about the healthcare you get.

You may access current information on contracted providers at any time on our Web site at www.premera.com. You may also call Customer Service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate a Traditional provider. The numbers are on the back cover of this booklet and on your Premera Blue Cross ID card.

We update this directory regularly but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the Global network.

Contracted Health Care Benefit Managers

The list of Premera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at <https://www.premera.com/visitor/partners-vendors> and changes to these contracts or services are reflected on the web site within 30 business days.

Other Providers

This plan covers providers who are not contracted as described above.

- Providers that are not in a Host Blue's Traditional network may still have a contract with the Host Blue. These providers will not bill you for any amount above the allowable charge for a covered service.
- **Non-Network Providers** There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet.

Balance Billing Protection

Non-participating providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, [Washington state and] federal law protects you from balance billing for:

Emergency Services from a nonparticipating hospital or facility or from a nonparticipating provider at the hospital or facility.

Emergency services includes certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-emergency services from a **nonparticipating provider** at an **network hospital or outpatient surgery center**. If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal [and state] law regarding balance billing do not apply for these services.

Air Ambulance

Your cost-sharing for non-participating air ambulance services shall be no more than if the services were provided by a network provider. The cost sharing amount shall be counted towards the network deductible and the network

out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

For the above services, you will pay no more than the plan's network cost-shares. See the **Summary of Your Costs**. Premera Blue Cross will work with the nonparticipating provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly.

Please note: Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Benefits For Non-Network Or Non-Contracted Providers

The following covered services and supplies provided by non-network or non-contracted providers will always be covered:

- Emergency services for a medical emergency. (Please see the **Definitions** section for definitions of these terms.) This plan provides worldwide coverage for emergency services.

The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.

- Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross.
- Covered emergency services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from a network provider, you can receive benefits for services provided by a non-network or non-contracted provider. However, you or your network provider must request this before you get the care. See **Prior Authorization** to find out how to do this.

WHAT ARE MY BENEFITS?

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be medically necessary (please see the **Definitions** section in this booklet) and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this plan is satisfied.
- It must be furnished by a "provider" (please see the **Definitions** section in this booklet) who's performing services within the scope of their license or certification.
- It must meet the standards set in our medical and payment policies. Our policies are used to administer the terms of the plan. Medical policies are generally used to determine if a member has coverage for a specific procedure or service. Payment policies define billing and provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA). Our policies are available to you and your provider at www.premera.com or by calling Customer Service.

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.

This plan complies with state regulations about coverage for diabetes medical treatment. Please see the **Prescription Drugs, Medical Equipment and Supplies, Preventive Care, Professional Visits and Services, and Diabetic Education** benefits.

WHAT'S MY COINSURANCE?

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

MEDICAL SERVICES

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

Acupuncture

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition. The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

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

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

This benefit covers:

- Allergy shots
- Testing
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip
- Transport from one medical facility to another as needed for your condition
- Transport to your home when medically necessary

These services are only covered when:

- Any other type of transport would put your health or safety at risk
- The service is from a licensed ambulance
- It is for the member who needs transport

Air or sea emergency medical transportation is covered when:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met, and
- Geographic restraints prevent ground transport
- Ground emergency transportation would put your health or safety at risk

Ambulance services that are not for an emergency must be medically necessary and need prior authorization. See **Prior Authorization** for details.

This benefit does not cover:

Services from an unlicensed ambulance

Blood Products and Services

Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider, subject to your calendar year deductible and coinsurance when you use a network provider.

Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury.

Cellular Immunotherapy And Gene Therapy

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. Services must meet Premera's medical policy. You can access our medical policies by contacting Customer Service or going to premera.com. Services also require prior authorization. See **Prior Authorization**.

Chemotherapy and Radiation Therapy

Treatment which uses powerful chemicals (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a doctor and approved by Premera to be covered. See **Prior Authorization**.

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Tooth extractions to prepare your jaw for radiation therapy

For drugs you get from a pharmacy, see **Prescription Drugs**. Some services need prior authorization before you get them. See **Prior Authorization** for details.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for your health condition and you must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the **Professional Visits And Services** benefit and lab tests are covered under the **Diagnostic X-ray, Lab and Imaging** benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening disease or conditions. The trial must also be funded or approved by a federal body, such as one of the National Institutes of Health (NIH), a qualified private research entity that meets the standards for NIH support grant eligibility, or by an institutional review board in Washington that has approval by the NIH Office for Protection from Research Risks.

- A "clinical trial" does not include expenses for:
- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition
- Services, supplies or pharmaceuticals that would not be charged to the member, if there were no coverage.
- Services provided in a clinical trial that are fully funded by another source

We encourage you or your provider to call Customer Service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial.

Contraceptive Management and Sterilization

Benefits are provided for the following:

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

Contraceptives Dispensed By A Pharmacy

Contraceptives (including emergency contraception) and 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.

The *Contraceptive Management and Sterilization* benefit doesn't cover:

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

Dental Injury and Facility Anesthesia

The medical benefits of this plan will be provided for the dental services listed below.

Dental Anesthesia

General anesthesia and related hospital or ambulatory surgical center services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 19 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

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

Dental Injury

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

These services are only covered when they're:

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

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

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

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

General anesthesia and related hospital or ambulatory surgical center services for dental procedures are covered when medically necessary for 1 of 2 reasons:

- The member is under the age of 19 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

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

Diagnostic X-ray, Lab and Imaging

Benefits are provided for diagnostic services, including administration and interpretation. However, diagnostic surgeries, including scope insertion procedures, such as endoscopies, can only be covered under the **Surgery** benefit.

Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Screening tests for prostate, colorectal and cervical cancer. Anesthesia that is delivered by an anesthesiologist for preventive colonoscopies and sigmoidoscopies is not covered unless it meets medical criteria.
- Colon cancer screening. Includes exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
- Services that are medically necessary to diagnose infertility or that are part of treatment for the cause of infertility.
- Laboratory services, including routine and preventive
- Pathology tests

In addition to *What's Not Covered?* this *Diagnostic X-ray, Lab and Imaging* benefit doesn't cover:

- Allergy testing. See the **Allergy Testing and Treatment** benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the **Hospital or Emergency Room** benefits.
- Mammography services. Please see the **Diagnostic And Screening Mammography** benefit.
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases. Call customer service before seeking testing, since it may require Prior Authorization.

This benefit does not cover testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment. When prescribed, prior authorization is not required for biomarker testing for members with stage 3 or 4 cancer, or for members with recurrent, relapsed, refractory, or metastatic cancer.

Diagnostic and Screening Mammography

The **Diagnostic and Screening Mammography** benefit covers diagnostic and screening mammography (including 3-D mammography) recommended by your physician, advanced registered nurse practitioner or physician's assistant.

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

As soon as the member is enrolled in Medicare Part B due to ESRD, the Group will pay the Medicare Part B premiums. The Group will continue to pay these premiums for as long as the member is enrolled on their current plan and eligible for Medicare due to ESRD.

Medicare has a waiting period, generally the first 90 days after dialysis starts. During this waiting period, benefits are subject to the same calendar year deductible and coinsurance, if any, as you would pay for outpatient services for other covered medical conditions. To find the amounts you are responsible for please see the first few subsections of this **What Are My Benefits?** section.

After Medicare's waiting period, the deductible and coinsurance for dialysis is waived.

Network providers are paid according to their provider contracts. The amount the plan pays non-contracted providers for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare.

If the dialysis services are provided by a non-network provider then you will owe the difference between the non-contracted provider's billed charges and the plan's payment for the covered services. See the **Allowable Charge** definition for more information.

Emergency Room

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For substance use disorder benefit information, please see the **Substance Use Disorder** benefit.

You may get care in the emergency room from non-contracted providers. They can bill you for amounts over this plan's allowable charge. See the definition of **Allowable Charge** to learn about allowable charges for emergency room care.

Foot Care

This benefit covers medically necessary routine foot care services that need care from a doctor.

This benefit covers:

- Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk
- Treatment of corns, calluses and toenails

This benefit does not cover routine foot care, such as trimming nails or removing corns and calluses that do not need care from a doctor.

Gender Affirming Care

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 a network or approved provider or facility. To find out whether the provider you have chosen is approved, please contact our Customer Service department.

Benefits for medically necessary gender affirming care services are subject to the same cost-shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages.

Benefits are provided for all gender affirming care surgical services which meet the Premera medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from Customer Service, or at www.premera.com.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of gender affirming care surgery, are covered under the surgical benefits applicable to those conditions.

Please Note: Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, are eligible under the general plan provisions for prescription drugs and behavioral health, subject to the applicable plan limitations and exclusions.

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 a network or approved provider or facility. To find out whether the provider you have chosen is approved, please contact our Customer Service department.

Benefits are provided for outpatient health education and community wellness services up to a combined 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. This benefit doesn't have a calendar year maximum for outpatient nicotine dependency programs.

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 education, pain management, childbirth and newborn parenting training and lactation.

Diabetes Health Education

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

Community Wellness

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

Many of our network hospitals offer a variety of community wellness classes and programs. To find out whether the provider you have chosen is approved, please contact our Customer Service department.

Nicotine Dependency Programs

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

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

Hearing Care

For hearing loss, often due to age or noise exposure.

Hearing Exams

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

The Routine Hearing Exams and Testing benefit includes:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- Hearing testing services, including the use of calibrated equipment.

Hearing Hardware

Benefits for hearing hardware are provided up to the benefit of \$5,500 per member every 5 years, after providing evidence of medical necessity.

To receive your hearing hardware benefit:

- Suitable evidence of medical necessity shall be required.
- **In-Area:** The firefighter shall submit evidence of medical necessity and an invoice to the City of Spokane, 808 W. Spokane Falls Blvd., Spokane, WA 99201. The City of Spokane will approve the invoice and the firefighter may then purchase the hearing aid.

Out-of-Area: If a firefighter resides outside the greater Spokane area, the firefighter shall submit evidence of medical necessity. Following a review by the City of Spokane, the firefighter may then purchase the hearing aid from the provider of his choice and pay any balances over the approved bid.

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

Benefits are provided for the following:

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

This benefit doesn't cover:

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

Home Health Care

Care is covered when a doctor states in writing that care is needed in your home. The care needs to be done by staff who works for a home health agency that is state-licensed or Medicare-certified.

Home health care provided as an alternative to hospitalization must have a written plan of care from your doctor. Medically intensive care in the home, or skilled hourly care provided as an alternative to facility-based care must have prior authorization in order to be covered.

This benefit covers:

- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health care agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

This benefit provides intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Home health care benefits aren't subject to a calendar year benefit maximum.

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.

Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies

Covered medical equipment, prosthetics and supplies (including sales tax for covered items) include:

Medical and Respiratory Equipment

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

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

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

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

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

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

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the **Prescription Drugs** benefit.

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

Prosthetics

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

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

Foot Orthotics and Therapeutic Shoes

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

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion, keratoconus, progressive high (degenerative) myopia, irregular astigmatism, aniridia, aniseikonia, anisometropia, corneal disorders, pathological myopia and post-traumatic disorders.

The Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids, and telephone alert systems

- Structural modifications to your home or personal vehicle
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition, including routine eye care
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the **Surgeries** benefit. Items provided and billed by a hospital are covered under the **Hospital** benefit.
- Over-the-counter orthotic braces, such as knee braces
- Non-wearable defibrillators, trusses and ultrasonic nebulizers
- Blood pressure cuffs or monitors (even if prescribed by a physician)
- Compression stockings that do not require a prescription
- Bedwetting alarms

Hospice Care

To be covered, 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 hospice services.

The plan provides benefits for covered services furnished and billed by a hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a 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.

The Hospice Care benefit covers:

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

Insulin and Other Hospice Provider Prescribed Drugs

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

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, transportation, and household supplies; housekeeping services; other than those of a home health aide as prescribed by the plan of care

Hospital

Inpatient Care

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

- Room and board expenses, including general duty nursing and special diets

- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration
- Medically necessary detoxification services

For inpatient hospital substance use disorder, except as stated above for medically necessary detoxification services, please see the **Substance Use Disorder** benefit.

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

For benefit information on professional diagnostic services done while at the hospital, see the **Diagnostic X-ray, Lab and Imaging** benefit.

This benefit doesn't cover:

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

Outpatient Care

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

Human Growth Hormone

Benefits are provided for human growth hormone.

This benefit doesn't cover:

- Treatment of idiopathic short stature without growth hormone deficiency
- Human growth hormone prescription drugs.

Infusion Therapy

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

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

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

Mastectomy and Breast Reconstruction

Benefits are provided for mastectomy necessary due to disease, illness or injury. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health And Cancer Rights Act of 1998 (WHCRA). For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- All stages of reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Protheseses
- Treatment of physical complications of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient. If you would like more information on WHCRA benefits, please call Spokane Firefighters Pension Board or go to www.dol.gov/ebsa/publications/whcra.html.

Maternity Care

Benefits for pregnancy, childbirth and abortions are provided on the same basis as any other condition.

Facility Care

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

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

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

Professional Care

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

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

This benefit covers medically necessary donor human milk obtained from a milk bank for inpatient use when ordered by licensed healthcare provider.

Medical Foods

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

Medical Transportation

This plan provides benefits for travel and lodging only for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services, unless transplant protocols require otherwise. Prior approval is required.

- Travel related to the covered transplants named in the **Transplants** benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the

hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.

Benefits are provided up to the benefit limit of \$7,500 per transplant.

See the **Summary of Your Costs** for any travel benefit limitations.

Benefits are provided for:

- Air transportation expenses between the member's home and the medical facility where services will be provided. Air travel expenses cover unrestricted coach class, flexible and fully refundable round-trip airfare from a licensed commercial carrier.
- Ferry transportation from the member's home community
- Lodging expenses at commercial establishments, including hotels and motels, between home and the medical facility where the service will be provided.
- Mileage expenses for the member's personal automobile
- Ground transportation, car rental, taxicab fares and parking fees, for the member and a companion (when covered) between the hotel and the medical facility where services will be provided.

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The mileage limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be tax advice.

Companion Travel

One companion needed for the member's health and safety is covered. For a child under age 19, a second companion is covered only if medically necessary.

Reimbursement of Travel Claims

- **Transplants:** You must pay for all travel expenses yourself and submit a Travel Claim Form.

A separate Claim Reimbursement Form is needed for each patient and each commercial carrier or transportation service used. You can get Claim Reimbursement Forms on our website at premera.com. You can also call us for a copy of the form.

You must attach the following documents to the Claim Reimbursement Form:

- A copy of the detailed itinerary as issued by the transportation carrier, travel agency or online travel web site. The itinerary must identify the names of the passengers, the dates of travel and total cost of travel, and the origination and final destination points.
- Receipts for all covered travel expenses

Credit card statements or other payment receipts are not acceptable forms of documentation.

This benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, other than for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior authorization
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network or that have not been designated by Premera to perform the services

- Travel insurance

Mental Health Care

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below. The **Mental Health Care** benefit does not have its own benefit maximum.

Benefits are subject to the same calendar year deductible and coinsurance, if any, as you would pay for inpatient services and outpatient visits for other covered medical conditions. To find the amounts you are responsible for, please see the first few subsections of this **What Are My Benefits?** section

Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice.

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits. "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 **Current Procedural Terminology** manual, published by the American Medical Association. Outpatient therapeutic visits can include real-time visits using telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.
- Treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders.
- Applied behavioral analysis (ABA) therapy for members with one of the following:
 - Autistic disorder
 - Autism spectrum disorder
 - Asperger's disorder
 - Childhood disintegrative disorder
 - Pervasive developmental disorder
 - Rett's disorder

Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:

- A licensed physician (M.D. or D.O.) who is a psychiatrist, developmental pediatrician or pediatric neurologist
- A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A licensed occupational or speech therapist
- A licensed psychologist (Ph.D.)
- A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy.
- A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. BCBA's are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

Mental health services other than ABA therapy must be furnished by one of the following types of providers to be covered:

- Hospital
- State-Licensed Community Mental Health Agency
- Licensed physician (M.D. or D.O.)
- Licensed psychologist (Ph.D.)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- 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 their license.
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.
- Washington state-licensed Behavioral Health Agency

When medically appropriate, services may be provided in your home.

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

For substance use disorder benefit information, please see the **Substance Use Disorder** benefit.

For prescription drug benefit information, please see the **Prescription Drugs** benefit.

The Mental Health Care benefit doesn't cover:

- Psychological treatment of sexual dysfunctions
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational or academic placement evaluations.

Neurodevelopmental Therapy (Habilitation)

Benefits are provided for the treatment of neurodevelopmental disabilities. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

Physical, speech and occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders, are covered under the **Mental Health Care** benefit.

Inpatient Care Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility that meets our clinical standards and will only be covered when services can't be done in a less intensive setting. These benefits aren't subject to a calendar year benefit limit.

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

- The member must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility that meets our clinical standards, 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.

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.

The plan 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.

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

Nutritional Therapy

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

Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) are provided up to a lifetime maximum benefit of \$5,000 per member. These procedures are not covered under other benefits of this plan. Covered orthognathic surgery for repair of congenital (apparent at birth) deformities determined to be medically necessary will not apply to any annual maximum or lifetime limits of this plan.

PRESCRIPTION DRUGS

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

Retail Pharmacy Prescriptions

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

Dispensing Limit

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

How To Use The Retail Pharmacy Benefit

- **Participating Retail Pharmacies** After you've paid any required cost-share, the plan will pay the participating pharmacy directly.

To avoid paying the retail cost for a prescription drug that's reimbursable at a lower allowable charge rate, be sure to present your identification card to the pharmacist for all prescription drug purchases.

- **Non-Participating Retail Pharmacies** You pay the full price for the drugs and submit a claim for reimbursement. Please see the **How Do I File A Claim?** section in this booklet for more information.

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

Mail-Order Pharmacy Program

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

Dispensing Limit

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

How To Use The Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the mail-order pharmacy program. After you've paid any required cost-share, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by our participating mail-order pharmacy.

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

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

Specialty Pharmacy Program

Specialty drugs are subject to the coinsurance specified above. These drugs are limited to a 30-day supply.

"Specialty drugs" are drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis.

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. It is a good idea for you and your health care provider to work with a network specialty pharmacy to arrange ordering and delivery of these drugs. You don't have to use the network specialty pharmacies. But if you use a non-participating retail pharmacy, you will pay the extra cost-share described earlier in this benefit. Non-network mail order pharmacies are not covered.

Contact Customer Service for details on which drugs are included in the specialty pharmacy program, or visit our Web site, which is shown on the back cover of this booklet. See **How Does Selecting A Provider Affect My Benefits?** for details about the provider networks

What's Covered

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

- Prescription drugs (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the **Definitions** section in this booklet).
- Medically necessary over the counter drugs purchased at a participating pharmacy and prescribed by a physician.
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Prescription drugs for the treatment of nicotine dependency.
- Prescription contraceptives and devices (e.g. oral drugs, diaphragms and cervical caps)
- Drugs to treat sexual dysfunction up to the manufacturer's maximum daily dosing.

Exclusions

This benefit doesn't cover:

- Non-prescription 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-participating mail-order pharmacies
- 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

- Blood or blood derivatives. See the **Blood Products and Services** benefit for coverage.
- 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. (see **Specialty Pharmacy Program** benefit).
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). Please see the **Infusion Therapy** benefit.
- Drugs to treat infertility, including fertility enhancement medications
- Weight management drugs
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit). Please see the **Home Medical Equipment (HME), Orthotics, Prosthetics And Supplies** benefit for available coverage.
- Immunization agents and vaccines, including the professional services to administer the medication.

Drug Discount Programs

Pharmacy Benefit Drug Program For pharmacy benefit claims, Premera Blue Cross will pay the Group a prescription drug rebate payment equal to a specific amount per paid brand-name prescription drug claim. Prescription drug rebates Premera Blue Cross receives from its pharmacy benefit manager in connection with Premera Blue Cross's overall pharmacy benefit utilization may be more or less than the Group's rebate payment. The Group's rebate payment shall be made to the Group on a calendar year quarterly basis unless agreed upon otherwise.

The allowable charge for prescription drugs may be higher than the price paid to the pharmacy benefit manager for those prescription drugs.

Premera Blue Cross and the Group agree that the difference between the allowable charge for prescription drugs and the price paid to the pharmacy benefit manager, and the prescription drug payments received by Premera Blue Cross from its pharmacy benefit manager, constitutes Premera Blue Cross property, and not part of the compensation payable under Premera Blue Cross's contract with the Group, and that Premera Blue Cross is entitled to retain and shall retain such amounts and may apply them to the cost of its operations and the pharmacy benefit.

Medical Benefit Drug Program The medical benefit drug program is separate from the pharmacy benefit drug program. It includes claims for drugs delivered as part of medical services. For medical benefit drug claims, Premera Blue Cross may contract with subcontractors that have rebate contracts with various manufacturers. Rebate subcontractors retain a portion of rebates collected as a rebate administration fees. Medical benefit drug rebates are provided as a credit toward the Group's administration fee. The Group's rebate payment is made to Group as a credit toward the administration fees paid to Premera Blue Cross.

Preventive Care

Benefits for preventive exams performed on an outpatient basis, including immunizations, are not subject to a separate benefit maximum.

Covered Services

Exams The following exam services are covered:

- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment

Immunizations Immunizations and seasonal immunizations are covered. Seasonal and travel immunizations and certain other immunizations, such as flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles immunizations, are covered when done by a pharmacy, the county health department, travel clinic or other mass immunizer location.

The Preventive Care benefit doesn't cover:

- Services not named above as covered
- 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. Please see the plan's non-preventive benefits for available coverage.
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability evaluations
- Preventive laboratory and imaging services, screening and diagnostic mammography. Please see the **Diagnostic X-ray, Lab and Imaging** benefit and the **Diagnostic and Screening Mammography** benefit for available coverage.
- Facility charges. When you get preventive care at a clinic or physician's office that is based in a hospital, you must pay hospital cost shares when there are any extra facility charges. See the **Hospital** benefit for those costs.

Professional Visits And Services

Outpatient Professional Exams and Visits

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

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see **Definitions**)
- Consultations and treatment for nicotine dependency
- Consultations with a pharmacist
- Real-time visits using online and telephonic methods with a doctor or other provider who also maintains a physical location.

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

For professional diagnostic services benefit information, please see the **Diagnostic X-ray, Lab and Imaging** benefit.

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

For benefit information on contraceptive injections or implantable contraceptives, please see the **Contraceptive Management and Sterilization** 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 Disorders (TMJ) Care** benefit.

The **Professional Visits And Service** 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

Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the

treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the **Rehabilitation Therapy** benefit.

Rehabilitation Therapy

This plan covers rehabilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider.

Rehabilitation therapy is therapy that helps get a part of the body back to normal health or function. It includes therapy to 1) restore or improve a function that was lost because of an accidental injury, illness or surgery; or 2) to treat disorders caused by a physical congenital anomaly.

Services provided for treatment of a mental health condition are provided under the **Mental Health Care** benefit.

Inpatient Care Benefits are available for inpatient facility and professional care. These benefits aren't subject to a calendar year benefit limit.

Inpatient rehabilitation care is covered when medically necessary and provided in a specialized inpatient rehabilitation center, which may be part of a hospital. If you are already an inpatient, this benefit will start when your care becomes mainly rehabilitative and you are transferred to an inpatient rehabilitation center. 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.

You must get prior authorization from us before you get treatment in an inpatient rehabilitation center. See **Prior Authorization** for details.

Outpatient Care

Benefits for outpatient care are available up to 45 visits per member each calendar year.

This benefit covers the following types of medically necessary outpatient therapy:

- Physical, speech, hearing and occupational therapies. Physical, speech, and occupational assessments and evaluations related to rehabilitation are also covered.
- Cardiac and pulmonary rehabilitation programs. These services are not subject to the benefit visit limit shown above.
- Cochlear implants
- Home medical equipment, medical supplies and devices.

The benefit does not cover:

- Treatment that the ill, injured or impaired member does not actively take part in.
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary

Skilled Nursing Facility Care

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

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

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

This benefit doesn't cover:

- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

Spinal and Other Manipulations

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

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

Available benefits for covered massage and physical therapy services are provided under the **Rehabilitation Therapy** benefits.

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

Substance Use Disorder

This benefit covers inpatient and outpatient substance use disorder treatment and supporting services. The **Substance Use Disorder** benefit does not have its own benefit maximum.

Most benefits are subject to the same calendar year deductible or coinsurance, if any, that you would pay for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, please see the **What Are My Cost-Shares?** section. As the result of applying the federal parity tests, your cost-shares for outpatient facility care for substance use disorder will match the cost share for non-preventive diagnostic services shown in the **Diagnostic X-ray, Lab and Imaging** benefit.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider. Covered outpatient visits can include real-time visits via telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.

The current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine is used to determine if substance use disorder is medically necessary.

Please Note: Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the **Emergency Room** and **Hospital** benefits.

The Substance Use Disorder benefit doesn't cover:

- Treatment of alcohol or drug use or abuse that does not meet the definition of **Substance Use Disorder** as stated in the **Definitions** section of this booklet
- 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, unless they are medically necessary
- Halfway houses, quarterway houses, recovery houses, and other sober living residences

Surgery

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are:

- Anesthesia or sedation and postoperative care as medically necessary. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
- Cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, and the transfusion of blood or blood derivatives.
- Surgery that is medically necessary to correct the cause of infertility. This does not include assisted reproduction techniques or sterilization reversal.
- Repair of a defect that is the direct result of an injury, providing such repair is started within 12 months of the date of the injury.
- Correction of functional disorders upon our review and approval

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

For services to change gender, please see the **Gender Affirming Services** benefit.

This benefit does not cover removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss.

Surgical Center Care - Outpatient

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

Temporomandibular Joint Disorders (TMJ) Care

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.

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

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

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

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

Therapeutic Injections

This benefit covers:

- Shots given in the doctor's office
- Supplies used during the visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

- Immunizations (see **Preventive Care**)
- Self-injectable drugs (see **Prescription Drugs**)
- Infusion therapy (see **Infusion Therapy**)
- Allergy shots (see **Allergy Testing and Treatment**)

Transplants

Covered Transplants

The Transplant benefit is not subject to a separate benefit maximum other than the maximums for transport and lodging described below. This benefit covers medical services only if provided by "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

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

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.") The plan reserves the right to base coverage on all of the following:

- Organ transplants and bone marrow/stem cell reinfusion procedures must meet the plan's criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed.

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

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

Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives other than bone marrow or stem cells. These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).

- Your medical condition must meet the plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and meets the approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services. Please call customer service.

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

Recipient Costs

This benefit covers transplant and reinfusion-related expenses, including the preparation regimen for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Covered donor 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.

Travel And Lodging

Benefits are provided for certain travel expenses related to services provided by an approved transplant provider. See **Medical Transportation** for details.

The *Transplants* benefit doesn't cover:

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, that are not specifically stated under this 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 an organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see the **Definitions** section in this booklet)
- Personal care items

- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future

Urgent Care

This plan covers care you get in an urgent care center. Urgent care centers have extended hours and are open to the public. You can go to an urgent care center for an illness or injury that needs treatment right away. Examples are minor sprains, cuts and ear, nose and throat infections. Covered services include the doctor's services.

Virtual Care

Virtual care uses technology to provides ease, convenience, and faster access to medical care. Providers covered under this benefit offer their services exclusively by methods like secure chat, text, voice or audio messaging, and video chat. They do not maintain a physical location that you can visit.

This benefit covers:

- Virtual general medical visits

Vision Care

Vision Exams

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

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

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

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

Vision Hardware

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

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

Benefits are provided for the following vision hardware and related services, up to a maximum benefit of \$500 per member per 2 consecutive calendar years.

What's Covered:

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

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

- This benefit will cover services and supplies (including hardware) received after your coverage under this benefit has ended, 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

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

The *Vision Hardware* benefit doesn't cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan. Please see the ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies*** benefit for hardware coverage for certain conditions of the eye.
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
 - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
 - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

Lasik Eye Surgery

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

Toric and Multifocal Lenses

Benefits are provided for toric and multifocal lenses at 100% of the allowable amount when billed after cataract surgery. Benefits are limited to 2 units per calendar year.

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

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care in Clark County, Washington and outside Washington and Alaska. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' network providers. The Host Blue is responsible for its network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

Your getting services through these Inter-Plan Arrangements does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization.

We process claims for the ***Prescription Drugs*** benefit directly, not through an Inter-Plan Arrangement.

BlueCard Program

Except for copays, we will base the amount you must pay for claims from Host Blues' network providers on the lower of:

- The provider's billed charges for your covered services; or

- The allowable charge that the Host Blue made available to us.

Often, the allowable charge is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid.

Clark County Providers Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with us. These providers will submit claims directly to us, and benefits will be based on our allowable charge for the covered service or supply.

Value-Based Programs You might have a provider that participates in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. If the Host Blue includes charges for these payments in the allowable charge for a claim, you would pay a part of these charges if a deductible or coinsurance applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax or fee to the allowable charge for the claim.

Non-Contracted Providers

It could happen that you receive covered services from providers in Clark County, Washington and outside Washington and Alaska that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowable charge for these providers or the pricing requirements under applicable law. Please see the definition of "Allowable Charge" in **Definitions** in this booklet for details on allowable charges.

In these situations, you may owe the difference between the amount that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See "**How Do I File A Claim?**" for more information. However, if you need hospital inpatient care, the service center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

More Questions

If you have questions or need to find out more about the BlueCard Program, please call our Customer Service Department. To find a provider, go to **www.premiera.com** or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment.

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed. This process is called prior authorization. You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays. This is so that Premera can confirm that these services are medically necessary and covered by the plan.

How Prior Authorization Works

We will make a decision on a request for services that require prior authorization in writing within 5 calendar days of receipt of all information necessary to make the decision. The response will let you know whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can ask for an appeal. See **Complaints and Appeals**.

If your life or health would be in serious jeopardy if you did not receive treatment right away, you may ask for an expedited review. We will respond in writing as soon as possible, but no more than 48 hours after we get all the information we need to make a decision.

Our prior authorization will be valid for 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization.

Prior Authorization for Medical Services, Supplies or Equipment

The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to find out if your service requires prior authorization.

- **In-Network providers or facilities** are required to request prior authorization for the service.
- **Non-Contracted and out-of-area providers and facilities** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

It is a good idea to ask Premera for prior authorization when you see a non-contracted provider. It is to your advantage to know ahead of time if the plan is not going to cover a service, equipment, or an inpatient stay.

Prescription Drugs

The plan has a specific list of prescription drugs that must have prior authorization before you get them at a pharmacy. The list is on our website at **premera.com**. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

If your provider does not get prior authorization, when you go to the pharmacy to get your prescription, the pharmacy will tell you that you need it. You or your pharmacy should inform your provider of the need for prior authorization. Your provider can fax us an accurately completed prior authorization form for review.

You can buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See **How Do I File A Claim?** for details.

Sometimes, benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- You may need to get a prescription drug from an appropriate medical specialist
- You may have to try a generic drug or a specified brand name drug first

These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.

Exceptions To Prior Authorization For Benefit Coverage

The following services do not require prior-authorization for benefit coverage, but they have separate requirements:

- Emergency care and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth. Emergency and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

CLINICAL REVIEW

Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our Web site. You or your provider may review them at www.premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown on the back cover.

Premera Blue Cross reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera Blue Cross following this review may be appealed in the manner described in ***Complaints And Appeals***.

In general, when there is more than one treatment option, the plan will cover the least costly option that will meet your medical needs. Premera Blue Cross works cooperatively with you and your physician to consider effective alternatives to hospital stays and other high-cost care to make better use of this plan's benefits.

PERSONAL HEALTH SUPPORT PROGRAMS

The plan offers participation in Premera Blue Cross's personal health support services to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:

- Helping to overcome barriers to health improvement or following providers' treatment plan
- Coordinating care services including access
- Helping to understand the health plan's coverage
- Finding community resources

Participation is voluntary. To learn more about the personal health support programs, contact Customer Service at the phone number listed on the back of your ID card.

WHAT'S NOT COVERED?

In addition to services listed as not covered under Covered Services, this section of your booklet lists services that are either limited or not covered by this plan.

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.
- Artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Diagnosis and treatment of underlying medical conditions that may cause infertility are covered on the same basis as any other condition.

Benefits From Other Sources

This plan does not cover services that are covered by other insurance or coverage, such as:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage
- Any type of liability insurance, such as home owner's coverage or commercial liability coverage
- Any type of excess coverage,

- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

This plan does not cover services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, or workers compensation or similar coverage for work-related conditions. For details, see *Third Party Recovery* in the *What If I Have Other Coverage* section of the booklet.

Benefits That Have Been Exhausted

Services in excess of benefit limitations or maximums of this plan.

Broken Or Missed Appointments

Caffeine Or Nicotine Dependency

Treatment of caffeine dependency; treatment of nicotine dependency except as stated under the *Prescription Drugs* and *Professional Visits and Services* benefits.

Charges For Records Or Reports

Charges from providers for supplying records or reports not requested for utilization review.

Comfort Or Convenience

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting
- Normal living needs, such as food, clothes, housekeeping and transport.
- Meal or dietary assistance, including “Meals on Wheels”

Complications

This plan does not cover complications of a non-covered service, including follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary.
Counseling education or training in the absence of illness including:

- Job help and outreach, social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
- Private school or boarding school tuition

Court-Ordered Services

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial care.

Dental Care

This plan does not cover dental care.

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

Dependent Coverage

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

Drugs And Food Supplements

Over-the-counter drugs, solutions, supplies, food and nutritional supplements other than those covered under the **Medical Foods** benefit; 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. Please see the **Prescription Drugs** benefit for details.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigative Services

Experimental or investigative, services or supplies.

Family Members Or Volunteers

Services or supplies that you provide to yourself. It does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of those people
- A volunteer

Governmental Facilities

This plan does not cover services provided by a non-contracting state or federal facility that are not emergency care unless required by law or regulation.

Hair Loss

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

Hearing Hardware

- Hearing aids (including batteries and related equipment) that exceed the maximum benefit per member in a period of 5 consecutive calendar years. These expenses are also not eligible for coverage under other benefits of this plan.
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.

Laser Therapy

Low-level laser therapy

Light Therapy for Vitiligo

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, national guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

Services or supplies:

- Ordered when this plan is not in effect or when the person is not covered under this plan
- Provided to someone other than the ill or injured member. This includes health care provider training or educational services.
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member, or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.

Non-Treatment Facilities, Institutions Or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities. See **Medical Services** for specific benefit information.

Not In The Written Plan Of Care

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

Orthodontia

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

Routine Or Preventive Care

- Impression casting for foot prosthetics or appliances and prescriptions thereof. However, foot-support supplies, devices and shoes are covered as stated under the **Medical Equipment and Supplies** benefit.
- Exams to assess a work-related disability or medical disability
- Services and supplies that aren't directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn't apply to services and supplies specified as covered under the following benefits:
 - **Diagnostic Services**
 - **Diagnostic and Screening Mammography**
 - **Preventive Care**
 - **Diabetes Health Education**

Recreational, Camp and Activity Programs

Recreational, camp and activity-based programs. These programs are not medically necessary and include:

- Gym, swim and other sports programs, camps and training
- Creative art, play and sensory movement and dance therapy
- Recreational programs and camps
- Wilderness, hiking, tall ship, and other adventure programs and camps
- Boot camp programs, outward bound programs and tall-ship programs
- Equine programs and other animal-assisted programs and camps
- Exercise and maintenance-level programs

Serious Adverse Events and Never Events

Members and this plan are not responsible for payment of services provided by network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure

codes and specific present-on-admission indicator codes. Network providers may not bill members for these services and members are held harmless.

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed on the back of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.

Services or Supplies for which You Do Not Legally Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment, including drugs, medications (except as specifically stated under the Prescription Drugs benefit), or penile or other implants.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea, or results of these treatments, except as stated under the Lasik Eye Surgery benefit.

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous

Weight Loss Surgery or Drugs

This plan does not cover surgery, drugs or supplements for weight loss or weight control.

Work-Related Illness or Injury

This plan does not cover any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see **Third Party Recovery** under **What If I Have Other Coverage**.

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

WHAT IF I HAVE OTHER COVERAGE?

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

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

Definitions

For the purposes of COB:

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

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

Primary And Secondary Rules

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

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

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

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

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

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

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

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

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

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

COB's Effect On Benefits

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

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. When this plan is secondary, it will reduce its benefits so that its benefits plus those of the primary plan total 100% of the allowable expense for each claim. **When paying a claim, the total amount paid by the secondary plan in combination with what is paid by the primary plan is never required to be more than one hundred percent of the highest total allowable expense of either plan plus any savings accrued from prior claims incurred in the same calendar year.**

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

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

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

THIRD PARTY RECOVERY

General

If you become ill or are injured by the actions of a third party, your medical care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or their insurance company may be required under law to pay for your medical care.

This plan does not pay for claims for which a third party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross and its affiliate to the extent we need in order to administer this section.

Definitions

The following definitions shall apply to this section:

Injury An injury or illness that a third party is or may be liable for.

Recovery All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.

Reimbursement Amount The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.

Responsible Third Party A third party that is or may be responsible under the law (“liable”) to pay you back for your injury.

Third Party A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers’ compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

Note: For this section, a third party does not include other health care plans that cover you.

You In this section, “you” includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

Benefits From Other Sources Benefits are not available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage, or Medical Premises coverage
- Boat coverage
- School or athletic coverage
- Any type of liability insurance, such as home owners' coverage or commercial liability coverage
- Any type of excess coverage

Work-Related Conditions Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required of or voluntarily obtained by the employer
- State or federal workers compensation acts
- Any legislative act providing compensation for work-related illness or injury

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

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan’s benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan’s right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
 - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan’s right to reimbursement first and in full shall apply even if:
 - The recovery is not enough to make you whole for your injury.

- The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
- The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
- The member is a minor, disabled person, or is not able to understand or make decisions.
- The member did not make a claim for medical expenses as part of any claim or demand
- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.
The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
 - Deny or delay claims related to your injury
 - Recoup directly from you all benefits the plan has provided for your injury
 - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.
Neither the plan nor Premera Blue Cross shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.
Claims for your injury shall not be paid until Premera Blue Cross receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage.

SUBSCRIBER ELIGIBILITY

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

- You must be, and continue to be, a full-time LEOFF I employee who regularly works 20 or more hours each week, or the minimum hours as required by federal or state law, and must be actively at work full-time on the effective date of coverage; or
- You must be a retired and/or disabled employee provided you are eligible to receive a retirement benefit under the LEOFF act

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

DEPENDENT ELIGIBILITY

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

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

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

CHANGES IN COVERAGE

The Group may change its terms, benefits and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees who become covered under this plan after the date the change becomes effective.

Persons Eligible For Medical Assistance

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

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

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

LEAVE OF ABSENCE

Coverage for a subscriber may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

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

MEDICARE SUPPLEMENT COVERAGE

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

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

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

Step 1

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

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or diagnosis code from the most current edition of the **International Classification of Diseases** manual.
- Procedure codes from the most current edition of the **Current Procedural Terminology** manual, the **Healthcare Common Procedure Coding** manual, or the **American Dental Association Current Dental Terminology** manual for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

Prescription Drug Claims

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

Participating Pharmacies

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

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

Non-Participating Pharmacies

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

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

Timely Filing

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

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

The plan won't provide benefits for claims we receive after the later of these 2 dates except when required by law.

Special Notice About Claims Procedure

We'll make every effort to process your claims as quickly as possible. We process claims in the order in which we receive them. We'll tell you if this 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 (see **Notices**) 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 needed to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of the plan's complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter stating these reasons.

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 all you have to pay is a copay for a covered service or supply, it is not considered a claim for benefits. However, you always have the right to get a paper copy of your explanation of benefits for the service or supply. You can call Customer Service. The phone number is on the back cover of your booklet and on your Premera ID card. Or, you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under **Complaints And Appeals**.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

What is a Complaint?

Other than denial of payment for medical services or nonprovision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with Premera.

How to file a complaint

Call customer service at 800-722-1471 (TTY:711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross

PO Box 91102

Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

What is an Appeal?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protection against balance billing as defined by federal and state law

WHAT YOU CAN APPEAL

Claims and Prior Authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified or our Level 1 appeal decision.
External	<p>If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal.</p> <p>OR</p> <p>You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.</p>	<p>Four months from the date you were notified of our Level 2 appeal decision.</p> <p>OR</p> <p>Four months from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.</p>

How to Submit an Appeal in Writing

<p>Step 1. Get the form</p>	<ul style="list-style-type: none"> Complete the Member Appeal Form, you can find it on premera.com or call customer service to request a copy. <p>If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-722-1471 (TTY:711)</p>
<p>Step 2. Collect supporting documents</p>	<ul style="list-style-type: none"> Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. If you would like someone to appeal on your behalf, including your provider, complete a Member Appeal Form with authorization, you can find it on premera.com. We can't release your information without this form.
<p>Step 3. Send in my appeal</p>	<p>To help process your appeal, be sure to complete the form and return with any supporting documents.</p> <p>Send your documents to:</p> <p>Premera Blue Cross</p> <p>Attn: Appeals Coordinator</p> <p>PO Box 91102</p> <p>Seattle, WA 98111-9202 Fax to 425-918-5592</p>

Note: You may also call customer service to verbally submit an appeal.

If you would like to review the information used for your appeal, send us a request in writing to:

Premera Blue Cross

Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111
Fax: 425-918-5592

Appeal Response Time Limits

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-service appeals (a decision made by us before you received services)	Within 15 days
All other appeals	15-30 days
External appeals	<ul style="list-style-type: none">• Urgent appeals within 72 hours• Other IRO appeals within 45 days after the IRO gets the information

IF WE NEED MORE TIME

Except for urgent appeals, we can extend the time limits. We will notify you, if for good cause, more time is needed. An extension cannot delay the decision beyond 30 days without your informed written consent.

WHAT HAPPENS IF YOU HAVE ONGOING CARE

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, inpatient care and rehabilitation.

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, the plan will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts the plan paid for ongoing care during the appeal review.

WHAT IF IT'S URGENT

If your condition is urgent, you will get our response sooner. Please see the table above. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professionals or your treating physician
- You are requesting coverage for inpatient or emergency care that you are currently receiving

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

HOW TO ASK FOR AN EXTERNAL REVIEW

External reviews will be done by an Independent Review Organization (IRO).

<p>Step 1. Get the form</p>	<p>We'll tell you about your right to an external review with the written decision of your internal appeal.</p> <ul style="list-style-type: none"> • Complete the Independent Review Organization (IRO) Request form, you can find it on premera.com or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
<p>Step 2. Collect supporting documents</p>	<ul style="list-style-type: none"> • Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
<p>Step 3. Send in my external review request</p>	<p>To help process your external review, be sure to complete the form and return with any supporting documents.</p> <p>Send your documents to: Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592</p>

Note: You may also call customer service to verbally submit an external review request.

External appeals are also available for decisions related to Premera's compliance with protections against balance billing in accordance with federal and state law..

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and Premera immediately. Premera will accept the IRO decision on behalf of the plan.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your Premera ID card.

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

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Evidence Of Medical Necessity

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

Healthcare Providers — Independent Contractors

All healthcare providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera Blue Cross and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

Intentionally False Or Misleading Statements

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

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

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

Please note: we cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Member Cooperation

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

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. (Genetic information is not collected or used for underwriting or enrollment purposes.)
- Coordinating benefits with other health care plans
- Conducting care management or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

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

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

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

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

Notice Of Other Coverage

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

- Any legal action or claim against another party for a condition or injury for which the plan provides benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
 - Personal injury protection (PIP)
 - Underinsured motorist coverage
 - Uninsured motorist coverage
 - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Notices

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

Right Of Recovery

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

Right To And Payment Of Benefits

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

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

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

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

Venue

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

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

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

DEFINITIONS

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

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protection against balance billing as defined by federal and state law.

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowable Charge

This plan provides benefits based on the allowable charge for covered services. We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us. The allowable charge is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the general rules.

General Rules

• Providers In Washington and Alaska Who Have Agreements With Us

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

Your liability for any applicable calendar year deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

• Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees

For covered services and supplies received outside the service area, allowable charges are determined as stated in the *What Do I Do If I'm Outside Washington And Alaska* section (*Out-Of-Area Care*) in this booklet.

• Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

Except as stated below, the allowable charge for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

- An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges. Note: Ambulances are always paid based on billed charges.

If applicable law requires a different allowable charge than the least of the three amounts above, this plan will comply with that law.

Non-Emergency Services Protected From Surprise Billing

A different rule applies to certain services from a non-network provider at an in-network hospital or outpatient surgery center in Washington. The services are surgery, anesthesia, pathology, radiology, laboratory, and

hospitalist care. For these services, the allowable charge is the median in-network rate for the same or similar service in the same or similar geographic area.

Dialysis Due To End Stage Renal Disease

- **Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees**

The allowable charge is the amount explained above in this definition.

- **Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

- The amount the plan allows for dialysis during Medicare's waiting period will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.
- The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See the Dialysis benefit for more details

Emergency Care

Consistent with the requirements of the Affordable Care Act, the allowable charge for non-network providers will be the greatest of the following amounts:

- The median amount that Global network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers

You do not have to pay amounts over the allowed amount for emergency care from non-contracted providers in Washington, Oregon, or Idaho.

If the non-contracted provider is not in Washington, Oregon or Idaho, you will be responsible for charges received from out-of-network providers above the allowable charge along with your deductible, copays and coinsurance.

Note: Non-contracted ambulances are always paid based on billed charges.

If you have questions about this information, please call us at the number listed on your Premera Blue Cross ID card.

Ambulatory Surgical Center

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

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

Calendar Year

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

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:
 - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
 - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
 - The United States Department of Defense
 - The United States Department of Veterans' Affairs

- A nongovernmental research entity abiding by current National Institute of Health guidelines

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.

Congenital Anomaly Of A Dependent Child

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

Custodial Care

Any portion of a service, procedure or supply that 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

Detoxification

Detoxification is active medical management of medical conditions due to substance intoxication or substance withdrawal, which requires repeated physical examination appropriate to the substance, and use of medication. Observation alone is not active medical management.

Donor Human Milk

Human milk that has been contributed to a milk bank by one or more donors.

Drug Benefits Manager

An entity that contracts with us to administer prescription drug benefits under this plan.

Effective Date

The date when your coverage under this plan begins.

Emergency Care

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above.

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

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:

- 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 Blue Shield Association Technical Evaluation Center (TEC).

Group

The entity that sponsors this self-funded plan.

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

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 substance use disorder or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Emergency

A medical condition, mental health, or substance use disorder which manifests itself by acute symptoms of sufficient severity, including but not limited to, severe pain or emotional distress such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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 Equipment

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

Medical 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 a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

A person covered under this plan as a subscriber.

Milk Bank

An organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors.

Non-Contracted Provider

A provider is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Non-Participating Provider

A provider that is not in one of the provider networks stated in the ***How Providers Affect Your Costs*** section or is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Abortion is included as part of obstetrical care.

Orthodontia

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

Orthotic

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

Outpatient

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

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

A licensed pharmacy which contracts with us or our drug benefit manager to provide prescription drug benefits.

Pharmacy Benefit Manager

An entity that contracts with us to administer the *Prescription Drugs* 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 their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

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

Plan (also called "This Plan")

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

Prescription Drug

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

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

- One of the following standard reference compendia:
 - **The American Hospital Formulary Service-Drug Information**
 - **The American Medical Association Drug Evaluation**
 - **The United States Pharmacopoeia-Drug Information**
 - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

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

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

Prior Authorization

Prior authorization is a process that requires you or a provider to follow to determine if a service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

See **Prior Authorization** for details.

Provider

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

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

Board Certified Behavior Analysts (BCBAs) will be considered health care providers for the purposes of providing applied behavior analysis (ABA) therapy, as long as both of the following are true: 1) They're licensed when required by the State in which they practice, or, if the State does not license behavior analysts, are certified as such by the Behavior Analyst Certification Board, and 2) The services they furnish are consistent with state law and the scope of their license or board certification. Therapy assistants/behavioral technicians/paraprofessionals that do not meet the requirements above will also be covered providers under this plan when they provide ABA therapy and their services are supervised and billed by a BCBA or one of the following state-licensed provider types: psychiatrist, developmental pediatrician, pediatric neurologist, psychiatric nurse practitioner, advanced nurse practitioner, advanced registered nurse practitioner, occupational or speech therapist, psychologist, community mental health agency that is also state-certified to provide ABA therapy.

Psychiatric Condition

A condition listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

Service Area

The area in which we directly operate provider networks. This area is made up of the states of Washington (except Clark County) and Alaska

Skilled Care

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

Skilled Nursing Facility

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

Subscriber

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

Substance Use Disorder

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 their social or economic function is substantially disrupted

We, Us and Our

Means Premera Blue Cross.

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O. Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Manager At

1-800-391-9701
www.express-scripts.com

Customer Service

Mailing Address

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

Phone Numbers

Local and toll-free number:
1-800-722-1471

Physical Address

3900 East Sprague
Spokane, WA 99202-4895

Local and toll-free TTY number:
1-800-842-5357

Care Management

Prior Authorization And Emergency Notification

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

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

Complaints And Appeals

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202
Fax: (425) 918-5592

BlueCard

1-800-810-BLUE(2583)

Website

Visit our website www.premera.com for information and secure online access to claims information