Amazon And Subsidiaries

Standard Plan

4000083

PREMERA | BLUE CROSS

INTRODUCTION TO YOUR STANDARD PLAN

This plan is self-funded by Amazon and Subsidiaries (“the Group”), which means that the Group is financially responsible for the payment of plan benefits. The Group has the final discretionary authority to determine eligibility for benefits and claims and to construe the terms of the plan.

The Group has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross Blue Shield Association, to process claims and for other administrative duties. The Group has delegated to us the discretionary authority to determine claims for benefits and to construe the terms used in this plan to the extent necessary to perform our services. Premera Blue Cross doesn't insure this plan. In this booklet Premera Blue Cross is called the “Claims Administrator.” This booklet replaces any other health plan 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, including changes which become effective on the beginning of the plan year, 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.

Group Name:	Amazon and Subsidiaries
Effective Date:	April 1, 2016
Group Number:	4000083
Plan:	Standard Plan
Certificate Form Number:	AMZN16S

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:

- **Medical Care Summary of Costs** – Table of cost-shares
- **How Does Selecting A Provider Affect My Benefits?** — How using in-network providers will cut your costs.
- **What Types Of Expenses Am I Responsible For Paying?** – Your copays, deductible and coinsurance.
- **What Are My Benefits?** — What's covered and what you need to pay for covered services.
- **Prior Authorization** – Describes services that are recommended for prior authorization and emergency admission notification.
- **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 submission.
- **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," "our" or "Claims Administrator" refer to Premera Blue Cross.

FOR MORE INFORMATION

Our contact information is on the last page of this booklet. Please visit our Web site or call Customer Service for help with:

- Questions about benefits or claims
- Questions or complaints about care you receive

You can also get benefit and claim information through our self-service automated system when you call Customer Service.

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

You can use our Web site to:

- Locate a health care provider near you
- 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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MEDICAL CARE SUMMARY OF COSTS

This is a summary of your costs for covered services. Your costs are subject to the all of the following:

- The allowable charge. This is the most this plan allows for a covered service. See "Definitions" for details.
- The conditions, time limits and maximum limits described in this contract. Some services have special rules. See *What Are My Benefits?* for these details.
- **The plan year deductible** is the amount of expense you must incur in each plan year (April 1 through March 31) for most covered services and supplies before this plan provides benefits. The plan year deductible amount required when services are furnished by in-network providers and the plan year deductible amount required when services are furnished by out-of-network providers are cross-applied. This means that any plan year deductible amount you pay for any covered service or supply helps satisfy the plan year deductible requirement of the other benefit level.

	In-Network Providers	**Out-of-Network Providers**
Individual deductible	$300	$600
Family deductible	$900	$1,800

- **The out-of-pocket maximum** is the most you pay each year for services from all providers. The out-of-pocket maximum required when services are furnished by in-network providers and the out-of-pocket maximum required when services are furnished by out-of-network providers are cross-applied. This means that any coinsurance amount you pay for any covered service or supply helps satisfy the coinsurance requirement of the other benefit level.

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$2,300	$4,600
Family out-of-pocket maximum	$4,900	$9,800

Please note: The cost-shares shown in the table below apply after the deductible has been met. Sometimes the deductible is waived and this is also shown below. Additionally, if the provider you see is an out-of-network provider, you'll also be responsible for amounts above the allowable charge, in addition to any applicable deductible, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum.

	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
COMMON MEDICAL SERVICES		
Professional Visits And Services (You may have additional costs for things such as x-rays. See those covered services for details.)	10%	30%
• Urgent Care	$75 copay, deductible & 10%	$75 copay, deductible & 30%
• Virtual Care (electronic visits and telehealth services)	10%	30%
• Therapeutic injections	10%	30%

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
COMMON MEDICAL SERVICES		
Preventive Care		
• Exams, screenings and immunizations	$0, deductible waived	$0, deductible waived
• Seasonal and travel immunizations	$0, deductible waived	$0, deductible waived
• Preventive colon health screenings including colonoscopies, sigmoidoscopies and double contract barium enemas (facility, anesthesia and professional charges)	$0, deductible waived	$0, deductible waived
Please see the surgical services benefit for coverage of non-preventive diagnostic surgeries.		
Health Management Health education, diabetes health education, community wellness and nicotine dependency treatment	$0, deductible waived	$0, deductible waived
Chemical Dependency Treatment		
• Office visits	10%	30%
• Outpatient facility care	10%	30%
• Inpatient facility care	10%	30%
Contraception Management and Sterilization		
• Female Contraceptive Management and Sterilization	$0, deductible waived	$0, deductible waived
• Male Contraceptive Management and Sterilization	$0, deductible waived	$0, deductible waived
Diagnostic Services		
• Preventive & screening diagnostic services	$0, deductible waived	$0, deductible waived
• Non-preventive diagnostic services	10%	30%
Diagnostic and Screening Mammography		
• Preventive & screening mammography	$0, deductible waived	$0, deductible waived
• Non-preventive diagnostic mammography	10%	30%
Surgical Services		
• Inpatient hospital	10%	30%
• Outpatient hospital, ambulatory surgical center	10%	30%
• Professional services	10%	30%
Emergency Room		
• Facility fees	$150 copay, deductible & 10%	$150 copay, deductible & 10%
• Emergency room physician services	10%	10%
• Diagnostic services	10%	10%
• Other services and supplies	10%	10%

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
COMMON MEDICAL SERVICES		
Ambulance Services	10%	10%
Hospital Services (Inpatient & Outpatient)	10%	30%
Mental Health Care		
• Office visits	10%	30%
• Outpatient facility care	10%	30%
• Inpatient facility care	10%	30%
Maternity and Newborn Care Prenatal, postnatal, delivery and inpatient care		
• Hospital	10%	30%
• Birthing center or short-stay facility	10%	30%
• Diagnostic tests during pregnancy	10%	30%
• Professional care	10%	30%
Home Health Care Limited to 130 visits per plan year (shared limit with acute nursing.)	10%	30%
Hospice Care		
• Home visits and respite care (unlimited)	10%	30%
• Inpatient hospice care (unlimited)	10%	30%
Rehabilitation Therapy and Chronic Pain Care		
• Inpatient (unlimited)	10%	30%
• Outpatient (physical, occupational and speech therapy are limited to 60 visits per plan year)	10%	30%
• Chronic pain care (unlimited)	10%	30%
Skilled Nursing Facility	10%	30%
Medical Equipment and Supplies		
• Breast pumps Coverage is provided for standard electric breast pumps or the rental of hospital grade pumps **Please Note:** The purchase of hospital grade pumps is not covered.	$0, deductible waived	$0, deductible waived
• Medical vision hardware	10%	30%
• Wigs or Hairpieces (1 every 365 days, up to a $500 benefit maximum)	10%	10%
• Foot orthotics and orthopedic shoes	10%	30%

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER COVERED SERVICES		
Alternative Care Limited to 18 visits per member per plan year	10%; deductible waived	10%; deductible waived
Allergy Testing and Treatment	10%	30%
Autism Spectrum Disorders	10%	30%
Blood Products and Services	10%	30%
Dialysis	10%	30%
Infertility And Assisted Fertilization Benefits are provided up to a $15,000 lifetime maximum for medical and pharmacy services combined.	10%	30%
Infusion Therapy	10%	30%
Mastectomy and Breast Reconstruction	10%	30%
Medical Foods	10%	30%
Neurodevelopmental Therapy • Inpatient (unlimited) • Outpatient (unlimited)	 10% 10%	 30% 30%
Nutritional Therapy	10%	30%
Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth)	10%	30%
Private Duty Nursing When medically necessary, benefits are provided in lieu of hospitalization with a written treatment plan by your physician.	10%	30%
Psychological and Neuropsychological Testing	10%	30%
Routine Hearing Exams (limited to 1 exam every 24 consecutive months) • Members under 18 • Members over 18	 $0, deductible waived 10%	 $0, deductible waived 30%

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
OTHER COVERED SERVICES		
Hearing Hardware Limited to $2,000 per member every 36 consecutive months.	10%	10%
Spinal and Other Manipulations Limited to 20 visits per plan year	10%	30%
Transgender Services	Covered as any other service	Covered as any other service
Transplants Services		
• Office visits	10%	Not covered*
• Inpatient facility fees	10%	Not covered*
• Other professional services	10%	Not covered*
• Travel and lodging (limited to $10,000 for any one transplant or procedure type)	Plan year deductible only	Plan year deductible only
***Please see the Transplants Services benefit for additional information.**		
Prescriptions – Retail Pharmacy Up to a 30-day supply		
• Generic Drugs	$10 copay	$10 copay
• Preferred Brand-Name Drugs	10% coinsurance up to a $30 maximum	10% coinsurance up to a $30 maximum
• Non-Preferred Brand-Name Drugs	30% coinsurance up to a $40 maximum	30% coinsurance up to a $40 maximum
Prescriptions – Mail-Order Pharmacy Up to a 90-day supply		
• Generic Drugs	$20 copay	$20 copay
• Preferred Brand-Name Drugs	10% coinsurance up to a $60 maximum	10% coinsurance up to a $60 maximum
• Non-Preferred Brand-Name Drugs	30% coinsurance up to a $80 maximum	30% coinsurance up to a $80 maximum
Prescriptions – Specialty Pharmacy Up to a 30-day supply	Same as retail pharmacy	Same as retail pharmacy

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

In-Network Providers

This plan is a Preferred Provider Plan (PPO). This means that the plan provides you with benefits for covered services from providers of your choice. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from in-network providers. There are some exceptions, which are explained below.

In-Network providers are:

- Providers in the Heritage network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- For care outside the service area (see "Definitions"), providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called "Host Blues" in this booklet.) See "Out-Of-Area Care" later in the booklet for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

Participating pharmacies are also in-network providers and are available nationwide.

In-network providers provide medical care to members at negotiated fees. These fees are the allowable charges for in-network providers. When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). In-network providers will not charge you more than the allowable charge for covered services. This means that your portion of the charges for covered services will be lower.

A list of in-network providers is in our provider directory. You can access the directory at any time on our Web site at **www.premera.com/amazon**. You may also ask for a copy of the directory by calling 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 an in-network provider. The numbers are on the back cover of this booklet and on your Premera Blue Cross ID card.

Important Note: You're entitled to receive a provider directory upon request, without charge.

Out-of-Network Providers

Out-of-network providers are providers that are not in one of the networks shown above. Your bills will be reimbursed at a lower percentage (the out-of-network benefit level).

- Some providers in Washington outside of the Heritage network have other contracts with us. Even though your bills will be reimbursed at the lower percentage (the out-of-network benefit level), these providers will not bill you for any amount above the allowable charge for a covered service. The same is true for a provider that is in a different network of the Host Blue. For help in finding in-network providers, contact our Customer Service department or visit **www.premera.com/amazon**.
- There are also out-of-network providers who do not have contracts with us, Premera Blue Cross Blue Shield of Alaska or the Host Blue at all. These providers may have the right to charge you more than the allowable charge for a covered service. Please see "Providers Outside Of Washington And Alaska" for additional information. You may also be required to submit the claim yourself. See "How Do I File A Claim?" for details.

Amounts in excess of the allowable charge don't count toward any applicable plan year deductible, coinsurance or out-of-pocket maximum.

Please Note: If the provider you see is an out-of-network provider, you'll also be responsible for amounts above the allowable charge, in addition to your plan year deductible and coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

In-Network Benefits For Out-of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered at the

in-network level of benefits up to the allowable charge:

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

  The benefits of this plan will be provided for covered emergency care without the need for any prior authorization and without regard to whether the health care provider furnishing the services is an in-network provider. Emergency care furnished by an out-of-network provider will be reimbursed on the same basis as an in-network provider.
- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory and may be subject to change. For information regarding providers in these categories, contact our Customer Service department.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by out-of-network hospital-based providers.
- Services from an out-of-network Radiologist, Anesthesiologist, Pathologist or Assistant Surgeon, when associated base services are rendered by an in-network provider or hospital. If you see a out-of-network provider, you may be responsible for amounts that exceed the allowable charge.
- Covered 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 an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. However, you must request this before you get the care. See "Prior Authorization" under “Care Management” to find out how to do this.

Please note: If you see a out-of-network provider, you may be responsible for amounts that exceed the allowable charge.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

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

COPAYMENTS

Copayments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service.

The copays applicable to the "Medical Services" portion of this plan are located under the "What Are My Copays?" provision in the "What Are My Benefits?" section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

PLAN YEAR DEDUCTIBLE

A plan year deductible is the amount of expense you must incur in each plan year (April 1 through March 31) for most covered services and supplies before this plan provides benefits. The amount credited toward the plan year deductible for any covered service or supply won't exceed the "allowable charge" (please see the "Definitions" section in this booklet).

Individual Deductible

An "Individual Deductible" is the amount each member must incur and satisfy before certain benefits

of this plan are provided.

Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member’s individual deductible will count toward the family deductible.

The plan year deductible amounts applicable to the “Medical Services” portion of this plan are located under the “What Are My Benefits?” section.

What Doesn't Apply To The Plan Year Deductible?

Amounts that don't accrue toward your plan year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- The coinsurance stated in the Prescription Drugs benefit

COINSURANCE

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. After you meet the plan year deductible, it’s the percentage of allowable charges that you're responsible for paying. In most cases, your coinsurance is 10% for in-network services and 30% for out-of-network services.

The coinsurance percentages applicable to the "Medical Services" portion of this plan is located under "Medical Care Summary of Costs" and "What's My Coinsurance?" in the "What Are My Benefits?" sections. Any benefits that are subject to a different coinsurance percentage will state that percentage in the benefit provision.

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the maximum amount each individual or family could pay each plan year for covered medical services, supplies and prescription drugs. The out-of-pocket maximum consists of your copays, coinsurance and plan year deductible

The plan has separate out-of-pocket maximums for network and out-of-network providers. The cost-shares shown under “What’s My Out-of-Pocket Maximum?” for network providers' care, apply to the in-network out-of-pocket maximum. The cost-shares for out-of-network providers' care apply to the out-of-network out-of-pocket maximum. **It could happen that you satisfy one of these maximums before the other. If this happens, you still have to pay cost-shares that apply to the second out-of-pocket maximum until it, too, is met.**

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowable charges for the remainder of that plan year for covered services from network and out-of-network providers.

Please refer to "What's My Out-of-Pocket Maximum?" in the "What Are My Benefits?" section for the amount of any out-of-pocket maximums you're responsible for.

There are some exceptions. Expenses that do not apply to the out-of-pocket maximum are:

- Charges above the allowable charge
- Charges not covered by the plan
- Your cost-shares for covered drugs purchased from non-participating pharmacies.

We keep track of the total cost-share amounts applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals a set maximum, called the "Family Out-Of-Pocket Maximum," we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that plan year. Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum. This plan has separate family out-of-pocket maximum limits for in-network providers and out-of-network providers.

WHAT ARE MY BENEFITS?

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

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or 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 must be incurred while you're covered under this plan.
- It must be furnished by a provider (please see the "Definitions" section in this booklet) who is performing services within the scope of his or her license or certification.
- It must meet the standards set in our medical and payment policies. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). 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 and federal regulations about coverage for diabetes medical treatment. Please see the Prescription Drugs, Medical Equipment and Supplies, Preventive Care, Professional Visits and Services, and Health Management benefits.

WHAT ARE MY COPAYS?

Urgent Care Copay

For each urgent care visit, you pay $75. Urgent Care visits are also subject to your plan year deductible.

Emergency Room Copay

For each emergency room visit, you pay $150. Emergency room visits are also subject to your plan year deductible and in-network coinsurance. The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

WHAT'S MY PLAN YEAR DEDUCTIBLE?

Individual Deductible

In-Network Deductible $300/person

Out-of-Network Deductible $600/person

Family Deductible

In-Network Deductible $900/family

Out-of-Network Deductible $1,800/family

The plan year deductible amount required when services are furnished by in-network providers and the plan year deductible amount required when services are furnished by out-of-network providers are cross-applied. This means that any plan year deductible amount you pay for any covered service or supply helps satisfy the plan year deductible requirement of the other benefit level.

Once the applicable Family Deductible has been met, the deductible will be considered met for all enrolled family members.

Please Note:

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. Allowable charges that apply to the plan year deductible will not count toward dollar benefit maximums. But if a member receives services or supplies covered by a benefit that has any other kind of maximum, the services or supplies that apply toward the plan year deductible will count toward that maximum.

WHAT'S MY COINSURANCE?

When you see in-network providers, your coinsurance is 10% of allowable charges.

When you see out-of-network providers, your coinsurance is 30% of allowable charges.

However, there are a few exceptions to the above coinsurance percentages. Please see the benefits listed below for details:

- The Alternative Care benefit
- The Ambulance Services benefit
- The Emergency Room Services benefit
- The Prescription Drugs benefit
- The Contraceptive Management and Sterilization benefit
- The Health Management benefit
- The Preventive Care benefit
- The Preventive Diagnostic Services benefit
- The Preventive Diagnostic and Screening Mammography benefit
- The Medical Equipment and Supplies benefit
- The Hearing Hardware benefit

WHAT'S MY OUT-OF-POCKET MAXIMUM?

Individual Out-of-pocket Maximum

In-Network Out-of-pocket Maximum.....	$2,300/person
Out-of-Network Out-of-pocket Maximum.....	$4,600/person

Family Out-of-pocket Maximum

In-Network Out-of-pocket Maximum.....	$4,900/family
Out-of-Network Out-of-pocket Maximum.....	$9,800/family

The out-of-pocket maximum required when services are furnished by in-network providers and the out-of-pocket maximum required when services are furnished by out-of-network providers are cross-applied. This means that any coinsurance amount you pay for any covered service or supply helps satisfy the coinsurance requirement of the other benefit level.

Once the applicable Family Maximum amount has been reached, the out-of-pocket maximum will be considered met for all enrolled family members.

MEDICAL SERVICES

Please Note: For a summary of the cost-shares for medical services outlined below, please see the "Medical Care Summary of Costs" earlier in this booklet.

Alternative Care

Benefits for Alternative Care services are subject to your in-network coinsurance when services are rendered by an in-network or out-of-network provider. Your plan year deductible is waived for Alternative Care.

Alternative care services are limited to 18 visits per member each plan year and must be provided by a provider who is licensed or certified to perform the services by the state in which the provider practices. The following services are covered when medically necessary:

- Acupuncture for the treatment of chronic pain caused by a covered illness or injury
- Massage therapy, with a physician prescription, for the treatment of chronic pain caused by a covered illness or injury

Please see the Rehabilitation Therapy And Chronic Pain Care and Neurodevelopmental Therapy benefits for more information on massage therapy performed by providers other than a licensed massage therapist.

Naturopathy and chiropractic services are covered as any other service and not subject to the 18 visit benefit maximum. Please see the Spinal And Other Manipulations benefit for more information on spinal and other manipulations performed by a physician or chiropractor.

Ambulance Services

Benefits for the following services are subject to your plan year deductible and in-network coinsurance.

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

Ambulatory Surgical Center Services

The ambulatory surgical center services are subject to your plan year deductible and applicable coinsurance.

If the provider you see is an out-of-network provider, you'll also be responsible for amounts above the allowable charge, in addition to your plan year deductible, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum.

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

Autism Spectrum Disorders

The Autism Spectrum Disorders benefit is not subject to a separate benefit maximum.

Benefits are subject to your plan year deductible and coinsurance where applicable.

If the provider you see is an out-of-network provider, you'll also be responsible for amounts above the allowable charge, in addition to your plan year deductible, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum.

This benefit covers Applied Behavioral Analysis (ABA); occupational, speech, and physical therapies; and behavioral health treatment, as described below, for dependent children. For treatment to be covered, the dependent child must have a primary diagnosis of one of the following autism spectrum disorders:

- Autistic disorder
- Childhood disintegrative disorder
- Rett's disorder
- Asperger's disorder
- Pervasive developmental disorders

For the purpose of this benefit, the definitions below apply:

- Applied Behavioral Analysis (ABA) is the design, implementation and evaluation of environmental changes to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function. ABA therapy programs include behavior modification, training and education. ABA seeks to foster or maintain basic skills, such as looking, listening and imitating. It also seeks to develop or maintain complex skills, such as reading, conversing, and understanding someone else's point of view.
- Program Manager is one of the covered licensed providers shown below or a board-certified behavioral analyst.

Covered Providers

- This benefit covers the following types of providers that are licensed by the state in which they practice:
  - A physician (MD or DO)
  - A nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
  - A masters-level mental health clinician
  - A speech, occupational or physical therapist
- This benefit also covers the following unlicensed providers:
  - Board-certified behavioral analysts (BCBA) that are certified by the Behavior Analyst Certification Board.
  - Therapy assistants (who may also be called behavioral technicians or paraprofessionals) when their services

are supervised by the member's program manager. Their services must also be billed by the member's program manager.

Covered Services

- Covered services include:
  - The assessment of the member's behavior before starting treatment, ABA program development and treatment planning to meet the member's needs. These services must be done by the member's program manager.
  - The member's direct clinical ABA treatment done by either the member's program manager or by a therapy assistant who is supervised by the member's program manager.
  - Occupational, speech and physical therapy – **Please note:** Benefits for occupational, speech and physical therapy are driven to this benefit with an Autism Spectrum Disorder diagnosis and are separate from the outpatient neurodevelopmental and rehabilitation therapy benefits. This benefit will not have a visit limit. Occupational, speech and physical therapy billed with a diagnosis other than Autism Spectrum Disorder will apply to the applicable benefit. Please see the Neurodevlopmental or Rehabilitation therapy benefits for additional information.
  - Mental health and chemical dependency treatment

Accessing Your Benefits

- You can visit Premera.com/amazon or call the BlueCard provider number on the back of your booklet to find a licensed provider in the network; OR
- You can visit the Behavioral Analyst Certification Board website at http://www.bacb.com/index.php to find a board-certified behavior analyst or therapy assistant. Members can search by city, state, or zip code.
- **If you need to submit a claim to us, you must include a receipt or other proof of payment**.

The Autism Spectrum Disorders benefit doesn't cover:

- A provider, program manager, therapy assistant or other individuals accompanying the member or a family member to health care appointments not part of the direct ABA services.
- Services provided in a public or private school or a home school that is part of the member's schooling instead of clinical ABA services. Examples include helping the member with homework or acting as a teacher's aide in class.
- Housework, chores, babysitting, or transportation for the member or family members
- Training of therapy assistants or the member's family (as distinct from supervision)
- Travel time
- Respite care for the member's family
- Services for a member who does not have a primary diagnosis of an autism spectrum disorder named in this benefit.
- Family member training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient.
- Prescription drugs. See the Prescription Drugs benefit for available coverage.
- Equestrian therapy

Blood Products and Services

Benefits are provided for blood and blood derivatives, subject to your plan year deductible and coinsurance.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services.

Benefits are subject to the same plan year deductible and 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 “Medical Care Summary of Costs” earlier in this booklet.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider.

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 chemical dependency treatment 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 Services and Hospital Inpatient Care benefits.

The Chemical Dependency Treatment benefit does not cover:

- Treatment of alcohol or drug use or abuse that does not meet the definition of "Chemical Dependency" 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
- Outward bound, wilderness, camping or tall ship programs or activities

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 Services benefit. For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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 for contraceptive management and sterilization aren't subject to any cost-shares (see "Definitions") when you use an in-network or out-of-network provider.

This benefit covers the following services and supplies received from a health care provider:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility charges will be subject to your cost-shares under the applicable facility benefit and are not covered by this benefit.

Contraceptives Dispensed By a Pharmacy

- Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the Prescription Drugs benefit. Your normal cost-share is waived for these devices, for generic emergency birth control drugs and for other birth control drugs that are generic or single-source brand name drugs when you get them from a participating pharmacy. Examples of covered devices are diaphragms and cervical caps.
- Over-the-counter female contraceptives that are prescribed by your healthcare provider and purchased through a licensed pharmacy are also covered. No cost-share is required when you get them through a participating pharmacy. **Please have your prescription ready for the pharmacist.**

The Contraceptive Management and Sterilization benefit doesn't cover:

- Over-the-counter male contraceptive drugs, supplies or devices
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.)
- Sterilization reversal

Diagnostic Services

Preventive Screening Services

Benefits for **preventive** screening services are not subject to your plan year deductible or coinsurance.

Preventive diagnostic screenings include, but are not limited to:

- Vitamin D testing
- Screening tests for prostate and cervical cancer
- Sexual health screenings for chlamydia, gonorrhea, hepatitis, HIV and syphilis
- BRCA genetic testing for women at risk for certain breast cancers
- Fecal Occult Blood Tests.
- Hepatitis C virus (HCV) screening for individuals with a high risk of infection
- Computerized Axial Tomography (CT) scan of the thorax to screen for lung cancer in adults 55 to 80 with a history of smoking
- Aortic ultrasounds and bone density scans (DEXA scan)

Please see the guidelines stated in the Preventive Care benefit provision.

All Other Diagnostic Services

Benefits for non-preventive **diagnostic** services are subject to your plan year deductible and applicable coinsurance. However, diagnostic surgeries, including scope insertion procedures, that do not meet preventive guidelines, are only covered under the Surgical Services benefit.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Diagnostic imaging and scans, including x-rays and EKGs. Positron Emission Tomography (PET scan), Magnetic Resonance Imaging (MRI), and Ultrasounds.
- Laboratory services
- Pathology tests

In addition to 'What's Not Covered?" this Diagnostic Services benefit doesn't cover:

- Allergy testing. See the Professional Visits and Services 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 Outpatient or Emergency Room Services benefits.

- Mammography services. Please see the Diagnostic and Screening Mammography benefit.

Please Note: Diagnostic surgeries, including scope insertion procedures that do not meet preventive guidelines, are covered under the Surgical Services benefit.

Preventive Colon Health Screenings

Preventive colon health screenings (including colonoscopies, sigmoidoscopies, and double contrast barium enemas). Benefits are provided for facility, anesthesia, and professional services. For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Please Note: Non-preventive colonoscopies and sigmoidoscopies are only covered under the surgical services benefit.

Diagnostic and Screening Mammography

Benefits for **preventive** mammography services are not subject to your plan year deductible or coinsurance. Please see the guidelines stated in the Preventive Care benefit provision.

Benefits for non-preventive **diagnostic** mammography services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

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.

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.

Please note: For individuals who have group health coverage and Medicare on the basis of ESRD, Medicare is secondary payer during the coordination period. The Balanced budget Act of 1997 retroactively extends the coordination period to 30 months for periods that began on or after February 5, 1996 (18 months before the law's effective date of August 5 1997).

Crucial to an understanding of the rules is the date of the beneficiary's entitlement to Medicare. A beneficiary who becomes entitled to Medicare solely because of ESRD has a three-month wait until he or she is covered under Medicare. In other words, **the individual becomes entitled to Medicare on the first day of the third month after the month in which a regular course of dialysis begins.** For example, an individual who starts a regular course of dialysis on July 15 would be entitled to Medicare on October 1.

Emergency Room Services

For each emergency room visit, you pay $150 copay. Emergency room services are also subject to your plan year deductible and in-network coinsurance. The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

This benefit is provided for emergency room services, including related services and supplies, such as 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 chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

Health Management

These services are not subject to your plan year deductible or coinsurance.

Benefits are provided for services furnished by in-network, out-of-network providers or approved providers. For help in finding covered providers, contact our Customer Service department or search the Find a Doctor tool on www.premera.com/amazon.

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.

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 last page of this booklet). For a reimbursement form, you can download claim forms from www.premera.com/amazon.

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 or visit www.premera.com/amazon to obtain a claim reimbursement form.

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

Home and Hospice Care

Benefits for the following services, supplies and drugs are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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

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

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

Home Health Care

This benefit provides up to 130 intermittent home visits per member each plan year by a home health care provider, or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit. Home health care that is provided as an alternative to inpatient hospitalization is not subject to this limit.

Hospice Care

Hospice care benefits for a terminally ill member are not subject to a plan year benefit maximum.

Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services do not

count toward the 130 intermittent home visit limit shown above under Home Health Care.

- **Respite care** 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. Inpatient facility hospice care is not subject to a plan year benefit limit.
- **Palliative care** in cases where the member has a serious or life-threatening condition. Coverage of palliative care is usually approved for 12 months at a time. It can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

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

This benefit does not cover:

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

Hospital Inpatient Care

The following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

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

This benefit does not 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 exceeds the length of stay that is medically necessary to treat your condition.

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

Other Outpatient Services

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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.

Infertility And Assisted Fertilization

Benefits are subject to the same plan year deductible and coinsurance, if any, that you would pay for inpatient or outpatient treatment for other covered medical conditions. For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

Benefits are provided for the testing, diagnosis and treatment of infertility, up to a $15,000 lifetime maximum for combined medical and pharmacy services, per member. **Important note:** This benefit’s lifetime maximum may be reduced if you have previously incurred infertility and assisted fertilization benefits on another Amazon and Subsidiaries medical plan. Examples of covered services include egg harvesting, artificial insemination (AI), gamete intra-fallopian transplant (GIFT), in vitro fertilization (IVF), and pre-implantation genetic diagnosis (PGD).

Infertility benefits are available to covered members with a specified infertility diagnosis or who have another medical condition that may cause infertility.

When two eligible members are involved in the treatment, services will be accrued to each member's benefit maximum as follows:

- Any eligible service, procedure, test, drug, or supply used to evaluate or treat one member should be billed to and assigned to that member's benefit maximum.
- Any eligible service, procedure, test, drug, or supply performed that cannot be assigned specifically to either of the members using the criteria described above, will be assigned to the member who the claim was submitted for.

Services that are not covered include, but are not limited to:

- Cryopreservation for active infertility treatment (beyond initial 12 month period)
- Fees paid to donors
- Infertility that is caused by hysterectomy or voluntary sterilization
- Sterilization reversal
- Non –prescription contraceptive drugs, supplies or devices
- Procedures, drugs, or supplies determined to be experimental or investigational
- Testing and treatment for potential surrogates.

Infertility Drugs

Infertility drugs, including fertility enhancement medications, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug, up to the combined $15,000 lifetime maximum per member for medical and pharmacy services. Please see the Prescription Drugs benefit for details.

Please Note: If the above infertility services and supplies are furnished by an out-of-network provider or facility, you’ll also be responsible for amounts above the allowable charge. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum. For an explanation of the amount you'll pay for services and supplies from in-network and out-of-network providers, please see the "What Are My Benefits?" section of this booklet.

Infusion Therapy

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- To enable another means for members who are unable to take sufficient volumes of fluids orally
- To provide prolonged nutritional support for members with gastrointestinal dysfunction

This benefit does not cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

Benefits for mastectomy or breast reconstruction services and supplies are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

Under the Women’s Health and Cancer Rights Act of 1998 (“WHCRA”), certain benefits must be provided for mastectomy and mastectomy-related services necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy and other mastectomy-related services, coverage will be provided for:

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

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, call the Benefits Service Center at 1-866-644-2696.

Medical Equipment and Supplies

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

You don't have to pay these cost-shares when you purchase a breast pump from a network provider as described later in this benefit.

To find the amounts you are responsible for, please see the “Medical Care Summary of Costs” earlier in this booklet.

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 equipment include: wheelchair, hospital-type bed, traction equipment, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

Respiratory equipment, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury such as ventilators or oximeters may follow different rental and purchase rules. Please contact customer service for more information.

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 are not limited to, dressings, braces, splints, rib belts, crutches and diabetic supplies, as well as related fitting expenses.

Diabetic supplies such as hypodermic needles, lancets, test strips, testing agents and alcohol swabs are also covered under your Prescription Drug benefit.

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

Prosthetics

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

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

Foot Orthotics

Benefits are provided for foot orthotics (shoe inserts), including fitting expenses. Benefits are also provided for therapeutic shoes prescribed for the treatment of diabetes.

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 and keratoconus.

Wigs or Hairpieces

Benefits are subject to your in-network plan year deductible and coinsurance. Benefits are provided for wigs or hairpieces due to medically induced hair loss. Examples of medically induced hair loss include, but are not limited to, hair loss resulting from injury, disease or treatment of disease, medication, radiation therapy or chemotherapy.

Benefit coverage is provided for one wig up to a benefit maximum of $500 every 365 days.

Breast Pumps

This benefit covers the purchase of standard electric breast pumps. Rental of hospital grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

For further information, please see the Preventive Care benefit.

The Medical Equipment and Supplies benefit does not 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 Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- 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
- Non-diabetic therapeutic shoes

Medical Foods

Benefits for medical foods, as defined below, are subject to your plan year deductible and applicable coinsurance when you use a network provider.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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.

Mental Health Care

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below.

Benefits are subject to the same plan year deductible and coinsurance, 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 “Medical Care Summary of Costs” earlier in this booklet.

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.
- 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.

Mental health services 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 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 his or her license.

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 chemical dependency treatment benefit information, please see the Chemical Dependency Treatment 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, including impotence and frigidity
- Outward bound, wilderness, camping or tall ship programs or activities
- 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

Benefits for the services below are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

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 Autism Spectrum Disorders benefit.

Inpatient Care – Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility that meets Premera's clinical standards, and will only be covered when services can't be done in a less intensive setting.

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, physician, chiropractor, naturopath, physical or occupational or speech therapist, or rehabilitation facility that meets Premera's clinical standards

When the above criteria are met, benefits will be provided for physical, speech and occupational and massage therapy services.

Please Note: Massage therapy performed by a massage therapist is covered under the Alternative Care benefit. For more information please see the Alternative Care benefit.

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

The plan does not provide this benefit and the Rehabilitation Therapy and Chronic Pain Care benefits for the same condition. Once a plan year maximum has been exhausted under one of these benefits, no further coverage is available.

This benefit does not cover:

- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care

Newborn Care

Newborn children are covered automatically for the first 31 days, beginning on the date of birth, when the mother is eligible to receive obstetrical care benefits under this plan. To continue benefits beyond the 31 day period, please see the dependent eligibility and enrollment guidelines outlined in the "Who Is Eligible For Coverage?" and "When Does Coverage Begin?" sections.

If the mother is not eligible to receive obstetrical care benefits under this plan, the newborn is not automatically covered for the first 31 days. For newborn enrollment information, please see the "Who Is Eligible For Coverage?" and "When Does Coverage Begin?" sections.

Benefits are subject to the applicable plan year coinsurance (deductible is waived) for the newborn child at the time of birth through discharge from the hospital. Once the newborn child is discharged, benefits are provided on the same basis as any other care, subject to the child's own applicable plan year deductible and coinsurance, and other provisions as specified in this plan. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

The Newborn Care benefit covers hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

This plan is subject to the Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”). As required under the NMHPA, the plan does not 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, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). As a result, the plan does not apply this restriction 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 accordance with the NMHPA, this plan does not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Professional Care

Benefits for services received in a provider's office are subject to the terms of the Professional Visit and Services benefit. Well-baby exams in the provider's office are covered under the Preventive Care benefit. This benefit covers:

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

Inpatient Professional Care

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

Outpatient Professional Visits

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

This benefit does not cover immunizations or outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and outpatient well-baby exams.

Nutritional Therapy

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. These services are not subject to a calendar benefit limit.

For covered services to manage diabetes, please see the Preventive Care benefit for benefit information.

Obesity Treatment

Non-Surgical Weight Management

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations and exclusions.

Non-Surgical Weight Management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits
- Physician visits
- Related lab and diagnostic services

For specific benefit information, please see the Mental Health Care, Nutritional Therapy, Rehabilitation Therapy and Chronic Pain Care, Professional Visits, Prescription Drug, and Diagnostic Services benefits.

Surgical Treatment of Morbid Obesity

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the criteria listed in Premera's current medical policy, applicable benefits, limitations and exclusions. The medical policy may be obtained by contacting Customer Service, or online at www.premera.com/medicalpolicies.

Prior authorization is highly recommended for members considering this approach to weight loss. For information on obtaining a prior authorization, please see "Prior Authorization" later in this booklet.

For specific surgical treatment benefit information, please see the Hospital Inpatient Care, Hospital Outpatient Care and Surgical Services benefits.

Coverage is available for bariatric procedures listed as medically necessary in the Premera Blue Cross medical policy and when the criteria of that policy are met. To qualify for the surgical treatment for morbid obesity benefit, the member must meet the following criteria:

- Age greater than or equal to 18 years.
- Diagnosed as morbidly obese with a Body Mass Index (BMI) greater than or equal to 40; or
- Overweight with a BMI greater than 35 with severe comorbidities, including but not limited to:
  - Coronary Heart Disease
  - Atherosclerotic Disease such as peripheral arterial disease, abdominal aortic aneurysm, symptomatic carotid artery disease
  - Type 2 Diabetes uncontrolled by medication
  - Hypertension
  - Sleep Apnea, moderate to severe
- Physician-supervised weight reduction program which includes;
  - A program of at least six consecutive months in duration, within the two year period prior to surgery being considered.
  - Evidence of active participation in a program documented in the member's medical record.
- Psychological evaluation by a licensed mental health provider to establish emotional stability and the ability to comply with post-surgical limitations.

For specific surgical treatment benefit information, please see the Hospital Inpatient Care, Hospital Outpatient

Care and Surgical Services benefits.

The Obesity Treatment benefit does not cover:

- Procedures or treatments that Premera Blue Cross and its affiliates deem are experimental and investigational (please see the "Definitions" section in this booklet)
- Surgical removal of excess abdominal, arm or other skin or liposuction unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Health clubs
- Wiring of the jaw
- Weight management drugs

Obstetrical Care

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for all female members. Preventive screening services that meet the guidelines for preventive care are covered for all eligible members as stated in the Preventive Care benefit.

The Obstetrical Care benefit includes coverage for abortion.

Benefits for professional and facility services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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.

This plan does not 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 accordance with the NMHPA, this plan does not, under Federal law, require that a provider obtain authorization from the plan 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

This benefit covers:

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

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

Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth)

Benefits for the following services are subject to your plan year deductible and coinsurance.

Covered expenses include charges made by a physician, a dentist and hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.

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

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

Dental Anesthesia

Benefits are subject to your plan year deductible and applicable coinsurance.

Covered services include general anesthesia and related facility services furnished by a hospital or ambulatory surgical center for dental procedures are covered if medically necessary when:

- The member is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office, or
- 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 dental services provided by the dentist. For dental services please see the Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth) for additional information.

Orthognathic Surgery (Jaw Augmentation Or Reduction)

For orthognathic surgery benefit information, please see the Oral And Maxillofacial Treatment (Mouth, Jaws, And Teeth).

Prescription Drugs

The 3-tier Prescription Drugs benefit provides coverage for medically necessary prescription 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.

The Prescription Drugs benefit requires you to pay either a copay or coinsurance for each separate new prescription or refill you get from in-network pharmacies. The copay amounts and/or coinsurance percentages are shown below. A "copay" is a fixed up-front dollar amount that you’re required to pay to the retail pharmacy or the in-network mail-order pharmacy for each prescription drug purchase. "Coinsurance" is the percentage of the allowable charge that you’re required to pay to the pharmacy for each prescription drug purchase.

Please note: Certain drugs are subject to prior authorization. As part of this review, some prescriptions may require additional medical information from the prescribing provider. See “Prior Authorization” in the Care Management section of your booklet for additional detail.

Retail Pharmacy Prescriptions

What is my cost share for prescriptions received from an in-network and out-of-network retail pharmacy?

Generic Drugs.....	$10 copay
Preferred Brand Name Drugs.....	10% coinsurance up to a $30 maximum
Non-Preferred Brand Name Drugs.....	30% coinsurance up to a $40 maximum

Dispensing Limit

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of up to a 90-day supply is allowed when the drug maker's packaging doesn't allow for a lesser amount.

How to Use the Retail Pharmacy Benefit

- **In-Network Retail Pharmacies** – After you’ve paid any required cost-share at the pharmacy, the plan will pay the in-network pharmacy directly.
- **Out-of-Network Retail Pharmacies** – You pay the full price for the prescription drug and then submit a claim for reimbursement. Please see the "How Do I File a Claim?" section in this booklet for more information.

You can lower your out-of-pocket costs by using an in-network pharmacy. These pharmacies agree not to charge you more than the allowable charge for covered drugs, and will submit claims directly to us. By showing your Premera Blue Cross ID card at an in-network pharmacy, you will not be charged more than the allowable charge for covered drugs. If you use an out-of-network pharmacy, or if you don't show your Premera Blue Cross ID card at an in-network pharmacy, you will be required to pay the full retail price for the drug, and then submit a claim for reimbursement. Your reimbursement, however, will be based on the allowable charge for the covered drugs.

If you need to find an in-network pharmacy near you, please call our Customer Service Department or use the Find a Doctor search on www.premera.com/amazon.

Mail-Order Pharmacy Program

What is my cost share for mail-order prescriptions received from an in-network pharmacy?

Generic Drugs.....	$20 copay
Preferred Brand Name Drugs.....	10% coinsurance up to a $60 maximum
Non-Preferred Brand Name Drugs.....	30% coinsurance up to a $80 maximum

Please note: The plan does not provide coverage for out-of-network mail-order pharmacy prescriptions.

Dispensing Limit

Benefits are provided for up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of an amount more than a 90-day supply is permitted when the drug maker's packaging doesn't allow for a specific 90-day amount.

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 in-network mail-order pharmacy directly. This benefit is limited to prescriptions filled by our in-network 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.

Specialty Pharmacy Program

Specialty drugs are subject to the cost shares 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, multiple sclerosis or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. You and your health care provider must work with a network specialty pharmacy to arrange ordering and delivery of these drugs. See “How Does Selecting A Provider Affect My Benefits?” for details about the provider networks.

Please note: This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. 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 last page of this booklet.

Prescription Drug Out-Of-Pocket Maximum

Each plan year, the prescription copays and coinsurance each member could pay to participating pharmacies is limited to $4,150. This total is called the "prescription drug out-of-pocket maximum." Once this maximum has been satisfied, you don't have to pay any more copays or coinsurance for prescription drugs and supplies covered under this benefit for the remainder of that plan year.

Copays and coinsurance paid to non-participating pharmacies don't apply toward the prescription drug out-of-pocket maximum. Also, if you must pay the difference in price between a brand name drug and its generic equivalent, this amount doesn't apply toward the prescription drug out-of-pocket maximum.

Amounts used to satisfy the prescription drug out-of-pocket maximum are not applied to any other out-of-pocket maximum of this plan.

Family Prescription Drug Out-Of-Pocket Maximum

We also keep track of the expenses applied to the prescription drug out-of-pocket maximum that are incurred by all enrolled family members combined. When the total equals $8,000, we will consider the prescription drug out-of-pocket maximum of every enrolled family member to be met for the year. The $8,000 is called the "family prescription drug out-of-pocket maximum." Only the amounts used to satisfy each enrolled family member’s prescription drug out-of-pocket maximum will count toward the family prescription drug out-of-pocket maximum.

What's Covered?

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

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the "Definitions" section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug. Review is required for compound drugs over $200.
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin). **Please Note:** Cost-shares are waived for diabetic supplies when insulin is purchased.
- 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.

- Self-administered oral medication that can be used to kill cancerous cells or slow their growth.
- Preventive anti-cancer medications for women who are at increased risk for breast cancer. Your normal cost-shares are waived.
- Prescription drugs and generic over-the-counter drugs for the treatment of nicotine dependency, including over-the-counter smoking cessation drugs (gum and patches), such as Zyban and Chantix.

  Your normal cost-share for drugs received from a participating pharmacy is waived for certain nicotine dependency drugs as described in the Preventive Care benefit.
- Preventive drugs required by the Affordable Care Act. Your normal cost-share is waived when you get them from a participating pharmacy
- Birth control drugs and devices that require a prescription. Your normal cost-share is waived for these devices, for generic emergency birth control drugs and for generic and single-source brand name birth control drugs when you get them from a participating pharmacy.
- Over-the counter female birth control devices and supplies. Your normal cost-share is waived when you get them from a participating pharmacy. You must bring a prescription for these to give to the pharmacist.
- Drugs to treat infertility, including fertility enhancement medications, are covered up to the combined total maximum of $15,000 per member per lifetime for pharmacy and medical services.
- Growth hormones are covered with prior authorization

What's Not Covered?

This benefit does not cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded, even if prescribed by a practitioner, unless otherwise stated in this benefit or required by law. Examples of such non-covered items include vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-prescription male contraceptive methods, such as condoms, even if prescribed 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
- 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. The exceptions are for injectable and implantable contraceptives and prescription drugs provided as part of the plan's Specialty Pharmacy provision (see "Specialty Pharmacy Program" earlier in this benefit), which are payable under this benefit, regardless of where they are administered.
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. The exception is self-administered injectable diabetic drugs. Please see the Infusion Therapy benefit.
- Drugs to treat sexual dysfunction
- 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 Medical Equipment and Supplies benefit for available coverage.
- Immunization agents and vaccines. Please see the Preventive Care benefit for available coverage.

Prescription Drug Volume Discount Program

Premera Blue Cross may receive per-claim rebates from its pharmacy benefit manager in connection with your Group's pharmacy benefit utilization. Such rebates constitute Premera Blue Cross property and are not part of the compensation payable to Premera Blue Cross under Premera Blue Cross 's contract with the Group.

In addition, Premera Blue Cross will separately credit to your Group fixed amounts per brand name prescription

drug claim, and these amounts are not reflected in your cost-share.

The allowable charge that your payment for prescription drugs is based upon is higher than the price we pay our pharmacy benefit manager for those prescription drugs. The difference constitutes our property, and not part of the compensation payable to us under our contract with the Group. We are entitled to retain and shall retain the difference and may apply it to the cost of our operations and the prescription drug benefit program. Your plan year deductible, coinsurance are based on the allowable charge.

Questions and Answers About Your Prescription Drug Benefit

1. Does this plan exclude certain drugs that my health care provider may prescribe, or encourage substitution for some drugs?

Yes. Your prescription drug benefit excludes certain categories of drugs. Please see “What's Not Covered?” in the section above for more information about what the Prescription Drug benefit does not cover.

This Prescription Drug benefit uses a drug list. (This is sometimes referred to as a “formulary.”) We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the list. This plan does provide benefits for non-preferred brand-name drugs, which aren't on the list, but at a higher cost to you.

You may also be responsible for amounts over your cost-shares when you purchase certain brand-name drugs. This plan encourages the use of appropriate "generic drugs" and "interchangeable biological products" (as defined below). When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug and an "interchangeable biological product" will be dispensed in place of the product prescribed. If your prescriber does not want to substitute a generic for the brand name drug, you pay only the brand name cost shares. However, if substitution of the generic drug for the brand-name drug is allowed by the prescriber, and you request the brand name drug, you’ll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name cost-share. Please consult with your pharmacist on the higher costs you’ll pay if you select a brand name drug.

A "generic drug" is a prescription drug product manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration (FDA). The FDA considers them to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

"Biological products" include vaccines, serums, antitoxins, blood or blood components. The FDA decides when these products are interchangeable. Interchangeable products are expected to produce the same medical result in any given patient as a biological product that the FDA has already approved. Except for this substitution process, the terms "drug" and "prescription drugs" will include biological products.

In no case will your out-of-pocket expense exceed the cost of the drug or supply.

Certain drugs need prior authorization. As part of this review, some prescriptions may require more medical information from the prescribing provider or substitution of equivalent medication. Please see “Prior Authorization" in the Care Management section of your booklet for more detail.

2. When can my plan change the pharmacy drug list? If a change occurs, will I have to pay more to use a drug I had been using?

Our Pharmacy and Therapeutics Committee reviews the drug list frequently throughout the year. This committee includes medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the list.

Changes to our drug list do not change your benefits.

3. How much do I have to pay to get a prescription filled?

The amount you pay for covered drugs dispensed by a retail or mail-order pharmacy is described above.

4. Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?

Yes. You may have lower out-of-pocket costs when you have your prescriptions filled by in-network pharmacies. Your benefit covers prescription drugs dispensed from an out-of-network pharmacy, but at a possible higher out-of-pocket cost to you.

You can find an in-network pharmacy near you by using the Find a Doctor tool on www.premera.com/amazon or by contacting our Customer Service Department at the number found on the

last page of this booklet.

Also see "Specialty Pharmacy Program" earlier in this benefit for information on participating specialty pharmacies.

5. How many days' supply of most medications can I get?

The dispensing limits, or days' supply, for drugs dispensed at retail pharmacies are described in the "Dispensing Limit" provision above.

Benefits for refills will be provided only when the member has used 75% of a supply of a single medication. The 75% is calculated based on both of the following:

- The number of units and days' supply dispensed on the last refill
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill

Exceptions to the limit may be allowed as required by law. For example, a pharmacist can authorize an early refill of a prescription for eye drops and eye ointment in some cases.

6. What other pharmacy services does my health plan cover?

This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this booklet.

Preventive Care

What Are Preventive Services?

Preventive services are defined as follows:

- Evidence-based items or services with a rating of “A” or “B” in the current recommendations of the U.S. Preventive Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

A full list of these preventive services is available on our website or by calling Customer Service. The list also provides the guidelines on how often the services should be provided and who should receive them. Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.

Services designated as preventive care when they meet the federal guidelines include periodic exams, routine immunizations described below and laboratory and imaging services that are covered as preventive under the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefits. This plan will still cover services as preventive if they are done more often than stated in the federal guidelines as long as they meet the other standards in the guidelines. For instance, if the guidelines give an age range in which a certain test is medically appropriate, the member must be in that age range for the test to be covered.

Please note: Some clinics that are based in or owned by a hospital charge a separate facility fee for all physician visits, including preventive service visits. These fees may not be covered by your preventive benefits and may result in an added out-of-pocket cost to you. When preventive care is only available in clinics that charge a facility fee, we will make an exception to cover the fee under the preventive benefit. If you feel that you have been charged this fee in error, please call Customer Service at the number listed on your ID card. You may also file a complaint or ask for an appeal. See "Complaints and Appeals" or call us.

Preventive Exams and Immunizations

Benefits for preventive exams and immunizations performed on an outpatient basis are not subject to your plan year deductible or coinsurance when you use an in-network or out-of-network provider.

Exams – The following exam services are covered as long as they fall within the federal guidelines above in this benefit:

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

- **Immunizations** – Seasonal and travel immunizations, such as flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles immunizations, are covered when done by any pharmacy, the county health department, travel clinic or other mass immunizer location, such as a grocery store, workplace or community center.
- **Please Note:** Travel immunizations are covered at 100% of allowable charges.

Fall Prevention

Professional services to prevent falling for members who are 65 or older and have a history of falling or mobility issues. For example, services may include physician visits and physical therapy.

Nutritional Counseling

Healthy eating assessments and dietary counseling, including services for eating disorders and diabetes.

Women's Preventive Care

Benefits for women's preventive care, as defined by regulation for women's health, aren't subject to any deductible or coinsurance when you use a network provider.

Examples of covered women's preventive care services include but are not limited to, contraceptive counseling, breast feeding counseling, maternity diagnostic screening, screening for gestational diabetes, and counseling about sexually transmitted infections. A full list of preventive services is available on our Web site or by calling Customer Service.

For more details, please see the following benefits:

- Contraceptive Management And Sterilization
- Medical Equipment And Supplies benefit (breast pumps)
- Diagnostic Services
- Health Management
- Obstetrical Care benefits

The Preventive Care benefit does not cover:

- 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 or medical disability evaluations
- Preventive laboratory and imaging services, screening and diagnostic mammography. Please see the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefit for available coverage.

Private Duty Nursing

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Benefits are provided for medically necessary special nursing care by a registered nurse or a licensed practical nurse, for members that are homebound, in lieu of hospitalization with a written treatment plan by your physician.

Professional Visits and Services

Benefits for the services listed below are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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")
- Diabetic foot care
- Repair of a dependent child’s congenital anomaly
- Consultations and treatment for nicotine dependency

Urgent Care Centers

This plan covers care you receive in an urgent care center, including the facility fees and supplies. 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.

You may have to pay separate cost-shares for other services you receive during an urgent care visit. This includes services such as x-rays, lab work, therapeutic injections and office surgeries. See those covered services for details.

Services received in an urgent care center are subject to a $75 copay, then your plan year deductible and applicable coinsurance.

Services you receive in an urgent care center that are billed by the hospital or emergency room are covered under the Emergency Room benefit.

Virtual Care

Virtual Care is the delivery of health-related services and information between a member and provider via telecommunications (email, telephone, video, and online) for the purpose of diagnosis, prevention, health advice, disease management and treatment.

- **Electronic Visits.** An electronic visit (“e-visit”) is a structured, secure online consultation between an approved physician and the member. This benefit will cover medically necessary e-visits for an illness or injury. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in his or her practice. Services delivered via e-visit are subject to standard office visit cost-shares and other provisions as stated in this booklet. Please call Customer Service for help in finding a physician approved to provide e-visits.
- **Telehealth Services.** Your plan covers access to care via online and telephonic methods when medically appropriate. Services must be medically necessary to treat a covered illness, injury or condition. Coverage for psychiatric conditions is medically appropriate for crisis and emergency evaluations or when the member is temporarily confined to bed for medical reasons only.

  Your provider will determine which conditions and circumstances are appropriate for telehealth services. Services delivered via telehealth methods are subject to standard office visit cost-shares and other provisions as stated in this booklet. See the last page for contact information for the preferred telehealth provider.
- **Premera Blue Cross Medical Advice Line.** You and your family have access to the Premera Blue Cross Medical Advice Line at 1-877-995-2696, 24 hours a day, 7 days a week. The Medical Advice Line can connect you to telehealth (virtual care) providers for a doctor’s visit via phone or online.

Therapeutic Injections and Allergy Tests

Benefits for these services are subject to your plan year deductible and applicable coinsurance.

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

Your plan year deductible and coinsurance, if any, may apply to other services you get during a visit. This includes services such as x-rays, lab work, facility fees and office surgeries.

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

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

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

For benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management and Sterilization 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 Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth) benefit.

The Professional Visits and Services benefit does not cover:

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

Psychological and Neuropsychological Testing

The following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

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

Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

See the Neurodevelopmental Therapy benefit for physical, speech or occupational therapy assessments and evaluations related to neurodevelopmental disabilities.

Rehabilitation Therapy and Chronic Pain Care

Benefits for the services below are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Rehabilitation Therapy

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

Please see the Neurodevelopmental Therapy benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

Inpatient Care – Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility that meets Premera's clinical standards, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

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

- You must not be confined in a hospital or other medical facility

- Services must be furnished and billed by a hospital, physician, chiropractor, naturopath, physical or occupational or speech therapist, or rehabilitation facility that meets Premera's clinical standards

When the above criteria are met, benefits will be provided for physical, speech and occupational and massage therapy services up to a combined maximum benefit of 60 visits per member each plan year. However, the visit limit does not apply when the outpatient services are to treat cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

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

Please note: Massage therapy performed by a massage therapist is covered under the Alternative Care benefit. Massage therapy must be prescribed by a physician. For more information please see the Alternative Care benefit.

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. However, inpatient services for chronic pain care aren't subject to the 24-month limit. For additional information please see Inpatient Care above.

The Rehabilitation Therapy and Chronic Pain Care benefit does not cover:

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

The plan will not provide the Rehabilitation Therapy and Chronic Pain Care benefit and the Neurodevelopmental Therapy benefit for the same condition. Once a plan year maximum has been exhausted under one of these benefits, no further coverage is available.

Skilled Nursing Facility Services

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

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.

Skilled nursing facility benefits are not subject to a plan year benefit maximum.

This benefit does not cover:

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

Spinal and Other Manipulations

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition. Benefits are limited to 20 visits per member per plan year.

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

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

Surgical Services

Benefits for the following services are subject to your plan year deductible and applicable coinsurance.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

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.
- Cornea transplantation, skin grafts, repair of a dependent child’s congenital anomaly, and the transfusion of blood or blood derivatives. Also covered is sexual reassignment surgery if medically necessary and not for cosmetic purposes.
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services as described in the Diagnostic Services or Preventive Care benefits. Please see the Diagnostic Services benefit for coverage of preventive screening services.

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

Temporomandibular Joint (TMJ) Disorders

For Temporomandibular Joint (TMJ) Disorder benefit information, please see the Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth).

Transgender Services

Benefits for medically necessary transgender 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. To find the amounts you are responsible for, please see the "Medical Care Summary of Costs" earlier in this booklet.

Benefits are provided for all transgender surgical services, including facility and anesthesia charges related to the surgery.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of transgender 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.

Transgender Surgical Services Criteria

"Surgical gender reassignment services" are defined as procedures approved in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), and will be considered medically necessary only if the following criteria are met:

Surgical gender reassignment services for breast surgery:

- You are at least 18 years old
- You are diagnosed as having gender identity disorder/gender dysphoria
- You must have one letter of recommendation for surgery, dated within the last six months, from a mental health professional. See the Mental Health Services section for definition of a mental health professional. The recommendation must be based on an assessment conducted within the last six months, and must verify that the decision is current, well thought out, not impulsive, and not due to any other treatable mental disorder.

Surgical gender reassignment services for genital surgery:

- You are at least 18 years old
- You are diagnosed as having gender identity disorder/gender dysphoria
- You have two letters of recommendations for surgery, dated within the last six months, from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist. The recommendations must be based on assessments conducted within the last six months, and must verify that the decision is current, well thought out, not impulsive, and not due to any other treatable mental disorder.
- Each recommendation must state that the surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Surgical procedures that are not included in the most current Standards of Care published by WPATH are excluded from this benefit.

Prior authorization is highly recommended for members considering transgender services. For information on obtaining a prior authorization, please see "Prior Authorization" later in this booklet.

Please Note: Any direct or indirect complications and aftereffects as a result of transgender services or surgery are covered under the same conditions and with the same benefit limits as complications and aftereffects of other services or surgery.

Transplants Services

Covered Transplants

The Transplants benefit is not subject to a separate benefit maximum other than those described below. This benefit covers medical services provided by in-network and out-of-network providers or "Approved Transplant Centers."

An Approved Transplant Center is a hospital or other provider that has developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by Premera. Whenever medically possible, we will direct you to an Approved Transplant Center that we have contracted with for transplant services. Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

In the instance that there are no approved transplant centers that can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

Inpatient/Outpatient Facility and Professional Services

Benefits for transplant related services are subject to your plan year deductible and applicable coinsurance.

Please Note: If services are received from an out-of-network facility or provider, you'll also be responsible for amounts above the allowable charge. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum.

For a summary of these cost-shares, please see the "Medical Care Summary of Costs" earlier in this booklet.

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your covered dependents may require an organ transplant (organ means organ, stem cell, bone marrow, and tissue):

- Heart
- Lung
- Heart/lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone marrow/stem cell

- Multiple organs replaced during one transplant surgery
- Tandem transplants (stem cell)
- Sequential transplants
- Re-transplant of the same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant (for example, a liver transplant with subsequent heart transplant).

This plan covers the following services:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
- Related supplies and services provided by the approved transplant center during the transplant process, which may include physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services
- Charges for activating the donor search process with national registries
- Compatibility testing of prospective organ donors who are immediate family members; for the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative (e.g., your biological parents, siblings or children)
- Inpatient and outpatient expenses directly related to a transplant

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant, and end either 180 days from the date of the transplant **or** upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

Pre-transplant evaluation/screening – Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program

Pre-transplant/candidacy screening – Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members

Transplant event – Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement, and

Follow-up care – Includes all covered transplant expenses, home health care services, home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Transportation and Lodging Expenses

Transport and Lodging

Transport and lodging benefits are subject to your plan year deductible (your coinsurance is waived).

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage reimbursement will be based on the current IRS medical mileage reimbursement. Please refer to the IRS Website http://www.irs.gov for current rates.

Lodging Allowances: Reimbursement of expenses incurred by a transplant patient and companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, or $100 per night total. This is in line with IRS guidelines.

Overall Maximum: Travel & Lodging reimbursement is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the member, companion, and donor.

Companions:

- Adult Patient – 1 companion is permitted.
- Child Patient – 2 parents or guardians are permitted

Non-Covered Expenses

- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her covered companion
- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations

Unless specified in the "What Is Covered" section under Transplant Services, **non-covered** charges include:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Services that are covered under any other part of this plan
- Services and supplies furnished to a donor when the recipient is not covered under this plan
- Home infusion therapy after the transplant occurrence
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Premera Blue Cross.

Travel and Lodging Reimbursement

Travel and lodging reimbursement benefits are available when travel is necessary in order to treat a life-threatening condition when a local treatment option isn't available within 100 miles of the patient's home. A life-threatening condition is defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Transportation and Lodging

Transport and lodging benefits are subject to your plan year deductible (your coinsurance is waived).

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation cost. Airfare must be for a regularly scheduled commercial flight (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage reimbursement will be based on the

current IRS medical mileage reimbursement. Please refer to the IRS Website http://www.irs.gov for current rates.

Lodging Allowances: Reimbursement of expenses incurred by a patient and companion for hotel lodging away from home is reimbursed at a rate of $100 per night total. This is in line with IRS guidelines.

Overall Maximum: Travel and lodging reimbursement is limited to $10,000 per member year.

Companions:

- Adult Patient – 1 companion is permitted.
- Child Patient – 2 parents or guardians are permitted

Non-Covered Expenses:

- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her covered companion
- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations/exclusions:

- Travel reimbursements are not covered for travel outside of the United States
- The patient must be covered by a Premera plan
- The medical treatment requiring travel must be a covered benefit

Prior authorization is highly recommended for members considering seeking care that requires travel for non-emergency, but life-threatening conditions. For information on obtaining a prior authorization, please see “Prior Authorization” later in this booklet or contact Premera Blue Cross for more details.

ROUTINE HEARING EXAMS

Benefits for routine hearing exams for members under the age of 18 are covered at 100% of allowable charges, when services are rendered by in-network or out-of-network providers.

Benefits for routine hearing exams for members age 18 and older are subject to your plan year deductible and applicable coinsurance.

If you see an out-of-network provider, you’ll also be responsible for amounts above the allowable charge. Amounts in excess of the allowable charge do not count toward the plan year deductible or out-of-pocket maximum.

For a summary of these cost-shares, please see the “Medical Care Summary of Costs” earlier in this booklet.

For each member, benefits are provided for routine hearing examination, or screening, once every 24 consecutive months.

Hearing exam services include:

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

The Routine Hearing Exams benefit does not cover hearing hardware or fitting examinations for hearing hardware.

HEARING HARDWARE

Benefits for hearing hardware are subject to your plan year deductible and in-network coinsurance. Benefits are provided up to the maximum benefit of $2,000 per member every 36 consecutive months.

To receive your hearing hardware benefit:

- 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
- Hearing aid instruments
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- 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 does not 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
- Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

PROVIDERS OUTSIDE OF 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 outside our service area. 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 outside our service area 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.

Non-Network Providers

When covered services are provided outside Washington and Alaska or in Clark County, Washington by providers that do not have a contract with the Host Blue, the allowable charge will be the least of the three amounts shown below.

- An amount that is no less than the lowest amount we pay 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

There is one exception: The allowable charge is the provider's billed charge for emergency care by an ambulance that does not have a contract with us or the local Blue Cross Blue Shield Licensee. If applicable law requires a different allowable charge than the least of the three amounts above, this plan will comply with that law. You are responsible for the difference between the amount that the out-of-network provider bills and this plan's payment for the covered services.

BlueCard Worldwide® Program

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 BlueCard Worldwide. BlueCard Worldwide is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide 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.

Services Received Outside the United States

Benefits for medically necessary services, supplies or drugs received outside of the United States are subject to your plan year deductible and in-network coinsurance, when the following requirements are met:

- Services must meet the Plan's medical necessity requirements. Benefits are not provided for services, drugs or supplies that are unapproved or are deemed experimental or investigational based on the terms of this plan, or medical standards in the United States. To ensure that services meet medically necessary requirements, prior authorization is highly recommended for certain non-emergency services. Call Customer Service before you receive care to make sure your service will be covered.
- Services, supplies or drugs must be received from a health care provider licensed by the appropriate jurisdiction, and performing services within the scope of his or her license and practice.
- Claims for reimbursement should clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider.

All services outside of the United States are paid at the in-network benefit level with respect to your co-insurance and deductible. However, if you see a provider outside of the United States for any reason other than a medical emergency, you may have to pay the difference between the allowed amount and the provider's billed charges. Please note that providers outside of the United States may require you to pay for the cost of your service up front. To be reimbursed, you will need to submit a claim form and detailed receipts. You can download the international claim form at www.premera.com/amazon or call our Customer Service department to receive a copy.

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 outside our service area, go to **www.premera.com** or call 1-800-810-BLUE (2583). You can also get BlueCard Worldwide 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

Prior authorization is when a planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not authorized and the reasons why. If you disagree with the decision, you can request an appeal. See "When You Have An Appeal" section or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the in-network benefit level for services you receive from a out-of-network provider.

How To Ask For Prior Authorization

It is your responsibility to get prior authorization. The services, devices and drugs on the prior authorization list need to be reviewed to make sure that they are medically necessary for you and meet this plan's other standards for coverage. It is to your advantage to know in advance if the plan would not cover them.

The plan has a specific list of services that recommend prior authorization with any provider. The list is on our Website at **www.premera.com/amazon**. Before you receive services, we suggest that you review this list. You or your provider can call us at the number listed on your ID card to request a prior authorization. You can also call us to ask about a specific service that your provider is planning for you.

Services From Network Providers: It is your network provider's responsibility to get prior authorization. Your network provider can call us at the number listed on your ID card to request a prior authorization.

Services From Out-of-Network Providers: It is your responsibility to get prior authorization for any services that are on the prior authorization list when you see a out-of-network provider. You or your provider can call us at the

number listed on your ID card to request a prior authorization. However, it is a good idea to call us to make sure the request was approved.

The plan has a specific list of services that recommend prior authorization with any provider. The list is on our Website at **www.premera.com/amazon** under "Make Sure You're Covered" in the Member Services tab. Before you receive services, we suggest that you review this list.

We will respond to a request for prior authorization within 5 calendar days of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible, but no later than 48 hours after we get all the information necessary to make a decision. We will provide our decision in writing.

Our prior authorizations will be valid for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you don't receive the service, drug or item within that time, you will have to ask us for another prior authorization.

Exceptions

The services below do not need prior authorization. Instead, we recommend that you tell us as soon as reasonably possible after you receive them:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification. If you are admitted to a out-of-network hospital due to a medical emergency, those services are always covered under your in-network cost-share. The plan will continue to cover those services until you are medically stable and can safely transfer to a network hospital. If you choose to remain at the out-of-network hospital after you are stable to transfer, coverage will revert to the out-of-network benefit. The plan will provide benefits based on the allowable charge. If the hospital is out-of-network, you may be billed for charges over the allowable charge
- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. Admissions to a out-of-network hospital will be covered at the out-of-network cost-share unless the admission was an emergency.

Prior Authorization For Prescription Drugs

Certain prescription drugs you receive through a pharmacy must have prior authorization before you get them at a pharmacy, in order for the plan to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is in the pharmacy section of our Website at **www.premera.com/amazon**. You will also find the specific list of prescription drugs requiring prior authorization on our Website. If your prescription drug is on this list, and you do not get prior authorization, when you go to the pharmacy to fill your prescription, your pharmacy will tell you that you need to obtain prior authorization. You or your pharmacy should call your provider to let him or her know. Your provider can fax us a prior authorization form for review.

You can buy the prescription 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 allowable charge. See "How Do I File A Claim?" for details.

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.

Services from Out-of-network Providers

This plan provides benefits for non-emergency services from out-of-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and only available from a out-of-network provider. You or your provider may request a prior authorization for the

in-network benefit before you see the out-of-network provider.

The prior authorization request must include the following:

- A statement that the out-of-network provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a network provider
- Any necessary medical records supporting the request.

  If the request is approved, the services will be covered at the in-network cost-share. In addition to the cost-shares, you will be required to pay any amounts over the allowable charge if the provider does not have an agreement with us or, for out-of-state providers, with the Host Blue Cross and/or Blue Shield Licensee.

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 website. You or your provider may review them at **www.premera.com/amazon**. 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 last page.

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." When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PERSONAL HEALTH SUPPORT

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

A licensed, certified, clinical professional will reach out to you by phone to help you identify and remove any medical or social barriers to good health or medically necessary health care that your provider recommends for you. They will also help you understand appropriate healthcare services and provider options that are covered by your benefit plan and non-covered services that may be available to you in your community.

Personal health support services are voluntary and are part of your existing benefit plan. You may choose to decline or terminate this service at any time. To learn more about the personal health support programs, contact Customer Service at 1-877-995-2696.

WHAT'S NOT COVERED?

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

LIMITED AND NON-COVERED SERVICES

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

Benefits from Other Sources

This plan does not cover services that are covered by such types of insurance 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 excess coverage

- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

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

Biofeedback

Biofeedback that is deemed experimental or investigational treatment for the condition (see "Definitions"). Examples of what is not covered are EEG biofeedback and neurofeedback

Caffeine or Nicotine Dependency

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

Charges for Records or Reports

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

Chemical Dependency Exceptions

Services for the following are excluded from the covered chemical dependency benefit:

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

Cosmetic Services

The plan does not cover services, drugs, or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are:

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation for the purpose of changing the appearance of the breasts, with or without chest reconstruction

The only exceptions to this exclusion are:

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

Counseling, Educational or Training Services

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Nutritional Therapy, Health Management, Professional Visits and Services and Mental Health Care benefits or for services that meet the standards for preventive services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy
- 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 are otherwise should be provided by school staff. This does not apply to training that is directed at the member's significant behavioral difficulties during schoolwork. Please see the Mental Health Care benefit.

Court-Ordered Services

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

Custodial Care

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

Dental Services

Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth, except as specified under the Dental Anesthesia Oral and Maxillofacial Treatment (Mouth, Jaws, and Teeth) benefit. This exclusion includes but is not limited to:

- Services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces and mouth guards

Donor Breast Milk

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 (except as required by law), supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription, except as required by law. Please see the Prescription Drugs benefit for details.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

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

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see the "Complaints And Appeals" section for an explanation of the appeals process.

Family Members or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Governmental Medical Facilities

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

- Your request for a benefit level exception for non-emergent care to the facility is approved (please see the "Prior Authorization")
- You're receiving care for a "medical emergency" (please see the "Definitions" section)
- The plan must provide available benefits for covered services as required by law or regulation

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants except as described under the Medical Equipment and Supplies benefit.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the Prescription Drugs benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

Illegal Acts and Terrorism

This plan does not cover illness or injuries resulting from a member's commission of:

- A felony (does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or revolt

Laser Therapy

Low-level laser therapy

Light Therapy for Vitiligo

Medical Equipment and Supplies

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

Military Service and War

This plan does not cover 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.

No Charge or You Don't Legally Have To Pay

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

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, juvenile detention facilities, group homes, foster homes, camps and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations. Please see the applicable medical benefit, the Mental Health Care benefit, or the Chemical Dependency Treatment benefit for details.

Not Covered

- Services or supplies ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits and under "Extended Benefits"
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services to manage the condition of diabetes covered under the Health Management benefit. This includes training or educational services to another provider.
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan

Not In the Written Plan Of Care

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

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.
- 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

Orthodontia Services

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

Outside The Scope of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider’s license or certification. Services or supplies that are furnished by a provider that isn’t licensed or certified by the state in which the services or supplies were received, except as allowed for applied behavior analysis providers by the Mental Health Care benefit.

Personal Comfort or Convenience Items

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

Rehabilitation Services

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

Routine or Preventive Care

- Routine or palliative foot care, including hygienic care
- Impression casting for foot prosthetics or appliances and prescriptions thereof
- Fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. However, foot-support supplies, devices and shoes are covered as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability

This exclusion does not apply to diabetic foot care. Please see the Professional Visits and Services benefit.

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 in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) Web page at **www.cms.hhs.gov**.

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exceptions

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

Sterilization Reversal

Reversal of surgical sterilization, including any direct or indirect complications thereof.

Transplant Coverage Exceptions

Services for the following are excluded from the covered transplant benefit:

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit
- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless Premera determines they are not considered "experimental/investigational services" (please see the "Definitions" section in this booklet)

Vision Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses,

and related supplies, except as covered under the Medical Equipment and Supplies benefit. Also not covered are non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

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

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous; peer-mediated groups or interventions

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.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

This plan coordinates benefits with other health care coverage you or your dependents may have. Coordination of Benefits is done based on a provision called "Non-Duplication Of Benefits" as described below.

All the benefits of your plan are subject to coordination of benefits (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.

Types Of Health Care Coverage Subject To Coordination

The following types of coverage are included in this plan's coordination provisions:

- Group or individual health insurance plans, including student health care coverage sponsored by a school, college, or university.
- Labor organization plans, trusteed and association plans, and employee benefit organization plans.
- Health insurance plans provided to federal, state or local government employees.
- Other government-sponsored coverage such as Medicare, but not including worker's compensation coverage.

Primary vs. Secondary Plan

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 coordination of benefits rules. When this plan is secondary, it will provide benefits as explained in "Non-Duplication Of Benefits" later in this section.

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.

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.

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-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.

Dependent Children Unless a court decree states otherwise, the rules below apply. For the purpose of these rules, the custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
  - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
    - The plan covering the custodial parent, first
    - The plan covering the spouse of the custodial parent, second
    - The plan covering the non-custodial parent, third
    - The plan covering the spouse of the non-custodial parent, last
  - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

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.

Non-Duplication Of Benefits

When this plan is secondary, coordination is based on a process called "non-duplication of benefits." This is a three-step process where we: (1) calculate what this plan would have paid if it had been primary; (2) calculate this plan's secondary payment by subtracting what the primary plan paid from what this plan would have paid if it had been primary; and, (3) determine the amount you are responsible for. This amount will depend on how much your primary plan paid, this plan's allowable charge, and whether you received services from a network or out-of-network provider.

When the primary plan pays an amount equal to or greater than what this plan would have paid if it had been primary, this plan will pay nothing.

The following examples show how non-duplication of benefits works for both network and out-of-network providers. These examples assume deductibles are met, and this plan pays 90% of allowable charges for network providers, and 70% for out-of-network providers. In the examples, the following amounts are used:

Provider's billed charge: $200.00

This plan's allowable charge:.....$180.00

Amount primary plan paid:.....$125.00

Example 1 - Network Provider

Step 1: Calculate what this plan would have paid if it had been the primary plan:

90% of $180.00 (allowable charge) = $162.00.

Step 2: Calculate the amount this plan pays as the secondary plan by subtracting the primary plan's payment from what this plan would have paid if it had been primary.

$162.00 (amount this plan would pay if primary) - $125.00 (other plan payment) = $37.00.

Step 3: Calculate the amount that is your responsibility. Because in this example a network provider was used, the amount you are responsible for is this plan's allowable charge minus what the primary and secondary plans have paid. The difference between the provider's billed charge and the allowable charge is written off by the network provider.

$180.00	Premera Blue Cross allowable charge
-$125.00	Primary plan's payment
-$ 37.00	Secondary (this plan's) payment
$ 18.00	Amount you are responsible for (our allowable charge minus payments from both plans.)

Example 2 - Out-of-network Provider

Step 1: Calculate what this plan would have paid if it had been the primary plan:

70% of $180.00 allowable charge = $126.00

Step 2: Calculate this plan's secondary payment by subtracting the primary plan's payment from what this plan would have paid if it had been primary:

$126.00 - $125.00 = $1.00

Step 3: Calculate the amount that is your responsibility. Because in this example a out-of-network provider was used, you are responsible for all amounts billed that are not paid by the primary and secondary plans:

$200.00	Provider's billed charge *
- $125.00	Primary plan's payment
- $ 1.00	Secondary (this plan's) payment
$ 74.00	Amount you are responsible for (provider's billed charge minus payments from both plans.) *

*Actual amount may be less if provider has a network agreement with primary plan.

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.

SUBROGATION AND REIMBURSEMENT

If the plan pays claims on your behalf for injury or illness for which another party is responsible, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance or other similar type of insurance or contract exists, the plan is entitled to be repaid for the amounts it pays out of any recovery from that responsible party. The responsible party is also known as the "third party" because it's a party other than you or the plan. Your submission of claims for illnesses or injury caused by a third party constitutes your agreement to the terms of this provision and your grant to the plan of a first priority equitable lien by agreement.

Definitions The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the plan, directly from third parties to the extent the plan has paid claims on your behalf for illnesses or injury caused by the third party.

- **Reimbursement** means that if you receive money from a third party for illnesses or injury caused by the third party, you are obligated to repay to the plan the amounts of any claims paid by the plan for illnesses or injury caused by the third party.
- **Restitution** means all equitable rights of recovery that the plan has for the amounts of any claims paid by the plan for illnesses or injury caused by the third party. Because the plan has paid the claims for your illness or injuries, the plan is entitled to recover those amounts.

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

The plan's first priority right will not be reduced due to a member's own negligence. In addition, the plan's first priority right will not be subject to any reduction on the ground that you are not made whole or by application of the common fund doctrine or any other responsibility for payment of attorney's fees and costs under the "common fund" or any other doctrine.

In recovering amounts paid for illnesses or injury caused by a third party, attorney's fees and legal costs related thereto, the, plan may hire an attorney or have the plan be represented by your attorney. The plan will not pay for any fees or legal costs incurred by you or on your behalf, but if the plan enters into a written agreement with your attorney to represent the plan as well as you, the plan will pay the fees and legal costs it incurs pursuant to its agreement with your attorney. If you retain an attorney or other agent to represent you in attempting to collect from a third party, you must require that legal representative to reimburse the plan directly from any settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify the plan in writing of the terms or conditions upon which the settlement is offered, and you or your legal representative must notify the third party of the plan's first priority interest in any settlement established by this provision. (See "Notices" later in this booklet.) You also must cooperate with the plan in recovering amounts paid by the plan on your behalf. If you or your legal representative fail to cooperate fully with the plan in the recovery of amounts paid by the plan for illnesses or injury caused by a third party, attorney's fees and legal costs related thereto, as described above, you are responsible for reimbursing the plan in full for such benefits.

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

To the extent that you recover from a third party, you agree to hold, and to instruct your attorney to hold, any recovered amounts in trust or in a segregated account until the plan's subrogation, reimbursement, and equitable rights or recovery are fully determined.

This subrogation and reimbursement provision shall apply with respect to not only participating subscribers but also with respect to such subscribers' spouses and/or dependents, any COBRA qualified beneficiaries, and any alternate recipients. It shall also apply with respect to any other person who may recover on behalf of the foregoing individuals.

WHO IS ELIGIBLE FOR COVERAGE?

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

SUBSCRIBER ELIGIBILITY

To be an eligible subscriber under this plan, an employee must be classified as one of the following:

- Regular full-time employee (Class F)
- Regular part-time employee (Class R or Class H)

For purposes of the plan, "employee" means an individual classified by the Group as its common-law employee and on the Employer's W-2 payroll, excluding: (a) any employee of a Related Company not participating in the plan; (b) any individual who is not treated by the Group as an employee for payroll tax purposes at the time he or she performs services for the Group (including those individuals paid by a temporary or other staffing agency), whether or not such individual is subsequently determined by a government agency, by the conclusion or settlement of threatened or pending litigation, or otherwise to be or have been a common-law employee of the

Employer during such period; (c) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)); (d) an employee not on the U.S. payroll of the Employer; (g) any such employee who is a nonresident alien with no U.S.-source income (within the meaning of Code Section 911(d)(2)); and (h) any employee who is included in a unit of employees covered by a collective bargaining agreement.

Related Companies that are not participating in the plan include: A9.com, Inc., Alexa Internet Inc., and Zappos.com, Inc.

Federal law requires employers like the Group to offer medical benefits to employees who work 30 or more hours per week. In February 2015, the Group began measuring actual hours worked by employees who are not otherwise eligible for coverage under the plan. This is referred to as the "Look-Back Measurement Method."

For newly hired employees who are not otherwise eligible for medical coverage as described above, your hours of service will be counted during the 11-month period that begins on the first day of the first month following your hire date (the "initial measurement period"). Your average hours of service will be determined during a two-month administrative period that begins immediately following the initial measurement period. If you provided an average of 30 or more hours of service per week or 130 hours per month, as applicable, during the initial measurement period, you will be notified of your eligibility to enroll in the plan. For the 12-month period immediately following the administrative period (the "initial stability period"), you will be treated as eligible for the plan.

Beginning on February 1 following your hire date and on every subsequent February 1 thereafter, your hours will also be tracked through the following January 31 (the "standard measurement period"). Your average hours of service will be determined during an administrative period that begins on the first day of the month following the standard measurement period and ends on March 31. If you provided an average of 30 or more hours of service per week or 130 hours per month, as applicable, during the standard measurement period, you will be notified of your eligibility to enroll in the plan. For the 12-month period immediately following the administrative period (the "standard stability period") that corresponds with the Plan Year, you will be treated as eligible for the plan.

Employees who become eligible for benefits under the Look-Back Measurement Method will receive information about medical benefit options and enrollment for the medical Plan Year beginning April 1.

Employees Performing Employment Services In Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. Because the Group is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, he or she may no longer be eligible for coverage. If you have any questions about whether you may be impacted by this provision, please contact Premera customer service at 1-877-995-2696.

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, unless legally separated. Lawful spouse means a legal union of two persons that was validly formed in any jurisdiction.
- The domestic partner of the subscriber. Domestic partnerships that are not documented in a state domestic partnership registry must meet all requirements as stated in the signed "Affidavit of Domestic Partnership."

  All rights, benefits and obligations afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible dependent child who is under 26 years of age. An eligible dependent child is one of the following:
  - A natural offspring of either or both the subscriber or spouse.
  - A legally adopted child of either or both the subscriber or spouse.
  - A child of a domestic partner.
  - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. Placed for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of

a child in anticipation of adoption of such child.

- A legally placed ward of the subscriber or spouse. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- Grandchildren in your court-ordered custody.
- A foster child.

Qualified Medical Child Support Orders

The plan extends medical benefits to an employee's non-custodial child, as required by any qualified medical child support order ("QMCSO") as defined in ERISA Section 609(a). The plan has procedures for determining whether an order or National Medical Support Notice qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures by calling the Employee Resource Center at 888.892.7180.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrolling for coverage and making enrollment elections depend on your employee class and your regularly scheduled work hours per week. For more details, see the table "How and When to Enroll in Benefits" below:

How and When to Enroll in Benefits			
If you are…	And your regularly scheduled work hours/week are…	You must enroll…	Your medical coverage will then begin…
A regular full-time employee (Class F)	40 hours/week	Within 30 calendar days starting on your date of hire	On your date of hire
A regular reduced-time employee (Class R)	30-39 hours/week	Within 30 calendar days starting on your date of hire	On your date of hire
A regular part-time employee (Class H)	20-29 hours/week	Within 30 calendar days starting on your date of hire	On your date of hire

If you do not elect benefits within the time frames listed above, you will not be eligible to enroll in benefits until the next Open Enrollment period unless you experience certain limited changes in status. Please see "Open Enrollment" and "Other Special Enrollment" later in this section.

For existing eligible employees who are currently covered under another medical plan offered by the Group and who elect this medical plan during Open Enrollment, coverage under this medical plan will be effective on the first day of the next plan year, beginning April 1.

SPECIAL ENROLLMENT

Dependents Acquired Through Marriage After the Subscriber's Effective Date

Eligible employees of the Group have 60 calendar days starting on the date of the marriage to add a qualifying dependent or spouse to their medical plan. Plan coverage will become effective as of the date enrolled. If the new dependent or spouse is not added within 60 calendar days of marriage, please see the "Open Enrollment" provision later in this section. Adding a dependent or spouse may change your plan tier, including premium contributions and plan deductible. Please see the "What's My Plan Year Deductible?" section.

Natural Newborn Children Born On or After the Subscriber's Effective Date

Newborn children are covered automatically for the first 31 days of life when the mother is eligible to receive obstetrical care benefits under this plan.

Eligible employees of the Group have 60 calendar days starting on the date of birth to add the qualifying dependent to their medical plan. Plan coverage will become effective as of the date of birth. If the new dependent

is not added within 60 calendar days of birth, please see the "Open Enrollment" provision later in this section. Adding a dependent may change your plan tier, including premium contributions and plan deductible. Please see the “What’s My Plan Year Deductible?” section.

Adoptive Children Acquired On or After the Subscriber's Effective Date

Eligible employees of the Group have 60 calendar days starting on the date of adoption or placement for adoption to add the qualifying dependent to their medical plan. Plan coverage will become effective as of the date of adoption or placement for adoption. If the new dependent is not added within 60 calendar days of adoption or placement for adoption, please see the "Open Enrollment" provision later in this section. Adding a dependent may change your plan tier, including premium contributions and plan deductible. Please see the “What’s My Plan Year Deductible?” section.

Children Acquired Through Legal Guardianship

Eligible employees of the Group have 60 calendar days starting on the date of legal guardianship being granted to add the qualifying dependent to their medical plan. Plan coverage will become effective as of the date that legal guardianship is granted.

If the new dependent is not added within 60 calendar days of assuming legal guardianship, please see the "Open Enrollment" provision later in this section. Adding a dependent may change your plan tier, including premium contributions and plan deductible. Please see the “What’s My Plan Year Deductible?” section.

Foster Children

Coverage for a foster child will be effective on the first of the month following placement, if the documentation is received within 31 days from the date on the court documentation. Otherwise, the foster child is effective on the first of the month following receipt of the court documentation.

OTHER SPECIAL ENROLLMENT

If an employee declines enrollment in the plan for himself or herself or his or her dependents (including a spouse) because of other health insurance or group health plan coverage, the employee may be able to enroll himself or herself or his or her dependents in this plan if the employee and his or her dependents lose eligibility for that other coverage (or if the employer stopped contributing towards such other coverage). In addition, if an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself or his or her dependents. These rights are referred to as “Special Enrollment Rights.”

The plan allows employees and dependents to enroll outside of the plan's annual open enrollment period, only in the cases listed below. These cases are generally known as “qualifying events.” In order to be enrolled, the applicant may be required to give the Group proof of these items. If the enrollment is not completed within 60 calendar days of the qualifying event, further chances to enroll, if any, depend on the normal rules of the plan that govern late enrollment.

Coverage will be effective as of the date enrolled.

The scenarios and requirements necessary to permit an employee or dependent to exercise his or her Special Enrollment Rights are described below. To request special enrollment or to obtain more information, contact the Benefits Service Center.

Involuntary Loss of Other Coverage

If an employee and/or dependent does not enroll in this plan or another plan sponsored by the Group when first eligible because they aren't required to do so, that employee and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- The employee and/or dependent was covered under group health coverage or a health insurance plan at the time coverage under the Group's plan is offered
- The employee and/or dependent's coverage under the other group health coverage or health insurance plan ended as a result of one of the following:
  - Loss of eligibility for coverage for reasons including, but not limited to legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment
  - Termination of employer contributions toward such coverage
  - The employee and/or dependent was covered under COBRA at the time coverage under this plan was

previously offered and COBRA coverage has been exhausted

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee isn't enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

Subscriber and Dependent Special Enrollment

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

State Medical Assistance and Children's Health Insurance Program

Employees and dependents that are eligible as described in "Who Is Eligible for Coverage?" have special enrollment rights under this plan if one of the statements below is true:

- The person qualifies for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP).
- The person no longer qualifies for health coverage under the state's medical assistance program or CHIP.

To be covered, the eligible employee or dependent must apply and any required subscription charges must be paid no more than 60 days from the date the applicable statement above is true. An eligible employee, who elected not to enroll in this plan when such coverage was previously offered, must enroll in this plan in order for any otherwise eligible dependents to be enrolled in accordance with this provision. Coverage for the employee will start on the date the dependent's coverage starts.

OPEN ENROLLMENT

If you are not enrolled when you first become eligible, or as allowed under "Other Special Enrollment" above, you cannot be enrolled until the Group's next open enrollment period. An open enrollment period occurs once a year, prior to the plan's effective date on April 1st of each year. During this period, eligible employees and their dependents can enroll for coverage under this plan.

If you're enrolled under one of the Group's other health care plans, or if you become ineligible for the other group health plan, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

CHANGES IN COVERAGE

No rights are vested under this plan. 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 subscribers and dependents that become covered under this plan after the date the change becomes effective.

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

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the Group. Transfers also occur if the Group replaces another plan with this plan. All transfers to this plan must occur during open enrollment or on another date set by the Group.

When you transfer from the Group's other plan, and there's no lapse in your coverage, the following provisions that apply to this plan, if applicable, will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Benefit maximums
- Out-of-pocket maximum
- Plan year deductible

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice, except as specified under "Extended Benefits," for Blue Badge employees on the last day of the month, for seasonal, temporary, Class M (ITS), and Class Q employees or interns on the Saturday of or following your last day at Amazon, in which one of these events occurs:

- For the subscriber and dependents when the subscriber's employment is terminated, the subscriber dies or is otherwise no longer eligible as a subscriber.
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she cannot meet the requirements for dependent coverage shown under the "Who Is Eligible For Coverage?" section.

The subscriber must notify the Group within 30 calendar days when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

No rights are vested under this plan. The Group is not required to keep the plan in force for any length of time. The Group reserves the right to amend, 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?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

- The child became disabled before reaching the limiting age (age 26)
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber is covered under this plan
- The subscriber provides us with proof of the child's disability and dependent status when requested, or if Premera certifies temporary or permanent disabled status.

To initiate a review of permanent or temporary disability status for your covered dependent turning age 26, please contact Premera Customer Service at 1-877-995-2696.

CONTINUED ELIGIBILITY WHILE ON SHORT-TERM DISABILITY FOR MEDICAL LEAVE

Coverage may continue for employees who are on an approved short-term disability leave for up to 26 weeks when receiving short-term disability benefits.

LEAVE OF ABSENCE

The leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

COBRA

When group coverage is lost because of a qualifying event, as shown below, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay a monthly charge for it.

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. The Group, **not Premera**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA requirements. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

Qualifying Events And Length Of Coverage

Please contact the Benefit Service Center immediately when one of the qualifying events highlighted below occurs. The continuation periods listed begin as of the first of the following month after which the qualifying event occurs.

Covered domestic partners and their children have the same rights to continuation coverage as covered spouses and their children.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
  - The subscriber's work hours are reduced.
  - The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.

  However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.
- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse and children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - The subscriber dies.
  - The subscriber and spouse legally separate or divorce.
  - The subscriber becomes entitled to Medicare.
  - A child loses eligibility for dependent coverage.

  In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions Of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice of Some Qualifying Events

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events and Lengths of Coverage." The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date the qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please Note: Determinations that a qualified**

member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice. Please include a copy of the determination with your notice to the Group.

Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

Important Note: If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you're informed by the Group.

The Group must notify qualified members of their rights under COBRA. The Group's third party plan administrator (**BenefitConnect**) is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its third party administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The third party administrator then has 14 days after it receives notice of a qualifying event from the Group in which to notify qualified members of their COBRA rights. If you have an urgent health care need before you receive your COBRA enrollment information contact the Benefits Service Center at 1.866.644.2696.

You Must Enroll and Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group for more information if you believe this may apply to you.

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments, due on the first of the month with a 30-day grace period, must also be paid to the Group.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under "Special Enrollment" or "Open Enrollment" in the "When Does Coverage Begin?" section. With one exception, family members added after COBRA begins are not eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under "Qualifying Events and Lengths Of Coverage" earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered subscriber while the covered subscriber is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered subscriber's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep the Group Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Group informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to the Group. To change your address at any time, please contact the Benefit Service Center.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which any charge required for it has been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly payment isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events and Lengths Of Coverage" in this section), COBRA coverage beyond 18 months ends if there's a final determination that a

qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which premium charges have been paid in the first month that begins no more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group health care plan after the date you elect COBRA coverage.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the Benefit Service Center at 1-866-644-2696. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Website at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website.

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under "Intentionally False Or Misleading Statements.

The inpatient benefits of this plan will continue to be available after coverage ends if:

- Your coverage didn't end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage;
- You were admitted to a medical facility prior to the date coverage ended; and
- You remained continuously confined in a medical facility because of the same medical condition for which you were admitted

Please Note: Newborns are eligible for Extended Inpatient benefits only if they are enrolled beyond the 31 day period specified in the Newborn Care benefit.

Such continued inpatient coverage will end when the first of the following occurs:

- You're covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this plan did not exist
- You're discharged from that facility or from any other facility to which you were transferred
- Inpatient care is no longer medically necessary

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 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 Website at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

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?

Medical 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. The claim form can be found on our Website, in the Forms section of www.premera.com/amazon.

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 as shown in the back of this booklet.

Prescription Drug Claims

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

In-Network Pharmacies

For retail pharmacy purchases at an in-network pharmacy, you don't have to send us a claim. Just show your Premera Blue Cross ID card at the pharmacy and they will bill us directly. If you don't show your ID card 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.

Out-of-Network 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.

You can download the prescription drug claim form at www.premera.com/amazon or call our Customer Service department to receive a copy.

Please Note: at an out-of-network pharmacy, you will have to pay the full cost for all new prescriptions and refills, and then submit a claim for reimbursement.

Timely Filing

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

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

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

Network providers are prohibited from seeking payment from the member when claims are not received within the timely filing limit, and must write off the charges. Timely filing limits may vary based on the location of the provider.

Special Notice About Claims Procedure

Premera makes every effort to process your claims as quickly as possible. We process claims in the order in which we receive them. We will 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 will 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:

- Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the diagnosis and treatment codes and their corresponding meaning (or a statement describing the availability of the codes and their meanings, upon request)
- 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.

Copayments are not considered claims.

If you disagree with the denial of a claim, you are required to use the plan's appeal processes before filing suit in court. However, if a claim for benefits or an appeal is ignored, in whole or in part, or not processed within the time shown in this plan, you may file suit in a state or federal court.

COMPLAINTS AND APPEALS

Please call Customer Service when you have questions about a benefit or coverage decision or the availability of a health care service. Customer Service can quickly and informally correct errors and clarify benefits. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

We suggest that you call your provider of care when you have questions about the health care services they provide.

If you need an interpreter to help with oral translation services, please call us. Customer Service will be able to guide you through the service.

WHEN YOU DO NOT AGREE WITH A PAYMENT OR BENEFIT DECISION

If payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask the plan to review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any requirements as necessary under federal laws and regulations.

What is an adverse benefit determination?

An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for services, based on:

- An individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- A limitation on otherwise covered benefits;
- A utilization review determination; or
- A determination that a service is experimental, investigational, or not medically necessary or appropriate.

WHEN YOU HAVE AN APPEAL

After you find out about an adverse benefit decision, you can ask for an internal appeal. Your plan includes two levels of internal appeals.

Your Level I internal appeal will be reviewed by people who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be done by a provider. They will review all of the information for your appeal and will provide a written determination. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel of people who were not involved in the Level I appeal. If your appeal involves medical judgment, a provider will be on the panel. You may participate in the Level II panel meeting in person or by phone. Please contact us for more details about this process.

Once the Level II review is complete, you will receive a written decision.

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an IRO. An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

Who may file an internal appeal?

You may file an appeal for yourself. You can also appoint someone to do it for you. This can be your doctor or provider. To appoint a representative, you must sign an authorization form and send it to us. The address and fax number are listed on the last page. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them. If you appoint someone else to act for you, that person can do any of the tasks listed below that you would need to do.

Please call us for an authorization form. You can also obtain a copy of this form on our Website at **www.premera.com/amazon**.

How do I file an internal appeal?

You may file an appeal by calling Customer Service or by writing to us at the address listed below. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination.

If you are in the hospital or away from home, or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

You may submit your written appeal request to:

Premera Blue Cross

Attn: Appeals Department, MS 123

P.O. Box 91102

Seattle, WA 98111-9202

Or, you may fax your request to:

Appeals Department

(425) 918-5592

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the last page of this benefit booklet. You can also get a description of the appeals process by visiting our website at www.premera.com/amazon.

How will I know that you received my request for an appeal?

We will confirm in writing that we have your request within 72 hours.

What if my situation is clinically urgent?

If your provider believes that your situation is clinically urgent under law, we will expedite your appeal; for example:

- Your doctor thinks a delay may put your life or health in serious jeopardy or would subject you to pain that you cannot tolerate
- The appeal is related to inpatient or emergency services and you are still in the emergency room or in the ambulance

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements. Please call Customer Service if you want to expedite your appeal. The number is listed on the last page.

If your situation is clinically urgent, you may also request an expedited external review at the same time you request an expedited internal appeal.

Can I provide additional information for my appeal?

You may supply more information to support your appeal either at the time you file an appeal or at a later date. Mail or fax the information to the address and fax number listed on the last page. Please give us this information as soon as you can.

Can I request copies of information relevant to my appeal?

Yes, this information will be provided as well as any new or additional information that was considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond before a decision is made.

What happens next?

The adverse benefit determination will be reviewed and you will receive a written decision within the time limits below:

- Expedited appeals: as soon as possible, but no later than 72 hours after we received your request. You will be notified of the decision by phone, fax or email and will be followed by a written decision.
- Adverse benefit determinations made prior to you receiving services: 15 days of the date we received your request.
- All other appeals: within 30 days of the date we received your request.

We will send you a notice of our decision (see "Notices") and the reasons for it. If the initial decision is upheld, we will tell you about your right to a Level II internal appeal or to an external review at the end of the internal appeals

process**.** You can also go to the next appeal step if we do not comply with the rules above when we handle your appeal.

Appeals Regarding Ongoing Care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, we will suspend the plan's denial of benefits during the internal appeal period. The plan's provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse the plan's denial. If the decision is upheld, you must repay all amounts the plan paid for such services. You will also be responsible for any difference between the allowable charge and the provider's billed charge if the provider is out-of-network.

WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the outcome of an internal appeal (Level I or Level II), you have the right to an external review. This includes internal decisions based on medical necessity, experimental or investigational, appropriateness, healthcare setting, level of care, or that the service is not effective or not justified. The external review will be done by an independent review organization (IRO) that is certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

If your internal appeal is denied, we will tell you about your rights to an external review and send you an IRO release form. Your written request for an external review and the signed release form must be received no later than 4 months after the date you received the appeal response.

You can request an expedited external review when your provider believes that your situation is clinically urgent under law.

When we receive your request, we will tell the IRO that you asked for an external review and forward your entire appeal file. We will also let you~~,~~ or your authorized appeals representative know where more information may be sent directly to the IRO and when the information must be sent. We will give the IRO any other information they ask for that is reasonably available to us.

When the IRO completes the external review

Once the external review is done, the IRO will let you and us know in writing of their decision within the time limits below:

- For expedited external reviews, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, e-mail or fax and will follow up with a written decision by mail.
- For all other reviews, within 45 days from the date the IRO receives your request

What happens next?

The plan is bound by the decision made by the IRO. If the IRO overturned the internal appeal decision, the plan will implement their decision in a timely manner.

If the IRO upheld the internal appeal decision, there is no further review available under this Plan's appeals process. However, you may have other steps you can take under State or Federal law, such as filing a lawsuit.

OTHER RESOURCES TO HELP YOU

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Customer Service at the number listed in the back of this booklet.

If you need help filing an appeal, you can also contact the Washington Consumer Assistance Program at any time during this process.

Washington Consumer Assistance Program

5000 Capitol Blvd.

Tumwater, WA 98501

1-800-562-6900

E-mail: cap@oic.wa.gov

You can also contact the Employee Benefits Security Administration (EBSA) of the U.S. Department of labor at 1-866-444-EBSA (3272).

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

Premera has 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 provider(s). No benefits will be available if the proof isn't provided or acceptable to the plan.

Intentionally False or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. If a plan member provides false information, intentionally misrepresents facts, or engages in fraud against the plan, the plan has the right to cancel the member's or the member's dependents', as applicable, coverage retroactively (i.e., rescind the coverage). Enrolling an ineligible individual or otherwise failing to comply with the plan's requirements for eligibility will constitute fraud or an intentional misrepresentation of a material fact that will trigger rescission. The member will be liable for all benefits already paid on his or her behalf or on behalf of the ineligible individual, as applicable. Please see the "Right of Recovery" provision later in this section.

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

Right To and Payment Of Benefits

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

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

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

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

Venue

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

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

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

ERISA PLAN IDENTIFYING INFORMATION

The following information has been provided by your Group to meet certain ERISA requirements for the summary plan description.

This plan is an employee welfare benefit plan that’s subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the "ERISA Plan" in this section. ERISA gives subscribers and dependents the right to a summary describing the ERISA Plan.

Name Of Plan

Amazon and Subsidiaries Shared Deductible Plan (a component of the Amazon Corporate LLC Group Health and Welfare Plan)

Name And Address Of Employer Or Plan Sponsor

Amazon Corporate LLC

P.O. Box 81226

Seattle, WA 98108

(206) 266-1000

Subscribers and dependents may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan and, if so, the sponsor's address.

Employer Identification Number "EIN"

91-1986545

Plan Number

501

Type Of Plan

Self-funded employee welfare benefit plan that is a group health plan. The ERISA Plan provides hospital and medical benefits.

Type Of Administration

Third-party administration for claims and certain administrative services.

Name, Address, And Telephone Number Of ERISA Plan Administrator

Amazon Corporate LLC

P.O. Box 81226

Seattle, WA 98108

(206) 266-1000

Agent For Service Of Legal Process

Amazon Corporate LLC

P.O. Box 81226

Seattle, WA 98108

Funding Medium

This plan is self-funded. No benefits are payable by an insurance company.

ERISA Plan Year

The ERISA Plan year is April 1 through March 31.

WHAT ARE MY RIGHTS UNDER ERISA?

As participants in an employee welfare benefit plan, subscribers have certain rights and protections. This section of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed

and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

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

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

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

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

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Ave., Suite 1110, Seattle, WA 98104; or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

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

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 plan year deductibles, 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 plan year deductibles, coinsurance 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**

  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 the service area 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

  There is one exception: The allowable charge is the provider's billed charge for emergency care by an ambulance that does not have a contract with us or the local Blue Cross Blue Shield Licensee.

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

- **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 pays for dialysis will be no less than a comparable provider that has a contracting agreement with us or another Blue Cross Blue Shield Licensee and no more than 90% of billed charges.

- **Emergency Care**

  Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:

  - The median amount that Heritage 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

  In addition to your deductible, copays and coinsurance, you will be responsible for charges received from out-of-network providers above the allowable charge.

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

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

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

Ambulatory Surgical Center

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

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

Chemical Dependency

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

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

Community Mental Health Agency

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

Complication of Pregnancy

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

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

Congenital Anomaly of A Dependent Child

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

Cost-Share

The member's share of the allowable charge for covered services. Deductible and coinsurance are types of cost-shares. See "What Are My Benefits" or the "Medical Summary of Costs" to find out what your cost-share is.

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.

Effective Date

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

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 chemical dependency 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. Amazon Corporate LLC is the sponsor of this plan.

Hospital

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

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

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

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

Illness

A sickness, disease, medical condition or pregnancy.

Injury

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

Inpatient

Confined in a medical facility as an overnight bed patient.

In-Network Pharmacy (Retail Pharmacy)

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

In-Network Provider

A provider that is in one of the networks stated in the "How Does Selecting a Provider Affect My Benefits?" section.

Medical Emergency

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) 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 is 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 or dependent.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy, except for complications of 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.

Out-of-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting a Provider Affect My Benefits?" section.

Outpatient

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

Pharmacy Benefits Administrator

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

Physician

A state-licensed:

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

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

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)

- Psychologist (Ph.D.)
- Naturopathic Physicians (N.D.)
- Nurse (R.N.)

Plan (also called "This Plan")

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

Plan Year

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

Premium

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan. Premium charges are automatically withheld by the Group from the Subscriber's paycheck.

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

Provider

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

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

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 Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

Service Area

The states of Washington (except Clark County) and Alaska

Skilled Care

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

Temporomandibular Joint (TMJ) Disorders

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

We, Us and Our

Means Premera Blue Cross

Where To Send Claims

MAIL YOUR CLAIMS TO

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

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O. Box 747000
Cincinnati, OH 45274-7000

Contact the Pharmacy Benefit Administrator At

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

Customer Service

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

Physical Address
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Health Savings Account/Flexible Spending Accounts – Connect Your Care (CYC)
1-877-995-2696
www.connectyourcare.com

Phone Numbers
Local and toll-free number:
1-877-995-2696

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

Care Management

Prior Authorization
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

Medical Advice Line
1-877-995-2696

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)

Visit Our Web Site

www.premera.com/amazon

COBRA Administration - BenefitConnect

BenefitConnect

P.O. Box 1185

Pittsburg, PA 15230

1.877.29COBRA (26272)

https://cobra.ehr.com

EAP – GuidanceResources

www.guidanceresources.com

1-855-435-4333

Company ID: “AmazonEAP”

Eligibility – Benefits Service Center

www.amazon.ehr.com

1-866-644-2696

Rethink First

1-877-988-8871

www.amazon.rethinkbenefits.com

Dental Benefits – Delta Dental of Washington

Group Number: 9013-1000

1-800-554=1907

www.deltadentalwa.com

Vision Benefits – Vision Service Plan

Group Number: 12077753

1-800-877-7195

www.vsp.com