

2025 Summary Plan Description

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| Additional information | Looking for something?  Here are the ways to navigate this document:   * Type CTRL+F to search for a term or phrase. * CTRL+Click to follow links to other sections or resources. |

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# Introduction

Microsoft provides industry-leading benefits to help you and your family get and stay well, prepare for your future, and enjoy life’s journey. Whether you are expecting a new child, looking for some legal advice for a new home, or managing a health condition, Microsoft is here to support you with benefits and resources to help you live life well.

This Summary Plan Description (SPD) provides details of the health and welfare benefits available to eligible employees and their eligible dependents, as described in this SPD. Other summary plan descriptions address health and welfare benefits that may be offered to other employees and their eligible dependents.

### About the SPD

This document is intended to serve as a Summary Plan Description (SPD) as defined by the Employee Retirement Income Security Act of 1974 (ERISA) for such programs described within that are governed by ERISA. The terms and conditions of the Microsoft Corporation Welfare Plan (Plan) are set forth in this SPD, in the Microsoft Corporation Welfare Plan wrap document (the “Welfare Plan”), the Benefits@Microsoft Program, the Microsoft Healthcare Reimbursement Plan, the Microsoft Dental and Vision Care Reimbursement Plan, the Microsoft Dependent Care Reimbursement Plan, and in the insurance policies and other component plan documents incorporated into the Welfare Plan. The Welfare Plan together with this SPD and the other incorporated documents constitutes the written instrument under which the Plan is established and maintained. Where there is an inconsistency or ambiguity between the terms of the Welfare Plan and the terms of a certificate of coverage for insured benefits, the terms of the certificate of coverage control when describing specific benefits that are covered or insurance-related terms. Where there is an inconsistency or ambiguity between the terms of the Welfare Plan and this SPD, the terms of the Welfare Plan control.

### Receipt of this document is not a contract

While Microsoft provides a benefit program for its employees and their eligible dependents, this benefit program does not constitute a contract of or inducement for employment with Microsoft, nor does it mean future employment for Microsoft is guaranteed.

### Benefits may be amended or terminated

While Microsoft expects to continue the benefits described in this document, benefits including, employer contributions, may be added, changed, and/or discontinued by Microsoft at any time. You will be notified of any benefits changes. The benefits featured in this document are listed in the Table of Contents above. The terms of this Plan can be amended in writing only, and cannot be altered, in any manner, by oral statements.

Nothing in this SPD shall be construed to require continuation of this Plan with respect to existing or future participants, dependents or beneficiaries.

### COBRA enrollees

This SPD generally applies to active employees and dependents, as well as individuals who are enrolled in continuation coverage for certain health-related benefits under the Plan through the Consolidated Omnibus Budget Reconciliation Act (COBRA). For COBRA enrollees, there are notations throughout this SPD that call out which benefits or features apply to you. For example:

The following notation generally indicates that a particular section applies to COBRA enrollees:

| **P** | COBRA enrollees |
| --- | --- |

The following notation generally indicates that a particular section does not apply to COBRA enrollees:

| does not apply | COBRA enrollees |
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### Summary of what’s available

Below is a summary of benefits available for active employees/dependents and COBRA enrollees. For detailed information, please refer to each section of this SPD.

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| **Benefit** | **Active employees/dependents** | **COBRA enrollees** |
| [Medical and prescription drugs](#_Section_III:_Medical) | Yes | Yes |
| [Other health & wellness benefits](#_Section_V:_Other) | Yes | Yes |

# Section I: Who’s eligible

What is in this section

[Eligibility 5](#_Toc361226773)

[Leaves of absence 10](#_Toc361226774)

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## Eligibility

What is in this section

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[When eligibility ends 9](#_Toc51077105)

[For COBRA enrollees 9](#_Toc51077106)

| **P** | COBRA enrollees – see section [For COBRA enrollees](#_For_COBRA_enrollees) for applicable information |
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### For employees

You are eligible for benefits if you are a Microsoft intern or a visiting researcher. For additional details, please review the full definition of eligible employee in the Glossary of this SPD, and the explanation of [workers who are not eligible](#_Ineligible_workers) for coverage.

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| Additional information | You are on the **Microsoft U.S. payroll** if you are paid from the Microsoft Payroll department located in the United States and Microsoft withholds and pays U.S. employment taxes on your payroll amounts. |

If you meet the following criteria, you are eligible to participate only in the Hawaii Only Plan (Premera) for medical coverage, even if you do not meet the definition of an eligible employee set forth earlier:

* An employee of Microsoft on the Microsoft U.S. payroll
* Reside in Hawaii

| Additional information | Additional eligibility requirements may apply to certain benefits. Please review the benefit sections of this SPD for more information. |
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#### If you are rehired by Microsoft

If you are rehired by Microsoft (and again become an eligible employee) during the same plan year and within 30 days of your previous termination of employment, your election in effect at the time of termination will be reinstated. You will not be permitted to make new benefit elections solely based upon the termination and rehire. If more than 30 days have passed since your previous termination of employment, you must reenroll as a new hire and make new benefit elections.

#### If you transfer from another Microsoft plan

If you transfer directly from another plan sponsored by Microsoft without a lapse in coverage, the benefits of this plan will begin without any loss.

#### If both you and your spouse/domestic partner, or the other parent of one or more of your children, work for Microsoft

Certain rules apply if both you and your spouse, domestic partner, or the other parent of one or more of your children (regardless of your marital or domestic partnership status) work for Microsoft and are both eligible for Microsoft benefit coverage:

* For medical benefits you may elect *one* of the following coverage options, but not both:
  + You may enroll in your own coverage, OR
  + You may enroll as a dependent in your spouse’s/domestic partner’s Microsoft coverage.
* An eligible child of two Microsoft employees can be enrolled only under one employee's medical benefit coverage. If such employees have two children, for example, one employee could cover one child and the other employee could cover the other child on their plan.

#### If both you and your parent (or the spouse/domestic partner of your parent) work for Microsoft

Certain rules apply if both you and your parent (or the spouse/domestic partner of your parent) work for Microsoft, and you are eligible for Microsoft benefit coverage both as an employee and as a dependent child:

* For medical benefits you may elect *one* coverage option, but not both:
  + You may enroll in your own coverage, OR
  + You may enroll as a dependent in your parent’s (or the spouse/domestic partner of your parent’s) Microsoft coverage.

#### Workers who are not eligible for coverage

The following persons are not eligible to participate as employees in the plan under this SPD, even if they meet the definition of a regular employee of Microsoft outlined in the prior section:

* Cooperatives
* Apprentices
* Nonresident aliens receiving no U.S. source income from Microsoft
* Employees covered by a collective bargaining agreement resulting from negotiations with Microsoft in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
* Persons providing services to Microsoft pursuant to an agreement between Microsoft and any other individual or entity, such as a staff leasing organization (leased employees)
* Temporary workers engaged through or employed by temporary or leasing agencies
* Workers who hold themselves out to Microsoft as being independent contractors or as being employed by or engaged through another company while providing services to Microsoft
* Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.
* All other workers who Microsoft does not classify as being an intern or a visiting researcher eligible to participate in the plan under this SPD, even if that classification is later determined to be incorrect or is retroactively revised.

### For dependents

If you enroll for coverage, you may also enroll your eligible dependents for medical coverage under the plan.

| **Your eligible dependents include your:** | |
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| Spouse | You must be lawfully married (whether the same or opposite sex of the employee) and not legally separated. You will be considered lawfully married if either of the following are true:   * You were married in a state, possession, or territory of the U.S. and you are recognized as lawfully married by that state, possession, or territory of the U.S.; or * You were married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize you as lawfully married.   In no event will the Plan recognize more than one spouse at any time. |
| Domestic partner | You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:   * You are each other's sole domestic partner and intend to remain so indefinitely * Neither of you is legally married * You are both at least 18 years of age and are mentally competent to consent to contract * You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside * You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes) * You are mutually responsible (financially and legally) for each other's common welfare |
| Dependent children under age 26 | Includes your:   * Biological child and/or your spouse’s/domestic partner’s biological child * Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence) * Legally adopted child, or child who has been placed with you for adoption, but not a foster child   A child’s eligibility as a dependent child under age 26 does not rely on the child’s financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors. |
| Incapacitated dependent children age 26 or over | An incapacitated dependent resides with the employee for more than half of the year, and is unable to sustain employment due to a developmental or physical disability that existed before the child reached age 26. The individual is chiefly dependent on the employee (or the employee’s spouse or domestic partner) for support.  Proof of incapacity must be submitted to the plan administrator:   * For Premera Blue Cross, Surest or Kaiser Foundation Health Plan of Washington (KFHPWA), within 90 days of the latest of the child's 26th birthday, your date of hire, or the date that you enroll the child in coverage if the child is already over age 26, and then annually thereafter * For Kaiser Permanente, within 60 days after receiving notice from Kaiser |

| Additional information | You may be required to provide evidence of your partnership in connection with a plan audit of dependent eligibility or a claim for benefits. If desired, you may sign the Microsoft Affidavit of Domestic Partnership before a notary and retain the affidavit in your records. To obtain a copy of the affidavit, email [Benefits](mailto:benefits@microsoft.com) or call (425) 706-8853. |
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| Additional information | **Important note about tax consequences of domestic partner benefits** Domestic partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical coverage that relate to your domestic partner, or your domestic partner’s children, generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which domestic partner benefits that have an imputed income are maintained by you, but you are not receiving a paycheck from the company, the company reserves the right to collect the income and employee FICA tax liability directly from you. These rules will not apply if your domestic partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code or state tax laws governing state income tax. |
| Additional information | Coverage for a child may be provided as the result of a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law. Once the Plan confirms the QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order unless another date is specified in the order. For more information, or to request the requirements for whether an order meets the requirements of a QMCSO, call the Microsoft QMCSO Service Center (833)-253-4929. |

#### Family members who are not eligible for coverage

The following is a list of dependents who are commonly mistaken as eligible dependents. This is not an all-inclusive list but rather common examples of ineligible dependents:

* Legally separated spouse, regardless of whether you are subject to a court order or agreement requiring you to provide them with health care coverage
* Divorced spouse, regardless of whether you are subject to a court order or agreement requiring you to provide them with health care coverage
* Parents, except as otherwise may be listed elsewhere in the SPD, regardless of whether they live with you and/or depend on you for financial support
* Grandparents, regardless of whether they live with you and/or depend on you for financial support
* Siblings, regardless of whether they live with you and/or depend on you for financial support
* Nieces, nephews, and grandchildren, regardless of whether they live with you and/or depend on you for financial support unless they meet the dependent eligibility definition described above
* Roommates
* Foster children
* Any person who is on active duty in the armed forces
* Anyone else who does not meet the definition of an eligible dependent
* Anyone for whom you fail to provide proof of eligible dependent status, if required or requested

### When eligibility ends

Your eligibility for Microsoft benefits described in this SPD ends with the last day of your employment at Microsoft, or the last day before you fail to satisfy the eligible employee requirements outlined above.

Eligibility for your dependents ends when your eligibility ends, or earlier if your dependent no longer meets the definition of an eligible dependent. Dependent children remain covered on the plan through the end of the month in which they turn 26.

In the event of your death, eligibility for your covered dependents ends:

* The end of the month if you die before the 15th of the month
* The 15th of the next month if you die on or after the 15th of the month

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| Additional information | Please review the [Coverage if you leave Microsoft](#_Section_XII:_Coverage) section for information on when coverage ends and your options for continuing coverage. |

### For COBRA enrollees

You are eligible for the benefits described in the applicable sections of this SPD if and to the extent that you are enrolled in continuation coverage under COBRA, as described in [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage).

| Additional information | You may be required to provide evidence of your partnership in connection with a plan audit of dependent eligibility or a claim for benefits. If desired, you may sign the Microsoft Affidavit of Domestic Partnership before a notary and retain the affidavit in your records. To access this form, go to [http://cobra.me.microsoft.com](http://cobra.me.microsoft.com/) > Reference Center > Microsoft Affidavit of Domestic Partnership. |
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## Leaves of absence

What is in this section

[Health benefits 10](#_Toc440487769)

| does not apply | COBRA enrollees – the Leaves of absence section does not apply |
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### Health benefits

You may be eligible for medical, prescription drug, and employee assistance plan (EAP) benefits while you are on an approved leave of absence as designated by the applicable Microsoft leave of absence policy.

| Additional information | To learn more about the leave of absence policy, contact Benefits by e-mail at [benefits@microsoft.com](mailto:benefits@microsoft.com) or by phone at (425) 706-8853. |
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| Additional information | Your coverage will remain in effect while you are on a leave of absence that complies with the Family and Medical Leave Act (FMLA). |
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If your eligibility for health benefits ends while you are on leave of absence (for example, where a personal leave of absence of more than 12 weeks is approved), you and your dependents may be eligible to continue coverage through COBRA provisions. Please review the [Coverage if you leave Microsoft](#_Section_XII:_Coverage) section for more information.

## If you have other health coverage (Coordination of Benefits)

What is in this section

[How Coordination of Benefits (COB) works 11](#_Toc357495540)

[COB with other health plans 11](#_Toc357495541)

[COB with other types of insurance 16](#_Toc357495542)

| **P** | COBRA enrollees – the Coordination of Benefits section applies |
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### How Coordination of Benefits (COB) works

If you or your covered dependents have health benefit coverage through another employer, a government plan or Medicare, your Microsoft health plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the following section, COB with other health plans, for more information.

If you or your covered dependents receive payments for health care from other sources, such as motor vehicle or liability insurance, your Microsoft health plan will seek to be reimbursed for benefits paid under the plan or take over your right to receive payments from the other party—this is called subrogation. Review the [COB with other types of insurance](#_COB_with_motor) section for more information.

All of your Microsoft health benefits—medical and prescription drugs are subject to these provisions.

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| **Examples** |
| * Mike works for Microsoft. Mike’s wife, Lee, is covered as a dependent on Mike’s Microsoft medical plan but also has coverage under Lee’s own employer’s medical plan. Lee’s plan would provide primary coverage for Lee and would coordinate benefits with Mike’s plan. * Jen is in a car accident. Jen is injured in the accident and incurs health care expenses that will be paid by the other driver’s vehicle insurance. The Microsoft plan will process any remaining expenses after the vehicle insurance has been exhausted per the plan guidelines. |

### COB with other health plans

The Microsoft health plan will coordinate coverage with other health plans, including:

* Medicare Part A or B
* A plan sponsored by one or more employers or employee organizations
* A government-sponsored program other than workers’ compensation

One health plan determines eligible benefits first and is considered primary and then the other health plan determines its share of the remaining balance and is considered secondary. Microsoft uses certain rules to determine which plan is primary and which is secondary, as described below.

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| Additional information | **Health plans** provide medical and prescription drug coverage.  **The primary plan** is the health plan that pays benefits first.  **The secondary plan** is the health plan that pays the balance for eligible expenses, subject to its plan benefits and limitations. |

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| Additional information | Due to IRS regulations, specific rules apply to the Health Savings Account if you have other plan coverage. Please review the [Health Savings Account](#_Health_Savings_Account_1) section of this SPD for more information. |

#### If both you and your spouse/domestic partner work for Microsoft

If both you and your spouse/domestic partner are employed by Microsoft, you may not enroll for employee coverage and also be enrolled as a dependent on your spouse/domestic partner’s coverage. You can each enroll in your own separate coverage with Microsoft or one of you can enroll as a dependent under your spouse’s/domestic partner’s coverage. Children may be enrolled as a dependent only on one Microsoft employee’s coverage.

#### If your spouse/domestic partner is eligible for coverage through another plan

If you enroll your spouse/domestic partner who is eligible for health coverage through their employer, you must notify Microsoft of your decision to coordinate coverage between that plan and the Microsoft plan when you enroll. Your spouse/domestic partner can do one of the following:

* Enroll in their employer’s health plan and use Microsoft coverage as the secondary plan at no charge
* Waive the coverage available through their employer and enroll as a dependent on your Microsoft plan; in this case, you will pay $150 per month to use the Microsoft plan as your spouse’s/domestic partner’s primary coverage

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| Additional information | This policy affects only employees whose spouse/domestic partner is eligible for health coverage through their employer. It does not affect the following groups:   * Employees who do not have a spouse/domestic partner * Employees whose spouse/domestic partner is not employed * Employees whose spouse’s/domestic partner’s employer does not provide a health plan * Employees whose spouse/domestic partner is not eligible for their employer’s health plan * Eligible dependent children enrolled in a Microsoft health plan * Employees and spouses/domestic partners who are both employed by Microsoft, and one is enrolled as a dependent on the other’s plan |

#### When Microsoft is primary or secondary

Microsoft uses the following rules to determine if the Microsoft plan is primary or secondary to other coverage.

##### Medicare

In most cases, the Microsoft plan is primary to Medicare, except if you have been eligible for Medicare due to end stage renal disease for more than 30 months. If you have COBRA continuation coverage under the Microsoft plan, however, Medicare is primary, except if you have been eligible for Medicare due to end stage renal disease for no more than 30 months. Medicare is also primary if and when you have been on a leave of absence and receiving disability benefits under the plan for at least 6 months. Your Microsoft plan will coordinate benefits with Medicare as required by federal law.

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| Additional information | Visit the online guide Medicare and Other Health Benefits or call the Medicare Coordination of Benefits Contractor (COBC) at (855) 798-2627 (TTY users should call (855) 797-2627) for information about how Medicare coordinates coverage with other health plans. |

##### Other plans

For Microsoft employees, the Microsoft plan (other than through COBRA) is always primary to other coverage, including coverage under your spouse/domestic partner’s plan, COBRA, Medicaid, or TRICARE medical. COBRA coverage under the Microsoft plan is always secondary to coverage under your spouse/domestic partner’s current employer’s plan. Any no-fault medical coverage for motor vehicles and boats, including Medical Payment (MEDPAY), Personal Injury Protection (PIP), Medical Premises (Medprem) for homeowners’ or commercial properties or excess accident and athletic policies, will be primary to the Microsoft plan.

For your spouse/domestic partner who has other coverage, the Microsoft plan is secondary unless the following conditions apply:

* If your dependent’s other coverage is under COBRA, Medicaid or TRICARE medical, the Microsoft plan is primary

If your dependent’s other coverage is under a retiree plan which has a COB provision, the Microsoft plan is primary

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| Additional information | Kaiser Permanente will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care, which are incorporated in the Evidence of Coverage. |

#### If your dependent child has coverage through another plan

* For adult dependent children covered as a subscriber under their own plan or as a dependent on a spouse/domestic partner’s plan, the Microsoft plan will be secondary. In addition, if an adult dependent child is also covered on more than one parent’s plan, the rules below will apply for determining the remaining order of liability.
* If your dependent child is covered under both parents’ plans, order of liability rules apply. For purposes of applying these order of liability rules, a stepparent’s plan that covers the child but not a parent will be deemed to cover a parent. Unless a court decree states otherwise, the rules below apply for dependent children covered by Microsoft and another plan. If a dependent child is covered by individuals other than parents or stepparents, these rules will apply as if those individuals were the parents. When the rules below do not establish an order, the plan that has covered the parent for the longest period of time is the primary payer.
* 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.
  + 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/domestic partner of the custodial parent, second
    - The plan covering the non-custodial parent, third
    - The plan covering the spouse/domestic partner 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.
* When the rules above do not establish an order, the plan that has covered the parent for the longest period of time is the primary payer.

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| Additional information | A child of two Microsoft employees can be enrolled under only one employee’s coverage. |

#### How Microsoft pays for secondary coverage

You and your dependents, as applicable, must follow the rules of the primary plan in order to receive secondary coverage under the Microsoft plan. When coverage for a particular item or service is denied or reduced under the primary plan, due to failure to follow the rules of that plan, the Microsoft plan will pay nothing, even if the Microsoft plan *otherwise* generally provides coverage for that item or service.

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| **Example** |
| Lisa works for Microsoft and Lisa’s husband, Joe, is covered as a dependent on Lisa’s plan. Joe’s coverage through Joe’s own employer is Joe’s primary plan. Joe’s primary plan requires a referral to be obtained before accessing specialty care or the plan pays nothing. If Joe doesn’t seek a referral, neither Joe’s primary plan nor the Microsoft plan will pay for the charge. Joe cannot bypass this referral requirement and submit a charge to the Microsoft plan as the secondary payer, even if the Microsoft plan does not have the same requirement for obtaining a referral. |

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| Additional information | Remember to tell your health care provider whether your Microsoft plan is primary or secondary to other coverage. This will prevent delays in receiving payment for your benefits. |

If the Microsoft plan is secondary, it will pay its share of any remaining costs within plan guidelines after the primary plan has paid and the deductible in the Microsoft plan, if applicable, has been met. The plan administrator (Premera, Surest, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente) will review the allowable charge for the primary plan and the amount the primary plan paid.

The Microsoft plan will pay, in total, the lesser of:

* The total amount the Microsoft plan would have paid if it were primary
* The allowable charge for the Microsoft plan
* The remaining balance of your provider’s bill for services covered by the Microsoft plan

Payments made by the primary plan will count toward the Microsoft plan’s deductible and coinsurance limits, if applicable, up to the allowed amount under the Microsoft plan.

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| **Example** |
| Milo works for Microsoft and has a domestic partner named Bo, who is covered as a dependent under Milo’s plan. Bo’s coverage through Bo’s own employer is Bo’s primary plan. Bo has a procedure that is billed at $1,000. Bo’s primary plan has an allowed amount of $900 for this service and pays the provider. The Microsoft plan has an allowed amount of only $700, so it does not pay any of the cost. However, $700 will be applied to the deductible for Milo’s and Bo’s coverage in the Microsoft plan, if they had not yet met their deductible yet on the Microsoft plan. |

#### How to submit a claim for secondary coverage

When obtaining care, your dependents with secondary coverage under the Microsoft plan will need to do the following:

* Present their employer’s plan ID card as primary insurance
* If the provider bills secondary insurance, present the Microsoft plan ID card as well
* If the provider does not bill secondary insurance, submit the following documents to your plan administrator (Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente):
  + An Explanation of Benefits (EOB) statement from the primary plan
  + For medical services, an itemized bill from the provider, noting the remaining costs after payment from the primary plan
  + For prescriptions, a copy of the pharmacy receipt that includes the drug name and amount paid

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| Additional information | Make sure to submit all claims within 12 months, even if no additional payment will be made. This will ensure that your spouse’s/domestic partner’s claims are applied to your deductible. |

The Microsoft plan will not pay a claim submitted more than 365 days from the date of service. Employee and/or dependents will have 365 days from the date of the primary insurance Explanation of Benefits (EOB) to submit claims to the plan administrator (Premera, Surest, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente) for consideration. If you cannot submit the claim in a timely manner due to circumstances beyond your control, the claim will be considered by the plan administrator for payment when submitted as a formal appeal.

If your coverage under the Kaiser Permanente plan is determined to be secondary, Kaiser Permanente might be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for services that are partially covered by either of your coverages during that calendar year. If you are entitled to a Benefit Reserve Account, Kaiser Permanente will provide you with detailed information about this account.

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| Additional information | |  |  |  | | --- | --- | --- | | For assistance with COB, please contact your administrator: | | | | Premera | (800) 676-1411 | [Premera Claim Reimbursement Request Form](https://www.premera.com/documents/011943.pdf) [[External Review Request Form](https://www.premera.com/documents/011943.pdf)](https://www.premera.com/documents/024229.pdf)  [Prescription Claim Form](https://www.premera.com/documents/C100188.pdf) | | Surest | (866) 222-1298 | [Surest Member Reimbursement Claim Form](https://hrportal.ehr.com/microsoftbenefits/shared/Surest-Member-Reimbursment-Claim-Form) | | Kaiser Foundation Health Plan of Washington | (888) 901-4636 | [Medical and Prescription Claim Form](https://wa.kaiserpermanente.org/html/public/customer-service/reimburse) | | Kaiser Permanente | (800) 464-4000 | Log on to [kp.org](http://kp.org/) to process your claims | |  | Kaiser Permanente group numbers:   * Northern California: 603873 * Southern California: 231325 | | |

### COB with other types of insurance (Subrogation)

If another party may be liable or legally responsible to pay for a member’s care, typically through another insurance plan, the Microsoft plan will seek to be reimbursed for amounts paid. The Microsoft plan may choose to:

* Subrogate—that is, take over—the member’s right to receive payments from the other party. The member or the member’s legal representative will transfer to the plan any rights the member might have to take legal action arising from the illness, sickness, or bodily injury to recover any sums paid under the plan on your behalf or that of your covered dependent. This is the plan’s right of subrogation.
* Recover from the member or the member’s legal representative any benefits paid under the plan from any payment you or your covered dependent is entitled to receive from the other party. This is the plan’s right of reimbursement.

|  |
| --- |
| **Examples** |
| * Felicia was injured in a car accident. Felicia received payment for related health care expenses through the other driver’s auto insurance policy. In this instance, the Microsoft plan may be able to recover medical expenses paid on the member’s behalf from the auto insurer. * Molike became ill from food poisoning and received a payment from the restaurant for related health care expenses through a liability policy. In this instance, the Microsoft plan may be able to recover medical expenses paid on the member’s behalf from the liability policy. |

|  |  |
| --- | --- |
| Additional information | The **other party** or other parties are defined to include, but not limited to, any of the following:   * The party or parties who caused the illness, sickness, or bodily injury * The insurer or other indemnifier of the party or parties who caused the illness, sickness, or bodily injury * The member’s own insurer (for example, in the case of Uninsured Motorist [UM], Underinsured Motorist [UIM], medical payments, or no-fault coverage, or, in the case of Personal Injury Protection – PIP, Medical Payments, or Med Pay) * A workers’ compensation insurer * Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, sickness, or bodily injury |

Other types of insurance that may provide health coverage might include but are not limited to:

* Personal Injury Protection (PIP) coverage
* Motor vehicle medical (Medpay) or motor vehicle no-fault coverage
* Workers’ compensation, labor and industry, or similar coverage
* Any excess insurance coverage
* Medical premises coverage
* Commercial liability coverage
* Boat coverage
* Homeowner policy
* School and/or athletic policies
* Other types of liability or insurance coverage

#### Right of reimbursement and subrogation

The following rules apply to the Microsoft plan’s right of reimbursement and subrogation:

* The Plan has a first priority with respect to its right to reimbursement or subrogation.
* The Plan has the right to 100% reimbursement in a lump sum.
* The Plan is not subject to any state laws or equitable doctrine, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person’s attorneys’ fees, and costs.
* The plan’s right to first priority shall not be reduced due to the member’s negligence, the member’s not being made whole, or attorney’s fees and costs, or due to any common fund doctrine.
* Reimbursement must be made to the Microsoft plan, regardless of whether the judgment, settlement, or other payments allocate any specified amount to reimbursement for medical expenses and regardless of whether such expenses are paid prior to or after the date of such judgment, settlement, or otherwise, and regardless of whether the covered person made claim for medical expenses as part of any claim or demand.
* The Plan’s recovery and reimbursement amount are recoverable even if the Participant’s recovery funds have been commingled with other assets and the Plan may recover from any available funds without the need to trace the source of the funds.
* The Microsoft plan may seek reimbursement from any recovery, whether by settlement, judgment, mediation, arbitration, or any other recovery made by or on behalf of:
  + A covered dependent
  + The estate of any covered member, or
  + Any incapacitated member
* The Plan requires the Participant’s legal representative or estate to cooperate fully with the Plan and not take any actions that would prejudice the Plan’s right of reimbursement.
* The Plan Administrator, in its sole discretion, or the Plan Administrator’s delegate, in the exercise of its fiduciary authority, may determine whether to pursue the Plan’s rights to reimbursement or subrogation.
* The Plan shall have the right to join or intervene in any suit or claim against a responsible third party brought by Participant or on the Participant’s behalf.
* No Participant or their representatives may assign any rights or causes of action that they might have against a third-party tortfeasor, person, or entity, which would grant the covered individual the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan’s subrogation and reimbursement rights apply even if the Participant or covered individual has died as a result of their personal injuries and is asserting a wrongful death or survivor claim against the third party under the laws of any state. The Plan’s right to recover by subrogation or reimbursement shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

Reimbursement will not exceed:

* The amount of benefits paid by the plan for the illness, sickness, or bodily injury, plus the amount of all future benefits that may become payable under the plan that result from the illness, sickness, or bodily injury. The plan will have the right to offset or recover such benefits from the amount received from the other party, and/or
* The amount recovered from the other party, or parties

If the member recovers payments from any of the sources identified above and fails to reimburse the Microsoft plan, the Microsoft plan may reduce future benefits by the amount received from the other party, or parties.

#### Working with the Microsoft health plan

The member or the member’s legal representative must:

* Notify the Microsoft plan in writing whenever benefits are paid under the Plan that arise out of any injury, sickness or other condition that provides or may provide the Plan subrogation or reimbursement rights.
* Notify the Microsoft plan in writing of any terms or conditions offered in a settlement before accepting any settlement or recovery on a claim against the other party
* Notify the other party of the Microsoft plan’s interest in the settlement established by this provision
* Cooperate fully with the Microsoft plan in asserting its subrogation and reimbursement rights
* Provide all information and sign and return all documents necessary to exercise the Microsoft plan’s right under this provision within 14 business days of receiving a request from the Microsoft plan

If the member or the member’s legal representative fails to cooperate fully as described above, they will be personally liable to the Microsoft plan for the amount paid on the member’s behalf.

In the event that the Plan advances moneys or provides benefits for an injury, sickness, or other conditions, and the member recover moneys or benefits from a third party in the amount of the moneys or benefits advance; or in the event that there is a disagreement regarding reimbursement of the Plan’s subrogation amount at the time of settlement, the Plan has an equitable lien in connection with such amounts and the member or the member’s legal representative agrees to hold any recovered funds in trust or in a segregated account for the benefit of the Plan until the Plan’s subrogation and reimbursement rights are fully determined.

**Other Reimbursements**

If you receive any payment, reimbursement or refund from any party for any item or service that previously was furnished to you and covered by the Plan, you must notify the Plan as soon as possible. The Plan will have the right to recover from you any and all amounts paid, reimbursed, or refunded that previously were paid or reimbursed by the Plan. To the extent that any such amounts previously were paid by you (*e.g.*, deductibles, coinsurance, or copayments), the Plan still may need to adjust your deductible and/or coinsurance or out of pocket maximum amounts as necessary to account for the subsequent payment, reimbursement, or refund to you.

##### Noncompliance

If the Participant receives a recovery but does not promptly segregate the recovery funds and reimburse the Plan in full from those funds, the Plan shall be entitled to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to:

1. Initiating an action against the Participant and/or the Participant’s attorneys to compel compliance with this Section;
2. Withholding or suspending benefits payable to or on behalf of the Participant and the Participant’s eligible Dependents until the Participant complies or until the reimbursement amount has been fully paid to the Plan; or
3. Initiating other appropriate actions.

If the Participant does not reimburse the Plan after receiving the recovery, the Participant shall be responsible for paying the Plan a reasonable interest per month on the reimbursement amount until the Plan receives reimbursement in full.

##### Conclusion of Claim

Once a Participant has settled or received an award or judgment or any type of recovery on a claim or suit against a responsible third party, the Participant shall hold any proceeds of a recovery in trust until the Plan’s rights and interests in such Recovery have been resolved and satisfied.

|  |  |
| --- | --- |
| Additional information | The Microsoft plan administrator has the exclusive responsibility and complete discretionary authority to control the operation and administration of this Plan, with all powers necessary to enable it to properly carry out such responsibility, including, but not limited to, the power to construe and interpret the terms of this summary plan description and any other Plan documentation. |

# Section II: Enrollment

What is in this section

[When you may enroll or make changes 21](#_Toc51079283)

[How to enroll 22](#_Toc51079284)

[First-time enrollment 24](#_Toc51079285)

[Open enrollment 26](#_Toc51079286)

[Life event enrollment 27](#_Toc51079287)

## When you may enroll or make changes

| **P** | COBRA enrollees – for more information about how to enroll, as well as a link to the COBRA enrollment tool, go to [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage) section. |
| --- | --- |

You may make benefit elections for you and your eligible dependents using the Benefits Enrollment tool at the following times:

* As a new employee, within 30 calendar days of your hire date
* During the annual open enrollment period in November for coverage effective the following January 1. The open enrollment period takes place in the fall each year, typically in the first few weeks of November, prior to Thanksgiving week. The specific dates will be communicated to you each year.
* If you experience a [qualifying life event](#_Qualifying_life_events_1), you can make limited changes to your benefits during the year
* Otherwise, you cannot make changes to your benefit elections until the next annual open enrollment period. The open enrollment period takes place in the fall each year, typically in the first few weeks of November, prior to Thanksgiving week. The specific dates will be communicated to you each year..

| Additional information | *You may make changes to your Health Savings Account (“HSA”) contributions at any time on the* [26T*Benefits Enrollment tool*](https://benefits.microsoft.ehr.com/us/en/tasks/pages/enrollbenefits_redirect.aspx)26T*. Changes to your HSA contributions are effective on the first day of the month following the change.* |
| --- | --- |

## How to enroll

What is in this section

[Charge for spouse/domestic partner medical coverage 22](#_Toc52349680)

[Taxes and your benefits 22](#_Toc52349681)

[Waiving coverage 23](#_Toc52349682)

[What Microsoft pays for coverage 23](#_Toc52349683)

| does not apply | COBRA enrollees – the How to enroll section does not apply |
| --- | --- |

### Charge for spouse/domestic partner medical coverage

When you enroll your eligible spouse/domestic partner for benefits, you will need to indicate whether they are also eligible for medical coverage through their employer.

There is no charge if your spouse/domestic partner is not eligible for other medical coverage. However, if they are eligible and waive that coverage, there is an additional charge of $150 per month for coverage in a Microsoft medical plan.

The charge does not apply if your spouse/domestic partner enrolls for coverage through their employer and you enroll them as a dependent in a Microsoft medical plan. The Microsoft plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the [Coordination of Benefits](#_If_you_have_1) section for more information.

If you do not indicate whether your spouse/domestic partner is eligible for other coverage when you enroll, you will automatically be charged the additional $150 per month. If you and your spouse or eligible domestic partner are both employed by Microsoft and one of you waives coverage and is enrolled as a dependent under the other employee’s coverage, there is no additional charge.

**Note**: Changes to your enrollment status that require the addition or removal of the $150 per month charge for spouse/domestic partner medical coverage will apply prospectively only, for pay periods following the date that you make the election change in the Benefits Enrollment tool.

### Taxes and your benefits

Certain benefits will be recorded as taxable income, or imputed income, in your paycheck and W-2 statement according to Internal Revenue Service (IRS) regulation, including:

* The value of medical coverage for your domestic partner and children of your domestic partner who are not your tax dependents
* Perks+, or PRO Club membership (for interns and visiting researchers who are employed in WA State)

### **Waiving coverage**

You may waive coverage by signing on to the [Benefits Enrollment tool](http://benefitsenroll.me.microsoft.com/) and electing the waive coverage option during your enrollment period.

If you decide to waive medical coverage, the next opportunity for you to change your coverage options will be during the next annual open enrollment period, unless you experience a qualifying status change as described in the [26TQualifying life events](#_Qualifying_life_events_1)26T section. The open enrollment period takes place in the fall each year, typically in the first few weeks of November, prior to Thanksgiving week. The specific dates will be communicated to you each year. Changes made during the open enrollment period will take effect on January 1st.

### What Microsoft pays for coverage

Microsoft contributes to the cost of your benefit coverage as follows:

| Benefit | Microsoft contributions |
| --- | --- |
| Medical and  prescription drug | * Microsoft provides coverage with no monthly premium costs for you and your eligible dependents |
| Spring Health, employee assistance program (EAP) | * Microsoft provides coverage for you and your eligible dependents |
| Perks+ | * Microsoft provides the Perks+ benefit, which is considered taxable income to you. * The Perks+ benefit allows for up to $1,500\* in reimbursement of program eligible, employee only expenses. * If you live in Washington State, you can choose to enroll in Perks+, or the PRO Club. If you elect PRO Club as your Perks+ option for 2025, Microsoft will pay an annual amount of $1673.29 toward your PRO Club membership (your responsibility will be a $65 per month cost share). The full value of the annual membership is $2,453.12 ($1673.29 paid by Microsoft plus $780 paid by you). You pay imputed income tax on the value of the Microsoft paid portion of your Pro membership, reflected in your paycheck. Assuming a 22 percent supplemental tax rate, $368.12 is the amount of tax you’d pay annually. Supplemental tax rate will vary based on your income. Consult your tax advisor for specific information. |

## First-time enrollment

What is in this section

[When to enroll 24](#_Toc356562366)

[When coverage begins 24](#_Toc356562367)

[If you take no action (default coverage) 24](#_Toc356562368)

| does not apply | COBRA enrollees – the First-time (new hire) enrollment section does not apply |
| --- | --- |

### When to enroll

You have 30 days from your hire date to make your benefit elections or waive coverage using the [Benefits Enrollment tool](http://benefitsenroll.me.microsoft.com/). If you do not enroll within this 30-day enrollment period, you will automatically be enrolled in default coverage as described below.

### When coverage begins

You’re eligible for benefits on your hire date, and benefit coverage begins as follows:

| Benefit | Coverage begins |
| --- | --- |
| Medical (including prescription drug) | Your hire date |
| Spring Health (EAP) | Your hire date |
| Perks+ | Your hire date |

### If you take no action (default coverage)

If you do not enroll or waive benefits through the [Benefits Enrollment tool](http://benefitsenroll.me.microsoft.com), you will be enrolled only in the default coverage as summarized below. The costs of default coverage are paid in full by Microsoft and some coverage will result in taxable income to you. Please note that default coverage covers only the employee and does not provide coverage for your dependents.

| Additional information | You have 30 days from your hire date to make your benefit coverage elections. Otherwise, your next opportunity to make changes is the annual open enrollment period or if you have a [26Tqualifying life event](#_Qualifying_life_events)26T. The open enrollment period takes place in the fall each year, typically in the first few weeks of November, prior to Thanksgiving week. The specific dates will be communicated to you each year. |
| --- | --- |

| **Benefit** | **Default coverage** | **Taxable income** |
| --- | --- | --- |
| Medical and prescription drug | * Surest Health Plan or, for employees, whose principal residence is in Hawaii, Hawaii Only Plan (Premera) | No |
| Perks+ | * Reimbursement up to $400 | Yes |

## Open enrollment

What is in this section

[When to enroll 27](#_Toc361301458)

[When coverage begins 27](#_Toc361301459)

[If you take no action 27](#_Toc361301460)

| | **P** | COBRA enrollees – the Open enrollment section applies, but enrollment is administered through a separate COBRA enrollment tool. For more information as well as a link to the COBRA enrollment tool, go to [26TContinuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage_1)26T section. | | --- | --- | |  |
| --- | --- | --- | --- |

### When to enroll

The open enrollment period takes place in the fall each year, typically in the first few weeks of November, prior to Thanksgiving week. The specific dates will be communicated to you each year. Open Enrollment is your annual opportunity to make changes to your benefit elections, including adding or deleting coverage for your dependents. You may review and submit any changes to your elections in the [26TBenefits Enrollment tool](https://benefits.microsoft.ehr.com/us/en/tasks/pages/enrollbenefits_redirect.aspx)26T.

If you are an employee on leave during the open enrollment period for the entirety or only a portion of open enrollment, you will be notified of open enrollment by mail. You must submit any changes to your benefit elections via the Benefits Enrollment tool or the enclosed enrollment form before the end of the enrollment period.

Typically, you cannot make changes to your benefit elections outside the annual open enrollment period. However, you can make certain coverage changes during the calendar year if you have a [26Tqualifying life event](#_Life_event_enrollment)26T.

| Additional information | For active employees, removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be deemed to have been enrolled in Microsoft benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event. |
| --- | --- |

### When coverage begins

The changes you make during open enrollment are effective the following January 1.

### If you take no action

If you do not make changes to your benefit elections during Open Enrollment through the Benefits Enrollment tool, your current coverage will continue uninterrupted.

## Life event enrollment

What is in this section

[When to enroll 27](#_Toc361220374)

[Qualifying life events 28](#_Toc361220375)

[Examples of consistency rule 30](#_Toc361220376)

| **P** | COBRA enrollees – for qualifying life event changes call the Microsoft COBRA Service Center at (833) 253-4929. For additional information, go to the [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage) section. |
| --- | --- |

### When to enroll

You can make certain benefit changes outside of open enrollment if you have a qualifying life event as described below. The benefit changes must be consistent with the qualifying life event you experience, as required by Federal law. You may make changes to your Health Savings Account (“HSA”) contributions at any time, whether or not you have experienced a qualifying life event. New HSA contribution elections are effective the first day of the month following the change.

If you experience one of these status changes, you must make any changes to your benefit elections using the [Benefits Enrollment tool](http://benefitsenroll.me.microsoft.com) or by contacting Benefits within:

* 30 days of the event that produced the change in status, or
* 60 days of the event for divorce or legal separation, or
* 90 days of the event for a marriage, the establishment of a domestic partnership, birth or legal adoption (or placement for adoption) of a child or a child of a domestic partner

| Additional information | *For active employees, removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be* ***deemed*** *to have been enrolled in Microsoft benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event.* |
| --- | --- |

### Qualifying life events

#### Special enrollment events

Under the Health Insurance Portability and Accountability Act (HIPAA), you may change your medical (including prescription drug) coverage if you lose other coverage or acquire a spouse or dependent. Though not required by HIPAA, Microsoft allows arrangements for domestic partners and their children if they are otherwise eligible for coverage. These special enrollment events include:

* Your marriage or establishment of your domestic partnership
* The birth or legal adoption (or placement for adoption) of a child, or a child of your domestic partner
* You or your spouse/domestic partner being named legal guardian of a child as appointed by the courts (or recognized as guardian by the state of residence)
* You or your eligible dependent becomes eligible for assistance under a Medicaid or state child health plan

* The loss of other health coverage by you or your eligible dependent, if not currently enrolled in Microsoft coverage, due to:
  + The exhaustion of COBRA coverage
  + The loss of eligibility due to change in employment
  + The end of employer contributions, resulting in a higher cost of coverage
  + The loss of eligibility for coverage under a Medicaid or state child health plan

If you experience a special enrollment event, you may make the following changes, as long as these changes are due to and consistent with the reason for the status change:

* Add medical (including prescription drug) coverage for yourself or your eligible dependents
  + **Note:** Adding eligible dependents to your plan or changing your medical plan may result in an increase to your annual deductible and coinsurance maximum. If you have questions, please contact [AskHR@microsoft.com](mailto:AskHR@microsoft.com).
* Change medical coverage options

#### Changes to your benefit elections for these life events will take effect as of the date that you make the election change, except as follows:

* Changes to your medical and Spring Health employee assistance program coverage will take effect as of the date of the special enrollment event (marriage, birth, legal adoption, etc.).

**Note**: Changes to your enrollment status that require the addition or removal of the $150 per month charge for spouse/domestic partner medical coverage will apply prospectively only, for pay periods following the date that you make the election change in the Benefits Enrollment tool.

| **Example** |
| --- |
| Birgit is enrolled in employee only medical coverage on the Health Savings Plan. Birgit has a baby, and within 90 days of the birth adds the baby to medical coverage on the Health Savings Plan, moving to employee +1 coverage. That new plan tier (employee +1) begins on the baby’s date of birth, which means Birgit’s annual deductible and coinsurance maximum will increase effective as of the baby’s date of birth due to the tier change from employee only to employee +1 coverage. |

#### Other life events

If you experience any of the following life events, you may be eligible to make limited benefit changes for yourself or your eligible dependents.

* A divorce, legal separation, or an annulment, or the dissolution of your domestic partnership
* The death of an eligible dependent
* A change in dependent child’s status such that they satisfy, or no longer satisfy, the requirements for dependent status
* A change in employment for you or your spouse/domestic partner, even if this change does not affect your eligibility for coverage (gain or loss of job, change in hours worked, taking or returning from unpaid leave)
* A change of residence for you or your eligible dependent (for example, an interstate transfer that results in a change of eligibility for a medical plan)
* You or your eligible dependent become eligible for Medicare or Medicaid
* The issuance of a qualified medical child support order (QMCSO) with respect to the health coverage for your eligible dependent child
* A significant change in dependent care cost or coverage for you or your spouse/domestic partner

| Additional information | You may be eligible (but not required) to make limited changes for certain life events, but you are required to remove your spouse or domestic partner dependent in the case of a divorce, legal separation, annulment, or the dissolution of your domestic partnership. |
| --- | --- |

If you experience one of these other life events listed above, you may make changes to the following benefits, as long as these changes are due to and consistent with the reason for the status change:

* Add medical (including prescription drug) coverage for yourself
* Add or delete medical (including prescription drug) for your eligible dependents
* Change from PRO Club to Perks+ if you move residences out of the eligible area (Washington State) for PRO Club.

Changes to your benefit elections for these life events will take effect as of the date of the election. The one exception is for changes due to a divorce, legal separation, annulment, or the dissolution of your domestic partnership, which will take effect as of the date of the qualifying event.

We reserve the right to request or require that you provide documentation proving the qualifying event that supports any benefit change you make under this section.

### Examples of consistency rule

The benefit changes you make must be due to and consistent with the reason for the status change, as demonstrated in the following examples. The Benefits Enrollment tool will request information about your life event to determine which benefit changes meet IRS requirements.

| **Example** |
| --- |
| Jodi’s (a Microsoft employee) family is covered by benefits through Jodi’s spouse’s employer. If eligibility for coverage through Jodi’s spouse’s employer is terminated due to Jodi’s spouse losing their job, the following changes may be made to Jodi’s Microsoft benefits:   * Enroll or change coverage in medical * Enroll or change from employee only to family coverage. (He cannot change the multiple of pay level of coverage if already enrolled) |

| **Example** |
| --- |
| Terika and their partner adopt a baby. Terika may make the following changes to their Microsoft benefits:   * Enroll or change medical plans, and add dependents |

# Section III: Medical and prescription drugs

What is in this section

[Introduction 32](#_Toc179825386)

[Health Savings Plan (Premera) 38](#_Toc179825387)

[HMO Plan Kaiser Foundation Health Plan of Washington (KFHPWA) only 104](#_Toc179825388)

[HMO Plan (Kaiser Permanente) – California only 163](#_Toc179825389)

[Hawaii-Only Plan (Premera) 167](#_Toc179825390)

[Surest Health Plan 230](#_Toc179825391)

| **P** | COBRA enrollees – the Medical and prescription drugs section applies |
| --- | --- |

## Introduction

Microsoft provides comprehensive medical, and prescription drug coverage for you and your family to help you get and stay well. This introduction provides an overview of these options and common plan terms and conditions. For specific information on the plans available please refer to the section on each plan option.

You may not assign your legal rights or rights to any payments under this Plan, nor may you use your right to benefits as security or collateral. The designation of an authorized representative to act on your behalf will not constitute an assignment of benefits under the plan. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services rendered to you, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan under any circumstances.

### Your plan options

All Microsoft employees are eligible to enroll themselves and their eligible dependents for medical coverage, which includes prescription drug coverage. Microsoft pays the cost of covering you and your eligible dependents on these plans, which means you pay no premiums for coverage.

Where you live determines which plans are available to you—the Health Savings Plan is a national plan (except Hawaii) and the HMO and Hawaii Only plans are available only in specific states.

|  | **Health Savings Plan (Premera)** | **Surest Health Plan** | **Hawaii Only Plan (Premera)** | **Kaiser Foundation Health Plan of Washington**  **HMO Plan** | **Kaiser Permanente HMO Plan** |
| --- | --- | --- | --- | --- | --- |
| Eligible employees | Employees in all states except Hawaii | Employees in all states except Hawaii | Employees in Hawaii | Employees in Washington | Employees in California |

| If enroll in a Premera plan and you live in an area with few or no Premera in-network providers, you will be enrolled for Access coverage in the Health Savings Plan. Access coverage provides in-network coverage for care with providers and facilities outside the Premera network. Network availability is determined by the Premera and national Blue Cross Blue Shield standard criteria. This coverage will remain in effect until a provider network is established in your area. |
| --- |

All of our medical plans cover services as long as they are medically necessary and provided by an eligible provider. All of the benefits for each medical plan are subject to the plan’s exclusions and limitations and each benefit may have additional eligibility criteria and exclusions and limitations. Please review the following sections for each medical plan for more information on what is covered.

|  |  |
| --- | --- |
| Additional information | **Medically necessary** services or supplies meet certain criteria, including:   * It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the patient's life or health, unless it is provided for preventive services when specified as covered under the plan * It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice   Review the [glossary](#_Glossary) for a full definition. |

### How the plans work

All of the Microsoft medical plans cover preventive care at 100% with in-network providers. For other care, you pay a share of the costs up to an annual maximum amount.

Each medical plan features a comprehensive network of providers and facilities where you may receive care at lower, negotiated rates. The HMO plans do not typically cover out-of-network care. The Health Savings Plan, Surest Health Plan, and Hawaii Only Plan cover in- or out-of-network care but provide more value if you use in-network providers.

#### In-network vs. out-of-network care

If you enroll in the Health Savings Plan, Surest Health Plan, or the Hawaii Only Plan, you receive the highest level of coverage and have the lowest out-of-pocket costs if you seek care from any of the providers or facilities in your medical plan’s network. Additional advantages of staying in-network include:

* Your provider files claims for you directly with Premera or Surest
* Lower, negotiated rates for care and prescriptions, called the allowable charge
* Your provider accepts the allowable charge as payment in full; you are not charged any additional costs

|  |  |
| --- | --- |
| Additional information | The **allowable charge** generally is the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. |

Note: The Plan will not discriminate against a health care professional or facility that acts within the scope of its license or certification under applicable state laws when choosing in-network health care professionals and facilities.

If you are enrolled in a Premera plan and obtain care from an out-of-network provider or facility, services generally are covered at a lower out-of-network benefit level. Except as provided under Federal Surprise Billing Protection, the allowable charge is 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 in-network provider
* 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
* The provider’s billed charges

The allowable charge may be adjusted pursuant to the plan administrator’s payment policies. For more information or assistance in determining whether or how the plan administrator’s payment policies may impact the allowable charge for a particular claim, contact Premera Customer Service at (800) 676-1411.

If you are enrolled in the Surest Plan and obtain care from an out-of-network provider or facility, services generally are covered at a lower out-of-network benefit level. Except as provided under Federal Surprise Billing Protection the eligible expenses (also known as the allowed amount) generally will be calculated based on 140% of the applicable Medicare reimbursement rate except as provided below. For more information or assistance on the Surest Plan payment policies contact their customer service at Surest Customer Service at (866) 222-1298.

Review the [glossary](#_Glossary) for a full definition.

Additional considerations include:

* You may have to pay the provider and submit a claim for reimbursement
* Coverage under the plan is limited to the allowable charge; you are responsible for any amount the provider charges above the allowable charge, where applicable

Below is an example of how much you can save through the negotiated rates that you receive with in-network providers.

| Out-of-network charge,  subject to deductible | In-network charge (allowable charge), subject to deductible | In-network provider  savings |
| --- | --- | --- |
| $150 | $100 | $50 |

### Federal No Surprise Billing Protection

Out-of-network providers generally have the right to charge you more than the Plan’s allowed amount or allowable charge for a covered service. This is called “balance billing.” However, Federal law protects you from balance billing for the following types of services:

* Emergency Care from an out-of-network hospital or independent freestanding emergency department.
* Out-of-network air ambulance services
* Any services from an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, or outpatient surgical center, provided that the out-of-network provider may balance bill you if the provider gives you advance notice and you provide your written consent, except for the following services (for which balance billing is never permitted):
  + Assistant Surgeon
  + Anesthesia
  + Pathology
  + Radiology
  + Laboratory
  + Hospitalist Care

Solely for purposes of determining your cost-sharing obligations for these services, the allowed amount or allowable charge is the lesser of (1) the out-of-network provider’s or facility’s billed charges, or (2) the Plan’s median in-network rate for the same or similar service provided in the same or similar specialty in the same geographic area (or any other amount specified for this purpose under applicable law).

Please Note: These balance billing protections do not apply to any other service from an out-of-network provider or facility. If the service is not listed above, the provider or facility may bill you for, and you may be required to pay, any amounts in excess of the plan’s allowed amount for the service (and any amounts that you pay in excess of the allowed amount will not count toward any applicable deductible, coinsurance, or out-of-pocket maximum).

### Plan comparison

The table below compares the four medical plans on various characteristics. For complete details, please review the following sections on each medical plan.

|  | **Health Savings Plan (Premera)** | **Hawaii Only Plan (Premera)** | **Surest Health Plan** | **Kaiser Foundation Health Plan of Washington**  **HMO Plan** | **Kaiser Permanente HMO Plan** |
| --- | --- | --- | --- | --- | --- |
| Deciding where to get care | * You decide each time you need medical care whether to use providers who are in-network or providers who are out-of-network * When you need care, you can choose your doctors, including specialists. You do not need a referral to receive care. | | * You decide each time you need medical care whether to use providers who are in-network or providers who are out-of-network * When you need care, you can choose your doctors, including specialists. You do not need a referral to receive care. | * You will be required to select a Primary Care Provider for each covered family member * You Primary Care Provider directs your care, including referrals to specialists | |
| In-network vs. out-of-network | * Your out-of-pocket costs vary depending on whether you use in-network providers or out-of-network providers. * Your costs are lower when you use an in-network provider. | | * Your out-of-pocket costs vary depending on whether you use in-network providers or out-of-network providers. * Your costs are lower when you use an in-network provider. | * Benefits are generally available only when utilizing the services of the HMO network providers. With few exceptions, out-of-network care is not covered | |
| Cost sharing | * Preventative care is covered and paid in full, when using in-network providers. * You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. * If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on whether you seek care in or out-of-network. * If you meet your deductible and then you reach your coinsurance maximum, the plan pays 100% of eligible expenses for the rest of the year. | | * Preventative care is covered and paid in full, when using in-network providers. * For most services, you pay a flat copayment * If you meet your annual out-of-pocket maximum, the plan pays 100% of eligible expenses for the rest of the year. | * Preventive care from an HMO network provider is covered and paid in full. * For most services, you pay a flat copayment. * If you have an inpatient hospital stay, you pay 10% of the cost. * If you meet your out-of-pocket maximum, the plan pays 100% of eligible expenses for the rest of the year. | * Preventive care from an HMO network provider is covered and paid in full. * For most services, you pay a flat copayment. * If you have an inpatient hospital stay, you pay 10% of the cost. * Coinsurance and most copayments are limited by an annual out-of-pocket maximum. |
| Filing a claim | * If using in-network benefits, your provider will file claims to the health plan on your behalf. * If using out-of-network benefits, you may be required to file a claim for reimbursement of the medical expenses. | | * If using in-network benefits, your provider will file claims to the health plan on your behalf. * If using out-of-network benefits, you may be required to file a claim for reimbursement of the medical expenses. | * Generally, no claim forms required | |
| Coverage out of the country | * Urgent or emergent services will be paid as emergency care. * Non-emergent facility and professional services are considered out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance apply. | | * Urgent or emergent services will be paid as emergency care. Members must submit a medical claim reimbursement form. * Non-emergent services will be processed as out-of-network based on billed charges. | * Emergency situations that occur outside the country are covered as in-network. There is also a $2,000 benefit per member per year for non-emergent claims incurred outside the area. | |

|  |  |
| --- | --- |
| Additional information | **Deductible** is theamount of covered medical costs you must pay each calendar year before the Plan begins to pay its share of allowable charges.  **Copayment** is a fixed, up-front dollar amount that you're required to pay for certain covered services.  **Coinsurance** The percentage of the allowable charge that you are required to pay for certain covered services.  **Out-of-pocket maximum** is the most you could pay each plan year for covered services and supplies. |

| Additional information | If you leave Microsoft, you may be eligible to continue your health coverage. For more information, visit the [Coverage if you leave Microsoft](#_Section_XII:_Coverage) section. |
| --- | --- |

## Health Savings Plan (Premera)

What is in this section

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|  |  |
| --- | --- |
| Additional information | For more information on how the plan works and additional resources, contact Premera Blue Cross at (800) 676-1411. |

### How the plan works

The Health Savings Plan provides comprehensive medical coverage and the flexibility to see any provider you choose.

* The Health Savings Plan is your **health coverage**, and provides coverage for health care that you might need during the year
* You also have the option to open a Health Savings Account on your own at the bank of your choice. The account is a custodial/bank account that comes with certain tax benefits when you use it to pay for health care expenses¾now, or in the future

### Where you can get care

With the Health Savings Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

* Your provider files claims directly with Premera
* Lower, negotiated rates for care and prescriptions
* The highest coverage levels

If you seek care with an out-of-network provider or facility, services are covered at a lower out-of-network benefit level. The allowable charge is 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

Review the [glossary](#_Glossary) for a full definition.

Please review the [What you pay](#_What_you_pay) section for information on coverage levels.

#### Finding an in-network provider

In Washington State, you can maximize your savings by using providers and facilities in the Premera network. In California, we have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross. In order for you to maximize your in-network savings for services received in California, you will need to choose only Anthem Blue Cross network providers. Note: Blue Shield of California network providers are not considered in-network for purposes of the Health Savings Plan, unless (and to the extent) they are also Anthem Blue Cross network providers.

Outside of Washington and California, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the [BlueCard®](#Bluecard) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Additional information | Visit the online Premera Medical Directory to find an in-network provider in the United States or call Premera Blue Cross at (800) 676-1411.   |  |  | | --- | --- | | **Active employees** go here… | **Active dependents or COBRA enrollees** go here… | | [26TPremera Medical Directory](https://benefits.microsoft.ehr.com/us/en/tasks/pages/premeraprovider_redirect.aspx)26T | [26TPremera.com](https://www.premera.com/)26T |   Additionally, both active employees and COBRA enrollees also have access to the [Embold Health Provider Guide](https://microsoft.emboldhealth.com/), a tool that helps you find highly rated healthcare providers in your area and insurance network. Embold uses healthcare claims data to score how well a doctor makes the correct diagnosis, chooses the right treatment plan, and delivers the best health outcome. These scores are developed using common and accepted measures in the medical community. |

#### Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [Blue Cross Blue Shield Global Core](#Bluecard), which provides referrals to doctors and other health care providers.

| Additional information | Call (800) 810-BLUE (2583) for Blue Cross Blue Shield Global Core referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands. |
| --- | --- |

If you are not using a Blue Cross Blue Shield Global Core provider, you will need to submit claim forms to Premera for reimbursement of services received outside the United States. When you submit a claim, 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. Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered as long as the services are:

* Medically necessary
* Provided by a licensed provider performing within the scope of their license and practice
* Not deemed experimental or investigational based on the terms of this plan or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [26Temergency care](#_Emergency_room_care_2)26T. Non-emergent facility and professional services are considered out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance would apply. Virtual Care services with a provider located outside of the United States are not covered.

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| Additional information | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#_Glossary) for a full definition. |

|  |  |
| --- | --- |
| Additional information | Please review the [What you pay](#_What_you_pay) section for information on coverage levels. |

#### Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#_Prescription__drugs) benefit for more information on what is covered.

|  |  |
| --- | --- |
|  |  |
| Additional information | Microsoft reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes. |
|  | |

|  | Retail pharmacy | Home delivery | Specialty pharmacy |
| --- | --- | --- | --- |
| Coverage | Up to a 90-day supply for [generic maintenance medication](#generichsp); all others are up to a 30-day supply\* | Up to 90-day supply\* only when using Express Scripts Pharmacy Home Delivery | Up to a 30-day supply\*  Additional clinical support for members using specialty drugs |
| In-network pharmacies | Express Scripts pharmacies bill the plan on your behalf  To find an Express Scripts retail pharmacy, call (800) 676-1411 | Express Scripts pharmacies bill the plan on your behalf | Walgreen’s Specialty Pharmacy or Accredo Specialty Pharmacy\*\* will bill the plan on your behalf |
| Out-of-network pharmacies | You will need to submit a prescription reimbursement form, with your receipt, for reimbursement | Not covered | Not covered |

\* Unless the drug maker’s packaging limits the supply in some other way.

\*\* Contact Walgreen’s Specialty Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days’ supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the chart above.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable

|  |  |
| --- | --- |
| Additional information | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Generic maintenance medications** have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply. |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| cid:image002.png@01D0FB63.FBAF7B20 | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. | |  |
|  |  |  |  |

Refer to the specific plan benefit for additional details.

### What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you’ll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

Premera utilizes medical and payment policies in administering coverage under this plan. The medical policies generally are used to further define medical necessity, experimental and investigative status, and other aspects for specific procedures, drugs, biologic agents, devices, and other items and services and levels of care. These medical policies are available at <http://premera.com> or by calling Customer Service. The payment policies are used to define provider billing and payment rules and adjustments that can apply in various different settings and circumstances. These payment policies are available to you by calling Customer Service and to your provider by calling Customer Service or going to <http://premera.com> and logging into Premera’s provider portal.

| **What you pay** | | | |
| --- | --- | --- | --- |
|  | Deductible  Coinsurance  Out-of-pocket maximum  **+**  = | | |
| You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera [allowable charge](#allowablechargehsp) is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care. | If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on where you seek care:   * In-network, you pay 10% * Out-of-network, you generally pay 30% of the allowable charge plus the difference between the provider’s bill and the allowable charge; only the allowable charge is applied to your coinsurance maximum | If you meet your deductible and then you reach your coinsurance maximum, you have reached your out-of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the provider’s bill and the [allowable charge](#Allowablecharge) if you seek out-of-network care. |
| Employee only | $1,750 | $1,000 | $2,750 |
| Employee +1 | $3,500 | $2,000 | $5,500 |
| Employee +2 or more | $4,375 | $2,500 | $6,875 |

|  |  |
| --- | --- |
| Additional information | The **allowable charge** is defined differently for in-network and out-of-network providers.   * For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. * For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

|  |
| --- |
| **Example** |
| Jakob needs to visit an allergist. Jakob can choose an in-network or an out-of-network provider. Both charge $115.  Assume the allowable charge is $100 for both the in-network and out-of-network provider.  The in-network provider accepts Premera’s allowable charge of $100 as full payment. Jakob hasn’t yet met the deductible, so will pay the allowable charge of $100 to the in-network provider.  The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full $115, and only the allowable charge of $100 would apply to Jakob’s deductible. |

|  |
| --- |
| **Example** |
| * Mimi needs to see a podiatrist. The visit costs $125. Mimi has met the deductible, so will pay just $10 for the visit if an in-network provider is used, with a $100 allowable charge ($100 x 10% coinsurance). If Mimi visits an out-of-network provider, for whom the allowable charge is also $100, Mimi would pay $55: * 30% of the $100 Premera allowable charge ($100 x 30% coinsurance = $30) * Plus, the difference between the out-of-network provider’s bill and the allowable charge ($125-$100=$25) |

|  |
| --- |
| **Example** |
| Kunji has an ear infection. The provider visit costs $175 and assume the allowable charge is $150 for both an in-network and out-of-network provider. Kunji has met the out-of-pocket maximum for the yeasr, so will pay nothing if Kunji visits the in-network provider.  If Kunji visits the out-of-network provider, Kunji’s cost will be $25, the difference between the out-of-network provider’s bill and the allowable charge ($175-$150=$25). |

#### Expenses covered at 100% and NOT applied to the deductible or coinsurance maximum

The following services are covered by the plan at 100% and do not count toward the deductible or coinsurance maximum.

* [26TPreventive care](#_Preventive_care)
* Care received through the T Spring Health, Employee Assistance Program (EAP).
* Care received through [the Family Health and](#_Family_Planning_and) Reproductive Support (Maven) program.

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

* Expenses incurred while the member was not covered under the plan
* Expenses for services, supplies, settings, or providers that are not covered under this plan
* Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits. Amounts for out-of-network care in excess of the allowable charge for the service or supply.
* Coinsurance for services covered under the [Weight Management program](#_Weight_Management_Program)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not reimbursable business expenses.

|  |  |
| --- | --- |
| Additional information | For more information about how to track your deductible and coinsurance, contact Premera Blue Cross at (800) 676-1411. |

#### Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

| Situation | Benefit coverage | What you need to do |
| --- | --- | --- |
| Emergency care | Benefits are provided regardless of network status | Go to the nearest emergency facility |
| You cannot find the provider specialty that you need in the Premera network | If the Premera network does not include a provider specialty (such as a speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level | To confirm this coverage is available, please contact Premera at (800) 676-1411 |
| Your provider’s contract with Premera is ending (continuity of care) | If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days. | To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, please contact Premera at (800) 676-1411 prior to the end of your provider’s contract with Premera |

#### Annual, lifetime, and other benefit maximums

There is no overall annual or lifetime maximum in the Health Savings Plan. However, annual, lifetime, and other benefit maximums apply to certain benefits. Please review the [What the plan covers](#_What_the_plan_1) section for details on annual, lifetime, and other benefit maximums.

|  |  |
| --- | --- |
| Additional information | A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#_Glossary) for a full definition.  An annual or other benefit maximum is the most a plan will pay toward a benefit for a member for services within a specified time period. Review the [glossary](#_Glossary) for a full definition. |

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| **Example** |
| There is a $6,000 weight management program benefit maximum for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options. |

|  |
| --- |
| **Example** |
| There is a $10,000 hearing hardware maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options. |

#### Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Premera or its designee may review a member’s medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Premera’s medical policies. The medical policies are on Premera’s website. You or your provider may review them at premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain this information by mail, please send your request to Medical Policies Coordinator, 7001 220th Street SW MS 438, Mountlake Terrace, WA 98043-2160.

Premera will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of fraud or an intentional misrepresentation of a material fact.

### What the plan covers

The tables below summarize what the Health Savings Plan covers, including what the plan pays for in-network and out-of-network care.

|  |  |
| --- | --- |
| Additional information | Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s [exclusions and limitations.](#_General_exclusions_and) |

| Additional information | CTRL+Click on the benefits below to access more information. |
| --- | --- |

| **Common benefits** | | |
| --- | --- | --- |
| These are the most commonly used benefits in the Health Savings Plan. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Preventive Care](#_Preventive_care)  Including well-child care through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the [Preventive Care Services list](https://www.premera.com/documents/022576.pdf) and [Preventive Drug list](https://www.premera.com/documents/022506.pdf)) | Preventive services: 100%  Preventive prescription drugs: 100% | Preventive services: 100% of allowable charges  Preventive prescription drugs: 100% |
| Including brand-name preventive with available generic equivalent (see the [Health Savings Plan Drug Formulary](ww.premera.com/documents/066481_2025.pdf) and preventive care above) | 90% after deductible | 90% after deductible\*  [\*Home delivery and Specialty medications are not covered](https://outlook.office365.com/owa/wopi/files/96164086-4b14-499b-9fd7-5624489694f5@microsoft.com/AAMkADk2MTY0MDg2LTRiMTQtNDk5Yi05ZmQ3LTU2MjQ0ODk2OTRmNQBGAAAAAADfnOTgct4BQpW4-OOSBGceBwAXCSSG8TcsSZE2aGEbmzulAAAAAAEMAAAXCSSG8TcsSZE2aGEbmzulAARFF6SmAAABEgAQAJWnTbGpwYxOpuTYVAa3R8I=_AADbmXo.MQkAAAAAAAA=/WOPIServiceId_FP_EXCHANGE_ORGID/WOPIUserId_23fc4fea-e150-4f47-bb69-61e0b6ef3d31/spd_corporate_2023_072023%20Final%20Redline.docx#_Prescription_limits) |
| [Physician services](#_Physician_Services)  Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility | 90% after deductible | 70% of allowable charges, after deductible |
| [Diagnostic Services](#_Diagnostic_Services)  Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. | 90% after deductible | 90% of allowable charges, after deductible |
| [Hospital inpatient care](#_Hospital_inpatient_care)  Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care | 90% after deductible | 70% of allowable charges, after deductible |
| [Hospital outpatient care/ambulatory surgical care center](#_Hospital_Outpatient_Care)  Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing | 90% after deductible | 70% of allowable charges, after deductible |
| [Urgent care](#_Physician_services) | 90% after deductible | 70% of allowable charges, after deductible |
| [Rehabilitation](#_Rehabilitative_Services_1) – Physical, Occupational and Speech Therapies | 90% after deductible | 70% of allowable charges, after deductible |
| [Contraception](#_Contraceptives_on)  Contraceptive devices and injections administered by a physician. Prescription forms of contraception are covered under preventive care. | 100% | 100% |
| [Maternity care](#_Maternity_care_2)  (Other than hospital inpatient or outpatient care) | 90% after deductible | 70% of allowable charges, after deductible |
| [Family Health and Reproductive Support](#_Maternity_Support_(Maven)) | Free virtual care and on-demand support (through Maven Clinic) for navigating family planning, pregnancy, parenting, perimenopause, and menopause. | Not applicable |
| [Mental health counseling, mental health inpatient and outpatient services, and chemical dependency treatment](#_Mental_health,_substance_3) | Outpatient services through [Microsoft CARES employee assistance program](#_Section_VII:_Microsoft):   * 100% of 12 sessions per issue per year (up to 24 sessions per year total) | Not applicable |
|  | 90% after deductible for inpatient and outpatient services | 90% of allowable charges, after deductible for inpatient and outpatient services |

| **Other benefits** | | |
| --- | --- | --- |
| The Health Savings Plan also covers these additional benefits. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Ambulance](#_Ambulance) (Ground or Water) | 90% after deductible | 90% after deductible |
| Air Ambulance | 90% after deductible | 90% of allowable charges, after deductible |
| [Chiropractic services](#_Chiropractic_services_1), acupuncture, and medical massage | 90% after deductible | 70% of allowable charges, after deductible |
| Combined 24-visit limit per member per calendar year | |
| [Diabetes health education](#_Hearing_Care) | 100% | 100% of allowable charges |
| [Emergency room care and professional services](#_Emergency_room_care_2) | 90% after deductible | 90% of allowable charges, after deductible |
| [Hearing care and hardware](#_Hearing_care_and) | Exams: 90% after deductible | Exams: 70% of allowable charges, after deductible |
| Hardware: 90% after deductible; $10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options | |
| [Home health care](#_Home_Health_Care) | 90% after deductible | 70% of allowable charges, after deductible |
| [Hospice care](#_Hospice_care) | 90% after deductible | 90% after deductible |
| [Medical equipment and supplies](#_Medical_equipment_and) | 90% after deductible | 90% of allowable charges, after deductible |
| [Nutritional therapy](#_Nutritional_therapy_1) | 100% | 100% of allowable charges |
| First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes. | |
| [Skilled nursing facility](#_Skilled_Nursing_Facilities) | 90% after deductible | 70% of allowable charges, after deductible |
| 120-day limit per member per calendar year | |
| [Surgical weight loss treatment](#_Surgical_weight_loss_1)  Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met | 90% after deductible | 70% of allowable charges, after deductible |
| [Temporomandibular joint (TMJ) dysfunction](#_Temporomandibular_joint_(TMJ)) | 90% after deductible | 70% of allowable charges, after deductible |
| [Transplants](#_Transplants) | 90% after deductible | 70% of allowable charges, after deductible |
| [Vision therapy](#_Vision_Therapy) | 90% after deductible | 70% of allowable charges, after deductible |
| 32-visit maximum, per member, for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options | |

| **Specialized benefits** | | |
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| Microsoft provides these unique benefits to you through the Health Savings Plan. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Autism/Applied Behavior Analysis (ABA) therapy](#_Autism/Applied_Behavior_Analysis) | 90% after deductible | 90% of allowable charges, after deductible |
| [Fertility and Family Building Benefit](#_Infertility_1) | 90% after deductible for coverage, within the Plan’s fertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy. | Not applicable |
| [Gender Affirming Surgical Services](#_Gender_Affirming_surgical) | 90% after deductible | 90% of allowable charges, after deductible |
| [Weight Management program](#_Weight_Management_Program)  Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity | 80% of charges up to a maximum lifetime benefit payment of $6,000. Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met. | Not applicable |

### Plan benefits

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| Additional information | The following pages provide details on what the plan covers. The plan’s [exclusions and limitations](#_General_Exclusions_and), including the requirement of medical necessity, apply to these benefits. |

#### 24-Hour Nurse Line

The Microsoft 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The 24-Hour Nurse Line cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

* Provide information, coaching, and support regarding a wide range of health issues, including:
  + Aches and pains
  + Diabetes
  + High blood pressure
  + Illnesses and infections
  + Infant care
  + Immunizations
* Provide information about Microsoft-sponsored health programs such as:
  + Disability leave
  + Ergonomic assistance
  + On-site flu shots
  + On-site mammogram screenings
  + Smoking cessation
  + Weight management
* Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premera Blue Cross. All Microsoft covered employees and their dependents can access the 24-Hour Nurse Line. The 24-Hour Nurse Line cannot be accessed while traveling outside of the United States.

##### Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Microsoft covered employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Microsoft Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.

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| Additional information | You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:   * (800) 676-1411 * For deaf or hard-of-hearing access (TTY), call (800) 676-1411 then provide the number 711 |

#### Ambulance

*Ground or Water*

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

*Air*

*In-network: 90%, deductible applies*  
*Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition when any other mode of transportation would endanger the member’s health or safety. This benefit is limited to the member that requires transportation.

For air ambulance services, please see [Federal No Surprise Billing Protection](#_Federal_No_Surprise) (above) for special rules that apply to out-of-network air ambulance services.

#### Autism/Applied Behavior Analysis (ABA) therapy

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

##### Who is eligible

This benefit is available for members who are diagnosed with Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD-10-CM*):

* Autistic Disorder
* Childhood Disintegrative Disorder
* Asperger’s Syndrome
* Rett’s Syndrome
* Other Pervasive Development Disorder Not Otherwise Specified/Atypical Autism

Pervasive Developmental Disorder unspecified

##### Eligible providers

**Licensed providers** — Medical doctors (MD); doctors of osteopathic medicine (DO); nurse practitioners (NP, ANP, ARNP, etc.); and master’s-level or above mental health clinicians and occupational, physical, and speech therapists, provided that they are providing the ABA services within the scope of their practice and licensure.

**Board Certified Behavioral Analysts** — BCBAs are certified by the Behavior Analyst Certification Board. These providers have master’s or doctoral degrees. For ABA services, typically a BCBA functions as a “Program Manager.” The Program Manager conducts behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The Program Manager also designs and periodically reviews behavior analytic interventions (program development and treatment planning) and may supervise Therapy Assistants. Therapy Assistant services must be billed by the Program Manager.

##### Covered services

Services must be ordered by the member’s treating physician to be covered. Program Manager benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the Therapy Assistants working directly with the member to implement the treatment plan.

In most cases, Therapy Assistants will provide the implementation portion of the treatment plan. Therapy Assistant time may be covered for face-to-face, in-person or virtual visits with the member to perform the tasks described in the treatment plan and to document outcomes, and for time to meet with the Program Manager for training and to discuss treatment plan issues. Therapy Assistant services that are billed by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

* Babysitting or doing household chores
* Time spent under the care of any other professional
* Travel time
* Home schooling in academics or other academic tutoring
* Activity therapy, such as music, dance or art therapies

Out-of-network providers

You may be billed for charges assessed above the allowable charges since these providers generally have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges will not count towards satisfying any deductible requirements, or the coinsurance maximum that applies under this plan.

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| Additional information | The **allowable charge** is defined differently for in-network and out-of-network providers. For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Services for this treatment that do not meet criteria described above are subject to retrospective denial of benefits.

##### Additional exclusions and limitations for autism/ABA therapy

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#_Rehabilitative_Services_1) benefit) or mental health services (which apply under the [mental health and chemical dependency](#_Mental_health,_substance_3) benefit).
* Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
* Other unspecified developmental disorders or delays, or any other delay or disorder in a child’s motor, speech, cognitive, or social development are not covered under this benefit.
* This benefit covers only the allowable fees for eligible services performed by the provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the provider, expenses of those working under the provider’s supervision, the member, and their family members will not be covered.

#### Cancer Support (Personalized by Thyme Care)

Microsoft provides access to Thyme Care at no cost to all employees and their eligible dependents aged 18 and older with a suspected or confirmed cancer diagnosis who are covered under a Microsoft U.S. Premera health plan. Thyme Care is a 24/7 evidence-based virtual cancer advocacy and navigation program offering individualized support in-between visits with your oncologist.

If you have cancer, or are caring for someone with cancer, Thyme Care provides:

* **24/7 access:** A Thyme Care expert is available anytime through confidential calls. You can also use Thyme Care Connect or text them for support with your questions or concerns.
* **On-demand nurse support:** Whether you’re concerned about potential side effects, need help understanding test results or medications, or simply want more guidance. Thyme Care can translate what the doctors are telling you and provide information to help plan for the road ahead.
* **Collaborative care focused on you:** Thyme Care takes care of your needs between visits and keeps your doctors and care teams updated, so you can rest assured that all the details are connected, and nothing gets lost.
* **Support beyond the clinic:** Get connected to the support and services you need. These may include financial help, transportation, in-home care, food assistance or community groups dedicated to supporting cancer patients.
* **Evidence-based resources:** Receive clinically informed content tailored to you with trusted information and expert tips on preparing for treatment, handling worries, talking to doctors, strategies for improving your sleep, exercise routine, and emotional well-being.
* **Support for life after cancer treatment:** Regular check-ins provide tips on ongoing care and helpful wellness information, including sleep, nutrition, exercise, mindfulness, and getting back to normal.

**Navigate cancer with confidence. With Thyme Care, you can:**

* Learn about your diagnosis and treatment options
* Address urgent concerns and unexpected challenges
* Manage symptoms and side effects
* Get emotional and mental health support
* Identify financial assistance and get help with insurance navigation
* Find in-network doctors or get help seeking a second opinion
* Connect with other helpful Microsoft benefits

**To enroll:**

Visit thymecare.com/Microsoft and click “Enroll Now” then follow the steps to get started.

If you have any issues or questions, call the Thyme Care team at 1-833-849-6300, and they can help you set up your account.

*Thyme Care does not diagnose oncologic conditions or provide cancer-directed therapies, treatments, or prescription of medications.*

* *Thyme Care will not share your medical records or medical information with anyone, including Microsoft or your health plan, unless you specifically authorize such disclosure.*

#### Chemotherapy and Radiation Therapy

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers the following services:

* Outpatient chemotherapy and radiation therapy services, including proton beam radiation therapy when medically necessary
* Supplies, solutions and drugs (See the [Prescription Drugs](#_Prescription_drugs_4) benefit for oral chemotherapy drugs)

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

#### Childbirth / Maternity Classes

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

#### This benefit covers childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth and Lamaze, breastfeeding and infant education classes. The benefit is for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered individual.

##### Additional exclusions and limitations for childbirth / maternity classes

In addition to the plan’s [exclusions and limitations](#_X-rays_and_lab), exercise classes, such as maternity yoga, are excluded from this benefit.

#### Chiropractic services, acupuncture, and medical massage therapy

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 24 visits per member per calendar year* *chiropractic, acupuncture, and medical massage therapy (combined)*

This benefit covers (1) chiropractic services from a licensed chiropractor or other provider licensed to perform chiropractic services, (2) acupuncture services provided, when medically necessary to relieve pain or to treat a covered illness, injury, or condition, from a licensed acupuncturist or other provider licensed to perform acupuncture, and (3) medical massage therapy from a provider licensed to perform medical massage therapy, with a physician’s prescription. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider’s scope of practice guidelines.

These covered services must be [medically necessary](#medicallynecessary) and will be covered only when the provider is providing the service within the scope of their state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) provided will accrue cumulatively toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you will have four visits available for covered medical massage and/or acupuncture services in that calendar year. Covered Massage Therapy services are limited to a maximum of one hour per day.

#### 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 the health condition according to the trial protocol and participating provider or information submitted by the member and the member must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service received. 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.

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 the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality; the Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above entities or the Department of Defense (DOD) or the Department of Veterans Affairs (VA); the VA, DOD, and Department of Energy if peer-reviewed and approved as per the Secretary of HHS; or a qualified private research entity that meets the standards for NIH support grant eligibility.

Routine patient costs in connection with 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

Those interested in this coverage are encouraged to contact customer service at 800-676-1411 before enrolling in a clinical trial. Customer service can help the member or provider verify that the clinical trial is a qualified clinical trial.

#### Contraception

*In-network: 100%  
Out-of-network: 100%*

This benefit covers FDA-approved contraceptive devices and injections for contraceptive purposes for women when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered. This benefit also covers office visits and consultations related to contraception management.

All FDA-approved single-source brand and generic birth control medications are covered under the [preventive care](#_Preventive_prescriptions) benefit at 100%.

#### Diabetes

##### Diabetes health education

*In-network: 100%  
Out-of-network: 100% of allowable charges*

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

##### Teladoc Health Condition Management - Diabetes Management, Diabetes Prevention, and Hypertension Programs

*In-network: 100%*

*Out-of-network: n/a*

Teladoc Health Condition Management for for Diabetes Management, Diabetes Prevention, and Hypertension Programs provide monitoring and health management support to individuals within the programs. If you qualify and enroll in any of the programs, you will receive the following benefits:

###### Diabetes Management

For members 13 and older who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

* A blood glucose meter that uses cellular technology to automatically upload blood sugar readings to a personal online account.
* A lancing device and unlimited lancets at no cost to you.
* Unlimited test strips for this meter at no cost to you. You can reorder test strips using the meter or online. The strips will be sent to you directly.
* Real-time feedback and tips based on your blood sugar readings that can help keep your levels within a healthy range.
* Coaching and support via phone, text, e-mail, or the program manager’s mobile app.
* Digital tools that support your mental health.

###### Diabetes Prevention

For members 18 and older who meet pre-diabetes criteria followed by the Centers for Disease Control. The program’s duration is 12 months, with an additional 12 months of access for maintenance. If you qualify and join the program, you will get:

* A cellular-connected scale that uploads readings to a personal online account.
* Real-time tips and personalized feedback on health, nutrition or lifestyle changes to help you learn and improve.
* Unlimited coaching and support via phone, text, e-mail or the mobile app.
* Complete CDC-recognized weight management curriculum based on in-app content and online resources.
* Periodic review of plan, self-monitoring data, and feedback from expert coach.
* Experiential learning missions covering nutrition, activity, motivation, sleep, and stress management.
* A mobile app, and device for tracking weight, steps, and achievement of health goals for food and physical activity.
* Digital tools that support your mental health.

###### Hypertension

For members 18 and older who have hypertension. If you qualify and join the program, you will get:

* A cellular-enabled blood pressure cuff that uploads blood pressure readings to a personal online account.
* Real-time tips and personalized feedback based on your blood pressure readings that can help keep your pressure within a healthy range.
* Unlimited coaching and support via phone, text, e-mail, or the mobile app. Access to online information.
* Digital tools that support your mental health.

*Additional support*

If you are 18 and older who qualify for more than one of the above programs you may be eligible for additional tools and devices to help you live healthier:

* For members with hypertension, a connected blood pressure monitors to help track your numbers.
* Members who qualify for the Diabetes Prevention or the Weight Loss Program may receive a smart scale

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to <https://teladochealth.com/microsoft-ccm> , or call Premera customer service.

#### Diagnostic Services

*In-network: 90%, deductible applies*

*Out-of-network: 90% of allowable charges, deductible applies*

Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. Included in the coverage are charges for the test or scan itself and charges to interpret the results. Some examples of what’s covered under this benefit are:

* Diagnostic imaging and scans (including x-ray, MRI, PET, CAT and EKGs)
* Services that are medically necessary to diagnose infertility
* Laboratory services
* Pathology tests

Diagnostic surgeries, including scope insertion procedures, can only be covered under the Surgical Services benefit.

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| Additional information | Prior authorization is strongly recommended for some diagnostic services. Some examples of these include but are not limited to: Genetic Testing, CAT scan, and MRI. Have your provider contact Premera to see if your service needs this pre-service review. |

#### Emergency room care and professional services

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#_Hospital_Emergency_Room) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency treatment](#_Mental_health,_substance_3) benefit.

Please see the [Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

#### Hearing care and hardware

##### Hearing exams and testing

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

* Examination of the inner ear and exterior of the ear
* Observation and evaluation of hearing, such as whispered voice and tuning fork
* Case history and recommendations
* The use of calibrated equipment

##### Hearing hardware

*In-network: 90%, deductible applies   
Out-of-network: 90%, deductible applies*

*Limit: up to $10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options*

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of $10,000 per member in a period of three consecutive calendar years.

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

* The hearing aid(s) (monaural or binaural) prescribed as a result of an exam or an FDA approved over-the-counter hearing aid(s) (monaural or binaural)
* Ear mold(s)
* Hearing aid rental while the primary unit is being repaired
* The initial batteries, cords, and other necessary ancillary equipment
* A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either the prescribing physician or audiologist
* Repairs, servicing, and alteration of hearing aid equipment

##### Additional exclusions and limitations for hearing care and hardware

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Hearing aids purchased before your effective date of coverage under this plan
* A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in one or more Premera-administered health plan options
* Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
* A prescription hearing aid that exceeds the specifications prescribed for correction of hearing loss
* Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
* Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

#### Home health care and Nursing care

In-home care, other than Hospice Care and Respite Care (non-hospice), can be broken into two categories for purposes of benefit coverage:

| **Benefit** | **Description** | **Care Duration** | **Coverage** |
| --- | --- | --- | --- |
| Home health care | * Short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. | * The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. | * In-network: 90%, deductible applies * Out-of-network: 70% of allowable charges, deductible applies |
| Nursing care | * Longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN). | * Generally needed for more than 4 hours per day. | * In-network: 90%, deductible applies * Out-of-network: 90%, deductible applies |

Read below for additional in-home care coverage details.

##### Home health care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers home visits for short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. The benefit includes the cost of a home health aide when acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.

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| Additional information | **Intermittent care** is care provided due to the medically predictable recurring need for skilled home health care services. |

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

##### Additional exclusions and limitations for home health care

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* 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
* Materials such as handrails and ramps
* Services performed by family members and volunteer workers
* Psychiatric care
* Unnecessary and inappropriate services
* Maintenance or [custodial care](#Custodial_Care)
* Diversional therapy
* Services or supplies not included in the written treatment plan
* Over-the-counter drugs, solutions, and nutritional supplements
* Dietary assistance, such as Meals on Wheels
* Services provided to someone other than the ill or injured enrollee

##### Nursing care

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

This benefit covers longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN) working under a licensed home health agency. Skilled hourly nursing care is provided in lieu of hospitalization and generally is needed for more than 4 hours per day. The nurse who is providing the care cannot be a permanent resident in the member’s home.

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| Additional information | **Skilled nursing care** is provided by a registered nurse (RN), or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it. |

##### Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for nursing care to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

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| Additional information | [Prior authorization](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

#### Hospice care

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice and Palliative Care Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a Master of Social Work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member’s doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 672 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.

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| Additional information | **Hospice care** is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member’s home.  **Intermittent care** is care provided due to the medically predictable recurring need for skilled home health care services.  **Respite care** is continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers. |

##### Additional exclusions and limitations for hospice care

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Bereavement or pastoral counseling
* Financial or legal counseling, including real-estate planning or drafting of a will
* Funeral arrangements
* Diversional therapy
* Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

#### Hospital inpatient care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers the following inpatient medical and surgical services:

* Room and board, including general duty nursing and special diets
* Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
* Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
* Diagnostic and therapeutic services
* Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the hospital inpatient care benefit), along with provider charges for that emergent condition, will be covered at the in-network level.

Please see [the Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

For substance abuse treatment, see the [mental health and chemical dependency treatment](#_Mental_health,_substance_3) benefit.

##### Additional exclusions and limitations for hospital inpatient care

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member’s medical condition makes inpatient care medically necessary
* Any days of inpatient care that exceed the length of stay required to treat the member’s condition

#### Hospital outpatient care and ambulatory surgical center care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers operating, procedure, and recovery rooms; plus, services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Please see [the Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

#### Fertility

*In-network: 90% after deductible for coverage, within the Plan’s fertility vendor (Progyny) provider network*

*Out-of-network: not applicable*

*Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more Microsoft health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below*

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| Additional information | *Members must contact their* ***Progyny Patient Care Advocate*** *at* ***(888) 203-5066*** *to confirm eligibility and utilize a Progyny Network Provider to access the benefit.* |

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

The Progyny SMART cycle benefit allows for:

* Two (2) Smart Cycles per household, with an additional Smart Cycle available if the first two do not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, subject to the restrictions described below for certain members who received fertility benefits of less than $15,000 under the Health Savings Plan prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.
* One (1) Smart Cycle per household, with an additional Smart Cycle available if the first does not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, for members who (1) have been enrolled continuously in one or more Premera-administered health plan options (such as the Health Savings Plan) since before 2018, and (2) incurred $15,000 or more in fertility benefits under the Plan during such continuous enrollment period prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

* Two consultations per calendar year
* Diagnostic testing
* Transvaginal ultrasounds
* Intrauterine insemination (also known as artificial insemination)
* In vitro fertilization (IVF)
* Gamete intra-fallopian transplant (GIFT)
* Intracytoplasmic sperm injection (ICSI)
* Pre-implantation genetic screening (PGS)
* Pre-implantation genetic diagnosis (PGD)
* Embryo assessment and transfer
* Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
* Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
* Purchase of donor tissue (sperm, eggs) as follows:
  + Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes ¼ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
  + A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

##### Additional exclusions and limitations for fertility

The following exclusions apply to this benefit:

* Fees paid to donors for their participation in any service
* Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
* Home ovulation prediction kits
* Services and supplies furnished for a dependent child (under age 26) except for oncofertility preservation due to cancer or medical treatments
* Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
* Fertility Services following a voluntary sterilization procedure

#### Maternity care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children.

For women’s preventive care visits during and after pregnancy, please see the preventive care benefit. If the physician bills the delivery together with the routine (preventive) prenatal care, 40% of the allowed amount applies to the preventive prenatal care benefit and 60% of the allowed amount applies to the maternity care benefit.

The home health care benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

* Prenatal testing when required to diagnose conditions of the unborn child
* Services of a licensed nurse or midwife (non-medical services, such as non-medical services performed by a doula are not covered)
* Miscarriages and terminations of pregnancy
* Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
* Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
* One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
* Home births include an allowance of up to $500 for eligible supplies and/or equipment used for home delivery, for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.
* Birth doula services are allowed up to a maximum benefit of $1,000 per pregnancy, after the deductible is met. Before seeking doula services, you must first be examined by a licensed physician, registered nurse or midwife and have a confirmed pregnancy.
* Covered doula services include:
  + In person, phone, and email support throughout the pregnancy and post-partum
  + Birth support
  + Lactation support
* Doula services are not covered for the following:
  + Babysitting or doing household chores
  + Travel time
  + Any other services not listed as covered doula services, above
* Eligible providers: Doula’s must be licensed in states that require a license. Otherwise, if the state does not require a license, then the doula must have a current certification under a recognized doula certification organization (examples include DONA International and PALS Doulas). Eligible doulas do not have to be an in-network provider.
* Exclusions: apprentice doulas

#### Medical equipment and supplies (durable medical supplies)

*In-network: 90%, deductible applies   
Out-of-network: 90% of allowable charges, deductible applies*

##### Covered services

This benefit covers charges for durable medical and surgical equipment and supplies (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment. The Plan reserves the right to require a period of rental prior to covering the purchase of equipment. Benefits for DME purchases will be reduced by any prior Plan benefits for renting the same equipment, unless (and to the extent that) the Plan required such prior rental.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member’s physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

No more than one item of DME per year will be covered for the same or similar purpose in order to be covered and the equipment and accessories to operate it must be:

* Made to withstand prolonged use
* Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
* Suited for use in the home

This list of covered DME includes, but is not limited to:

* Braces
* Crutches
* Wheelchairs
* Wheelchair seat lift mechanism and/or a power seat elevation device
* Prostheses
* Cochlear Implants and associated supplies
* Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
* Wigs (up to $2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
* You may purchase one over-the-counter breast pump or rent a hospital grade breast pump during a calendar year (one or the other, but not both). The pump must be for your own use. Replacement supplies may be purchased on an as needed basis. In-network purchase/rental for the pump and replacement supplies is covered at 100%. Out of network purchase/rental for the pump and replacement supplies is covered at 100% of allowable charge. Deductible does not apply. Batteries are not covered.
* Continuous glucose monitors and their supplies are covered at 100% of allowable charges; deductible does not apply.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

* Corneal ulcer/abrasion
* Bullous keratopathy
* Recurrent erosion of cornea
* Keratoconus
* Tear film insufficiency (dry-eye syndrome)

Cataract surgery

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | A [**prior authorization**](https://outlook.office365.com/owa/wopi/files/96164086-4b14-499b-9fd7-5624489694f5@microsoft.com/AAMkADk2MTY0MDg2LTRiMTQtNDk5Yi05ZmQ3LTU2MjQ0ODk2OTRmNQBGAAAAAADfnOTgct4BQpW4-OOSBGceBwAXCSSG8TcsSZE2aGEbmzulAAAAAAEMAAAXCSSG8TcsSZE2aGEbmzulAARFF6SmAAABEgAQAJWnTbGpwYxOpuTYVAa3R8I=_AADbmXo.MQkAAAAAAAA=/WOPIServiceId_FP_EXCHANGE_ORGID/WOPIUserId_23fc4fea-e150-4f47-bb69-61e0b6ef3d31/spd_corporate_2023_072023%20Final%20Redline.docx#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

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| Additional information | Certain supplies such as hypodermic needles, test strips and glucose monitors are covered at 100% by the [preventive care](#_Preventive_care) benefit. |
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##### Additional exclusions and limitations for medical equipment and supplies (durable medical supplies)

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following durable medical equipment and supplies will not be covered by this plan when they are:

* Normally of use to persons who do not have an injury, illness, disease, or medical condition
* For use in altering air quality or temperature
* For exercise, training and use during participation in sports, recreation, or similar activities
* Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
* Special or extra-cost convenience items and/or features
* Structural modifications to your home and/or private vehicle
* Replacement of lost or stolen equipment or supplies
* Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

#### Medical Foods

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

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 counseling, mental health inpatient and outpatient services, and chemical dependency treatment

*Inpatient and Outpatient:*

* *100%, up to calendar year visit limits through Microsoft CARES employee assistance program*
* *In-network: 90%, deductible applies*
* *Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary treatment for:

* mental health conditions such as, but not limited to the diagnosis and treatment stress, anxiety, or depression, or other psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
* chemical dependency such as substance use disorder and alcohol use disorder

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage.

| **Type of care** | **You will be covered as follows** |
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| Through the [Microsoft CARES employee assistance program (EAP)](#_Section_VII:_Microsoft) as administered by Spring Health | No deductible applies  100% of 42 sessions per person, per year |
| Inpatient and Outpatient benefits | * In-network: 90%, deductible applies; out-of-network: 90% of allowable charges, deductible applies |

##### Eligible providers

Eligible providers include:

* A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
* A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
* A master’s level mental health provider licensed, registered, or certified as legally required to provide mental health services
* Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

##### Prior Authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for inpatient care and residential treatment centers to determine coverage is available before the service occurs. When an emergency admission occurs, notification to Premera within two days is also recommended. Either the member or the provider may contact Premera for a prior authorization.

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| Additional information | A [**prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

##### Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Testing must be ordered by a physician for the purpose of diagnosing or medical management
* Smoking cessation programs or materials; (Microsoft provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the [prescription drug](#_Prescription_drugs) benefit.)
* Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary
* Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.

#### Nutritional therapy

This benefit covers outpatient nutritional therapy visits with a dietitian, nutritional therapist or certified lactation consultant to manage a covered condition, illness or injury.

First 12 visits per member per calendar year:

*In-network: 100%   
Out-of-network: 100% of allowable charges*

*Limit: first 12 visits per member per calendar year*

After the initial 12 visits per member (in the same calendar year) benefit coverage remains available for a covered condition, illness or injury (see examples below) as follows:

* *In-network: 90%, deductible applies*
* *Out-of-network 70% of allowable, deductible applies*

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

* Hypertension
* Cardiac problems
* Feeding difficulties
* Gastric reflux disease

Nutritional therapy visits received in connection with a diagnosed eating disorder or diabetes are unlimited and will be covered at 100% of allowable charges.

#### Onsite Mammography Screening

Microsoft offers access to an onsite mammography screening in select Microsoft locations to employees and their spouse/domestic partners enrolled in a Microsoft Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

##### Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Microsoft partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

##### When Do the Screenings Occur?

Periodically each year, usually during the fall.

##### Eligibility

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.

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| Additional information | At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician. |

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

#### Physician services

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers:

* Medical and surgical services of a physician
* Urgent care visits at an urgent care facility
* Care via online and telephonic methods when medically appropriate:
  + Benefits for telemedicine are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
* Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider

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| Additional information | An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:   * Requires prompt medical attention to avoid serious deterioration of the member’s health * Does not require the level of care provided in the emergency room or a hospital * Cannot be postponed until the member’s physician is available   A **Physician** is 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 treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing a service for which benefits are specified in this SPD and 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.) * Advanced Registered Nurse Practitioner (A.R.N.P.) * Nurse (R.N.) * Naturopathic physician (N.D.) |
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#### Plastic and reconstructive surgery

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers services, supplies, and procedures for plastic or reconstructive surgery purposes, along with complications of these services, supplies, or procedures, for the following:

* Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
* Treatment for a congenital anomaly of a covered child
* Treatment of visible birth marks of a covered child
* All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
* Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.

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| Additional information | A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.  A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment. |

#### Prescription drugs

*In-network: 90%, deductible applies, up to limits provided below  
Out-of-network: 90%, deductible applies, up to limits provided below*

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member’s use outside of a medical facilityanddispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also, included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit and are not subject to the deductible. Brand-name preventive medications with an available generic equivalent will not be covered by the preventive care benefit. Review the [preventive care](#_Preventive_care) benefit for more information.

##### Generic drug substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you’ll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you’ll be charged the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Note: The difference in price between the brand name drug and the generic equivalent will not apply to your deductible and/or coinsurance maximum. Even if you reach your deductible or coinsurance maximum, you will still be responsible for the full amount of the difference in price between the brand name drug and the generic equivalent.

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| Additional information | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Brand-name** prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.  **Generic drugs** are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired. |
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##### Prescription limits

|  | Retail pharmacy | Home delivery | Specialty pharmacy |
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| Coverage | * Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply\* | * Up to 90-day supply\* is covered only when using Express Scripts Pharmacy Home Delivery | * Up to a 30-day supply\* * Additional clinical support for members using specialty drugs |
| In-network pharmacies | * Express scripts pharmacies bill the plan on your behalf * To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411 | * Express scripts pharmacies bill the plan on your behalf | * Walgreen’s Specialty Pharmacy or Accredo Specialty Pharmacy\*\* will bill the plan on your behalf |
| Out-of-network pharmacies | * You will need to submit a prescription reimbursement form, with your receipt, for reimbursement | * Not covered | * Not covered |

\* Unless the drug maker’s packaging limits the supply in some other way.

\*\* Contact Walgreen’s Specialty Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days’ supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable

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| Additional information | **Generic maintenance medications** have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply. |
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| Additional information | Premera provides a customer service team dedicated to Microsoft employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:   * Status of mail order prescriptions * Plan design, including which medications are covered or not covered * Location of retail pharmacies |
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##### Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization.

* Prescription drugs (Federal Legend and 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](#prescriptiondrug).
* Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to standard supply limit.
* Inhalation spacer devices and peak flow meters
* Glucagon and allergy emergency kits
* Prescribed injectable medications for self-administration (such as insulin)
* Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
* Disposable diabetic testing supplies, including test strips, testing agents, and lancets
* Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
* Human growth hormone
* Prescription drugs for smoking cessation
* Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days.

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the [preventive care](#_Preventive_care) benefit.

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for certain prescription drug is available before prescription can be filled.

To determine if prior authorization is required for a particular drug, refer to the [formulary drug list,](https://www.premera.com/documents/052148_2025.pdf) or either the member or the provider may contact Premera.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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##### Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

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
* Be under the care of an appropriate medical specialist
* Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.

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| Additional information | For questions about your pharmacy benefits or quantity limits, please contact Premera Customer Service at (800) 676-1411. |
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The table below provides information on how to submit information for a medical necessity review.

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| **Drug** | **Information** |
| Certain drugs require a prior authorization. Examples include but are not limited to: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications. | Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review.  If you would like to find out if your drug requires review, refer to the [formulary drug list](https://www.premera.com/documents/052148_2025.pdf), or call Premera Customer Services at (800) 676-1411. |

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| Additional information | Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process. |
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##### Drug-usage patterns

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

##### Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this Plan and what coverage limitations are in your contract.

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| Additional information | If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411. |
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If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

##### Pharmacy manufacturer coupons and financial assistance

In order to avoid potential adverse tax consequences, enrollees in the Health Savings Plan should not utilize pharmacy manufacturer coupons or other financial assistance for prescription drugs.

##### Additional exclusions and limitations for prescription drugs

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
* 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. These may include, but are not limited to, nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as “Plan B”), aspirin for women and men, folic acid for women and iron supplements.
* Over-the-counter contraceptives, supplies and devices (except as required by law)
* Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth or stop hair loss not related to alopecia areata, or prevent wrinkles)
* Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
* Drugs for experimental or investigational use
* Any prescription refilled too soon or 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
* Replacement of lost or stolen medication
* Devices and appliances, support garments, and non-medical supplies
* This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Microsoft coverage (for example, drugs administered while hospitalized)
* Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place
* Shipping and handling charges for prescriptions drugs are not covered.

#### Preventive care

*Preventive services:*

*In-network: 100%*

*Out-of-network: 100% of allowable charges*

This benefit covers routine exams, immunizations and health screenings, such as:

* Routine physicals for women and men
* Women’s preventive care including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)
* Well-child exams, including physical exams, tests, and immunizations, through age 18
* Hearing screening for children through age 18
* Routine prenatal and postnatal care (if the physician bills the delivery together with the routine prenatal care, 40% of the allowed amount applies to the preventive care benefit and 60% of the allowed amount applies to the [maternity care](#_Maternity_care_2) benefit)
* Routine eye exams
* Flu shots
* Colorectal cancer screening
* Prostate cancer screening
* Lung cancer screening
* Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

*Preventive prescription drugs:*

*In-network: 100%*

*Out-of-network: 100%*

This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.

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| Additional information | For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](https://www.premera.com/documents/022576.pdf) and the [Preventive Drug list](https://www.premera.com/documents/022506.pdf), or contact Premera Customer Service at (800) 676-1411.  For information on how to fill your prescription, see the [prescription drug](#_Prescription_drugs_4) section. |

#### Rehabilitation

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

* Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
* Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting (see inpatient benefits). Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy, including cardiac rehabilitation, are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which they practice subject to the Plan’s review and approval of your treatment plan for physical therapy and functional occupational therapy services. Premera or its designee may review a member’s treatment plan for the purpose of verifying that the treatment is clinically safe, effective, and appropriate for the member’s condition. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Please refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

#### Respite Care (Non-Hospice)

*In-network: 90%, deductible applies   
Out-of-network: 90%, deductible applies*

*Limit: 672 hours per calendar year*

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 672 hours per calendar year in the member’s residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs.

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#_Home_Health_Care) benefit. For the respite care application and more information on this benefit, please call Premera Customer Service at (800) 676-1411.

##### Additional exclusions and limitations for respite care:

In addition to the plan’s [exclusions and limitations](#_General_exclusions_and), the following exclusions and limitations apply to this benefit:

* Respite care provided by a non-certified or non-licensed provider or agency
* Respite care provided by a family member or friend
* Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
* Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

#### Skilled nursing facility

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 120 days per member per calendar year*

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.

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| Additional information | **Custodial care** is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#_Glossary) for a full definition. |
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Services and supplies eligible for reimbursement include:

* Room and board, meals, and general nursing care
* Services and supplies furnished and used while you are in the skilled nursing facility, such as:
  + The use of special treatment rooms
  + Routine lab exams
  + Physical
  + Occupational or speech therapy
  + Respiratory and other gas therapy
  + Drugs and biologicals (such as blood products and solutions)
  + Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for skilled nursing facilities to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

##### Additional exclusions and limitations for skilled nursing facility

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Custodial care is not provided
* Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder

#### Sterilization services

##### Elective Sterilization – Female

*In-network: 100%  
Out-of-network: 100% of allowable charges*

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

##### Elective Sterilization – Male

*In-network: 100%, deductible applies  
Out-of-network: 100% of allowable charges, deductible applies*

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

#### Surgical weight loss treatment

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

##### Who is eligible

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.

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| Additional information | Contact Premera at (800) 676-1411 for a copy of the policy. |
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Examples of qualifying criteria include:

* A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m2) or BMI greater than 35 Kg per m2 in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
* Physician-supervised weight reduction program which includes:
  + A program lasting at least three consecutive months within the 12-month period before surgery is considered,
  + Evidence of active participation in a program documented in the member’s medical records,
  + A psychological evaluation and clearance by a licensed mental health provider, to help rule out other psychological disorders, inability to provide informed consent, or inability to comply with pre- and post-surgical requirements.

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

#### Temporomandibular joint (TMJ) dysfunction

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofacial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.

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| Additional information | While not required by the Plan, pre-service review is strongly recommended for some TMJ services, to ensure that coverage is available. For a list of such services, please call (800) 676-1411. Fax pre-service review requests to Dental Review at (425) 918-5956 or mail to:  Dental Review MS 173 P.O. Box 91059 Seattle, WA, 98111-9159 |
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TMJ services and supplies for the treatment of TMJ dysfunction and myofacial pain dysfunction include:

* Diagnostic and follow-up examinations
* Diagnostic X-ray services
* Oral surgery
* Physical therapy
* Biofeedback
* Transcutaneous Electrical Nerve Stimulation (TENS)
* TMJ splints or TMJ guards

#### Transfusions, blood, and blood derivatives

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

#### Gender Affirming surgical services

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#_Prescription_drugs_4) and [mental health](#_Mental_health,_substance_3) benefits.

##### When services are covered

##### Gender affirming surgical services will be covered if you are diagnosed as having gender dysphoria or gender incongruence, and the surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior authorization, also referred to as a pre-service review, is strongly recommended for coverage to be made available for gender affirming surgical services. Either the member or the provider may contact Premera for prior authorization. The most current WPATH Standards of Care outline the specific requirements that must be met in order for the gender affirming surgical services to be deemed medically necessary. Any prior authorization request must include documentation showing that all required elements under the most current WPATH Standards of Care have been met. See the [Microsoft Gender-Affirming Benefit Information](https://www.premera.com/documents/031800.pdf) for additional information.

For gender affirming surgical services, the prior authorization should include:

* The surgical procedure(s) for which coverage is being requested
* The date the procedure will be performed
* Information supporting the criteria listed above has been met, based on the surgery being requested

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| Additional information | [**Prior authorization**](https://outlook.office365.com/owa/wopi/files/96164086-4b14-499b-9fd7-5624489694f5@microsoft.com/AAMkADk2MTY0MDg2LTRiMTQtNDk5Yi05ZmQ3LTU2MjQ0ODk2OTRmNQBGAAAAAADfnOTgct4BQpW4-OOSBGceBwAXCSSG8TcsSZE2aGEbmzulAAAAAAEMAAAXCSSG8TcsSZE2aGEbmzulAARFF6SmAAABEgAQAJWnTbGpwYxOpuTYVAa3R8I=_AADbmXo.MQkAAAAAAAA=/WOPIServiceId_FP_EXCHANGE_ORGID/WOPIUserId_23fc4fea-e150-4f47-bb69-61e0b6ef3d31/spd_corporate_2023_072023%20Final%20Redline.docx#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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* Information supporting the criteria listed above has been met, based on the surgery being requested

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| Additional information | Your physician can fax this information to (800) 843-1114 or mail it to:  Premera Blue Cross Attn: Integrated Health Management P.O. 91059 Seattle, WA  98111-09159 |
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#### Transplants

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion¾procedures cannot be experimental or investigational.

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| Additional information | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#_Glossary) for a full definition. |
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| Additional information | The transplant benefit doesn’t cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure. |

##### Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.

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| Additional information | **Approved transplant center** is a hospital or other provider, located in the United States, that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#_Glossary) for a full definition. |
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##### Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

##### Additional exclusions and limitations for transplants

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Nonhuman or mechanical organs, unless they are not experimental or investigational
* Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
* Donor costs are not covered if the recipient of the transplant service is not a Microsoft enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
* Donor costs are not covered by Microsoft if benefits are available under other group or individual coverage
* Donor costs are not covered for transportation for typing or matching

**Travel and Lodging Reimbursement Benefit**

*In-network: 100%, deductible applies (additional IRS limitations below)*

*Out-of-network: 100%, deductible applies (additional IRS limitations below)*

*Limit: $10,000 per member, per calendar year*

The following travel and lodging reimbursement benefits are available when travel is necessary to obtain covered services under the Plan that are not available within 100 miles of the member’s residence.

**Travel Allowances:** Travel expenses are reimbursed between the member’s residence and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical expenses, for current mileage reimbursement rates.

**Lodging Allowances:** Hotel or motel stays (or similar accommodations) away from the geographic area of the member’s residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of $50 per night per person, or up to $100 per night total for the member and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

**Overall Maximum:** The travel and lodging reimbursement benefit is limited to a total of $10,000 per member per calendar year.

**Companions:** The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

* Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
* Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

**Limits: Eligible** travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit to the IRS website, [**www.irs.gov**](http://www.irs.gov), for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice. Please consult with a personal legal or tax advisor for more information.

**Non-Covered Expenses:**

* Alcohol/tobacco
* Car rental expenses
* Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
* Baggage fees
* Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
* Expenses for persons other than the patient and an eligible companion
* Lodging at a residence owned by a family member or friend
* Costs for pets or animals, other than service animals
* Meals
* Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
* Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
* Telephone calls

**Limitations/exclusions:**

* The travel and lodging must occur, and the treatment must be provided, within the United States
* The patient must be covered by one of Microsoft’s Premera plans at the time the treatment is provided, and the travel and lodging expenses are incurred
* The medical treatment for which the patient is required to travel more than 100 miles from the patient’s residence must be a covered benefit under the Plan

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.

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| Title: Question icon - Description: Additional information | [**Prior authorization**](file:///C:/Users/us43272/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XAV5T4XL/Travel%20and%20Lodging%20Expenses_Final%20051922%20(004).docx#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

#### Virtual Care

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

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 their practice.

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. 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. Virtual Care with a provider located outside of the United States is not covered.

#### Vision therapy

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 32-visit benefit maximum, per member, for the duration of the member’s continuous enrollment*

This benefit covers vision training, eye training or eye exercises up to a maximum of 32 treatment visits, for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options, for the following conditions only:

* Amblyopia
* Convergence insufficiency
* Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the Vision plan. Costs of equipment and supplies associated with vision therapy are not covered.

#### Weight Management program

*In-network (eligible providers): 80%, up to $6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options, deductible and coinsurance maximum do not apply*

*Out-of-network: not applicable*

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance maximum are met.

##### Who is eligible

Members are eligible for this benefit if they meet the following criteria:

* Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
* Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
  + Congestive heart failure
  + Coronary heart disease
  + Depression
  + Diabetes
  + Hyperlipidemia
  + Hypertension

Dependent children are not eligible for this benefit.

##### Eligible providers

Approved weight management providers of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program’s physician, personal trainer, dietitian, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when they complete the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.

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| Additional information | For more information about approved [weight management providers](https://www.premera.com/documents/048804.pdf), or to find an approved provider in your area, call Premera Blue Cross at (800) 676-1411. |
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##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | **Prior authorization** is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility before service is provided. Services are subject to eligibility and benefits at the time of service. | |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A Weight Management Recommendation form or confirmation of your BMI and co-morbid conditions must be submitted to Premera in order to receive reimbursement from Premera. Your physician’s recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that you are strongly recommended to complete in advance to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician.
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician’s approval

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| Additional information | To obtain a copy of the Weight Management Recommendation form, contact Premera Blue Cross at (800) 676-1411.  Your physician can fax this information to (800) 676-1477. |
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1. Premera will review the information submitted and verify the coverage through a prior authorization

##### Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

###### Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim billing member claim form on a monthly or quarterly basis to Premera for reimbursement. Upon completion of the program, you must submit the final weight management final billing claim form for your final payment. Final claims payment is contingent on receiving the form with all biometric information completed.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

###### Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

##### Additional exclusions and limitations for Weight Management program

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Food
* Nutritional supplements (i.e., protein shakes)
* Drugs or surgical procedures to assist in reducing weight or curbing hunger are not covered under the weight management program benefit. Please refer to the [Prescription drugs](#_Prescription_drugs_4) or [Surgical weight loss treatment](#_Surgical_weight_loss_1) benefit for coverage.

### Exclusions and limitations

* Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
* Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
* Expenses in excess of the applicable annual and lifetime benefit maximums
* Services for which a claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
* Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements); and herbal or naturopathic/homeopathic medicine
* Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
* Charges for or in connection with services or supplies that are determined to be experimental or investigational
* Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers’ Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
* Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies.
* This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
* Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
* If other insurance is available for medical benefits, the Participant must put such other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.
* Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits 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
* In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
* Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
* Services of a social worker except as provided in the hospice care benefit, the home health care benefit, and the mental health and chemical dependency benefit
* Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.
* Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
* Massage therapy that is not medically necessary, or is furnished without a prescription
* Activity therapy, such as music, dance or art therapies
* Charges to obtain, train, or maintain service animals and emotional support animals
* Any benefits or services not specifically provided for in the SPD
* Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
* Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
* Procedures for sterilization reversals
* Hypnotherapy, regardless of provider
* Hippotherapy or other forms of equine or animal-based therapy
* Electronic services and/or consults, except as specifically described under the plan
* Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but not limited to a provider covered dependents under the plan (whether or not living in the household), 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 that are illegal, outside the scope of the provider’s license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
* Separate charges for records or reports, except those Premera requests for utilization review
* Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
* 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 and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
* Services or supplies for any of the following:
  + Education and training programs including testing or supplies/materials, including vision training supplies
  + Educational or recreational therapy or programs; this includes but is not limited to boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
  + Social, cultural, or vocational rehabilitation or vision training supplies
* Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
* Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months.
* Services for individuals not eligible for coverage under the Microsoft Plan will not be reimbursed except in the following circumstances:
  + Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
  + Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
* Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
* When Coordinating Benefits (COB) if you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
* Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan
* Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in-network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

* [Autism/ABA therapy](#_Autism/Applied_Behavior_Analysis)
* [Hearing care and hardware](#_Hearing_care_and)
* [Home health care](#_Home_Health_Care)
* [Hospice care](#_Hospice)
* [Hospital inpatient care](#_Hospital_Emergency_Room)
* [Fertility](#_Infertility_1)
* [Medical and surgical equipment and supplies](#_Medical_equipment_and)
* Mental health and chemical dependency treatment
* [Prescription drugs](#_Prescription_drugs_4)
* [Skilled nursing facility](#_Skilled_nursing_facility_3)
* [Transplants](#_Transplants)
* [Weight Management program](#_Weight_Management_Program)

### How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

To submit a claim online:

From the Benefits Site, select **View My Claims**, which will direct you to the Premera Portal. Or sign in to your account on [premera.com](https://www.premera.com/). Next, from the top menu bar select **Claims** and then **Submit Claims**. Follow the steps and upload a copy of the itemized receipt.

To submit a claim via mail, fax or email:

1. Download the [Premera Claim Reimbursement Request Form](https://www.premera.com/documents/011943.pdf) You can also e-mail Premera from your Microsoft email address (employees) to [microsoft@premera.com](mailto:microsoft@premera.com) or through your Secure Messaging center in the Premera portal (all enrollees including dependents and COBRA members) to request a claim form.
2. Complete the claim form, including all of the following information:
   1. Your name and the member’s name
   2. Identification numbers shown on your identification card (including the 3-digit plan prefix or MSJ)
   3. Provider’s name, address, and tax identification number
   4. If you are seeking secondary coverage from the Microsoft health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
   5. If treatment is as a result of an accident: the date, time, location and brief description of the accident
   6. Date of onset of the illness or injury
   7. Date of service
   8. Diagnosis or ICD-10 code (this information can be found on the provider bill)
   9. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
   10. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Submit the completed form to:  
   Mail: Premera Blue Cross  
   P.O. Box 91059  
   Seattle, WA 98111-9159  
   Fax: (800) 676-1477  
   Email from Microsoft email address: [claims.microsoft@premera.com](mailto:claims.microsoft@premera.com)Email through the Secure Messaging center in your Premera portal

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| Additional information | COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage_1) section.  *In the following circumstances, you may submit claims according to the* [*appeals process*](#_Appeal_for_internal)*:*   * *If you cannot submit the claim in a timely manner due to circumstances beyond your control* * *If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child* |
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#### Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera’s control.

If your claim relates to an item for which the Plan requires you to obtain approval (or “prior authorization”) before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day period for up to an additional 15 days if the extension is required due to matters beyond Premera’s control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination period to respond to your claim (as provided above) will be suspended as of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for “urgent care,” meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

* Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
* Premera’s denial notice may be oral, with a written or electronic confirmation to follow within three days.
* If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera’s determination no later than 48 hours after (1) Premera’s receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.

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| Additional information | **Explanation of benefits (EOB)** is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any). |
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Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable laws and regulations:

* Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
* Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

#### Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

* The specific reason or reasons for the denial
* Reference to the specific plan provisions on which the denial is based
* A description of any additional material or information needed from you and the reason it is needed
* An explanation of the appeals procedures and the applicable time limits
* A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
* If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
* If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
* Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the plan’s standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal
* Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

#### Appeal for internal review

If you do not agree with the decision made by the plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

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| Additional information | An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process does not apply to appeals of denied COBRA eligibility claims. |
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| Additional information | If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim. |
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##### Submitting an appeal for internal review

You or your authorized representative\* must provide the following information as part of your written appeal to the Premera Appeals Department.:

* Your name,
* Your Premera member number,
* The name of this plan, and
* A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.

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| Additional information | The appeal should be mailed or faxed submitted to Premera:  Appeals Coordinator Premera Blue Cross  P.O. Box 91102  Seattle, WA 98111-9202  Fax: (425) 918-5592 |
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\*You may, at your own expense, have a representative file an appeal on your behalf. Your attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose, you must submit a completed and signed [Microsoft Member Appeals form](https://www.premera.com/documents/019063.pdf) which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as Premera Blue Cross’s internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.

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| Additional information | To file an urgent care appeal request, you may fax a request to (425) 918-5592. |

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| Additional information | The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above. |

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| Additional information | **An urgent care claim or appeal is** one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. |
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##### Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

##### Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

* The specific reason or reasons for the denial
* Reference to the specific plan provisions on which the denial is based
* A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
* A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
* A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the Plan’s standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal
* Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

#### Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial (1) has a retroactive effect and is considered a rescission of coverage under the law, or (2) is based on medical judgment including:

* Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
* A determination that a treatment is experimental or investigational

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| Additional information | An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information. |
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The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

##### Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.

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| Additional information | If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review. |
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| Additional information | Mail or fax the written request to:  Premera Blue Cross Attn: Microsoft Member Appeals – IRO Mail Stop 123  P.O. Box 91102 Seattle, WA 98111-9202  Fax: (425) 918-5592 |
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##### External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information, and the IRO review begins.

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| Additional information | If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow. |
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The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

##### Decision on the external review

The plan is bound by the IRO’s decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan’s appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

#### Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.

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| Additional information | If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272). |
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#### Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

### Health Savings Account (HSA)

The Health Savings Account is an interest-bearing savings account designed to allow you to pay for medical expenses (both now and in the future) with tax-free dollars. The Health Savings Account is yours—you own, manage, and control the funds in the account. If you do not spend it, you get to keep it in the account, and you can watch it grow over time.

The Health Savings Account can only be opened to those enrolled in a high-deductible health plan, such as the Health Savings Plan, that meets certain Internal Revenue Service (IRS) criteria.

The Health Savings Account features triple tax savings—tax-free contributions into your account, tax-free earnings on interest and dividends, and tax-free when you withdraw funds to pay for eligible health care expenses.

A Health Savings Account is not an ERISA employee benefit plan established or maintained by Microsoft. Microsoft will not: (1) limit your ability to move your funds from one Health Savings Account to another, (2) impose conditions on utilization of your Health Savings Account funds, (3) make or influence investment decisions with respect to your Health Savings Account funds, or (4) receive any payment or compensation in connection with your Health Savings Account. Your choice whether or not to participate in a Health Savings Account is completely voluntary.

#### Setting up your account

If you decide you would like to open an HSA, you may do so at the bank of your choice. All contributions to the account would be managed by you, not Microsoft.

#### Eligibility to contribute your own money to an HSA

You are eligible for a Health Savings Account if:

* You are enrolled in a Health Savings Account-compatible, high-deductible health plan (such as the Premera Health Savings Plan offered by Microsoft)
* You are not covered by another health plan (other than another high-deductible health plan), including coverage under your spouse’s/domestic partner’s health plan or Medicare
* You are not covered by your spouse’s General Purpose Healthcare Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) (except a limited purpose FSA or HRA)
* You cannot be claimed as a dependent on another person’s tax return
* You are not enrolled in Medicare (parts A, B, C or D) or TRICARE, and you have not received medical or prescription benefits from the Veteran’s Administration (VA) in the preceding three months (other than benefits for preventive care or a service-connected disability, as defined by applicable law). (Note: mere eligibility for medical benefits from the Veteran’s Administration does not disqualify you from participating in the HSA.)

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| Additional information | You still have medical coverage under the Health Savings Plan even if you cannot contribute, or decide not to contribute, to a Health Savings Account. |
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**If you do not qualify to contribute to a Health Savings Account** because you have coverage under another health plan, you or your spouse/domestic partner can take action if you wish to address your eligibility issue.

* If you are covered by your spouse’s/domestic partner’s health plan, you should have them remove you as a covered dependent and/or withdraw from their General Purpose Healthcare FSA/HRA.
* If you are enrolled in Medicare or TRICARE (medical), or if you have received VA medical/prescription benefits in the past three months (other than for preventive care or service-connected disability), you are not eligible for the Health Savings Account and typically you cannot take action to address your eligibility issue.

#### Contributions to your Health Savings Account

You may make tax-free contributions to your account. If you and your spouse both have an HSA, your combined HSA contributions may not exceed the annual family coverage contribution limit (that is, $7,750 in 2023). Individuals age 55 or over may make an additional annual catch-up contribution as listed below.

Due to IRS regulations, the annual combined tax-free contribution to the Health Savings Account cannot exceed the maximum annual limits listed in the table below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Annual tax-free contribution limits for the Health Savings Account** | | | | | |
|  | |  |  |  | *Maximum*  *annual limit* |
| Interns and Visiting Researchers | | Employee only |  |  | $4,300 |
| Employee + 1 |  |  | $8,550 |
| Employee + 2 or more |  |  | $8,550 |
| Age 55 or over catch-up contribution | |  |  |  | Maximum contribution plus $1,000 |
|  |  | | | | |
| Additional information | If you exceed the allowable maximum, excess contributions not removed before your tax filing deadline are subject to an additional 6% excise tax. | | | | |

If during the year you become eligible to contribute to a health savings account, or are already eligible to contribute to a health saving account but make a mid-year change in your Health Savings Plan coverage level (e.g., from employee-only to employee-plus-one coverage) due to a qualified status change event, then in determining your employee maximum contribution for the year, you may be treated as having been for the entire year eligible to contribute to a health savings account, and enrolled in the coverage that you had as of December 1. This is called the “last month rule.” However, if you use the last month rule and then cease to be eligible to contribute to your health savings account before December 31 of the following year, you may be subject to income and additional taxes on a portion of your previous health savings account contributions.

Microsoft’s contribution to your health savings account will not be affected by the last month rule, but rather will continue to be prorated on a per pay period basis (and/or twice annual basis, in January and July, as applicable), based upon your coverage level at the time of each Microsoft contribution.

#### Eligible expenses

The money in your Health Savings Account can be withdrawn on a tax-free basis to pay for qualified medical expenses, as defined by IRS section 223(d)(2) and section 213(d). If the amount withdrawn is used for something other than qualified medical expenses and you are under age 65 then it will be subject to income tax and an additional 20% tax. For more information on tax treatment for Health Savings Accounts, refer to IRS Publication 969.

When you reach age 65, the funds in your Health Savings Account can be used for additional medical expenses, such as insurance premiums (such as Medicare Part A&B, but not Medicare Supplemental plans) and your share of retiree medical insurance premiums.

You are responsible for maintaining records of the medical expenses paid through the Health Savings Account. In the event of an IRS audit, you may need to provide documentation that the Health Savings Account was used for qualified medical expenses.

## HMO Plan Kaiser Foundation Health Plan of Washington (KFHPWA) only

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### How the plan works

The Kaiser Foundation Health Plan of Washington (KFHPWA) HMO Plan offers the convenience of “one-stop shop” medical care. Your Provider Network is KFHPWA’s Core Network (Network). Members are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and care pursuant to a Pre-authorization. Your providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about your care. There is also a pharmacy, laboratory, and X-ray facility at every Kaiser Permanente location, so it is easy and efficient to get the care you need when you need it.

#### Important notice under Federal Health Care Reform

KFHPWA recommends each member choose a Primary Care Physician. This decision is important since the designated Primary Care Physician provides or arranges for most of the member’s health care. The member has the right to designate any Primary Care Physician who participates in one of the KFHPWA networks and who is available to accept the member or the member’s family members. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, please call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

For children, the member may designate a pediatrician as the primary care provider.

The member does not need prior authorization from KFHPWA or from any other person (including a Primary Care Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for obtaining prior authorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

### Federal No Surprise Billing Protection

Out-of-network providers generally have the right to charge you more than the Plan’s allowed amount or allowable charge for a covered service. This is called “balance billing.” However, Federal law protects you from balance billing for the following types of services:

* Emergency Care from an out-of-network hospital or independent freestanding emergency department.
* Out-of-network air ambulance services
* Any services from an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, or outpatient surgical center, provided that the out-of-network provider may balance bill you if the provider gives you advance notice and you provide your written consent, except for the following services (for which balance billing is never permitted):
  + Surgery
  + Anesthesia
  + Pathology
  + Radiology
  + Laboratory
  + Hospitalist Care

Solely for purposes of determining your cost-sharing obligations for these services, the allowed amount or allowable charge is the lesser of (1) the out-of-network provider’s or facility’s billed charges, or (2) the Plan’s median in-network rate for the same or similar service provided in the same or similar specialty in the same geographic area (or any other amount specified for this purpose under applicable law).

Please Note: These balance billing protections do not apply to any other service from an out-of-network provider or facility. If the service is not listed above, the provider or facility may bill you for, and you may be required to pay, any amounts in excess of the plan’s allowed amount for the service (and any amounts that you pay in excess of the allowed amount will not count toward any applicable deductible, coinsurance, or out-of-pocket maximum).

#### Women’s health and cancer rights

If the member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the member will also receive coverage 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.
* Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the member and the attending physician and will be subject to the same cost shares otherwise applicable under the Benefits Booklet.

#### Statement of rights under the Newborns’ and Mothers’ Health Protection Act

Carriers offering KFHPWA coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, 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). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

#### For more information

KFHPWA will provide the information regarding the types of plans offered by KFHPWA to members on request. Please call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 888-901-4636.

### Where you can get care

The KFHPWA HMO Plan provides comprehensive medical care with several contracted providers, facilities and pharmacies through the KFHPWA Network in Washington. Kaiser Permanente facilities are treated as part of the KFHPWA Network if you need medical services while outside Washington State as described under receiving care in another Kaiser Foundation Health Plan Service Area, below. Benefits will not be denied for any health care service performed by a registered nurse licensed to practice under Washington regulations (Chapter 18.88 RCW), if, the service performed was within the lawful scope of the nurse’s license and this plan would have covered the service if it had been performed by a doctor of medicine licensed to practice under Washington regulations (Chapter 18.71 RCW).

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| Additional information | In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, KFHPWA will not be liable for administering coverage beyond the limitations of available personnel and facilities. |
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#### Receiving Care in another Kaiser Foundation Health Plan Service Area

If you are visiting the service area of another Kaiser Permanente region, services may be available from designated providers in that region and treated as within the KFHPWA Network if the services otherwise would have been covered under this SPD. These “visiting member” services are subject to the provisions set forth in this SPD including, but not limited to, preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente regional health plan service areas, including provider and facility locations, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636. Information is also available online at <https://wa.kaiserpermanente.org/html/public/services/traveling>.

#### Receiving Care outside the Kaiser Foundation Health Plan Network

If you choose to receive services from a non-KFHPWA HMO (Core) Network provider or facility, except as otherwise specifically provided in this SPD, those services will not be covered, and you will be responsible for the full price of the services. Any amounts you pay for non-covered services will not count toward your out-of-pocket limit.

Services provided outside the KFHPWA Network may not be covered. The plan covers select services outside of the KFHPWA Network, including:

| **Covered care outside the KFHPWA Network** | |
| --- | --- |
| **Emergency care** | You can obtain emergency care from the closest facility to you. **You must call the hospital notification line at (888) 457-9516 within 24 hours of admission to a non-contracted facility, or as soon thereafter as medically possible.** Review the [emergency](#_Emergency_Room) benefits for more information. |
| **Urgent care** | If you are outside the KFHPWA service area, you may receive urgent care at any medical facility. Urgent care within the KFHPWA service area is covered at KFHPWA facilities. Please review the [urgent care](#_Urgent_Care) benefits for more information.  For urgent care during office hours, you can call your personal physician’s office first to see if you can get a same-day appointment. If a physician is not available or it is after office hours, you may speak with a licensed care provider anytime at (800) 297-6877 or (206) 630-2244. You may also check <https://wa-doctors.kaiserpermanente.org/> or call Member Services to find the nearest urgent care facility in your network. |
| **Out of area benefit** | If you are outside the KFHPWA service area, the plan covers services up to a maximum of $2,000 per member per calendar year. All applicable costs, benefits, limitations and exclusions apply as if services were covered within the KFHPWA service area. |
| Travel and lodging reimbursement | Travel and lodging reimbursement benefits are available when travel is necessary to obtain covered treatment for a medical condition only when a treatment option is not available within 100 miles of your home. The plan covers services up to $10,000 per member per calendar year. |
| **Prior authorization** | Your primary care physician may refer you to a non-contracted provider outside the KFHPWA Network. Prior authorization must be provided by your primary care physician and approved by KFHPWA. KFHPWA will generally process prior authorization requests and provide notification for benefits within the following timeframes:   * Standard requests – within 5 calendar days   + If insufficient information has been provided a request for additional information will be made within 5 calendar days. The provider or facility then will have 5 calendar days to provide the necessary information. A decision will be made within 4 calendar days of the later of (1) receipt of the requested information or (2) the deadline for receipt of the requested information. * Expedited requests – within 2 calendar days   If insufficient information has been provided a request for additional information will be made within 1 calendar day. The provider or facility then will have 2 calendar days to provide the necessary information. A decision will be made within 2 calendar days of the later of (1) receipt of the requested information or (2) the deadline for receipt of the requested information. |
| **Your provider’s contract with Kaiser is ending (continuity of care)** | If you are receiving ongoing treatment (such as physical therapy) for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days. A specific time period. During any such extension of in-network benefits, you may be required to pay any amounts over the allowable charge. |
| [Family Health and Reproductive Support](#_Maternity_Support_(Maven)) | Free virtual care and on-demand support (through Maven Clinic) for navigating family planning, pregnancy, parenting, perimenopause, and menopause. |

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| Additional information | **Urgent care** is for the sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within 24 hours of its onset. |
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#### Primary care physician

You and your primary care physician coordinate your care with specialists and other members of the KFHPWA care team.

You should select a primary care physician for yourself and your covered dependents when you enroll in the KFHPWA HMO Plan. You may select one physician for your entire family, or a different physician for each member. You can select or change your primary care physician by contacting Kaiser Permanente Member Services customer service at (206) 630-4636 or (888) 901-4636, or by visiting KFHPWA online at <https://wa.kaiserpermanente.org>. If your selected primary care physician is accepting patients, the change will be made within 24 hours of the request. If a primary care physician accepting new members is not available in your area, contact the Kaiser Permanente Member Services, who will ensure you have access to a primary care physician by contacting a physician’s office to request they accept new members.

For your personal physician, choose from these specialties:

* Family medicine
* Adult medicine/internal medicine
* Pediatrics/adolescent medicine (for children up to 18)

If you don’t choose a physician when you first become a KFHPWA member, you will be matched with a physician to make sure you have one assigned to you if you get sick or injured. You can change your personal physician at any time, for any reason.

If your primary care physician no longer participates in KFHPWA’s network, you can use their services for up to 60 days after you’ve been sent a written notice about selecting a new physician.

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| Additional information | A **Physician** is a state-licensed:   * Doctor of Medicine and Surgery (M.D.) or * Doctor of Osteopathy (D.O.)   In addition, professional services provided by one of the following types of providers may be covered under this plan, but only when the provider is providing a service that is within the scope of their state license and for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:   * Chiropractor (D.C.) * Dentist (D.D.S. or D.M.D.) * Optometrist (O.D.) * Podiatrist (D.P.M.) * Psychologist (Ph.D.) * Nurse (R.N.) licensed in Washington state * Naturopathic physician (N.D.) |
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| Additional information | Call (206) 630-4636 or (888) 901-4636 or visit KFHPWA online at <https://wa.kaiserpermanente.org> for a listing of personal physicians, referral specialists, women’s health care providers, Health Care Benefit Managers and KFHPWA-designated specialists. Information available online includes each physician’s location, education, credentials, and specialties. | |
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#### Specialist care

Unless indicated in the table below or the [What the plan covers](#_What_the_plan_3) section, you will need a prior authorization from your primary care physician before the plan will cover care from specialists. To access a KFHPWA-designated specialist, consult your KFHPWA primary care physician. For a list of KFHPWA-designated Specialists, contact Member Services at (206) 630-4636 or (888) 901-4636 or view the Provider Directory located at <https://wa.kaiserpermanente.org>.

| **Specialty care that doesn’t require a referral** | |
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| **KFHPWA-designated specialists** | Preauthorization is not required for services with most specialists at Kaiser Permanente -owned or -operated medical centers. To obtain or request a complete list of these specialists, contact Member Services at (206) 630-4636 or view the Provider Directory located at <https://wa.kaiserpermanente.org/>. |
| **Women's health care direct access providers** | Female members may make appointments directly with specialists who are contracted by KFHPWA without a referral for the following care areas:   * Medically necessary maternity care * Covered reproductive health services * Preventive care (well care) and general examinations * Gynecological care * Follow-up visits with: General and Family Practitioners, Physician's Assistants, Gynecologists, Certified Nurse Midwives, Licensed Midwives, Doctors of Osteopathy, Pediatricians, Obstetricians, or Advanced Registered Nurse Practitioners who are contracted by KFHPWA   Care is covered as if your primary care physician has been consulted. However, if your provider diagnoses a condition that requires referral to other specialists or hospitalization, you must obtain prior authorization under KFHPWA requirements. |

#### Second opinions

You can get a second opinion on a medical diagnosis or treatment plan from a KFHPWA provider by visiting a KFHPWA-designated specialist. Second opinions are covered when prior authorization is received or when obtained from a KFHPWA-designated specialist.

Prior authorization for a second opinion does not imply that KFHPWA will authorize you to return to the physician providing the second opinion for additional treatment. Your coverage is determined by your medical plan benefits. Coverage for services, drugs, devices, etc., prescribed or recommended as a result of the consultation is determined by your medical plan benefits.

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| Additional information | The KFHPWA medical director will determine the necessity, nature, and extent of treatment to be covered in each individual case, and the judgment will be made in good faith. You may refuse any recommended services to the extent permitted by law. If you obtain care not recommended by KFHPWA, you do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan benefits. |
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#### Process for medical necessity determination

Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

##### First level review

First level reviews are performed or overseen by appropriate clinical staff using KFHPWA approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the member’s medical record, and consultation with qualified health professionals and multidisciplinary health care team members. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the member’s health care team when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

##### Second level (practitioner) review

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the member’s health care team when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

#### Filling a prescription

Depending on your needs, you may fill up to a 30-day supply of your prescription at a KFHPWA-designated pharmacy or up to a 90-day supply from KFHPWA-designated mail order service. Review the [prescription drugs](#_Prescription_drugs_3) benefit for more information on what is covered.

### What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care, and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are responsible for 10% up to an annual out-of-pocket maximum. When it comes to preventive care, the plan covers 100% when you use network providers.

| **What you pay** | | |
| --- | --- | --- |
| Copayments  Coinsurance  Out-of-pocket maximum  **+**  = | | |
| For office visits, outpatient surgery, and prescriptions, you pay a flat dollar copayment at the time you receive care, and the plan pays the remainder of the charges. | If you have an inpatient hospital stay, you pay 10% of the cost, called coinsurance, and the plan pays the rest. | If you reach your annual out-of-pocket maximum, the plan pays 100% of eligible expenses from that point forward. The out-of-pocket maximum is $1,500 per person, up to a $4,500 maximum for three or more covered family members. |

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| Additional information | **Copayment** is a fixed, up-front dollar amount that you're required to pay for certain covered services.  **Coinsurance** is the percentage amount that you are required to pay for certain covered services.  **Out-of-pocket maximum** is the most you could pay each plan year for covered services and supplies. |
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##### Medical care copayments

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| --- | --- | --- |
| **Type of visit** | **Copayment** | **Coinsurance** |
| **Primary Care Physician** | $20 | None |
| **Specialist** | $40 | None |
| **Emergency (waived if admitted)** | $75 | None |
| **Hospital – outpatient** | $100 | None |
| **Hospital – inpatient** | None | 10% |

##### Prescription drug copayments

|  |  |  |
| --- | --- | --- |
| **Type of prescription**  **(30-day supply)** | **KFHPWA**  **pharmacy copayment** | **KFHPWA**  **mail order copayment** |
| **Value-based** | $0 | $0 |
| **Preferred generic** | $10 | $5 |
| **Preferred brand** | $25 | $20 |
| **Non-preferred generic and brand**  (when prescribed by KFHPWA provider) | $50 ($35 maximum for insulin) | $45 ($35 maximum for insulin) |

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| Additional information | **Value-based drugs** are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.  **Preferred generic drugs** are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.  **Preferred brand-name** drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.  The **Preferred drug list** is the list of brand-name prescription drugs that are covered under the KFHPWA HMO Plan. |

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| Additional information | Call (206) 630-4636 or (888) 630-4636 or visit [KFHPWA](https://wa.kaiserpermanente.org) online to review the Preferred drug list. |

#### Out-of-pocket maximum

The annual out-of-pocket maximum is capped at $1,500 for each covered member—this means that once a member reaches their out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you’ll pay for the year is $4,500. Member payments for the Weight Management program do not count toward the out-of-pocket limit. All cost shares for covered services apply to the out-of-pocket maximum.

#### Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. KFHPWA may review a member’s medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, KFHPWA may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specific in this SPD. Such determination shall be based on established clinical criteria.

KFHPWA will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of an intentional misrepresentation of a material fact by the patient, member, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application, or for nonpayment of premiums.

### What the plan covers

The table below summarizes the benefits of the KFHPWA HMO Plan at Kaiser Permanente facilities. You can refer to the details following this table for more information about benefit limits and cost sharing.

The KFHPWA HMO Plan provides benefits for routine patient costs of qualified individuals in approved clinical trials to the extent benefits for these costs are required by law. Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials require prior authorization.

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| Additional information | *Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s* [*exclusions and limitations.*](#_Exclusions_and_limitations)  *You have the right to participate in decisions regarding your health care and you may refuse any recommended treatment or diagnostic plan to the extent permitted by law. If you obtain care not recommended by KFHPWA, you do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan Benefits.* |

| Additional information | CTRL+Click on the benefits below to access more information. |
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| **Common benefits** | |
| --- | --- |
| These are the most commonly used benefits in the Kaiser Foundation Plan or Washington HMO Plan. | |
| **Benefit** | **Coverage** |
| [Preventive care](#_Preventive_care_1)  Including well-baby care, well-child care routine gynecological exams, immunizations, female sterilization, FDA-approved contraceptive drugs, devices, including device removal, and counseling, preferred contraceptive drugs as recommended by the USPSTF when obtained with a prescription, and annual routine physical exams (see <https://wa.kaiserpermanente.org/>) | 100%; includes well-baby care, child and adult routine exams, and maintenance medications |
| [Prescription drugs](#_Prescription_drugs_3) | No copayment preventive; $10 copayment preferred generic; $25 copayment preferred brand; $50 copayment non-preferred. ($35 maximum for insulin) |
| [Primary care office visit](#_Primary_care_physician) | $20 copayment |
| [Specialist office visit](#_Specialist_care) | $40 copayment |
| [Hospital care—inpatient](#_Hospital_care)  Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care | 90% |
| [Hospital care—outpatient](#_Hospital_care)  Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing | $100 copayment |
| [Urgent care](#_Urgent_Care) | $20 copayment for visits with primary care providers; $40 copayment for visits with specialists |
| [Rehabilitation and Habilitative Care – Physical, Occupational, Speech and Massage Therapies](#_Rehabilitation_and_Habilitative) | Inpatient: 90%; up to 60 days combined per calendar year  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists; up to 60 visits combined per calendar year |
| [Maternity and pregnancy care](#_Maternity_and_pregnancy) | Inpatient: 90%  Outpatient: 100% for routine prenatal and postpartum visits; $20 copayment for other visits with primary care providers; $40 copayment visits with specialists |
| [Maternity support](#_Maternity_Support_(Maven)) | Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents. |
| [Mental health and wellness counseling, mental health and wellness inpatient and outpatient services, and substance use disorder](#_Mental__health) | Inpatient: 90%  Outpatient services: through [Microsoft CARES employee assistance program](#_Section_VII:_Microsoft):   * 100% of 12 sessions per issue per year (up to 24 sessions per year total)   Outpatient services under the KFHPWA HMO Plan: $20 copayment |

| **Other benefits** | |
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| The Kaiser Foundation Plan or Washington HMO Plan also covers these additional benefits. | |
| **Benefit** | **Coverage** |
| [Acupuncture](#_Acupuncture) | $20 copayment; up to a maximum of eight visits per member per medical diagnosis per calendar year without prior authorization; additional visits are covered with prior authorization  No visit limit for treatment for [substance use disorder](#_Substance_use_disorder) |
| [Ambulance](#_Ambulance_1) | 90% |
| [Detoxification services for alcoholism and drug abuse](#_Detoxification_services_for) | Inpatient: 90%  Outpatient: $75 copayment per visit to any emergency facility (copayment waived if admitted) |
| [Devices, equipment, and supplies](#_Devices,_equipment,_and) | 90% |
| [Diabetic needs and supplies](#_D_iabetic_needs) | Insulin, needles, syringes, test strips and lancets covered under the prescription drug benefit  90% for external insulin pumps, blood glucose monitors, and related supplies under the devices, equipment, and supplies benefit  100% for diabetic retinal screening |
| [Dialysis (home and outpatient)](#_Dialysis_(Home_and) | Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists; $100 copayment for outpatient hospital care |
| [Emergency care](#_Emergency_care_1) | $75 copayment per visit to any emergency facility (copayment waived if admitted) |
| [Hearing care and hardware](#_Hearing_care_and_1) | $20 copayment for visits with primary care providers; $40 copayment for visits with specialists  Hardware: 90%; $10,000 hardware limit per member in a period of 36 consecutive (rolling) months |
| [Home health care](#_Home_health_care_1) | 100% |
| [Hospice care](#_Hospice__care) | 100% |
| [Infusion](#_Laboratory_and_radiology) therapy | Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists  100% for associated infused medications |
| [Laboratory and radiology](#_Laboratory_and_radiology_1) | 100% |
| [Manipulative therapy](#_Manipulative_(chiropractic)_therapy) | $20 copayment; up to a maximum of twenty visits per member per calendar year |
| [Naturopathy](#_Naturopathy) | $20 copayment; up to a maximum of three visits per member per medical diagnosis per calendar year without prior authorization. Additional visits are covered with prior authorization. |
| [Neurodevelopmental therapy](#_N_eurodevelopmental_therapy) | Inpatient: 90%; up to 60 days per calendar year  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists; up to 60 visits per calendar year |
| [Nutritional services](#_Nutritional_services) | 90% |
| [Obesity-related surgery](#_Obesity_related_surgery) | Inpatient: 90%  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists |
| [Out-of-area benefit](#_Out_of_area) | Prescription drugs and medical services obtained outside the KFHPWA service area are covered up to $2,000 per member per calendar year |
| [Skilled nursing facility](#_Skilled_nursing_facility_1) | 90%; up to 60 days per member per calendar year at a skilled nursing facility |
| [Substance use disorder](#_Substance_use_disorder) | Inpatient: 90%  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists; $100 copayment for outpatient hospital care |
| [Temporomandibular joint (TMJ) dysfunction](#_Temporomandibular_Joint_(TMJ)_1) | Inpatient: 90%  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists |
| [Tobacco cessation](#_Tobacco_cessation) | 100% |
| [Transplants](#_Transplants_1) | Inpatient: 90%  Outpatient: $20 copayment for visits with primary care providers; $40 copayment for visits with specialists |

| **Specialized benefits** | |
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| Microsoft provides these unique benefits to you through the Kaiser Foundation Plan or Washington HMO Plan. | |
| **Benefit** | **Coverage** |
| [Autism/Applied behavior analysis (ABA) therapy](#_Autism/Applied_Behavior_Analysis_1) | 90% |
| [Fertility](#_Infertility_4) | 90% for coverage, within the Plan’s fertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy; please see Fertility and Family Building for more information |
| [Gender affirming services](#_Gender_health_services) | $20 copayment for visits with primary care providers; $40 copayment for visits with specialists; $100 copay for outpatient hospital care |
| Travel and lodging reimbursement | In-network: 100%, deductible applies (additional IRS limitations) Out-of-network: 100%, deductible applies (additional IRS limitations)  Limit: $10,000 per calendar year |
| [Weight management program](#_Weight_Management_program_3) | 80% up to $6,000 maximum for the duration of your continuous enrollment in the KFHPWA HMO Plan |

### Plan benefits

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| Additional information | The following pages provide details on the plan’s benefits. The plan’s [exclusions and limitations](#_Exclusions_and_limitations), including the requirement of medical necessity, apply to these benefits. |

#### Acupuncture

*$20 copayment; up to eight visits per member per diagnosis per calendar year without prior authorization.*

Additional visits are covered when prior authorized. Members may make appointments without prior authorization with KFHPWA-contracted providers. Visit limit does not apply for treatment for [substance use disorder](#_Substance_use_disorder).

Related laboratory and radiology services are covered only when obtained through a KFHPWA facility under the [laboratory and radiology](#_Laboratory_and_radiology_1) benefit.

##### Additional exclusions and limitations for acupuncture

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* Herbal supplements
* Services not within the scope of the practitioner's licensure

#### Ambulance

*Surface Ambulance (ground or water) - Out-of-network: 90%, deductible applies*

*Air Ambulance: Out-of-network: 90% of allowable charges, deductible applies*

Coverage includes licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the member’s condition when any other mode of transportation would endanger the member’s health or safety. This benefit is limited to the member that requires transportation.

Emergency ambulance services is covered only when:

• Transport is to any facility that can treat your condition

• Any other type of transport would put your health or safety at risk

• The service is from a licensed ambulance.

Emergency air or sea medical transportation is covered only when:

• The above requirements for ambulance service are met, and

• Geographic restraints prevent ground Emergency transportation to the nearest facility that can treat your condition, or ground Emergency transportation would put your health or safety at risk.

Benefits are also provided at 100% for transportation from hospital-to-hospital, as medically necessary for the member's care when approved by KFHPWA.

For ambulance services, please see [Federal No Surprise Billing Protection](#_Federal_No_Surprise) for special rules that apply to out-of-network air ambulance services.

#### Autism/Applied Behavior Analysis (ABA) therapy

*Plan pays 90%*

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

##### Who is eligible

This benefit will be available to members covered by KFHPWA, whose primary diagnosis is the following *(Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5),* or with any of the following Pervasive Developmental Disorders *(International Classification of Diseases, 10th Revision, Clinical Modification / ICD-10-CM)*:

* Autistic Disorder
* Childhood Disintegrative Disorder
* Asperger's Disorder
* Rett's Disorder and Pervasive Development Disorder Not Otherwise Specified/Atypical Autism
* Pervasive Developmental Disorder

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| Additional information | * If you need assistance confirming the diagnosis your doctor provides is an eligible diagnosis for the Autism/Applied Behavioral Analysis benefit you may contact Kaiser Permanente Member Services at (206) 630-4636. |
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##### Eligible providers

The benefit covers services through providers who have met established qualifications for certification (known as certified providers) and who perform services in consultation with a certified provider (known as therapy assistants).

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| Additional information | Call (206) 630-4636 or (888) 901-4636 or visit KFHPWA online for a list of approved Certified Autism Providers (not including Therapy Assistants) eligible for reimbursement under this benefit, to receive a copy of the certification criteria, or for an application for providers not currently on the list. |
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For the purpose of this benefit only, services of a certified provider will be covered even if the provider does not meet the plan's requirements as an eligible provider under the [rehabilitative services](#_Rehabilitation_and_Habilitative) or [mental health and wellness](#_Mental__health) benefit.

##### Covered services

Services must be ordered by the member’s treating physician to be covered. An approved certified provider acts as the program manager for the member. Benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

In most cases, therapy assistants will provide the implementation portion of the treatment plan. Therapy assistant time is eligible for face-to-face time with the member to perform the tasks described in the treatment plan and to document outcomes; and time to meet with the program manager for training and to discuss treatment plan issues. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

Claims for ABA services should clearly list the level of service (certified provider/program manager; or therapy assistant), the date the service was provided, the time the service started and ended, the hourly charge for the service, and the total charge for that service.

ABA services are not covered for the following:

* Babysitting or doing household chores
* Time spent under the care of any other professional
* Travel time
* Home schooling in academics or other academic tutoring

##### Benefit coverage above the allowable charge

If you obtain services from a non-KFHPWA provider or at a non-KFHPWA facility that nevertheless are covered under this SPD, you may be billed for charges assessed above the allowable charge. Any amounts you pay for charges in excess of allowable charges will not count towards satisfying any deductible requirements, or out-of-pocket maximums that may apply to other benefits provided through this plan.

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| Additional information | An **allowable charge**, where expenses incurred from a non-KFHPWA provider or facility are covered under this SPD, is the negotiated amount that KFHPWA providers and facilities have agreed to accept as payment in full for those same services. Members shall be responsible for paying any difference between the non-KFHPWA provider’s or facility’s charge for the services and the allowable charge. |
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##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact KFHPWA for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by KFHPWA that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service. | |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. KFHPWA and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For ABA/Autism benefits, the prior authorization requires the following documents:

* The treating physician’s order for ABA services
* The clinical documentation of the qualifying diagnosis
* The Plan of Treatment created by the approved Program Manager

KFHPWA will issue a prior authorization that will provide services for a six-month period of time. The prior authorization process and subsequent clinical review includes the following steps:

The following is the process for a prior authorization for the autism/ABA therapy benefit and subsequent clinical review:

1. The treating physician or specialist diagnoses the member with an Autism Spectrum Disorder (Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, and Asperger’s Disorder) and refers the child for ABA treatment.
2. An initial evaluation is performed by the approved certified provider to determine if the member is a candidate for an ABA and/or related structured behavioral program. If the member is determined to be a candidate by the evaluating approved certified provider, the approved certified provider would create and submit a treatment plan including type and frequency of services planned for the immediate six-month period. The approved certified provider must send the treatment plan to KFHPWA so that eligibility for services can be determined.
3. Every six months, the approved certified provider who is overseeing the treatment must submit an updated treatment plan to KFHPWA. The approved certified provider must determine that the treatment plan and services being provided are in accordance with ABA guidelines. If any substantial change in the frequency or type of program is necessary during the six-month treatment time, a revised Treatment Plan should be submitted to KFHPWA for notification of the revision of the treatment plan.
4. Progress reports should be created at least monthly by the certified provider to include documentation of the therapy assistant interventions and/or their own interventions with the member and a written summary of the member’s progress. If the member has not made progress in the last six months, the updated treatment plan should reflect a change in approach. Progress reports should be available to KFHPWA upon request.

Services for this treatment that do not meet criteria described in the program are subject to retrospective denial of benefits.Claims for these services must be accompanied by a completed Autism/ABA Therapy Services Billing Summary signed by the certified provider and the child’s parent if therapy is for a minor dependent.

##### Additional exclusions and limitations for autism/ABA therapy

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* This benefit is not provided for rehabilitative services (which apply under the [rehabilitation](#_Rehabilitation_and_Habilitative) services benefit) or mental health services (which apply under the Mental health counseling, [mental health and wellness inpatient and outpatient services, and substance use disorder treatment](#_Mental__health) benefit).
* Benefits for services provided by volunteers, childcare providers, or family members, and benefits paid for by state, local, and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books, and other training aids will also not be covered.
* Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development are not covered under this benefit
* This benefit covers only the allowable fees for eligible services performed by the approved certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the approved certified provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the approved certified provider and expenses of those working under the approved certified provider's supervision, the dependent, and their family members will not be covered.

#### Circumcision

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

#### Devices, equipment, and supplies (Durable Medical Supplies)

*Plan pays 90%*

The following services are covered:

* Orthopedic Appliances: Orthopedic appliances that are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration/improvement of its function. Excluded appliances include over-the-counter arch supports, and orthopedic shoes that are not attached to an appliance. Therapeutic shoes, modifications, and shoe inserts for severe diabetic foot disease are not excluded.
* Durable Medical Equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the member's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment.
* Hearing care: Programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; replacement batteries.
* Prosthetic Devices: Prosthetic devices are items that replace all or part of an external body part, or function thereof
* Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening
* Post-mastectomy bras/forms: Post-mastectomy bras are limited to two every six months (replacements within this 6-month period are covered when medically necessary due to a change in the member’s condition)
* Sales tax for devices, equipment, and supplies
* Custom arch supports and shoe inserts
* Wigs (up to $2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)

Prior authorization is required for devices, equipment and supplies including repair, adjustment, or replacement of appliances and equipment.

##### Additional exclusions and limitations for devices, equipment, and supplies

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* Take-home dressings and supplies following hospitalization
* Other supplies, dressings, appliances and devices not specifically listed as covered above
* Replacement or repair of appliances, devices, and supplies due to loss, theft, breakage from willful damage, neglect, wrongful use, or personal preference
* Structural modifications to a member’s home or personal vehicle

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| Additional information | KFHPWA will determine if equipment is made available on a rental or purchase basis. |
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#### Detoxification services for alcoholism and drug abuse

*Inpatient: Plan pays 90%*

*Outpatient: $75 copayment for emergency facility (waived if admitted)*

Benefits are provided for withdrawal of alcohol and/or drugs from a member for whom consequences of abstinence are so severe that they require medical or nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the member's health. Chemical withdrawal (detoxification) is provided without prior authorization.

The member must notify KFHPWA via the notification line at (888) 457-9516 within 24 hours following inpatient admission, or as soon as medically possible. If a member is hospitalized in a non-Kaiser Permanente facility or program, KFHPWA reserves the right to require transfer of the member to a Kaiser Permanente facility or program upon consultation between a KFHPWA provider and the attending physician. If the member refuses transfer to a Kaiser Permanente facility or program, all further costs incurred during the hospitalization are the responsibility of the member.

#### Diabetic needs and supplies

*Insulin, needles, syringes, test strips and lancets covered under the* [*prescription drug*](#_Prescription_drugs_3) *benefit.*

*90% for external insulin pumps, blood glucose monitors, and related supplies covered under the* [*devices, equipment, and supplies*](#_Devices,_equipment,_and) *benefit.*

*100% for diabetic retinal screening.*

#### Dialysis (Home and Outpatient)

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

Dialysis in an outpatient or home setting is covered for members with acute kidney failure or end-stage renal disease (ESRD)

Dialysis requires prior authorization

#### Emergency care

*Kaiser Permanente Facility: $75 copayment (waived if admitted)*

*Non-Kaiser Permanente Facility: 90% of allowable charges*

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| Additional information | An **allowable charge** is the negotiated amount that KFHPWA providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

At non-Kaiser Permanente, the plan covers the allowable charge provided you:

* Pay the emergency services copayment
* Notify KFHPWA at (888) 457-9516 within 24 hours following inpatient admission, or as soon as medically possible

Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient.

If the member is admitted to an inpatient facility directly from the emergency room, the emergency services copayment is waived. Inpatient hospital care will be covered at 90%. Please see the [hospital care](#_Hospital_care) benefit for more information.

If a member is hospitalized in a non-Kaiser Permanente facility, KFHPWA reserves the right to require transfer of the member to a Kaiser Permanente facility, upon consultation between a KFHPWA provider and the attending physician. If the member refuses to transfer to a Kaiser Permanente facility, all further costs incurred during the hospitalization are the responsibility of the member.

Care that is a direct result of the emergency must be obtained from KFHPWA providers, unless a KFHPWA provider has previously authorized such follow-up care from a non-KFHPWA provider.

Please see the [Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

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| Additional information | *Urgent care received at any hospital emergency department is not covered unless prior authorization is received by a KFHPWA provider. Please see the* [*urgent care*](#_Urgent__care) *benefit for more information.* |

#### Gender health services

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

This benefit covers medically necessary gender reassignment surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health and wellness treatment associated with gender reassignment surgery is available under the prescription drugs and mental health and wellness benefits.

##### Who is eligible

Surgical gender reassignment services will be considered medically necessary if all the following criteria are met:

* For all surgical procedures recognized as medically necessary in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), other than genital and breast surgery, if you are at least 18 years old and diagnosed as having gender identity disorder
* You have been an active member in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months
* For breast/chest surgery, have one letter of recommendation for surgery from a mental health professional
* For genital surgery, you have received recommendations for surgery 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.

#### Growth hormone

*90% under the* [*prescription drugs*](#_Prescription_drugs_3) *benefit*

This benefit covers growth hormones for treatment of growth disorders.

#### Hearing care and hardware

##### Hearing care

*Hospital – Inpatient: Member pays 10% plan coinsurance*

*Hospital – Outpatient: Member pays $100 copayment*

*Outpatient Services: Member pays $20 copayment for primary care providers; $40 copayment for specialty care provider services*

Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at KFHPWA-approved facilities.

Cochlear implants or Bone Anchored Hearing Aids (BAHA) when KFHPWA criteria is met. Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants only when provided at Kaiser Permanente-approved facilities.

Covered for cochlear implants and BAHA including implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).

##### Hearing hardware

*Plan pays 90% up to a maximum benefit of $10,000 per member in a period of three consecutive (rolling) calendar years of continuous enrollment.*

*After Allowance: Not covered; Member pays 100% of all charges*

*One hearing aid or a single pair of hearing aids (either prescription or over the counter) including hearing aid examinations.*

*Benefits cover the following:*

*• Ear mold(s)*

*• Repairs, servicing, and alteration of prescription hearing aid equipment.*

#### Home health care

*Plan pays 100% with no visit limit*

Home health care services are covered when services are received from KFHPWA providers for members who meet the following criteria:

* Except for patients receiving palliative care services, the member must be unable to leave home due to their health problem or illness (unwillingness to travel and/or arrangements for transportation do not constitute inability to leave the home).
* The member requires intermittent skilled home health care services.
* A KFHPWA provider has determined that such services are medically necessary and are most appropriately rendered in the member's home.

Covered services for home health care include the following services on an intermittent basis:

* Nursing care
* Restorative physical therapy
* Restorative occupational therapy, restorative respiratory therapy
* Restorative speech therapy
* Durable medical equipment
* Medical social worker
* Limited home health aide services

Home health care services require prior authorization

##### Additional exclusions and limitations for home health care

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* Private duty nursing
* Housekeeping or meal services
* Any care provided by or for a member of the member’s family
* Any other services rendered in the home that do not meet the definition of skilled home health care (such as custodial care) or are not specifically listed as covered under this plan

#### Hospice care

*Plan pays 100%; up to five consecutive days per occurrence*

* Hospice care is covered when provided by a licensed hospice care program. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a member and any family members who are caring for the member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the member and their family during the final stages of illness. In order to qualify for hospice care, the member’s provider must certify that the member is terminally ill and is eligible for hospice services.

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| Additional information | **Hospice care** means a coordinated program of home and inpatient care, available 24 hours a day.  **Respite care** means continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers. |

##### Inpatient hospice services

Short-term care for inpatient hospice services shall be covered when preauthorized. Respite care is covered for a maximum of five consecutive days per 3-month period of hospice.

##### Other covered hospice services, when billed by a licensed hospice program, include:

* Inpatient and outpatient services and supplies for injury and illness
* Semi-private room and board, except when a private room is determined to be necessary
* Durable medical equipment when billed by a licensed hospice care program

Hospice care requires prior authorization.

##### Additional exclusions and limitations for hospice care

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Private duty nursing
* Financial or legal counseling services
* Meal services
* Any services provided by family members

#### Hospital care

*Inpatient: Plan pays 90% for inpatient medical and surgical services*

*Outpatient: $100 copayment for outpatient hospital surgery including ambulatory surgical centers*

##### Inpatient services

Inpatient services include:

* Room and board (including private room when prescribed) and general nursing services
* Hospital services (including use of operating room, anesthesia, oxygen, X-ray, laboratory, and radiotherapy services)
* Drugs and medications administered during confinement
* Medical implants
* Withdrawal management services

Alternative care arrangements may be covered as a cost-effective alternative instead of otherwise covered medically necessary hospitalization or other institutional care with the consent of the member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements must be determined to be appropriate and medically necessary based upon the member’s medical condition. Such care is covered to the same extent the replaced hospital care is covered. Alternative care arrangements also require prior authorization.

Members are required to notify KFHPWA by way of the KFHPWA notification line at (888) 457-9516 within 24 hours following any admission, or as soon as medically possible, upon receiving any of the following non-scheduled services:

* Withdrawal management services
* Emergency psychiatric services
* Labor and delivery
* Inpatient admissions needed for treatment of urgent conditions that cannot reasonably be delayed until prior authorization can be obtained

Non-emergency inpatient hospital services require prior authorization, which will be initiated with KFHPWA by your provider.

##### Additional exclusions and limitations for hospital care

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the dressings and supplies following hospitalization are excluded from this benefit, as are internally implanted insulin pumps, artificial larynx and any other implantable device that has not been approved by KFHPWA’s medical director.

##### Continuation of Inpatient Services

A Member who is receiving covered services in a hospital on the date of termination of coverage shall continue to be eligible for covered services while an inpatient for the condition for which the Member was hospitalized, until one of the following events occurs:

* According to KFHPWA clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
* The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
* The Member becomes covered under another plan with a group health plan that provides benefits for the hospitalization.
* The Member becomes enrolled under a plan with another carrier that provides benefits for the hospitalization.

Please see the [Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency and non-emergent services provided by an out-of-network provider.

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| Additional information | Call the notification line at (888) 457-9516 within 24 hours of any admission or nonscheduled services. |

#### Fertility

*In-network: 90%, within the Plan’s fertility vendor (Progyny) provider network*

*Out-of-network: not applicable*

*Limit: Up to two Smart Cycles per household and one additional Smart Cycle if neither of the first two results in a successful pregnancy. Coverage is subject to all applicable plan copay and coinsurance requirements.*

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

Members must contact their Progyny Patient Care Advocate at (888) 203-5066 to confirm eligibility and utilize a Progyny Network Provider to access the benefit.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

* Two consultations per calendar year
* Diagnostic testing
* Transvaginal ultrasounds
* Intrauterine insemination (also known as artificial insemination)
* In vitro fertilization (IVF)
* Gamete intra-fallopian transplant (GIFT)
* Intracytoplasmic sperm injection (ICSI)
* Pre-implantation genetic screening (PGS)
* Pre-implantation genetic diagnosis (PGD)
* Embryo assessment and transfer
* Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation due to cancer or medical treatments.
* Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
* Purchase of donor tissue (sperm, eggs) as follows:
  + Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes ¼ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
  + A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

##### Additional exclusions and limitations for fertility

The following exclusions apply to this benefit:

* Fees paid to donors for their participation in any service
* Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
* Home ovulation prediction kits
* Services and supplies furnished for a dependent child (under age 26)
* Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
* Fertility Services following a voluntary sterilization procedure
* This benefit is only available to KFHPWA members, not visiting members.

#### Infusion therapy

*$20 copayment for primary care providers; $40 copayment for specialists*

This benefit covers medically necessary infusion therapy such as antibiotics, hydration, chemotherapy and pain management.

*Plan pays 100% for associated infused medications.*

#### Laboratory and radiology

*Plan pays 100%*

This benefit covers nuclear medicine, radiology, ultrasound and laboratory tests, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to prior authorization except when associated with Emergency services or inpatient.

Services received as part of an emergency visit are covered as Emergency Services.

Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in KFHPWA medical centers, at <https://wa.kaiserpermanente.org>, or upon request from Member Services.

#### Manipulative (chiropractic) therapy

*$20 copayment; up to twenty visits per member per calendar year*

This benefit covers visits for manipulative therapy of the spine and extremities when KFHPWA clinical criteria are met.

##### Additional exclusions and limitations for manipulative therapy

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Supportive care primarily to maintain the level of correction already achieved
* Care primarily for the convenience of the member
* Care on a non-acute, asymptomatic basis
* Charges for any other services that do not meet KFHPWA’s clinical criteria as medically necessary

#### Maternity and pregnancy care

*Inpatient: Plan pays 90%*

*Outpatient: Plan pays 100% for routine prenatal and postpartum visits; $20 copayment for primary care providers; $40 copayment for specialists for non-routine maternity care, including care for complications or termination of pregnancy.*

Coverage includes complications of pregnancy, in-utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when medically necessary and prenatal and postpartum care for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services when medically necessary, as determined by KFHPWA’s medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Home births are considered outpatient services. Childbirth classes are covered at 100%. As described in the preventive care section, breastfeeding support, supplies, and counseling are covered at 100%.

The member's physician, in consultation with the member, will determine the member's length of inpatient stay following delivery. Treatment for post-partum depression or psychosis is covered only under the [mental health and wellness](#_Mental__health) benefit.

##### Additional exclusions and limitations for maternity and pregnancy care

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Birthing tubs
* Genetic testing of non-members
* Fetal ultrasound in the absence of medical indications

#### Mental health and wellness

*Inpatient: Plan pays 90%*

*Outpatient: 100%, up to calendar year visit limits through Microsoft CARES employee assistance program, otherwise $20 copayment for primary care providers; $40 copayment for specialists*

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| Additional information | *To access Spring Health go to Microsoft.springhealth.com to access these benefits. For counseling through Kaiser, you must contact the KFHPWA Behavioral Health Unit at (888) 287-2680 or (206) 630-1680.* |

##### Inpatient care

Benefits include coverage for acute treatment and stabilization of psychiatric emergencies, residential treatment and partial hospitalization programs in KFHPWA-approved hospitals. Coverage for services incurred at non-Kaiser Permanente facilities exclude any charges that would otherwise be excluded for hospitalization within a Kaiser Permanente facility. Substance use disorder services are covered subject to the [substance use disorder](#_Substance_use_disorder) services benefit. Preauthorization is required for Residential Treatment and non-Emergency inpatient hospital services provided in out-of-state facilities.

Services provided under involuntary commitment statutes must be provided at facilities approved by KFHPWA. Services for any involuntary court-ordered treatment program can be covered¾only if determined to be medically necessary by KFHPWA’s medical director.

Coverage for voluntary or involuntary emergency inpatient psychiatric services is subject to the emergency care benefit under [emergency services](#_Emergency_care_1) section, including the 24-hour notification and transfer provisions.

##### Outpatient care

This benefit covers outpatient care although not required, you may wish to exhaust the [Microsoft CARES employee assistance program](#_Section_VII:_Microsoft) before obtaining services under this benefit, because Microsoft pays the entire cost of EAP benefits.

| **Type of outpatient care** | **You will be covered as follows** |
| --- | --- |
| Short-term counseling  [employee assistance program (EAP)](#_Section_VII:_Microsoft) as administered by Spring Health | Outpatient services through Spring Health employee assistance program:   * 100% of 24 short-term counseling sessions per calendar year.   A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour. |
| KFHPWA | Inpatient: 90%  Outpatient services under the KFHPWA HMO Plan: $20 copayment |

Mental health and wellness services provide the most clinically appropriate and medically necessary level of mental health care intervention as determined by KFHPWA’s medical director. Treatment may use psychiatric, psychological, and/or psychotherapy services to achieve these objectives.

Services rendered to treat mental health conditions are covered. Mental health conditions mean those conditions covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded. Mental health and wellness services mean medically necessary outpatient services, residential treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, except as otherwise excluded.

Mental health and wellness services including medical management and prescriptions are covered the same as for any other condition. Prescriptions are covered under the [prescription drugs](#_Prescription_drugs_3) benefit.

##### Additional exclusions and limitations for mental health and wellness

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* Covered services are limited to those services authorized by KFHPWA's medical director for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected, given the most clinically appropriate level of mental health care intervention
* Academic or career counseling and personal growth or relationship enhancement
* Assessment and treatment services that are primarily vocational and academic
* Court-ordered or forensic treatment not considered medically necessary, including reports and summaries
* Work- or school-ordered assessment and treatment not considered medically necessary
* Counseling for overeating not considered medically necessary
* Specialty treatment programs such as "behavior modification programs" not considered medically necessary
* Relationship counseling or phase-of-life problems (V-code only diagnoses)
* Custodial care not considered medically necessary
* Experimental or investigational therapies.
* Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools.
* All other provisions, exclusions, and limitations under this plan also apply

#### Naturopathy

*$20 copayment; up to three visits per member per medical diagnosis per calendar year without prior authorization*

Additional visits are covered with prior authorization. Related laboratory and radiology services are covered only when obtained through a Kaiser Permanente facility under the [laboratory and radiology](#_Laboratory_and_radiology_1) benefit.

##### Additional exclusions and limitations for naturopathy

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), herbal supplements, nutritional supplements, and any services not within the scope of the practitioner's licensure are excluded from this benefit.

#### Neurodevelopmental therapy

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists*

*Limit: up to 60 days/visits per calendar year (combined with the* [*rehabilitation benefit*](#_Rehabilitation_and_Habilitative)*)*

Covered services include: physical therapy, occupational therapy, and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled members. Coverage also includes maintenance of a covered member in cases where significant deterioration in the member's condition would result without the services.

##### Additional exclusions and limitations for neurodevelopmental therapy

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* All services must be provided at a Kaiser Permanente facility or a KFHPWA-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
* Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
* Specialty treatment programs
* Inpatient residential treatment services
* Specialty rehabilitation programs including “behavior modification programs”
* Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member's level of functioning (except as set forth in this section for treatment of neurodevelopmental conditions)
* Recreational life-enhancing relaxation or palliative therapy
* Implementation of home maintenance programs
* Any services not specifically included as covered in this section
* Any services that are excluded by the plan

#### Nutritional services

*Plan pays 90%*

Covered services include parenteral nutritional therapy, enteral therapy when Medically Necessity criteria are met and when given through a PEG, J tube or orally, or for an eosinophilic gastrointestinal disorder, and dietary formula for the treatment of phenylketonuria. Necessary equipment and supplies covered under the [devices, equipment, and supplies benefit](#_Devices,_equipment,_and).

##### Additional exclusions and limitations for nutritional services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), this benefit excludes any other of the following:

* Dietary formulas or medical foods
* Oral nutritional supplements that do not meet Medical Necessity criteria or are not related to the treatment of inborn errors of metabolism
* Special diets
* Prepared foods/meals

#### Obesity-related surgery

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists*

Coverage includes bariatric surgery and related hospitalizations when KFHPWA criteria are met. Obesity related services require prior authorization. Services related to obesity screening and counseling are covered as Preventive Services. Weight-loss programs and related physician visits for medication monitoring are not covered, except those covered under the [weight management](#_Weight_Management_program_3) benefit or as described in the preventive care section.

##### Additional exclusions and limitations for obesity-related surgery

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Related weight-loss programs
* Prescribing and monitoring of drugs
* Structured weight-loss and/or exercise programs or membership
* Specialized nutritional counseling

#### Onsite Mammography Screening

Microsoft offers access to an onsite mammography screening in select Microsoft locations to employees and their spouse/domestic partners enrolled in a Microsoft Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

##### Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Microsoft partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

##### When Do the Screenings Occur?

Periodically each year, usually during the fall.

##### Eligibility

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.

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| Additional information | At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician. |

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

#### Out-of-area benefit

*Plan pays 100%; up to a maximum of $2,000 per member per calendar year*

All applicable cost shares, contract provisions, limitations and exclusions apply the same as if services were covered within KFHPWA’s service area.

Members may be asked to pay the provider at the time services are received. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care up to the maximum amount.

Submit a claim to KFHPWA for the services on a Medical & Prescription Drug Claim(s) Form for Member Reimbursement. Submit the form with all necessary supporting documentation (i.e., itemized bills and receipts, explanation of the services, and the identification information from your ID card).

[Submit a claim](https://wa.kaiserpermanente.org/html/public/customer-service/reimburse) to KFHPWA for the services for Member Reimbursement. Submit the form with all necessary supporting documentation (i.e., itemized bills and receipts, explanation of the services, and the identification information from your ID card).

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| Additional information | Send claims to:  Kaiser Foundation Health Plan of Washington, Claims Administration P.O. Box 34585 Seattle, WA 98124-1585 |

#### Plastic and reconstructive services

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

Covered services include:

* Correction of a congenital disease or congenital anomaly.
* Correction of a medical condition following an injury or resulting from surgery that has produced a major effect on the member's appearance. The service must, in the opinion of a KFHPWA provider, reasonably correct the condition.
* Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed
* Members will be covered for all stages of reconstruction on the non-diseased breast produce a symmetrical appearance
* Complications of covered mastectomy services, including lymphedemas, are covered

Plastic and reconstructive surgery requires prior authorization.

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| Additional information | A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth. |

##### Additional exclusions and limitations for plastic and reconstructive services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Cosmetic services and surgery
* Treatment for complications resulting from cosmetic surgery
* Complications of non-covered services

#### Podiatric services

*$20 copayment for primary care providers; $40 copayment for specialists*

Routine foot care is covered when such care is directly related to the treatment of diabetes and, when approved by KFHPWA’s medical director, other clinical conditions that affect sensation and circulation to the feet.

##### Additional exclusions and limitations for podiatric services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit: all other routine foot care.

#### Prescription drugs

This benefit covers all FDA-approved, medically necessary prescription drugs, when prescribed for the member’s use outside of a medical facilityanddispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located.

All drugs, supplies and devices must be obtained at a KFHPWA-designated pharmacy except for drugs dispensed for emergency services or for emergency services obtained outside of the KFHPWA service area. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory available at <https://wa.kaiserpermanente.org> or can be obtained by contacting the Kaiser Permanente Member Services at (206) 630-4636.

Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider’s office.

Members may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA’s business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, members receive and pay the prescription drug cost share for up to 7-day supply or if less, the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at [www.kp.org/wa/formulary](http://www.kp.org/wa/formulary). Members can request an emergency fill by calling (855) 505-8107.

Certain drugs are subject to prior authorization as shown in the Preferred drug list (formulary).

Certain maintenance drugs will be covered at 100% under the [preventive care benefit](#_Preventive_care_1).

Weight loss drugs in accordance with criteria established by KFHPWA are covered subject to a $50 copayment.

##### Prescription drug copayments

| **Type of prescription  (30-days up to a 90-day supply)** | **KFHPWA pharmacy copayment** | **KFHPWA mail order copayment** |
| --- | --- | --- |
| Value-based | $0 | $0 |
| Preferred Generic | $10 | $5 |
| Preferred Brand | $25 | $20 |
| Non-Preferred generic and brand  (when prescribed by KFHPWA provider) | $50 ($35 maximum for insulin) | $45 ($35 maximum for insulin) |

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| dditional information | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Value-based drugs** are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.  **Preferred generic drugs** are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.  **Preferred brand-name** drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.  The **preferred drug list** is the list of prescription drugs that are covered under the KFHPWA HMO Plan. |

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| Additional information | To review the Preferred Drug list, call (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](https://wa.kaiserpermanente.org) online. |

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| Additional information | *You will be charged, under the benefit, for replacing lost, stolen, or damaged prescription drugs, or devices.* |

##### Covered drugs

This benefit covers:

* Prescription drugs, including preferred generic, preferred brand, and non-preferred (if prescribed by a KFHPWA provider)
* Supplies, and devices, including diabetic supplies (insulin, needles, syringes, test strips and lancets)
* Prescription drugs, including medications and injections, for anticipated illness while traveling
* Routine costs for prescription medications provided in a clinical trial. “Routine costs” means items and services delivered to the member that are consistent with and typically covered by the plan or coverage for a member who is not enrolled in a clinical trial.

The KFHPWA Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at [www.kp.org/wa/formulary](http://www.kp.org/wa/formularym), or upon request from Member Services.

Members may request a coverage determination by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.

Prescription drugs have been approved by the Food and Drug Administration (FDA) and can, under Federal or state law, be dispensed only pursuant to a prescription order. These drugs include off-label use of FDA-approved drugs, provided that such use is:

* Documented to be effective in one of the standard reference compendia
* Shown by a majority of well-designed clinical trials published in peer-reviewed medical literature to provide improved efficacy or safety of the agent in comparison to standard therapies (or over placebo if no standard therapies exist)
* Approved by the Federal Secretary of Health and Human Services

If a member has a new prescription for a chronic condition, the member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through KFHPWA’s preferred specialty pharmacy vendor and/or network of specialty pharmacies. For a list of specialty drugs or more information about KFHPWA’s specialty pharmacy network, please go to the KFHPWA website at [www.kp.org/wa/formulary](http://www.kp.org/wa/formulary) or contact Member Services at (206) 630-4636 or toll-free at (800) 901-4636.

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| Additional information | **Standard reference compendia** refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia—Drug Information, or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies. |

##### Medicare Part D coverage

This benefit is equal to or greater than the Medicare Part D prescription drug benefit. Eligible members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the plan and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date; however, the member could be subject to payment of higher Part D premiums if the member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.

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| Additional information | For more information about prescription drug policies or benefits, call (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](https://wa.kaiserpermanente.org) online. |

##### Additional exclusions and limitations for prescription drugs

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Drugs and injectables, except as described in this summary
* Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulation, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF)
* Compounds which include a non-FDA approved drug
* Growth hormones for idiopathic short stature without growth hormone deficiency
* Prescription drugs/products available over the counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable
* Administration of drugs and injectables. This exclusion does not apply to drugs and supplements in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010.

#### Preventive care

*Plan pays 100% for services detailed in the KFHPWA* *well-care schedule and preventive (maintenance) medications*

Covered services include, but are not limited to:

* Well-baby care
* Well-childcare
* Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF)
* Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians
* Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women’s preventive and wellness services guidelines. Flu vaccines are covered up to the Allowed Amount when provided by a non-network provider.
* Immunizations recommended by the Centers for Disease Control’s Advisory Committee on Immunization Practices
* Female sterilization
* FDA-approved contraceptive drugs, devices, including device removal, and counseling
* Preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription
* Routine physical exam
* Mammograms (age appropriate)
* Routine prostate screening
* Colorectal cancer screening for members who are age 50 or older or who are under age 50 and at high risk
* Routine bone density screening
* Obesity screening/counseling; healthy diet; and physical activity counseling (special services are available if the member’s BMI is 30 or higher as outlined in USPSTF guidelines).

Additional preventive services for women include:

* Well-woman visits, including preconception, prenatal and postpartum care
* Preferred FDA-approved contraception methods (including sterilization) and counseling
* Breastfeeding supplies
* Human Papillomavirus (HPV) testing
* Screening for gestational diabetes, domestic violence, and sexually transmitted infections
* Breast cancer preventive medications for asymptomatic women who are at increased risk for breast cancer and at low risk for adverse medication effects

Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. In the event that these preventive care services are not available from a KFHPWA provider, non-network providers may furnish them without cost share when preauthorized.

Value-based (maintenance) medications include prescriptions for chronic conditions and FDA-approved contraception methods in the KFHPWA preferred drug list. All preventive drugs, supplies, and devices must be obtained at a KFHPWA-designated pharmacy.

For a complete list of what is considered preventive care and paid 100% by the plan, see the Preventive Care service list and the Preventive Drug list, or contact KFHPWA at (206) 630-4636 or (888) 901-4636

##### Additional exclusions and limitations for preventive care

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), laboratory services that are not in accordance with the KFHPWA well-care schedule will be excluded from this benefit and subject to cost shares:

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| Additional information | Review the <https://wa.kaiserpermanente.org/> for preventive services. |

#### Radiation therapy

*$40 copayment for oncology, radiation therapy, and chemotherapy specialists*

Chemotherapy treats cancer with one or more chemotherapeutic agents (drugs) as part of a standardized regimen. Chemotherapy may also be prescribed to treat other conditions. Oral chemotherapy drugs are covered subject to the Prescription Drug cost share.

Radiation therapy is the medical use of ionizing radiation, generally as part of cancer treatment to control or kill malignant cells. Radiation therapy is synergistic with chemotherapy, and has been used before, during, and after chemotherapy in susceptible cancers.

#### Respiratory therapy

*$20 copayment for primary care providers; $40 copayment for specialists.*

Respiratory therapy is delivered by a respiratory therapist. Respiratory therapists are specialists and educators in cardiology and pulmonology. Respiratory therapists are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer anesthesia for surgery or conscious sedation.

#### Rehabilitation and Habilitative Care

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists*

*Limit: up to 60 days/visits, whichever occurs first, per calendar year (combined with the* [*Neurodevelopmental therapy*](#_Neurodevelopmental_therapy_for) *benefit). Services with mental health diagnoses are covered with no limit.* *Cardiac rehabilitation is covered for up to a total of 36 visits per cardiac event when clinical criteria are met. Prior authorization is required.*

Rehabilitation services restore function following illness, injury or surgery, limited to the following restorative therapies: physical therapy, occupational therapy, massage therapy, and speech therapy.

Habilitative care includes Medically Necessary services or devices designed to help a Member keep, learn, or improve skills and functioning for daily living. Services may include: occupational therapy, physical therapy, speech therapy is covered when prescribed by a physician.

##### Inpatient care

Inpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

##### Outpatient care

Outpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

##### Additional exclusions and limitations for rehabilitation services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), services are subject to all terms, conditions, and limitations of this plan, including the following:

* All services must be provided at a Kaiser Permanente facility or a KFHPWA-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
* Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
* Specialty treatment programs
* Inpatient Residential Treatment services
* Specialty rehabilitation programs including “behavior modification programs”
* Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member’s level of functioning (except as described for neurodevelopmental therapy)
* Recreational, life-enhancing, relaxation or palliative therapy
* Implementation of home maintenance programs

#### Reproductive Health

*Plan pays 100% for services*

Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal.

See [Maternity and pregnancy](#_Maternity__and) for termination of pregnancy services.

Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.

All methods for Medically Necessary FDA-approved (over the counter) contraceptive drugs, devices, and products. Condoms are limited to 120 per 90-day supply.

Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider’s office.

#### Skilled nursing facility

*Plan pays 90%; up to 60 days per member per calendar year*

Skilled nursing care in a skilled nursing facility is covered when full-time skilled nursing care is necessary in the opinion of the attending KFHPWA provider.

Care may include room and board, general nursing care, drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility. Short-term restorative physical therapy, occupational therapy, and speech therapy are also included.

##### Additional exclusions and limitations for skilled nursing facility

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Personal comfort items such as telephone and television
* Rest cures
* Domiciliary or convalescent care

#### Sterilization services

##### Elective Sterilization

Plan pays 100% for FDA-approved sterilization procedures, such as vasectomy, tubal litigation, services, and supplies.

##### Additional exclusions and limitations for sterilization services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), procedures and services to reverse sterilization are excluded from this benefit.

#### Substance use disorder

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

##### Inpatient services

Residential treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Preauthorization is required for Residential Treatment and non-Emergency inpatient hospital services provided in out-of-state facilities. The member may receive two days of treatment before being subject to medical necessity review for continued care. The member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Members may contact Member Services at (206) 630-4636 or toll-free at (800) 901-4636 to request Preauthorization.

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| Additional information | **Residential treatment centers or services** offer facility-based treatment providing active treatment in a controlled environment. At least weekly physician visits are required, and services must offer treatment by a multi-disciplinary team of licensed professionals. |
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##### Outpatient services

All alcoholism and/or drug abuse treatment services must be:

* Provided at a Kaiser Permanente facility or Kaiser Permanente-approved treatment facility
* Deemed medically necessary; the following services are covered on an inpatient or outpatient basis: inpatient residential treatment services, diagnostic evaluation and education, organized individual and group counseling, and/or prescription drugs and medicines
* Court-ordered treatment is covered only if determined to be medically necessary

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| Additional information | **Substance use disorder** means an illness characterized by physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the member's health is substantially impaired or endangered or their social or economic function is substantially disrupted. |
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##### Additional exclusions and limitations for substance use disorder

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), the following services and supplies are excluded from this benefit:

* Experimental or investigational therapies.
* Facilities and treatment programs which are not certified by the Department of Social Health Services

#### Telehealth Services

*Plan pays 100%*

Telemedicine Services provided by the use of real time interactive audio and video communications or store and forward technology between the patient at the originating site and a Network Provider at another location. Store and forward technology means sending a Member’s medical information from an originating site to the provider at a distant site for later review. The provider follows up with a medical diagnosis for the Member and helps manage their care. Services must meet the following requirements:

* Be a covered service under this SPD.
* The originating site is qualified to provide the service.
* If the service is provided through store and forward technology, there must be an associated office visit between the Member and the referring provider.
* Is Medically Necessary.
* Online (E-Visits): A Member logs into the secure Member site at <http://www.kp.org/wa> and completes a questionnaire. A KFHPWA medical provider reviews the questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Members during in-person visits at a KFHPWA facility or pharmacy. More information is available at <https://wa.kaiserpermanente.org/html/public/services/evisit>. Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above.

##### Additional exclusions and limitations for telemedicine

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations), fax and email; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above are excluded.

#### Temporomandibular Joint (TMJ) services

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

##### Covered services

* Medical and surgical services related to hospital charges for the treatment of TMJ disorders. TMJ appliances are covered under Devices, Equipment, and Supplies.
* Medically necessary orthognathic (jaw) surgery for the treatment of severe TMJ disorders for which non-surgical interventions have not been successful, radiology services, TMJ specialist services, and fitting/adjustment of splints

##### Additional exclusions and limitations for Temporomandibular Joint (TMJ) services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Treatment for cosmetic purposes
* Bite blocks
* Dental services, including orthodontic therapy and braces for any condition
* Severe obstructive sleep apnea

Any hospitalizations related to these exclusions are also excluded.

#### Tobacco cessation

*Plan pays 100%*

This benefit covers:

* Individual and group sessions through KFHPWA-designated tobacco cessation programs
* Tobacco cessation pharmacy products
* Educational materials when provided through KFHPWA

#### Transplants

*Inpatient: Plan pays 90%*

*Outpatient: $20 copayment for primary care providers; $40 copayment for specialists; $100 copayment for outpatient hospital care*

Transplants include:

* Heart
* Heart-lung
* Single lung
* Double lung
* Kidney
* Pancreas
* Cornea
* Intestinal/multi-visceral
* Bone marrow
* Liver
* Stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high-dose chemotherapy

Covered services are limited to the following:

* Inpatient and outpatient medical expenses
* Evaluation testing to determine recipient candidacy
* Donor matching tests
* Hospital charges
* Procurement center fees
* Professional fees
* Travel costs for a surgical team, and
* Excision fees
* Donor costs for a covered organ recipient are limited to
* Procurement center fees
* Travel costs for a surgical team
* Excision fees
* Follow-up services for specialty visits
* Re-hospitalization
* Maintenance medications during an inpatient stay

##### Additional exclusions and limitations for transplants

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations)](#_General_Exclusions_and), the following services and supplies are excluded from this benefit:

* Donor costs to the extent that they are reimbursable by the organ donor's insurance
* Treatment of donor complications
* Living expenses
* Transportation expenses, except as set forth under this plan

#### Travel and Lodging Reimbursement

In-network: 100%, deductible applies (additional IRS limitations described below)

Limit: $10,000 per calendar year

Travel and lodging reimbursement benefits are available when travel is necessary to obtain covered treatment for a medical condition only when a treatment option is not available within 100 miles of the patient’s home.

Travel Allowances: Travel is reimbursed between the patient’s home and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical expenses, for current mileage reimbursement rates.

Lodging Allowances: Hotel or motel stays (or similar accommodations) away from home. Reimbursement of expenses incurred by a patient and companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of $50 per night per person, or up to $100 per night total for the patient and one companion (see below), in accordance with applicable IRS reimbursement requirements.

Overall Maximum: The travel and lodging reimbursement benefit is limited to a total of $10,000 per member per plan year.

Companions: The travel and lodging benefit is available for the patient, as well as a companion, to the extent that a companion is needed to accompany the patient for the treatment due to medical necessity or safety concerns.

• Adult Patient (age 18 or older) – 1 companion is permitted.

• Child Patient – 1 parent or guardian is permitted

Limits: Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS limits, if applicable, in effect on the date you incurred the expense, which are subject to change. Please visit the IRS website, www.irs.gov, for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice. Please consult with a personal legal or tax advisor for more information.

Non-Covered Expenses:

• Alcohol/tobacco

• Car rental expenses

• Any airfare, train or bus fare, or upgrades for any ticket other than a regularly scheduled commercial flight in coach class

• Baggage fees

• Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)

• Expenses for persons other than the patient and an eligible covered companion

• Lodging at a residence owned by a family member or friend

• Costs for pets or animals, other than service animals

• Meals

• Personal care items (e.g., shampoo, deodorant, toothbrush etc.)

• Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)

• Telephone calls

Limitations/exclusions:

• The travel and lodging must occur, and the treatment must be provided, within the United States

• The patient must be currently covered by the Microsoft provided KFHPWA plan

• The medical treatment for which the patient is required to travel more than 100 miles from the patient’s residence must be a covered benefit under the Plan

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.

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| Title: Question icon - Description: Additional information | [**Prior authorization**](file:///C:/Users/c054643/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/0XA356SC/Travel%20and%20Lodging%20Expenses_Final%20051922%20(002).docx#priorauthorization) is an advance determination by KFHPWA that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

#### Urgent care

*Inside KFHPWA’s service area*—*$20 copayment for primary care providers; $40 copayment for specialists*

Care for urgent conditions within the KFHPWA service area is not covered at non-Kaiser Permanente facilities except for emergency services. These emergency services will be subject to the applicable emergency care copayment of $75, plus the difference between the non- Kaiser Permanente facility’s charge and the KFHPWA allowable charge.

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| Additional information | An **allowable charge** is the negotiated amount that KFHPWA providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

#### Weight Management program

*Plan pays 80%; up to $6,000 maximum for the duration of your continuous enrollment in the KFHPWA HMO Plan (out-of-pocket maximum does not apply)*

This benefit provides coverage for comprehensive and clinically based weight management programs for the treatment of obesity. *This benefit is available to KFHPWA HMO members but is administered by Premera Blue Cross.*

##### Who is eligible

Members are eligible for the Weight Management program benefit if they meet the following criteria:

* Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30), or
* Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
  + Congestive heart failure
  + Coronary heart disease
  + Depression
  + Diabetes
  + Hyperlipidemia
  + Hypertension

Dependent children are not eligible for this benefit.

##### Eligible providers

Approved [weight management providers](https://www.premera.com/documents/048804.pdf) of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program’s physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the member begins the program and when they complete the program. If the program is not approved and contracted for until after the member has started treatment under the program, no part of the cost of the program will be covered under this benefit.

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| Additional information | For more information about approved [weight management providers](https://www.premera.com/documents/048804.pdf). |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact KFHPWA for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by KFHPWA that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service. |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. KFHPWA and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](https://www.premera.com/documents/011944.docx) or confirmation of your BMI and co-morbid conditions should be submitted to Premera prior to receiving reimbursement from Premera. Your physician’s recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that must be completed to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician.
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician’s approval

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| Additional information | Your physician can fax this information to (800) 676-1477 |

1. Premera Blue Cross will review the information submitted and verify the coverage through a prior authorization

Participation in the program should begin within six months of the prior authorization being issued or a new prior authorization will need to be requested.

##### Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the member. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

###### Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim weight management billing claim form on a monthly or quarterly basis to Premera for reimbursement. You may also submit a final weight management final billing claim form at the end of the program.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

###### Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

##### Additional exclusions and limitations for Weight Management program

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_General_Exclusions_and), the following exclusions and limitations apply to this benefit:

* Food
* Nutritional supplements (i.e., protein shakes)
* Drugs or surgical procedures to assist in reducing weight or curbing hunger

### Exclusions and limitations

#### General exclusions

In addition to [exclusions associated with specific benefits](#_Additional_exclusions_Limitations), the following services are not covered:

* Benefits and related services, supplies and drugs that are not medically necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered under the [What the plan covers](#_What_the_plan_3) section, except as required by law
* Follow-up services related to a non-covered service, except as required by federal law
* Complications of non-covered services
* Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided under the [What the plan covers](#_What_the_plan_3) section
* Services for which a claim was not received by KFHPWA within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
* Devices, equipment, and supplies, except as specifically stated under the [devices, equipment, and supplies](#_Devices,_equipment,_and) benefit
* Benefits that overlap or duplicate benefits for which the member is eligible under any other group plan, workers’ compensation or similar employee benefit law, Medicare Part A or B, or a government-sponsored program of any type
* Those parts of an examination and associated reports and immunizations required for employment, immigration (except for immigration exams authorized by Microsoft and provided by designated immigration exam providers), license, travel (except for medications and injections for anticipated illness while traveling), or insurance purposes that are not deemed medically necessary by KFHPWA for early detection of disease, all diagnostic services not specifically stated under Preventive Services
* Cosmetic services related to sexual reassignment surgery including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-covered services; travel
* Services and supplies related to sexual reassignment surgery, such as sex-change operations or transformations and procedures, or treatments designed to alter physical characteristics, unless specifically stated under the gender affirming service benefit
* Services or supplies not specifically listed as covered under the [What the plan covers](#_What_the_plan_3) section
* The cost of services and supplies resulting from a member's loss of or willful damage to appliances, devices, supplies, and materials covered by KFHPWA for the treatment of disease, injury, or illness
* Orthoptic therapy (eye training)
* Specialty treatment programs such as weight reduction, behavior modification programs and rehabilitation
* Hypnotherapy and all services related to hypnotherapy
* Prognostic (predictive) genetic testing and related services, unless specifically provided in [hospital care](#_Hospital_care) benefit. Testing for individuals not enrolled in the plan (for example, surrogate parent).
* Fetal ultrasound in the absence of medical indications
* Liquid diet or fasting programs, membership in diet programs or health clubs, wiring of the jaw, and complications from surgery or fasting programs; however, medically necessary surgery may be covered if specific criteria as determined by KFHPWA is met
* Services or supplies for which no charges are made, or for which a charge would not have been made if the member had no health care coverage or for which the member is not liable; services provided by a member of the member's family or self-care
* Autopsy and associated expenses
* Services provided by government agencies, except as required by federal or state law
* Services covered by the national health plan of any other country the member resides in
* Internally implanted insulin pump, artificial heart, artificial larynx, and any other implantable device that has not been approved by KFHPWA’s medical director
* Travel-related vaccinations and medications are usually not covered. Visit <https://healthy.kaiserpermanente.org/washington/get-care/traveling/> for more details.
* Services that are illegal, outside the scope of the provider’s license or certification, or furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received

#### Dental benefits exclusions

Dentist’s or oral surgeon’s fees; dental care, surgery, services, and appliances, including: reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery, and any other dental services not specifically listed as covered in this summary.

#### Convalescent care exclusions

Convalescent care is excluded.

#### Investigational or experimental treatment exclusions

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| Additional information | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#_Glossary) for a full definition. |

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| Additional information | The transplant benefit doesn’t cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure. |

KFHPWA consults with KFHPWA's medical director and then uses the following criteria to decide if a particular service is experimental or investigational:

* A service is considered experimental or investigational for a member's condition if any of the following statements apply to it at the time the service is or will be provided to the member:
  + The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted
  + The service is the subject of a current new drug or new device application on file with the FDA
  + The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial
  + The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives
  + The service is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services
  + The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy
  + The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service
* The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
  + The member's medical records
  + The written protocol(s) or other document(s) pursuant to which the service has been or will be provided
  + Any consent document(s) the member or member's representative has executed or will be asked to execute, to receive the service
  + The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body
  + The published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and
  + Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions

Coverage decisions may be appealed as set forth in the [What the plan covers](#_What_the_plan_3) section.

#### Vehicle insurance exclusions

* Any services to the extent benefits are "available" to the member as defined herein through vehicle, homeowner's, property, or other insurance policy, except for individual or KFHPWA insurance, whether the member asserts a claim or not
* Medical coverage, medical "no fault" coverage, personal injury protection coverage, or similar medical coverage in the policy
* Benefits are deemed to be "available" to the member if the member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first-party benefits under the policy

#### Additional exclusions and limitations

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

* [Acupuncture](#_Acupuncture)
* [Autism/ABA therapy](#_Autism/Applied_Behavior_Analysis_1)
* [Devices, equipment, and supplies](#_Devices,_equipment,_and)
* [Home health care](#_Home_health_care_1)
* Hospice care
* [Hospital care](#_Hospital_care)
* [Fertility](#_Infertility_4)
* [Manipulative therapy](#_Manipulative_(chiropractic)_therapy)
* [Maternity and pregnancy care](#_Maternity__and)
* [Mental health and wellness](#_Mental__health)
* [Naturopathy](#_Naturopathy)
* [Neurodevelopmental therapy for children](#_N_eurodevelopmental_therapy)
* [Nutritional services](#_Nutritional_services)
* [Obesity-related surgery](#_Obesity_related_surgery)
* [Plastic and reconstructive services](#_Plastic_and_reconstructive)
* [Podiatric services](#_Podiatric_services)
* [Prescription drugs](#_Prescription_drugs_3)
* [Preventive care](#_Preventive_care_1)
* [Rehabilitation](#_Rehabilitation_and_Habilitative)
* [Skilled nursing facility](#_Skilled_nursing_facility_1)
* Sterilization
* [TMJ](#_Temporomandibular_Joint_(TMJ)_1)
* [Transplants](#_Transplants_1)
* [Weight Management program](#_Weight_Management_program_3)

### How to file a claim

In most cases, when you receive care from a KFHPWA provider or facility, your provider will submit bills directly to KFHPWA, and this submission is your claim for benefits. If your provider does not submit a bill directly to KFHPWA, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 90 days of the service. The plan will not consider claims submitted more than 12 months after the date of service, except in the absence of legal capacity.

Claims for benefits may be made before or after services are obtained. For out-of-country claims (Emergency care only) – submit the claim and any associated medical records translated into English at the member’s expense, including the type of service, charges in U.S. Dollars, and proof of travel to KFHPWA, P.O. Box 34585, Seattle, WA 98124-1585.

To submit a claim:

1. Download the KFHPWA Claim Form or call Kaiser Permanente Member Services at (206) 630-4636 or (888) 901-4636 to request the KFHPWA Claim form
2. Complete the form with the necessary information such as an itemization of services received including codes and conditions. Proof of payment is also required if members are seeking reimbursement.
3. Gather copies of your receipts from your covered visit
4. Send your completed form and additional paperwork to:  
   Claims Reimbursement  
   PO BOX 34585   
   Seattle WA 98124-1585

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| Additional information | COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage_1) section.  *Claims regarding plan eligibility for you, your spouse/domestic partner, or dependent child can be sent to:*  Kaiser Foundation Plan of Washington Member Appeal Department,  PO Box 34593,  Seattle, WA 98124-1593 |
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#### Claim review and payment

KFHPWA will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim within the following timeframes after KFHPWA receives your claim.

* **Pre-service claims**— KFHPWA will provide notice of a claim approval or denial within 15 days. This 15-day period may be extended for an additional 15 days if the extension is required due to matters beyond KFHPWA's control. You will have at least 45 days to provide any additional information requested of you by KFHPWA.
* **Urgent care**—KFHPWA will process claims and notify claimants of the decision, in immediate request situations, within 72 hours.
* **Concurrent urgent requests**—KFHPWA will process claims for concurrent urgent requests within 24 hours.
* **Concurrent non-urgent requests**—You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated.
* **Urgent care review requests**—KFHPWA will process claims for urgent care review requests within 48 hours.
* **Non-urgent pre-service review requests**—KFHPWA will process claims for non-urgent pre-service review requests within 15 calendar days. Timeframes for pre-service claims can be extended by KFHPWA for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.
* **Post-service review requests**—KFHPWA will process claims for post-service review requests within 30 calendar days. Timeframes for post-service claims can be extended by KFHPWA for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.
* **Claims involving urgently needed care**—If your claim involves urgent care, you or your authorized representative will be notified of KFHPWA's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; KFHPWA then must inform you of its decision within 48 hours of receiving the additional information.
* **Concurrent care claims**—If your claim is one involving concurrent care, KFHPWA will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. Where urgent care is involved, you will have at least 48 hours to respond to this request. KFHPWA will respond within 24 hours of receipt of the additional information. If the claim does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframes appropriate to the type of claim, (i.e., as a pre-service claim or a post-service claim).
* **Post-service claims**—If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of KFHPWA's decision on your claim if it is denied in whole or in part. This notification will be issued no more than 30 days after KFHPWA receives the claim. KFHPWA may extend this 30-day period for up to 15 days if the extension is required due to matters beyond KFHPWA's control. You will have at least 45 days to provide any additional information requested of you by KFHPWA if the need for the extension is due to KFHPWA's need for additional information from you or your health care providers.

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| Additional information | **Explanation of benefits (EOB)** is the statement you receive from KFHPWA detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any). |

In paying for services, KFHPWA may make payment to the employee, provider or another carrier. KFHPWA may also make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments. Payments are subject to applicable law and regulation. Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee.

#### Denied claims notice

If all or part of your claim is denied, KFHPWA will send you an Explanation of Benefits (EOB) or other notice with the following information:

* The reasons for the denial
* The plan provisions on which the denial is based
* Any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
* An explanation of the procedure for appeals and the applicable time limits, along with a statement of your right to bring a civil action under ERISA Section 502(a) upon an adverse decision on appeal
* A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
* If you have filed a claim with KFHPWA relating to plan eligibility, and this claim is denied, KFHPWA will send you a notice explaining your appeal rights
* Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the Plan's standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal; and
* Contact information for Kaiser Permanente Member Services or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

#### Appeal for internal review

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. Assistance is available to members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).

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| Additional information | An appeal is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process does not apply to appeals of denied COBRA eligibility claims. |

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| Additional information | If you fail to file the internal appeal within the timeframe specified above, you will permanently lose your right to appeal the denied claim. |

##### Submitting an appeal for internal review

You must provide the following information as part of your oral or written appeal to KFHPWA’s Member Appeals Department:

* Your name,
* Your KFHPWA member number,
* The name of this plan, and
* A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.

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| Additional information | The appeal should be submitted to KFHPWA at the following address:  Kaiser Foundation Plan of Washington Member Appeal Department,  PO Box 34593,  Seattle, WA 98124-1593 |

You may, at your own expense, have an attorney or other representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed KFHPWA Appointment of Representative form with your written internal appeals request to the address above.

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| Additional information | To obtain a copy of the KFHPWA Appointment of Representative form, contact KFHPWA at (888) 901-4636. |

In the case of an urgent care claim, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone, facsimile or other similarly expeditious method. If your provider believes your situation is urgent as defined under law and so notifies KFHPWA, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

You may also begin an external review at the same time as the internal appeals process if this is an urgent care situation or you are in an ongoing course of treatment. To request this step, you must call Member Appeals. The external review agency is not legally affiliated or controlled by KFHPWA. The external review agency decision is final and is generally binding upon the Plan.

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| Additional information | To file an urgent care appeal request, you may call KFHPWA directly at (866) 458-5479 or you may fax a request to (206) 630-1859. |

##### Internal review and timeframe

All of the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to your claim by asking KFHPWA.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by KFHPWA in connection with your appeal, KFHPWA will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by KFHPWA, KFHPWA will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If the claim is a post-service claim, you will receive a decision within a reasonable period of time, but not later than 60 days after receipt of your appeal request.

If the claim is a pre-service claim, you will receive a decision within a reasonable period of time, but not later than 30 days after receipt of your appeal request.

##### Denied appeal notice

If the previous denial is upheld in whole or in part, the notice of the decision on appeal will specify:

* The reasons for the denial
* The Plan provisions on which the denial is based
* A contact point through which the member may review or receive free copies of any documents, records or other information relevant to your claim for benefits
* A statement of your right to bring a civil action under ERISA 502(a) following an adverse benefit determination upon the conclusion of your appeal
* A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the Plan's standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal; and
* Contact information for Kaiser Permanente Member Services or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

If KFHPWA fails to grant or reject your request within the applicable required timeframe, you may proceed as if the claim had been rejected.

#### Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial constitutes a rescission of coverage or is based on medical judgment including:

* Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
* A determination that a treatment is experimental or investigational

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| Additional information | An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information. |

The external review is available only after you have properly exhausted the internal appeal as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is generally binding upon the plan.

##### Submitting an appeal for external review

An External Review Request Form will be sent with your Internal Appeal determination letter notifying you of your rights to an External Review.

To initiate the External Review, you must complete and sign the External Review Request Form and send it to KFHPWA at the address below no later than 120 days after the date you receive your Internal Appeal determination letter, which the Plan deems to be 7 days after the date on the Internal Appeal determination letter.

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| Additional information | If you fail to submit the completed and signed form within this timeframe, you will permanently lose your right to an External Review. |

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| Additional information | To obtain a copy of the External Review Request form, contact KFHPWA at (888) 901-4636.  Mail the External Review Request form to: Kaiser Foundation Health Plan Washington Member Appeal Department P.O. Box 34593 Seattle, WA 98124-1593 |

##### External review and timeframe

If your claim is eligible for External Review, KFHPWA will notify the IRO of your request for an External Review and send them all the information included in your Internal Appeal and other relevant materials within six days of receipt.

The IRO will contact you and/or KFHPWA directly if additional information is needed. KFHPWA will provide the IRO with any additional information the IRO requests that is reasonably available. The External Review request is considered complete when the IRO has all the requested information, and the IRO review begins.

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| Additional information | If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and KFHPWA will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow. |

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the External Review is pending. Your decision whether to file the External Review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

##### Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and KFHPWA in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the Plan's appeal process, and there are no further appeals available from KFHPWA or Microsoft or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

#### Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the Plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.

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| Additional information | If you have questions about understanding a denial of a claim or your appeal rights, you may contact KFHPWA at (206) 630-4636 or (888) 901-4636 or visit KFHPWA [online](https://wa.kaiserpermanente.org). You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272). |

#### Right to recover benefits paid in error

If KFHPWA makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, KFHPWA has the right to recover payment including deducting the amount paid by mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although KFHPWA may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

#### Release of medical information

As part of this plan, physicians, hospitals or other providers may disclose to KFHPWA medical information necessary to administer claims. KFHPWA will keep this information confidential.

## HMO Plan (Kaiser Permanente) – California only

[How the plan works 159](#_Toc361400308)

[Where you can get care 159](#_Toc361400309)

[What you pay 159](#_Toc361400310)

[What the plan covers 161](#_Toc361400311)

[Exclusions and limitations 161](#_Toc361400312)

[How to file a claim 161](#_Toc361400313)

### How the plan works

The Kaiser Permanente HMO Plan offers the convenience of “one-stop shop” medical care. Your providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about your care. There’s also a pharmacy, laboratory, and X-ray facility at every Kaiser Permanente location, so it’s easy and efficient to get the care you need when you need it.

### Where you can get care

The HMO Plan provides comprehensive medical care and prescription drug coverage with contracted providers, facilities, and pharmacies through the Kaiser Permanente network in California and eight other states. Kaiser Foundation Health Plan of Washington facilities are treated as part of the Kaiser Permanente network if you need medical services while in Washington State. Services provided outside the Kaiser Permanente’s service area may not be covered. You may need a referral from your primary care physician before the plan will cover care from specialists.

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| Additional information | To find an in-network provider of pharmacy, go to www.KP.org or contact the Member Service Contact Center at (800) 464-4000. |

### What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care, and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are responsible for 10% up to an annual out-of-pocket maximum. When it comes to preventive care and preventive prescriptions, the plan covers 100% when you use in-network providers.

| **What you pay** | | |
| --- | --- | --- |
| Copayments  Coinsurance  Out-of-pocket maximum  **+**  = | | |
| For office visits, outpatient surgery, and prescriptions, you pay a flat dollar copayment at the time you receive care, and the plan pays the remainder of the charges. | If you have an inpatient hospital stay, you pay 10% of the cost, called coinsurance, and the plan pays the rest. | If you reach your annual out-of-pocket maximum, the plan pays 100% of eligible expenses from that point forward. The out-of-pocket maximum is $1,500 per person, up to a $4,500 maximum for three or more covered family members. |

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| Additional information | **Copayment** is a fixed, up-front dollar amount that you are required to pay for certain covered services in the HMO plans.  **Coinsurance** is the percentage amount that you are required to pay for certain covered services.  **Out-of-pocket maximum** is the most you could pay each plan year for covered services and supplies. |

##### Medical care copayments

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| **Type of visit** | **Copayment** | **Coinsurance** |
| **Primary Care Physician** | $20 | None |
| **Specialist** | $40 | None |
| **Emergency (waived if admitted)** | $75 | None |
| **Hospital – outpatient** | $100 | None |
| **Hospital – inpatient** | None | 10% |

##### Prescription drug copayments

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| **(When prescribed by a Kaiser provider and obtained at a  Kaiser pharmacy)** | **Copayment** |
| **Generic** | $10 |
| **Brand** | $25 |

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| Additional information | **Generic drugs** are equivalent to a brand-name drug but available at a lower cost because the patent has expired.  **Brand-name** drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired. |

#### Out-of-pocket maximum

The annual out-of-pocket maximum is capped at $1,500 for each covered member—this means that once a member reaches their out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you’ll pay for the year is $4,500. Most copays and coinsurance count toward the annual out-of-pocket maximum, with the exception of prescription drugs and infertility treatment.

### What the plan covers

Benefits under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively), which are incorporated by reference in this SPD.

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| **Active employees/dependents** go here… | **COBRA enrollees** go here… |
| * [Evidence of Coverage – Northern California](https://hrportal.ehr.com/LinkClick.aspx?fileticket=gObaroCm1jE%3d&portalid=270) * [Evidence of Coverage – Southern California](https://hrportal.ehr.com/LinkClick.aspx?fileticket=CM5_6B-G5Ww%3d&portalid=270) | For more information, go to [http://cobra.me.microsoft.com](http://cobra.me.microsoft.com/) > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents |

### Exclusions and limitations

Exclusions and Limitations under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively) which are incorporated by reference in this SPD.

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| **Active employees/dependents** go here… | **COBRA enrollees** go here… |
| * [Evidence of Coverage – Northern California](https://hrportal.ehr.com/LinkClick.aspx?fileticket=gObaroCm1jE%3d&portalid=270) * [Evidence of Coverage – Southern California](https://hrportal.ehr.com/LinkClick.aspx?fileticket=CM5_6B-G5Ww%3d&portalid=270) | For more information, go to [http://cobra.me.microsoft.com](http://cobra.me.microsoft.com/) > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents |

| Additional information | Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the Benefits and Cost Sharing section in the Evidence of Coverage. |
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### How to file a claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the Evidence of Coverage provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Kaiser Permanente Health Plan.

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| **Active employees/dependents** go here… | **COBRA enrollees** go here… |
| * [Evidence of Coverage – Northern California](http://hrweb/doclibrary/HRWeb/Country/US/EOC_KaiserPermanente_NorthernCA_2023.pdf) * [Evidence of Coverage – Southern California](http://hrweb/doclibrary/HRWeb/Country/US/EOC_KaiserPermanente_SouthernCA_2023.pdf) | For more information, go to [http://cobra.me.microsoft.com](http://cobra.me.microsoft.com/) > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents |

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| Additional information | For more information about filing a claim, contact the Member Services Contact Center at (800) 464-4000. |

## Hawaii-Only Plan (Premera)

What is in this section

[How the plan works 163](#_Toc52351196)

[Where you can get care 163](#_Toc52351197)

[What you pay 166](#_Toc52351198)

[What the plan covers 169](#_Toc52351199)

[Plan benefits 173](#_Toc52351200)

[Exclusions and limitations 211](#_Toc52351201)

[How to file a claim 214](#_Toc52351202)

### How the plan works

The Hawaii-Only Plan provides comprehensive medical coverage and the flexibility to see any provider you choose. Preventive care is covered at 100% with in-network providers and facilities and you pay a share of other expenses up to an annual maximum amount.

### Where you can get care

With the Hawaii-Only Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

* Your claims are filed directly with Premera by your provider
* Lower, negotiated rates for care and prescriptions
* The highest coverage levels

If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement

Please review the [What you pay](#_What_you_pay_2) section for information on coverage levels.

#### Finding an in-network provider

In Hawaii, you can maximize your savings by using providers and facilities in the Premera network.

Outside of Hawaii, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the [BlueCard®](#Bluecard) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

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| Additional information | Visit the online [Premera Medical Directory](https://www.premera.com/) to find an in-network provider in the United States or call Premera Blue Cross at (800) 676-1411. |

#### Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [Blue Cross Blue Shield Global Core](#Bluecard), which provides referrals to doctors and other health care providers.

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| Additional information | Call (800) 810-BLUE (2583) for Blue Cross Blue Shield Global Core referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands. |

If you are not using a Blue Cross Blue Shield Global Core provider, you will need to submit claim forms to Premera for reimbursement of services received outside the United States. When you submit a claim, 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. Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered as long as the services are:

* Medically necessary
* Provided by a licensed provider performing within the scope of their license and practice
* Not deemed experimental or investigational based on the terms of this plan, or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance would apply.

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| Additional information | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#_Glossary) for a full definition. |

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| Additional information | Please review the [What you pay](#_What_you_pay_2) section for information on coverage levels. |

#### Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#_Prescription_drugs_5) benefit for more information on what is covered.

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| Additional information | Microsoft reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes. |

|  | Retail pharmacy | Home delivery | Specialty pharmacy |
| --- | --- | --- | --- |
| Coverage | * Up to a 90-day supply for [generic maintenance medication](#generichawaii); all others are up to a 30-day supply\* | * Up to 90-day supply\* only when using Express Scripts Home Delivery | * Up to a 30-day supply\* * Additional clinical support for members using specialty drugs |
| In-network pharmacies | * Express Scripts pharmacies bill the plan on your behalf * To find an Express Scripts retail pharmacy, call (800) 676-1411 | * Express Scripts pharmacies bill the plan on your behalf | * Walgreen’s Specialty Pharmacy or Accredo Specialty Pharmacy\*\* will bill the plan on your behalf |
| Out-of-network pharmacies | * You will need to submit a prescription reimbursement form, with your receipt, for reimbursement | * Not covered | * Not covered |

\* Unless the drug maker’s packaging limits the supply in some other way.

\*\* Contact Walgreen’s Specialty Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days’ supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the chart above.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable

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| Additional information | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Generic maintenance medications** have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply. |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| cid:image002.png@01D0FB63.FBAF7B20 | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. | | |  |
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Refer to the specific plan benefit for additional details.

### What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you’ll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

Premera utilizes medical and payment policies in administering coverage under this plan. The medical policies generally are used to further define medical necessity, experimental and investigative status, and other aspects for specific procedures, drugs, biologic agents, devices, and other items and services and levels of care. These medical policies are available at <http://premera.com> or by calling Customer Service. The payment policies are used to define provider billing and payment rules and adjustments that can apply in various different settings and circumstances. These payment policies are available to you by calling Customer Service and to your provider by calling Customer Service or going to <http://premera.com> and logging into Premera’s provider portal.

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| **What you pay** | | |
| Deductible  Coinsurance  Out-of-pocket maximum  **+**  = | | |
| You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera [allowable charge](#allowablechargehawaii) is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care. | If you reach the deductible, then you begin to pay coinsurance up to a capped amount called the coinsurance maximum. That means you pay only a portion of your health care costs and the plan pays the rest. The coinsurance amount you pay depends on where you seek care:   * In-network, you pay 10% * Out-of-network, you pay 30% of the allowable charge plus the difference between the provider’s bill and the allowable charge; only the allowable charge is applied to your coinsurance maximum. | If you meet your deductible and then you reach your coinsurance maximum, you’ve reached your out-of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the [allowable charge](#Allowablecharge) and the provider’s billed charges if you seek out-of-network care. |
| $300 per person, up to  $900 family maximum | $1,200 per person, up to  $3,600 family maximum | $1,500 per person, up to  $4,500 family maximum |

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| Additional information | The**allowable charge** is defined differently for in-network and out-of-network providers.   * For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. * For out-of-network providers, the allowable charge is the lowest of three amounts as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

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| **Example** |
| Jakob needs to visit an allergist. Jakob can choose an in-network or an out-of-network provider. Both charge $115.  The in-network provider accepts Premera’s allowable charge of $100 as full payment. Jakob hasn’t yet met the deductible, so will pay the allowable charge of $100 to Jakob’s in-network provider.  The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full $115. If the allowable charge for the out-of-network provider is also $100, then only that $100 amount would apply to Jakob’s deductible. |

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| **Example** |
| * Mimi needs to see a podiatrist. The visit costs $125. Mimi has met the deductible, so will pay just $10 for the visit if an in-network provider is used with a $100 allowable charge ($100 x 10% coinsurance). If Mimi visits an out-of-network provider for whom the allowable charge is also $100, Mimi would pay $55: * 30% of the $100 Premera allowable charge ($100 x 30% coinsurance = $30) * Plus, the difference between the out-of-network provider’s bill and the allowable charge ($125-$100=$25) |

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| **Example** |
| Kunji sees a doctor about an ear infection. The provider visit costs $175, and the allowable charge is $150. Kunji has met the out-of-pocket maximum, so will pay nothing if the provider is in-network.  If Kunji visits an out-of-network provider for whom the allowable charge is also $150, Kunji will pay $25, the difference between the out-of-network provider’s bill and the allowable charge ($175-$150=$25) |

#### Expenses covered at 100% and NOT applied to the deductible or coinsurance maximum

The following services are covered by the plan at 100% with in-network providers and do not count toward the deductible or coinsurance maximum.

* [Preventive care](#_Preventive_care_2)
* Care received through the [Spring Health employee assistance program](#_Section_VII:_Microsoft)

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

* Expenses incurred while the member was not covered under the Plan
* Expenses for services, supplies, settings, or providers that are not covered under this Plan
* Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits
* Amounts for out-of-network care in excess of the allowable charge for the service or supply
* Coinsurance for services covered under the [Weight Management program](#_Weight_Management_program_2)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not reimbursable business expenses.

#### Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

| Situation | Benefit coverage | What you need to do |
| --- | --- | --- |
| Emergency care | Benefits are provided regardless of network status | Go to the nearest emergency facility |
| You cannot find the provider specialty that you need in the Premera network | If the Premera network does not include a provider specialty (such as speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level | To confirm this coverage is available, please contact Premera at (800) 676-1411 |
| Your provider’s contract with Premera is ending | If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days. | To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, please contact Premera at (800) 676-1411 prior to the end of your provider’s contract with Premera |

#### Annual, lifetime, and other benefit maximums

There is no overall annual or lifetime maximum in the Hawaii-Only Plan. However, annual, lifetime, and other benefit maximums apply to certain benefits. Please review the [What the plan covers](#_What_the_plan_5) section for details on annual, lifetime, and other benefit maximums.

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| Additional information | A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#_Glossary) for a full definition.  An annual or other benefit maximum is the most a plan will pay toward a benefit for a member for services within a specified time period. Review the [glossary](#_Glossary) for a full definition. |

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| **Example** |
| There is a $6,000 weight management program lifetime benefit maximum for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options. |

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| **Example** |
| There is a $10,000 hearing hardware maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options. |

#### Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Premera or its designee may review a member’s medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent, or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Premera’s medical policies. The medical policies are on Premera’s website. You or your provider may review them at premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain this information by mail, please send your request to Medical Policies Coordinator, 7001 220th Street SW MS 438, Mountlake Terrace, WA 98043-2160.

Premera will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of fraud or an intentional misrepresentation of a material fact.

### What the plan covers

The tables below summarize what the Hawaii-Only Plan covers, including what the plan pays for in-network and out-of-network care.

|  |  |
| --- | --- |
| Additional information | Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s [exclusions and limitations.](#_Exclusions_and_limitations_2) |

| Additional information | CTRL+Click on the benefits below to access more information. |
| --- | --- |

| **Common benefits** | | |
| --- | --- | --- |
| These are the most commonly used benefits in the Hawaii-Only Plan. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Preventive Care](#_Preventive_care_2)  Including well-child care through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the [Preventive Care Services list](https://www.premera.com/documents/022576.pdf) and [Preventive Drug list)](https://www.premera.com/documents/022506.pdf) | Preventive services: 100%  Preventive prescription drugs: 100% | Preventive services: 70% of allowable charges after deductible; well-child care through age 6 covered at 100%  Preventive prescription drugs: 100% |
| [Prescription drugs](#_Prescription_drugs_5)  Including brand-name preventive with available generic equivalent (see the [Hawaii-Only Plan Drug Formulary](https://www.premera.com/documents/052148_2025.pdf) and preventive care above) | 90% after deductible | 90% after deductible\*  \*Home delivery and Specialty medications are not covered. |
| [Physician services](#_Physician_services_1)  Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility | 90% after deductible | 70% of allowable charges, after deductible |
| [Diagnostic Services](#_Diagnostic_Services)  Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. | 90% after deductible | 90% of allowable charges, after deductible |
| [Hospital inpatient care](#_Hospital_inpatient_care_2)  Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care | 90% after deductible | 70% of allowable charges, after deductible |
| [Hospital outpatient care/ambulatory surgical care center](#_Hospital_outpatient_care_1)  Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing | 90% after deductible | 70% of allowable charges, after deductible |
| [Urgent care](#_Physician_services_1) | 90% after deductible | 70% of allowable charges, after deductible |
| [Rehabilitation](#_Rehabilitation_1) – Physical, Occupational and Speech Therapies | 90% after deductible | 70% of allowable charges, after deductible |
| [Contraception](#_Contraception_1)  Contraceptive devices and injections administered by a physician and prescription forms of contraception. | 100% | 100% |
| [Maternity care](#_Maternity_care_3)  (Other than hospital inpatient or outpatient care) | 90% after deductible | 70% of allowable charges, after deductible |
| [Family Health and Reproductive Support](#_Maternity_Support_(Maven)) | Free virtual care and on-demand support (through Maven Clinic) for navigating family planning, pregnancy, parenting, perimenopause, and menopause. | Not applicable |
| [Mental health counseling, mental health inpatient and outpatient services, Attention Deficit Disorder, and chemical dependency treatment](#_Mental_health,_Attention_1) | Outpatient services through [Spring Health, administrator of the employee assistance program](#_Section_VII:_Microsoft):   * 100% of 12 sessions per issue per year (up to 24 sessions per year total) | Not applicable |
| 90% after deductible for inpatient and outpatient services | 90% of allowable charges, after deductible for inpatient and outpatient services |

| **Other benefits** | | |
| --- | --- | --- |
| The Hawaii-Only Plan also covers these additional benefits. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Ambulance](#_Ambulance_2) (Ground or Water) | 90% after deductible | 90% after deductible |
| Air Ambulance | 90% after deductible | 90% of allowable charges, after deductible |
| [Chiropractic services, acupuncture, and medical massage](#_Chiropractic_services,_acupuncture,) | 90% after deductible | 70% of allowable charges, after deductible |
| Combined 24-visit limit per member per calendar year | |
| [Diabetes health education](#_Diabetes_health_education_1) | 100% | 70% of allowable charges, after deductible |
| [Emergency room care and professional services](#_Emergency_care) | 90% after deductible | 90% of allowable charges, after deductible |
| [Hearing care and hardware](#_Hearing_care_and_2) | Exams: 90% after deductible | Exams: 70% of allowable charges, after deductible |
| Hardware: 90% after deductible; $10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options | |
| [Home health care](#_Home_health_care_2) | 90% after deductible | 70% of allowable charges, after deductible |
| [Hospice care](#_Hospice_care_1) | 90% after deductible | 90% after deductible |
| [Medical equipment and supplies](#_Medical_equipment_and_1) | 90% after deductible | 90% of allowable charges, after deductible |
| [Nutritional therapy](#_Nutritional_therapy_2) | 100% | 70% of allowable charges, after deductible |
| First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes. | |
| [Skilled nursing facility](#_Skilled_nursing_facility_2) | 90% after deductible | 70% of allowable charges, after deductible |
| 120-day limit per member per calendar year | |
| [Surgical weight loss treatment](#_Surgical_weight_loss)  Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met | 90% after deductible | 70% of allowable charges, after deductible |
| [Temporomandibular joint (TMJ) dysfunction](#_Temporomandibular_joint_(TMJ)_2) | 90% after deductible | 70% of allowable charges, after deductible |
| [Transplants](#_Transplants_2) | 90% after deductible | 70% of allowable charges, after deductible |
| [Vision therapy](#_Vision_therapy_1) | 90% after deductible | 70% of allowable charges, after deductible |
| 32-visit maximum, per member, for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options | |

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| **Specialized benefits** | | |
| Microsoft provides these unique benefits to you through the Hawaii-Only Plan. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage**  (may be subject to balance billing) |
| [Autism/Applied Behavior Analysis (ABA) therapy](#_Autism/Applied_Behavior_Analysis_2) | 90% after deductible | 90% of allowable charges, after deductible |
| [Fertility](#_Infertility_3) | 90% after deductible for coverage, within the Plan’s fertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy. | Not applicable |
| [Transgender services](#_Transgender_services_2) | 90% after deductible | 90% of allowable charges, after deductible |
| [Weight Management program](#_Weight_Management_program_2)  Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity | 80% of charges up to a maximum lifetime benefit payment of $6,000. Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met. | Not applicable |

### Plan benefits

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| Additional information | The following pages provide details on what the plan covers. The plan’s [exclusions and limitations](#_Exclusions_and_limitations_2), including the requirement of medical necessity, apply to these benefits. |

#### 24-Hour Nurse Line

The Microsoft 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The 24-Hour Nurse Line cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

* Provide information, coaching, and support regarding a wide range of health issues, including:
  + Aches and pains
  + Diabetes
  + High blood pressure
  + Illnesses and infections
  + Infant care
  + Immunizations
* Provide information about Microsoft-sponsored health programs such as:
  + Disability leave
  + Ergonomic assistance
  + On-site flu shots
  + On-site mammogram screenings
  + Smoking cessation
  + Weight management
* Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premera Blue Cross. All Microsoft covered employees and their dependents can access the 24-Hour Nurse Line. The 24-Hour Nurse Line cannot be accessed while traveling outside of the United States.

##### Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Microsoft covered employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Microsoft Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.

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| Additional information | You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:   * (800) 676-1411 * For deaf or hard-of-hearing access (TTY), call (800) 676-1411 then provide the number 711 |

#### Ambulance

Ground or Water

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

Air

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition when any other mode of transportation would endanger the member’s health or safety. This benefit is limited to the member that requires transportation.

For air ambulance services, please see [Federal No Surprise Billing Protection](#_Federal_No_Surprise) for special rules that apply to out-of-network air ambulance services.

#### Autism/Applied Behavior Analysis (ABA) therapy

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

##### Who is eligible

This benefit is available for members who are diagnosed with Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD-10-CM*):

* Autistic Disorder
* Childhood Disintegrative Disorder
* Asperger’s Syndrome
* Rett’s Syndrome
* Other Pervasive Development Disorder/Atypical Autism
* Pervasive Developmental Disorder unspecified

##### Eligible providers

##### **Licensed providers** — Medical doctors (MD); doctors of osteopathic medicine (DO); nurse practitioners (NP, ANP, ARNP, etc.); and master’s-level or above mental health clinicians and occupational, physical, and speech therapists, provided that they are providing the ABA services within the scope of their practice and licensure.

##### **Board Certified Behavioral Analysts** — BCBAs are certified by the Behavior Analyst Certification Board. These providers have master’s or doctoral degrees. For ABA services, typically a BCBA functions as a “Program Manager.” The Program Manager conducts behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The Program Manager also designs and periodically reviews behavior analytic interventions (program development and treatment planning) and may supervise Therapy Assistants. Therapy Assistant services must be billed by the Program Manager.

##### Covered services

Services must be ordered by the member’s treating physician to be covered. Program Manager benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan.

In most cases, Therapy Assistants will provide the implementation portion of the treatment plan. Therapy assistant time may be covered for face-to-face, in-person or virtual visits with the member to perform the tasks described in the treatment plan and to document outcomes, and for time to meet with the Program Manager for training and to discuss treatment plan issues. Therapy Assistant services that are billed by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

* Babysitting or doing household chores
* Time spent under the care of any other professional
* Travel time
* Home schooling in academics or other academic tutoring
* Activity therapy, such as music, dance or art therapies

##### Out of network providers

You may be billed for charges assessed above the allowable charges since these providers have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges will not count towards satisfying any deductible requirements, or the coinsurance maximum that may apply under this plan.

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| Additional information | The **allowable charge** is defined differently for in-network and out-of-network providers. For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine before service is provided. Services are subject to eligibility and benefits at the time of service. |

Services for this treatment that do not meet criteria described above are subject to retrospective denial of benefits.

##### Additional exclusions and limitations for autism/ABA therapy

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#_Rehabilitation_1) benefit) or mental health services (which apply under the [mental health and chemical dependency](#_Mental_health,_Attention_1) benefit)
* Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
* Other unspecified developmental disorders or delays, or any other delay or disorder in a member’s motor, speech, cognitive, or social development are not covered under this benefit
* This benefit covers only the allowable fees for eligible services performed by the provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the provider, expenses of those working under the provider’s supervision, the member, and their family members will not be covered.

#### Cancer Support (Personalized by Thyme Care)

Microsoft provides access to Thyme Care at no cost to all employees and their eligible dependents aged 18 and older with a suspected or confirmed cancer diagnosis who are covered under a Microsoft U.S. Premera health plan. Thyme Care is a 24/7 evidence-based virtual cancer advocacy and navigation program offering individualized support in-between visits with your oncologist.

If you have cancer, or are caring for someone with cancer, Thyme Care provides:

* **24/7 access:** A Thyme Care expert is available anytime through confidential calls. You can also use Thyme Care Connect or text them for support with your questions or concerns.
* **On-demand nurse support:** Whether you’re concerned about potential side effects, need help understanding test results or medications, or simply want more guidance. Thyme Care can translate what the doctors are telling you and provide information to help plan for the road ahead.
* **Collaborative care focused on you:** Thyme Care takes care of your needs between visits and keeps your doctors and care teams updated, so you can rest assured that all the details are connected, and nothing gets lost.
* **Support beyond the clinic:** Get connected to the support and services you need. These may include financial help, transportation, in-home care, food assistance or community groups dedicated to supporting cancer patients.
* **Evidence-based resources:** Receive clinically informed content tailored to you with trusted information and expert tips on preparing for treatment, handling worries, talking to doctors, strategies for improving your sleep, exercise routine, and emotional well-being.
* **Support for life after cancer treatment:** Regular check-ins provide tips on ongoing care and helpful wellness information, including sleep, nutrition, exercise, mindfulness, and getting back to normal.

**Navigate cancer with confidence. With Thyme Care, you can:**

* Learn about your diagnosis and treatment options
* Address urgent concerns and unexpected challenges
* Manage symptoms and side effects
* Get emotional and mental health support
* Identify financial assistance and get help with insurance navigation
* Find in-network doctors or get help seeking a second opinion
* Connect with other helpful Microsoft benefits

**To enroll:**

Visit thymecare.com/Microsoft and click “Enroll Now” then follow the steps to get started.

If you have any issues or questions, call the Thyme Care team at 1-833-849-6300, and they can help you set up your account.

*Thyme Care does not diagnose oncologic conditions or provide cancer-directed therapies, treatments, or prescription of medications.*

* *Thyme Care will not share your medical records or medical information with anyone, including Microsoft or your health plan, unless you specifically authorize such disclosure.*

#### Chemotherapy and Radiation Therapy

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers the following services:

* Outpatient chemotherapy and radiation therapy services, including proton beam radiation therapy when medically necessary
* Supplies, solutions and drugs (See the [Prescription Drugs](#_Prescription_drugs_5) benefit for oral chemotherapy drugs)

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Childbirth / Maternity Classes

*In-network: 100%   
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth and Lamaze, breastfeeding and infant education classes. The benefit is for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered individual.

##### Additional exclusions and limitations for childbirth / maternity classes

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations_2), exercise classes, such as maternity yoga, are excluded from this benefit.

#### Chiropractic services, acupuncture, and medical massage therapy

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 24 visits per member per calendar year* *chiropractic, acupuncture, and medical massage therapy (combined)*

This benefit (1) covers chiropractic service from a licensed chiropractor or other provider licensed to perform chiropractic services, (2) acupuncture services provided, when medically necessary to relieve pain or to treat a covered illness, injury, or condition, from a licensed acupuncturist or other provider licensed to perform acupuncture, and (3) medical massage therapy from a provider licensed to perform medical massage therapy, with a physician’s prescription. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider’s scope of practice guidelines.

These covered services must be medically necessary and will be covered only when the provider is providing the service within the scope of their state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) provided will accrue cumulatively toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you will have four visits available for covered medical massage and/or acupuncture services in that calendar year. Covered Massage Therapy services are limited to a maximum of one hour per day.

#### 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 the health condition according to the trial protocol and participating provider or information submitted by the member and the member must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service received. 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.

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 the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality; the Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above entities or the Department of Defense (DOD) or the Department of Veterans Affairs (VA); the VA, DOD, and Department of Energy if peer-reviewed and approved as per the Secretary of HHS; a qualified private research entity that meets the standards for NIH support grant eligibility.

Routine patient costs in connection with 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

Those interested in this coverage are encouraged to contact customer service at 800-676-1411 before enrolling in a clinical trial. Customer service can help the member or provider verify that the clinical trial is a qualified clinical trial.

#### Contraception

*In-network: 100%  
Out-of-network: 100%*

This benefit covers FDA-approved contraceptive devices and injections for contraceptive purposes for women when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered. This benefit also covers office visits and consultations related to contraception management.

All FDA-approved generic birth control medications are covered under the [prescription drug](#_Prescription_drugs_5) benefit at 100%.

#### Dental services

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider’s license.

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| P6876C1T316#yIS1 | Review the [Dental plan](#_Section_V:_Dental) section for information on your dental benefits. |

##### Covered services

This benefit covers treatment of serious dental issues, such as a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth, when not part of the dentition (gums, teeth, teeth supporting structure).

Hospital or outpatient facility fees and skilled observation for anesthesia administration related to dental treatments may be covered by the medical benefit when the following criteria are met.

Dental treatment in a hospital or outpatient facility is required because of any of the following:

* A physician has determined that the member’s medical condition would place them at undue risk if the dental treatment were performed in a dental office. Some examples, though not all inclusive, are:
  + Cardiac conditions
  + Chronic respiratory disease, such as emphysema
  + Hemophilia or other blood disease
  + History of allergy to local anesthesia
  + Severe anemia
  + Severe hypertension
  + Uncontrolled diabetes
* The severity of the dental condition prevents treatment in the dental office setting.
* General anesthesia in a dental office, hospital or outpatient facility is required because of any of the following:
  + The member has a physical or mental disability and cannot be managed with local anesthesia, intravenous (IV) or non-intravenous conscious sedation.
  + The member has tried and failed other means of patient management (including premedication) in the office setting.
  + Other means of patient management are contraindicated for the member.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera’s medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| P6901C1T317#yIS1 | [**Prior authorization**](#priorauthorization)is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

##### Additional exclusions and limitations for dental services

In addition to the plan’s [[exclusions and limitations](#_Exclusions_and_limitations_2),](#_Exclusions_and_limitations_3) the following exclusions and limitations apply to this benefit:

* Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
* Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
* Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.
* Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofacial pain dysfunction (MPD); benefits may be available under the Microsoft temporomandibular dysfunction benefit
* The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

#### Diabetes

##### Diabetes health education

*In-network: 100%  
Out-of-network: 100% of allowable charges*

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

##### Teladoc Health Condition Management - Diabetes Management, Diabetes Prevention, and Hypertension Programs

*In-network: 100%*

*Out-of-network: n/a*

Teladoc Health Condition Management for Diabetes Management, Diabetes Prevention, and Hypertension Programs provide monitoring and health management support to individuals within the programs. If you qualify and enroll in any of the programs, you will receive the following benefits:

###### Diabetes Management

For members 13 and older who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

* A blood glucose meter that uses cellular technology to automatically upload blood sugar readings to a personal online account.
* A lancing device and unlimited lancets at no cost to you.
* Unlimited test strips for this meter at no cost to you. You can reorder test strips using the meter or online. The strips will be sent to you directly.
* Real-time feedback and tips based on your blood sugar readings that can help keep your levels within a healthy range.
* Coaching and support via phone, text, e-mail, or the program manager’s mobile app.
* Digital tools that support your mental health.

###### Diabetes Prevention

For members 18 and older who meet pre-diabetes criteria followed by the Centers for Disease Control. The program’s duration is 12 months, with an additional 12 months of access for maintenance. If you qualify and join the program, you will get:

* A cellular-connected scale that uploads readings to a personal online account.
* Real-time tips and personalized feedback on health, nutrition or lifestyle changes to help you learn and improve.
* Unlimited coaching and support via phone, text, e-mail or the mobile app.
* Complete CDC-recognized weight management curriculum based on in-app content and online resources.
* Periodic review of plan, self-monitoring data, and feedback from expert coach.
* Experiential learning missions covering nutrition, activity, motivation, sleep, and stress management.
* A mobile app, and device for tracking weight, steps, and achievement of health goals for food and physical activity.
* Digital tools that support your mental health.

###### Hypertension

For members 18 and older who have hypertension. If you qualify and join the program, you will get:

* A cellular-enabled blood pressure cuff that uploads blood pressure readings to a personal online account.
* Real-time tips and personalized feedback based on your blood pressure readings that can help keep your pressure within a healthy range.
* Unlimited coaching and support via phone, text, e-mail, or the mobile app. Access to online information.
* Digital tools that support your mental health.

*Additional support*

If you are 18 and older who qualify for more than one of the above programs you may be eligible for additional tools and devices to help you live healthier:

* For members with hypertension, a connected blood pressure monitors to help track your numbers.
* Members who qualify for the Diabetes Prevention or the Weight Loss Program may receive a smart scale

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to [teladochealth.com/microsoft-ccm](file:///C:/Users/reocaa/Downloads/oe25UAT/SPDsFinal/http;/teladochealth.com/microsoft-ccm) , or call Premera customer service.

#### Diagnostic Services

*In-network: 90%, deductible applies*

*Out-of-network: 90% of allowable charges, deductible applies*

Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. Included in the coverage are charges for the test or scan itself and charges to interpret the results. Some examples of what’s covered under this benefit are:

* Diagnostic imaging and scans (including x-ray, MRI, PET, CAT and EKGs)
* Services that are medically necessary to diagnose infertility
* Laboratory services
* Pathology tests

Diagnostic surgeries, including scope insertion procedures, can only be covered under the Surgical Services benefit.

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| Additional information | Prior authorization is strongly recommended for some diagnostic services. Some examples of these include but are not limited to: Genetic Testing, CAT scan, and MRI. Have your provider contact Premera to see if your service needs this pre-service review. |

#### Emergency room care and professional services

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#_Hospital_inpatient_care_2) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency](#_Mental_health,_Attention_1) benefit.

Please see the [Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

#### Hearing care and hardware

##### Hearing exams and testing

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

* Examination of the inner ear and exterior of the ear
* Observation and evaluation of hearing, such as whispered voice and tuning fork
* Case history and recommendations
* The use of calibrated equipment

##### Hearing hardware

*In-network: 90%, deductible applies   
Out-of-network: 90%, deductible applies*

*Limit: up to $10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in a Premera-administered health plan option*

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of $10,000 per member in a period of three consecutive calendar years.

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

* The hearing aid(s) (monaural or binaural) prescribed as a result of an exam or an FDA approved over-the-counter hearing aid(s) (monaural or binaural)
* Ear mold(s)
* Hearing aid rental while the primary unit is being repaired
* The initial batteries, cords, and other necessary ancillary equipment
* A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either the prescribing physician or audiologist
* Repairs, servicing, and alteration of hearing aid equipment

##### Additional exclusions and limitations for hearing care and hardware

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Hearing aids purchased before your effective date of coverage under this plan
* A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in a Premera-administered health plan option
* Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
* A prescriptions hearing aid that exceeds the specifications prescribed for correction of hearing loss
* Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
* Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

#### Home health care and Nursing care

In-home care, other than Hospice Care and Respite Care (non-hospice), can be broken into two categories for purposes of benefit coverage:

| **Benefit** | **Description** | **Care Duration** | **Coverage** |
| --- | --- | --- | --- |
| Home health care | * Short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. | * The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. | * In-network: 90%, deductible applies * Out-of-network: 70% of allowable charges, deductible applies |
| Nursing care | * Longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN). | * Generally needed for more than 4 hours per day. | * In-network: 90%, deductible applies * Out-of-network: 90%, deductible applies |

Read below for additional in-home care coverage details.

##### Home health care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers home visits for short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. The benefit includes the cost of a home health aide when acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.

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| Additional information | **Intermittent care** is care provided due to the medically predictable recurring need for skilled home health care services. |

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

##### Additional exclusions and limitations for home health care

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* 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
* Materials such as handrails and ramps
* Services performed by family members and volunteer workers
* Psychiatric care
* Unnecessary and inappropriate services
* Maintenance or [custodial care](#Custodial_Care)
* Diversional therapy
* Services or supplies not included in the written treatment plan
* Over-the-counter drugs, solutions, and nutritional supplements
* Dietary assistance, such as Meals on Wheels
* Services provided to someone other than the ill or injured enrollee

##### Nursing care

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

This benefit covers longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN) working under a licensed home health agency. Skilled hourly nursing care is provided in lieu of hospitalization and generally is needed for more than 4 hours per day. The nurse who is providing the care cannot be a permanent resident in the member’s home.

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| Additional information | **Skilled nursing care** is provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it. |

##### Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for nursing care to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

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| Additional information | [Prior authorization](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

#### Hospice care

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice and Palliative Care Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a Master of Social Work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member’s doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 672 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.

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| Additional information | **Hospice care** is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member’s home.  **Intermittent care** is care provided due to the medically predictable recurring need for skilled home health care services.  **Respite care** is continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers. |

##### Additional exclusions and limitations for hospice care

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Bereavement or pastoral counseling
* Financial or legal counseling, including real-estate planning or drafting of a will
* Funeral arrangements
* Diversional therapy
* Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

#### Hospital inpatient care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers the following inpatient medical and surgical services:

* Room and board, including general duty nursing and special diets
* Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
* Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
* Diagnostic and therapeutic services
* Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the hospital inpatient care benefit), along with provider charges for that emergent condition, will be covered at the in-network level.

Please see [the Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

For substance abuse treatment, see the [mental health and chemical dependency](#_Mental_health,_Attention_1) benefit.

##### Additional exclusions and limitations for hospital inpatient care

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member’s medical condition makes inpatient care medically necessary
* Any days of inpatient care that exceed the length of stay required to treat the member’s condition

#### Hospital outpatient care and ambulatory surgical center care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers operating, procedure, and recovery rooms; plus, services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Please see [the Federal No Surprise Billing Protection](#_Federal_No_Surprise) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

#### Fertility

*In-network: 90% after deductible for coverage, within the Plan’s fertility vendor (Progyny) provider network*

*Out-of-network: not applicable*

*Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more Microsoft health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below*

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| Additional information | *Members must contact their* ***Progyny Patient Care Advocate*** *at* ***(888) 203-5066*** *to confirm eligibility and utilize a Progyny Network Provider to access the benefit.* |

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

The Progyny SMART cycle benefit allows for:

* Two (2) Smart Cycles per household, with an additional Smart Cycle available if the first two do not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, subject to the restrictions described below for certain members who received fertility benefits of less than $15,000 under the Health Savings Plan prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.
* One (1) Smart Cycle per household, with an additional Smart Cycle available if the first does not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, for members who (1) have been enrolled continuously in one or more Premera-administered health plan options (such as the Health Savings Plan) since before 2018, and (2) incurred $15,000 or more in fertility benefits under the Plan during such continuous enrollment period prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

* Two consultations per calendar year
* Diagnostic testing
* Transvaginal ultrasounds
* Intrauterine insemination (also known as artificial insemination)
* In vitro fertilization (IVF)
* Gamete intra-fallopian transplant (GIFT)
* Intracytoplasmic sperm injection (ICSI)
* Pre-implantation genetic screening (PGS)
* Pre-implantation genetic diagnosis (PGD)
* Embryo assessment and transfer
* Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
* Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
* Purchase of donor tissue (sperm, eggs) as follows:
  + Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes ¼ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
  + A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

##### Additional exclusions and limitations for fertility

The following exclusions apply to this benefit:

* Fees paid to donors for their participation in any service
* Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
* Home ovulation prediction kits
* Services and supplies furnished for a dependent child (under age 26), except for oncofertility preservation due to cancer or medical treatments
* Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
* Fertility Services following a voluntary sterilization procedure

#### Maternity care

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children. Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

* Prenatal testing when required to diagnose conditions of the unborn child
* Normal deliveries and cesarean sections
* Services of a licensed nurse or midwife (non-medical services, such as non-medical services performed by a doula are not covered)
* Miscarriages and terminations of pregnancy
* Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
* Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
* One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
* Home births include an allowance of up to $500 for eligible supplies and/or equipment used for home delivery; for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.
* Birth doula services up to a maximum benefit of $1,000 per pregnancy, after deductible is met. Before seeking doula services, you must be examined by a licensed physician, registered nurse or midwife and have a confirmed pregnancy.
* Covered doula services include:
  + In person, phone, and email support throughout the pregnancy and post-partum
  + Birth support
  + Lactation support
* Doula services are not covered for the following:
  + Babysitting or doing household chores
  + Travel time
  + Any other services not listed as covered doula services, above
* Eligible providers: a doula who is state-licensed if the state requires a license. If the state does not require a license, then the doula must have a current certification under a recognized doula certification organization (examples include DONA International and PALS Doulas). Eligible doulas do not have to be an in-network provider.
* Exclusions: apprentice doulas

The [home health care](#_Home_health_care_2) benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

#### Medical equipment and supplies (durable medical supplies)

*In-network: 90%, deductible applies   
Out-of-network: 90% of allowable charges, deductible applies*

##### Covered services

This benefit covers charges for durable medical and surgical equipment and supplies (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment. The Plan reserves the right to require a period of rental prior to covering the purchase of equipment. Benefits for DME purchases will be reduced by any prior Plan benefits for renting the same equipment, unless (and to the extent that) the Plan required such prior rental.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member’s physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

In order to be covered, DME must be no more than one item of equipment for the same or similar purpose regardless if the plan covered the initial item or not, and the equipment and accessories to operate it must be:

* Made to withstand prolonged use
* Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
* Suited for use in the home

This list of covered DME includes, but is not limited to:

* Braces
* Crutches
* Wheelchairs
* Wheelchair seat lift mechanism and/or a power seat elevation device when a member meets the applicable medical necessity requirements for a power wheelchair
* Prostheses
* Cochlear Implants and associated supplies
* Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
* Wigs (up to $2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
* You may purchase one over-the-counter breast pump or rent a hospital grade breast pump during a calendar year (one or the other, but not both). The pump must be for your own use. Replacement supplies may be purchased on an as needed basis. In-network purchase/rental for the pump and replacement supplies is covered at 100%. Out-of-network purchase/rental for the pump and replacement supplies is covered at 100% of allowable charge. Deductible does not apply. Batteries are not covered.
* Continuous glucose monitors and their supplies are covered at 100% of allowable charges. Deductible does not apply.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

* Corneal ulcer/abrasion
* Bullous keratopathy
* Recurrent erosion of cornea
* Keratoconus
* Tear film insufficiency (dry-eye syndrome)
* Cataract surgery

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | A [**prior authorization**](https://outlook.office365.com/owa/wopi/files/96164086-4b14-499b-9fd7-5624489694f5@microsoft.com/AAMkADk2MTY0MDg2LTRiMTQtNDk5Yi05ZmQ3LTU2MjQ0ODk2OTRmNQBGAAAAAADfnOTgct4BQpW4-OOSBGceBwAXCSSG8TcsSZE2aGEbmzulAAAAAAEMAAAXCSSG8TcsSZE2aGEbmzulAARFF6SmAAABEgAQAJWnTbGpwYxOpuTYVAa3R8I=_AADbmXo.MQkAAAAAAAA=/WOPIServiceId_FP_EXCHANGE_ORGID/WOPIUserId_23fc4fea-e150-4f47-bb69-61e0b6ef3d31/spd_corporate_2023_072023%20Final%20Redline.docx#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

##### Additional exclusions and limitations for medical equipment and supplies (durable medical supplies)

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following DME and supplies will not be covered by this plan when they are:

* Normally of use to persons who do not have an injury, illness, disease, or medical condition
* For use in altering air quality or temperature
* For exercise, training and use during participation in sports, recreation, or similar activities
* Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
* Special or extra-cost convenience items and/or features
* Structural modifications to your home and/or private vehicle
* Replacement of lost or stolen equipment or supplies
* Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

#### Medical Foods

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

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 counseling, mental health inpatient and outpatient services, Attention Deficit Disorder, and chemical dependency treatment

*Inpatient and Outpatient:*

* *100%, up to calendar year visit limits through Microsoft CARES employee assistance program*
* *In-network: 90%, deductible applies*
* *Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary treatment for:

* mental health conditions such as, but not limited to the diagnosis and treatment stress, anxiety, or depression, or other psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
* chemical dependency such as substance use disorder and alcohol use disorder

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage.

| **Type of care** | **You will be covered as follows** |
| --- | --- |
| Through the [Spring Health employee assistance program (EAP)](#_Section_VII:_Microsoft) | No deductible applies  100% of 24 sessions per person per year. |
| Inpatient and Outpatient benefits | * In-network: 90%, deductible applies; out-of-network: 90% of allowable charges, deductible applies |

##### Eligible providers

Eligible providers include:

* A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
* A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
* A master’s level mental health provider licensed, registered, or certified as legally required to provide mental health services
* Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

##### Prior Authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for inpatient care and residential treatment centers to determine coverage is available before the service occurs. When an emergency admission occurs, notification to Premera within two days is also recommended. Either the member or the provider may contact Premera for a prior authorization.

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| Additional information | A [**prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

##### Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Testing must be ordered by a physician for the purpose of diagnosing or medical management
* Smoking cessation programs or materials; (Microsoft provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the [prescription drug](#_Prescription_drugs) benefit.)
* Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary
* Educational or recreational therapy or programs; this includes but is not limited to boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.

#### Nutritional therapy

This benefit covers outpatient nutritional therapy visits with a dietitian, nutritional therapist or certified lactation consultant to manage a covered condition, illness or injury.

First 12 visits per member per calendar year:

*In-network: 100%   
Out-of-network: 70% of allowable charges, deductible applies*

After the initial 12 visits per member (in the same calendar year) benefit coverage remains available for a covered condition, illness or injury (examples below) as follows:

*In-network: 90%, deductible applies*

*Out-of-network 70% of allowable, deductible applies*

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

* Hypertension
* Cardiac problems
* Feeding difficulties
* Gastric reflux disease

Nutritional therapy visits received in connection with a diagnosed eating disorder or diabetes is unlimited and will be covered at 100% of allowable charges.

#### Onsite Mammography Screening

Microsoft offers access to an onsite mammography screening in select Microsoft locations to employees and their spouse/domestic partners enrolled in a Microsoft Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

##### Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Microsoft partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

##### When Do the Screenings Occur?

Periodically each year, usually during the fall.

##### Eligibility

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.

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| Additional information | At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician. |

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

#### Physician services

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers:

* Medical and surgical services of a physician
* Urgent care visits at an urgent care facility
* Care via online and telephonic methods when medically appropriate:
  + Benefits for telemedicine are subject to standard office visit cost-shares and other provisions as stated in this booklet. 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
* Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider

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| Additional information | An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:   * Requires prompt medical attention to avoid serious deterioration of the member’s health * Does not require the level of care provided in the emergency room or a hospital * Cannot be postponed until the member’s physician is available   A **Physician** is 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 treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing service for which benefits are specified in this SPD and 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.) * Physician Assistant (P.A.) * Podiatrist (D.P.M.) * Psychologist (Ph.D.) * Advanced Registered Nurse Practitioner (A.R.N.P.) * Nurse (R.N.) * Naturopathic physician (N.D.) |
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#### Plastic and reconstructive surgery

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers services, supplies, and procedures for plastic or reconstructive surgery purposes, along with complications of these services, supplies, or procedures, for the following:

* Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
* Treatment for a congenital anomaly of a child
* Treatment of visible birth marks of a covered child
* All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
* Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.

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| Additional information | A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.  A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment. |

#### Prescription drugs

*In-network: 90%, deductible applies, up to limits provided below  
Out-of-network: 90%, deductible applies, up to limits provided below*

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member’s use outside of a medical facilityanddispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also, included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit and are not subject to the deductible. Brand-name preventive medications with an available generic equivalent will not be covered by the preventive care benefit. Review the [preventive care](#_Preventive_care_2) benefit for more information.

##### Generic drug substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you’ll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you’ll be charged the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Note: The difference in price between the brand name drug and the generic equivalent will not apply to your deductible and/or coinsurance maximum. Even if you reach your deductible or coinsurance maximum, you will still be responsible for the full amount of the difference in price between the brand name drug and the generic equivalent.

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| Additional information | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Brand-name** prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.  **Generic drugs** are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired. |

##### Prescription limits

|  | Retail pharmacy | Home delivery | Specialty pharmacy |
| --- | --- | --- | --- |
| Coverage | * Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply\* | * Up to 90-day supply\* only when using Express Scripts Pharmacy Home Delivery | * Up to a 30-day supply\* * Additional clinical support for members using specialty drugs |
| In-network pharmacies | * Express scripts pharmacies bill the plan on your behalf * To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411 | * Express scripts pharmacies bill the plan on your behalf | * Walgreen’s Specialty Pharmacy, or Accredo Specialty Pharmacy\*\* or Express Scripts Retail Pharmacy\*\*\* will bill the plan on your behalf |
| Out-of-network pharmacies | * You will need to submit a prescription reimbursement form, with your receipt, for reimbursement | * Not covered | * Not covered |

\* Unless the drug maker’s packaging limits the supply in some other way.

\*\* Contact Walgreen’s Specialty Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days’ supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable

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| Additional information | **Generic maintenance medications** have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply. |

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| Additional information | Premera provides a customer service team dedicated to Microsoft employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:   * Status of mail order prescriptions * Plan design, including which medications are covered or not covered * Location of retail pharmacies |

##### Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization:

* Prescription drugs (Federal Legend 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](#prescriptiondrug).
* Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to standard supply limit.
* Inhalation spacer devices and peak flow meters
* Glucagon and allergy emergency kits
* Prescribed injectable medications for self-administration (such as insulin)
* Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
* Disposable diabetic testing supplies, including test strips, testing agents, and lancets
* Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
* Human growth hormone
* Prescription drugs for smoking cessation
* Birth control medications
* Immunization agents and vaccines
* Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days.

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for a certain prescription drug is available before the prescription can be filled.

To determine if prior authorization is required for a particular drug, refer to the [formulary drug list,](https://www.premera.com/documents/052148_2025.pdf) or either the member or the provider may contact Premera.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

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
* Be under the care of an appropriate medical specialist
* Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.

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| Additional information | For questions about your pharmacy benefits or quantity limits, please contact Premera Customer Service at (800) 676-1411. |

The table below provides information on how to submit information for a medical necessity review.

| **Drug** | **Information** |
| --- | --- |
| Certain drugs require prior authorization. Examples include but are not limited to: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications. | Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review.  If you would like to find out if your drug requires review, refer to the [formulary drug list](https://www.premera.com/documents/052148_2025.pdf), or call Premera Customer Services at (800) 676-1411. |

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| Additional information | Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA-approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process. |

##### Drug-usage patterns

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

##### Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this Plan and what coverage limitations are in your contract.

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| Additional information | If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411. |

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

##### Additional exclusions and limitations for prescription drugs

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
* 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. These may include but are not limited to: nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as “Plan B”), aspirin for women and men, folic acid for women and iron supplements.
* Over-the-counter contraceptives, supplies and devices (except as required by law)
* Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth or stop hair loss not related to alopecia areata, or prevent wrinkles)
* Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
* Drugs for experimental or investigational use
* Any prescription refilled too soon or 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
* Replacement of lost or stolen medication
* Devices and appliances, support garments, and non-medical supplies
* This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Microsoft coverage (for example, drugs administered while hospitalized)
* Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place
* Shipping and handling charges for prescriptions drugs are not covered.

#### Preventive care

*Preventive services:*

* *In-network: 100%*
* *Out-of-network: 70% of allowable charges, deductible applies; well-childcare through age 6 is covered at 100%*

This benefit covers routine exams, immunizations and health screenings, such as:

* Routine physicals for women and men
* Women’s preventive care, including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)
* Well-child exams, including physical exams, tests, and immunizations, through age 11 and annual physical exams for age 12 through 18
* Hearing screening for children through age 18
* Routine eye exams
* Flu shots
* Colorectal cancer screening
* Prostate cancer screening
* Lung cancer screening
* Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

*Preventive prescription drugs:*

* *In-network: 100%*
* *Out-of-network: 100%*

This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.

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| Additional information | For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](https://www.premera.com/documents/022576.pdf) and the [Preventive Drug list,](https://www.premera.com/documents/022506.pdf) or contact Premera Customer Service at (800) 676-1411. For information on how to fill your prescription, see the [prescription drug](#_Prescription_drugs_5) section. |

#### Rehabilitation

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

* Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
* Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting (see inpatient benefits). Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy, including cardiac rehabilitation, are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which they practice, subject to the Plan’s review and approval of your treatment plan for physical therapy and functional occupational therapy services. Premera or its designee may review a member’s treatment plan for the purpose of verifying that the treatment is clinically safe, effective, and appropriate for the member’s condition. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Please refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

#### Respite Care (Non-Hospice)

*In-network: 90%, deductible applies   
Out-of-network: 90%, deductible applies*

*Limit: 672 hours per calendar year*

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 672 hours per calendar year in the member’s residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#_Home_health_care_2) benefit. For the respite care application and more information on this benefit, please call Premera Customer Service at 800-676-1411.

##### Additional exclusions and limitations for respite care:

In addition to the plan’s [exclusions and limitations](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

1. Respite care provided by a non-certified or non-licensed provider or agency
2. Respite care provided by a family member or friend
3. Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
4. Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

#### Skilled nursing facility

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 120 days per member per calendar year*

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.

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| Additional information | **Custodial care** is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#_Glossary) for a full definition. |

Services and supplies eligible for reimbursement include:

* Room and board, meals, and general nursing care
* Services and supplies furnished and used while you are in the skilled nursing facility, such as:
  + The use of special treatment rooms
  + Routine lab exams
  + Physical
  + Occupational or speech therapy
  + Respiratory and other gas therapy
  + Drugs and biologicals (such as blood products and solutions)
  + Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for skilled nursing facilities to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |
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Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

##### Additional exclusions and limitations for skilled nursing facility

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Custodial care is not provided
* Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder

#### Sterilization services

##### Elective Sterilization – Female

*In-network: 100%  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

##### Elective Sterilization – Male

*In-network: 100%  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

#### Surgical weight loss treatment

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

##### Who is eligible

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.

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| Additional information | Contact Premera at (800) 676-1411 for a copy of the policy. |

Examples of qualifying criteria include:

* A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m2) or BMI greater than 35 Kg per m2 in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
* Physician-supervised weight reduction program which includes:
  + A program lasting at least three consecutive months within the 12-month period before surgery is considered,
  + Evidence of active participation in a program documented in the member’s medical records,
  + A psychological evaluation and clearance by a licensed mental health provider, to help rule out other psychological disorders, inability to provide informed consent, or inability to comply with pre- and post-surgical requirements.

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

#### Temporomandibular joint (TMJ) dysfunction

*In-network: 90%, deductible applies   
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofacial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.

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| Additional information | While not required by the Plan, pre-service review is strongly recommended for some TMJ services, to ensure that coverage is available. For a list of such services, please call 1-800-676-1411. Fax pre-service review requests to Dental Review at (425) 918-5956 or mail to:  Dental Review MS 173 P.O. Box 91059 Seattle, WA, 98111-9159 |

TMJ services and supplies for the treatment of TMJ dysfunction and myofacial pain dysfunction include:

* Diagnostic and follow-up examinations
* Diagnostic X-ray services
* Oral surgery
* Physical therapy
* Biofeedback
* Transcutaneous Electrical Nerve Stimulation (TENS)
* TMJ splints or TMJ guards

#### Transfusions, blood, and blood derivatives

*In-network: 90%, deductible applies  
Out-of-network: 90%, deductible applies*

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

#### Gender Affirming surgical services

*In-network: 90%, deductible applies  
Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#_Prescription_drugs_5) and [mental health](#_Mental_health,_Attention_1) benefits.

##### When services are covered

##### Gender affirming surgical services will be covered if you are diagnosed as having gender dysphoria or gender incongruence, and the surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior authorization, also referred to as a pre-service review, is strongly recommended for coverage to be made available for gender affirming surgical services. Either the member or the provider may contact Premera for prior authorization. The most current WPATH Standards of Care outline the specific requirements that must be met in order for the gender affirming surgical services to be deemed medically necessary. Any prior authorization request must include documentation showing that all required elements under the most current WPATH Standards of Care have been met. See the [Microsoft Gender-Affirming Benefit Information](https://www.premera.com/documents/031800.pdf) for additional information.

For gender affirming surgical services, the prior authorization should include:

* The surgical procedure(s) for which coverage is being requested
* The date the procedure will be performed
* Information supporting the criteria listed above has been met, based on the surgery being requested

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| Additional information | [**Prior authorization**](https://outlook.office365.com/owa/wopi/files/96164086-4b14-499b-9fd7-5624489694f5@microsoft.com/AAMkADk2MTY0MDg2LTRiMTQtNDk5Yi05ZmQ3LTU2MjQ0ODk2OTRmNQBGAAAAAADfnOTgct4BQpW4-OOSBGceBwAXCSSG8TcsSZE2aGEbmzulAAAAAAEMAAAXCSSG8TcsSZE2aGEbmzulAARFF6SmAAABEgAQAJWnTbGpwYxOpuTYVAa3R8I=_AADbmXo.MQkAAAAAAAA=/WOPIServiceId_FP_EXCHANGE_ORGID/WOPIUserId_23fc4fea-e150-4f47-bb69-61e0b6ef3d31/spd_corporate_2023_072023%20Final%20Redline.docx#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

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| Additional information | Your physician can fax this information to (800) 843-1114 or mail it to:  Premera Blue Cross Attn: Integrated Health Management P.O. 91059 Seattle, WA  98111-09159 |

#### Transplants

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion¾procedures cannot be experimental or investigational.

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| Additional information | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#_Glossary) for a full definition. |

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| Additional information | The transplant benefit doesn’t cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure. |

##### Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.

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| Additional information | **Approved transplant center** is a hospital or other provider, located in the United States, that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#_Glossary) for a full definition. |

##### Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

##### Additional exclusions and limitations for transplants

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Nonhuman or mechanical organs, unless they are not experimental or investigational
* Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
* Donor costs are not covered if the recipient of the transplant service is not a Microsoft enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
* Donor costs are not covered by Microsoft if benefits are available under other group or individual coverage
* Donor costs are not covered for transportation for typing or matching

**Travel and Lodging Reimbursement Benefit**

*In-Network: 100%, deductible applies (additional IRS limitations below)*

*Out-of-network: 100%, deductible applies (additional IRS limitations below)*

*Limit: $10,000 per member, per calendar year*

The following travel and lodging reimbursement benefits are available when travel is necessary to obtain covered services under the Plan that are not available within 100 miles of the member’s residence.

**Travel Allowances:** Travel expenses are reimbursed between the member’s residence and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical expenses, for current mileage reimbursement rates.

**Lodging Allowances:** Hotel or motel stays (or similar accommodations) away from the geographic area of the member’s residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of $50 per night per person, or up to $100 per night total for the member and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

**Overall Maximum:** The travel and lodging reimbursement benefit is limited to a total of $10,000 per member per calendar year.

**Companions:** The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

* Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
* Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

**Limits: Eligible** travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit to the IRS website, [**www.irs.gov**](http://www.irs.gov), for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice. Please consult with a personal legal or tax advisor for more information.

**Non-Covered Expenses:**

* Alcohol/tobacco
* Car rental expenses
* Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
* Baggage fees
* Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
* Expenses for persons other than the patient and an eligible companion
* Lodging at a residence owned by a family member or friend
* Costs for pets or animals, other than service animals
* Meals
* Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
* Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
* Telephone calls

**Limitations/exclusions:**

* The travel and lodging must occur, and the treatment must be provided, within the United States
* The patient must be covered by one of Microsoft’s Premera plans at the time the treatment is provided and the travel and lodging expenses are incurred
* The medical treatment for which the patient is required to travel more than 100 miles from the patient’s residence must be a covered benefit under the Plan

##### Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.

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| Title: Question icon - Description: Additional information | [**Prior authorization**](file:///C:/Users/us43272/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XAV5T4XL/Travel%20and%20Lodging%20Expenses_Final%20051922%20(004).docx#priorauthorization) is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. |

#### Virtual Care

*In-network: 90%, deductible applies*

*Out-of-network: 70% of allowable charges, deductible applies*

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 their practice.

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. 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. Virtual Care with a provider located outside of the United States is not covered.

#### Vision therapy

*In-network: 90%, deductible applies  
Out-of-network: 70% of allowable charges, deductible applies*

*Limit: up to 32-visit benefit maximum, per member, for the duration of the member’s continuous enrollment*

This benefit covers vision training, eye training or eye exercises up to a maximum of 32 treatment visits, for the duration of the member’s continuous enrollment in a Premera-administered health plan option, for the following conditions only:

* Amblyopia
* Convergence insufficiency
* Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the Vision plan. Costs of equipment and supplies associated with vision therapy are not covered.

#### Weight Management program

*In-network (eligible providers): 80%, up to $6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options; deductible and coinsurance maximum do not apply*

*Out-of-network: not applicable*

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance maximum are met.

##### Who is eligible

Members are eligible for this benefit if they meet the following criteria:

* Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
* Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
  + Congestive heart failure
  + Coronary heart disease
  + Depression
  + Diabetes
  + Hyperlipidemia
  + Hypertension

Dependent children are not eligible for this benefit.

##### Eligible providers

Approved weight management providers of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program’s physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when they complete the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.

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| Additional information | For more information about approved [weight management providers](https://www.premera.com/documents/048804.pdf), or to find an approved provider in your area, call Premera Blue Cross at (800) 676-1411. |

##### Prior Authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

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| Additional information | [**Prior authorization**](#priorauthorization) is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service. |

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](https://www.premera.com/documents/011944.docx) or confirmation of your BMI and co-morbid conditions must be submitted to Premera in order to receive reimbursement from Premera. Your physician’s recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that you are recommended to complete in advance to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician’s approval

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| Additional information | To obtain a copy of the Weight Management Recommendation form, contact Premera Blue Cross at (800) 676-1411.  Your physician can fax this information to (800) 676-1477. |

1. Premera will review the information submitted and verify the coverage through a prior authorization

##### Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

###### Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim billing member claim form on a monthly or quarterly basis to Premera for reimbursement. Upon completion of the program, you must submit the weight management billing claim form for your final payment. Final claims payment is contingent on receiving the form with all the biometric information completed.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

###### Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

##### Additional exclusions and limitations for Weight Management program

In addition to the plan’s [[exclusions and limitations](#_General_Exclusions_and)](#_Exclusions_and_limitations_2), the following exclusions and limitations apply to this benefit:

* Food
* Nutritional supplements (i.e., protein shakes)
* Drugs or surgical procedures to assist in reducing weight or curbing hunger are not covered under the weight management program benefit. Please refer to the [Prescription drugs](#_Prescription_drugs_5) or [Surgical weight loss treatment](#_Surgical_weight_loss) benefit for coverage.

### Exclusions and limitations

* Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
* Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
* Expenses in excess of the applicable annual and lifetime benefit maximums
* Services for which a claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
* Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements), and herbal or naturopathic/homeopathic medicine
* Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
* Charges for or in connection with services or supplies that are determined to be experimental or investigational
* Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers’ Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
* Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies. This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
* Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
* If other insurance is available for medical benefits, the Participant must put such other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.
* Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits 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
* In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
* Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
* Services of a social worker except as provided in the hospice care benefit, the home health care benefit and the mental health, substance use disorder, and alcohol use disorder treatment benefit
* Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.
* Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
* Massage therapy that is not medically necessary, or is furnished without a prescription
* Activity therapy, such as music, dance or art therapies
* Charges to obtain, train, or maintain service animals and emotional support animals
* Any benefits or services not specifically provided for in this SPD
* Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
* Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
* Procedures for sterilization reversals
* Hypnotherapy, regardless of provider
* Hippotherapy or other forms of equine or animal-based therapy
* Electronic services and/or consults, except as specifically described under the plan
* Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but is not limited to a provider who is a covered dependent under the plan (whether or not living in the household), 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 that are illegal, outside the scope of the provider’s license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
* Separate charges for records or reports, except those Premera requests for utilization review
* Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
* 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 and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
* Services or supplies for any of the following:
  + Education and training programs including testing or supplies/materials, including vision training supplies
  + Educational or recreational therapy or programs; this includes but is not limited to boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
  + Social, cultural, or vocational rehabilitation or vision training supplies
* Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
* Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months
* Services for individuals not eligible for coverage under the Microsoft Plan will not be reimbursed except in the following circumstances:
  + Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
  + Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
* Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
* When Coordinating Benefits (COB) and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
* Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan
* Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in-network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

* [Autism/ABA therapy](#_Autism/Applied_Behavior_Analysis_2)
* [Hearing care and hardware](#_Hearing_care_and_2)
* [Home health care](#_Home_health_care_2)
* [Hospice care](#_Hospice_care_1)
* [Hospital inpatient care](#_Hospital_inpatient_care_2)
* [Fertility](#_Infertility_3)
* [Medical and surgical equipment and supplies](#_Medical_equipment_and_1)
* [Mental health and chemical dependency](#_Mental_health,_Attention_1)
* Prescription drugs
* [Skilled nursing facility](#_Skilled_nursing_facility_2)
* Transplants
* [Weight Management program](#_Weight_Management_program_2)

### How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

To submit a claim online:

From the Benefits Site, select View My Claims, which will direct you to the Premera Portal. Or sign in to your account on premera.com. Next, from the top menu bar select Claims and then Submit Claims. Follow the steps and upload a copy of the itemized receipt.

To submit a claim via mail, fax or email:

1. Download the [Premera Claim Reimbursement Request Form](https://www.premera.com/documents/011943.pdf). You can also email Premera from your Microsoft email address (employees) to [microsoft@premera.com](mailto:microsoft@premera.com) or through your Secure Messaging center in the Premera portal (all enrollees including dependents and COBRA members) to request a claim form.
2. Complete the claim form, including all of the following information:
   1. Your name and the member’s name
   2. Identification numbers shown on your identification card (including the 3-digit plan prefix or MSJ)
   3. Provider’s name, address, and tax identification number
   4. If you are seeking secondary coverage from the Microsoft health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
   5. If treatment is as a result of an accident: the date, time, location and brief description of the accident
   6. Date of onset of the illness or injury
   7. Date of service
   8. Diagnosis or ICD-10 (this information can be found on the provider bill)
   9. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
   10. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Submit the completed form to:  
   Premera Blue Cross  
   Mail: P.O. Box 91059  
   Seattle, WA 98111-9159  
   Fax: (800) 676-1477  
   Email from Microsoft email address: [claims.microsoft@premera.com](mailto:claims.microsoft@premera.com)Email through the Secure Messaging center in your Premera portal

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| Additional information | COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage_1) section.  *In the following circumstances, you may submit claims according to the* [*appeals process*](#_Appeal_for_internal_1)*:*   * If you cannot submit the claim in a timely manner due to circumstances beyond your control   If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child |

#### Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera’s control.

If your claim relates to an item for which the Plan requires you to obtain approval (or “prior authorization”) before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day period for up to an additional 15 days if the extension is required due to matters beyond Premera’s control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination period to respond to your claim (as provided above) will be suspended as of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for “urgent care,” meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

* Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
* Premera’s denial notice may be oral, with a written or electronic confirmation to follow within three days.
* If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera’s determination no later than 48 hours after (1) Premera’s receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.

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| Additional information | **Explanation of benefits (EOB)** is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any). |

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

* Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
* Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

#### Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

* The specific reason or reasons for the denial
* Reference to the specific plan provisions on which the denial is based
* A description of any additional material or information needed from you and the reason it is needed
* An explanation of the appeals procedures and the applicable time limits
* A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
* If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
* If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
* Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the plan’s standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal
* Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

#### Appeal for internal review

If you do not agree with the decision made by the plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

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| Additional information | An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process does not apply to appeals of denied COBRA eligibility claims. |

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| Additional information | If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim. |

##### Submitting an appeal for internal review

You or your authorized representative\* must provide the following information as part of your written appeal to the Premera Appeals Department:

* Your name,
* Your Premera member number,
* The name of this plan, and
* A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.

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| Additional information | The appeal should be mailed or faxed to Premera:  Appeals Coordinator Premera Blue Cross  P.O. Box 91102  Seattle, WA 98111-9202  Fax: (425) 918-5592 |

You may, at your own expense, have a representative file an appeal on your behalf. Your attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose, you must submit a completed and signed [Microsoft Member Appeals Form](https://www.premera.com/documents/019063.pdf) which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as Premera Blue Cross’s internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.

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| Additional information | To file an urgent care appeal request, you may fax a request to (425) 918-5592. |

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| Additional information | The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above. |

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| Additional information | **An urgent care claim or appeal is** one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. |

##### Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by requesting these from Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

##### Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

* The specific reason or reasons for the denial
* Reference to the specific plan provisions on which the denial is based
* A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
* A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
* A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
* If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

* Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
* The denial code and its meaning
* A description of the Plan’s standard for denying the claim
* Information regarding available internal and external appeals, including how to initiate an appeal
* Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

#### Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial (1) has a retroactive effect and is considered a rescission of coverage under the law, or (2) is based on medical judgment including:

* Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
* A determination that a treatment is experimental or investigational

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| Additional information | An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information. |

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

##### Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.

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| Additional information | If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review. |

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| Additional information | Mail or fax the written request to:  Premera Blue Cross Attn: Microsoft Member Appeals – IRO Mail Stop 123  P.O. Box 91102 Seattle, WA 98111-9202  Fax: (425) 918-5592 |

##### External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information, and the IRO review begins.

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| Additional information | If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow. |

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

##### Decision on the external review

The plan is bound by the IRO’s decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan’s appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the external review decision.

#### Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.

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| Additional information | If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272). |

#### Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

## Surest Health Plan

What is in this section

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### How the plan works

The Surest Health Plan (“Surest Plan”) allows you to make informed choices about your health care, cost, and coverage needs – in advance of receiving care. With the Surest mobile app and the Surest website [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com), members can search for available care, cost, and coverage options from any geographic location to choose the best option for them, or members can call Surest Member Services at (866) 222-1298 for assistance navigating their coverage options. Capitalized terms in this section of the SPD are defined in the Surest Glossary (or elsewhere in the Glossary).

The Surest Plan features comprehensive coverage; no deductible; simple copayments for Covered Health Services; and an annual out-of-pocket maximum.

### Where you can get care

With the Surest Health Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide United Healthcare network feature certain advantages, including:

* Your provider files claims directly with Surest
* Lower, negotiated rates for care and prescriptions
* The highest coverage levels

If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement.

#### Finding an in-network provider

You can maximize your savings by using providers and facilities in UnitedHealthcare’s Choice Plus network. Members in California have access to UnitedHealthcare’s Select Plus network.

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| P1046C1T63#yIS1 | Visit the online Surest provider directory (<https://benefits.surest.com>) to find an in-network provider or call Surest at (866) 222-1298.  Additionally, both active employees and COBRA enrollees also have access to the [Embold Health Provider Guide](https://microsoft.emboldhealth.com/), a tool that helps you find highly rated healthcare providers in your area and insurance network. Embold uses healthcare claims data to score how well a doctor makes the correct diagnosis, chooses the right treatment plan, and delivers the best health outcome. These scores are developed using common and accepted measures in the medical community. |

As a member enrolled in the Surest Plan, you may choose any eligible Provider each time you need to receive a Covered Health Service. The choices you make may affect the amount you pay, as well as the level of benefits you receive. You will receive the highest level of benefits from the Surest Plan (and in most instances, your out-of-pocket expenses will be substantially less) when you receive care from in-network Providers. The Surest Plan features a large network of in-network Providers through UnitedHealthcare’s network which can be found in the Surest mobile app or at [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website, or you can call Surest Member Services (866) 222-1298 for assistance.

Claims for benefits under the Surest Plan are payable only for Covered Health Services that are Medically Necessary.

The total cost of Covered Health Services is shared between you and the Surest Plan. Your share consists of copayments, which Surest assigns to Covered Health Services. Your copayments for Covered Health Services are listed in the Benefit Features section, Prescription Drugs section, and on the Surest mobile app and Surest website [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com).

The Surest Plan does not have a deductible or coinsurance and will cover the remainder of the Eligible Expense for Covered Health Services after any copayments are applied. The Surest Plan does have an out-of-pocket maximum, which is the maximum total amount of copayments you will be required to pay each calendar year for Covered Health Services.

If you use an in-network Provider, you generally will be responsible for lower copayments, and the Provider may not charge you any additional fees or amounts. If you use an out-of-network Provider, your costs generally will be higher. In addition to your higher out-of-network copayment, in many cases you may be responsible for the Provider’s total billed amounts that exceed the Eligible Expenses that the Surest Plan pays for a Covered Health Service (known as out-of-network Provider “balance billing”), which can be significant.

Once your total copayments reach your applicable out-of-pocket maximum, the Surest Plan will cover 100% of Eligible Expenses for the remainder of the calendar year, not including any out-of-network Provider balance billing amounts, when applicable. Out-of-network Provider balance billing amounts are NOT Eligible Expenses and are not counted towards your out-of-pocket maximums.

#### In-Network Benefits

In-network Providers are responsible for obtaining Prior Authorization and completing all notification requirements for you, when applicable. Therefore, it is important that you confirm the Provider's current status before you receive services, as a Provider’s network status may change from time to time. For current in-network Provider information, refer to the Surest mobile app or go to [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com), or call Surest Member Services (866) 222-1298 for assistance.

If you receive Covered Health Services from an out-of-network Provider because Surest incorrectly informed you that the Provider was an in-network Provider, either through the Surest mobile app, the Benefits.Surest.com website, or in response to your request to Surest Member Services for that information, you may be eligible for the same coverage and copayment (with no out-of-network Provider balance billing) that would have applied if the Covered Health Service had been provided from an in-network Provider.

Do not assume that all services furnished by an in-network Provider are Covered Health Services. In some cases, in-network Providers may furnish services that are not Covered Health Services under the Surest Plan. Refer to the Surest mobile app or the [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website, or call Surest Member Services (866) 222-1298 for assistance.

#### Out-of-Network Benefits

The Surest Plan generally provides benefits for medical Claims incurred with an out-of-network Provider or facility at a lower level. In addition to potentially owing a higher copayment, if you choose to seek Covered Health Services out-of-network, except as described below, you may also be responsible for the difference between the amount billed by the out-of-network Provider or facility and the amount Surest determines to be the Eligible Expense for reimbursement. The amount in excess of the Eligible Expense could be significant, and this amount will NOT apply to the out-of-network out-of-pocket maximum. You may want to ask the out-of-network Provider about their billing practices before you receive care.

For Covered Health Services provided by an out-of-network Provider, the Eligible Expenses generally will be calculated based on 140% of the applicable Medicare reimbursement rate except as provided below.

If Surest determines that care is not reasonably available to you from an in-network Provider, Surest will work with you to coordinate care through an out-of-network Provider in accordance with Surest’s policies. In those cases, the Covered Health Services rendered by the specified out-of-network Provider will be processed as in-network benefits, subject to an applicable in-network copayment and no out-of-network Provider balance billing. Requests for this arrangement should be made by calling Surest Member Services at the number on your member ID card **before** you obtain such services.

For ground or water ambulance transportation provided by an out-of-network Provider, the Eligible Expense, which includes mileage, is determined based on the median amount negotiated with in-network Providers for the same or similar service, unless a different rate is agreed upon by the out-of-network Provider and Surest, or a different amount is required by applicable law.

In some cases involving out-of-network Providers and facilities, listed below, special “surprise billing” rules apply under federal law. In these cases, you will be required to pay the in-network copayment only, which will accumulate toward your in-network out-of-pocket maximum, and may not be balance billed by the out-of-network Provider.

* Covered Health Services that are ***non-Emergency* *Ancillary Services received from an out-of-network Provider at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center***.
* Covered Health Services that are ***non-Emergency*, *non-Ancillary Services received at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center, from an out-of-network Provider who has not satisfied advance patient notice and consent requirements required by law.***
* Covered Health Services received from an out-of-network Provider at an in-network ***hospital, hospital outpatient department, critical access hospital, or ambulatory surgery center due to*** ***unforeseen, urgent medical needs***.
* Covered Health Services that are ***Emergency Health Services provided by an out-of-network Provider or facility***.
* Covered Health Services that are ***air ambulance services provided by an out-of-network Provider***.

Eligible Expenses are determined in accordance with Surest’s reimbursement policy guidelines or as required by law.

If you are using an out-of-network Provider, you are also responsible for ensuring that any necessary Prior Authorizations have been obtained, or the services may not be covered by the Surest Plan.

Out-of-network Providers are not required to file Claims with Surest, and except as required by law, Surest may issue payment on an out-of-network Claim to the member, and not to the out-of-network Provider or facility directly. In those cases, you will be responsible for paying the Surest payment amount to the out-of-network Provider or facility, in addition to any applicable copayment and balance billing amounts. If you obtain Covered Health Services from an out-of-network Provider and/or facility that requires that you remit the full amount billed, contact Surest Member Services (866) 222-1298 for a Claim form to file a Claim for reimbursement. This may require an itemized bill from the Provider.

#### Prior Authorization

Select services require Prior Authorization whether provided by in-network or out-of-network Providers.

In-network Providers are responsible for obtaining Prior Authorization when required for Covered Health Services, including planned inpatient admissions, as well as providing post-admission notification within 24 hours of Emergency inpatient admissions. Inpatient stays will be reviewed for Medical Necessity, length of stay, and level of care. All acute inpatient rehabilitation (AIR) admissions, long-term acute care (LTAC) admissions, and Skilled Nursing Facility (SNF) admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.

**Important: If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations have been obtained or the services may not be covered by the Surest Plan. Contact Surest Member Services at (866) 222-1298 prior to obtaining out-of-network services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your member ID card.**

If your Prior Authorization is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review, if applicable). This information can also be found in the “[If Your Medical Claim is Denied](#If_Medical_Claim_Denied_Surest)” section.

The Prior Authorization list is subject to change without advance notice. The most current Prior Authorization list can be obtained by contacting (or having your Provider contact) the pre-certification number on your member ID card or calling Surest Member Services at (866) 222-1298.

Prior Authorization is ***required*** for the following services:

Acute care hospitalizations (planned)

Acute inpatient rehabilitation

Applied behavioral analysis

Non-Emergency air transportation

Bariatric surgery

Bone growth stimulators

BRCA testing

Select cardiovascular procedures

Select chemotherapy

Clinical trials

Cochlear implant surgery

Coverage with Evidence Development

Potentially Cosmetic and Reconstructive surgery

Select durable medical equipment, orthotics, and prosthetics

Select genetic and molecular tests

Select injectable medications

Intensity-modulated radiation therapy

Long-term acute care

MR-guided focused ultrasound

Organ transplants

Orthognathic surgery

Partial hospitalization

Proton beam therapy

Residential treatment facilities

Skilled Nursing Facilities

Sleep apnea procedures

Sleep studies

Select spinal surgeries

Vein procedures

Ventricular assist devices

#### ***If you have questions about Prior Authorization or need to confirm whether or not Prior Authorization is required, please contact Surest Member Services at (866) 222-1298.***

#### Utilization Management

Utilization Management processes are conducted by Surest to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review. Based on a pre-service, concurrent, or post-service review, Surest may deny coverage if, in its determination, such services are not Medically Necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Surest’s medical policies.

#### Travel outside the United States

For members traveling outside the United States, only Emergency Care is covered. Non-emergent care outside of the U.S. will be processed as out-of-network based on billed charges.If you receive Emergency Care outside the United States, you will need to submit a Claim for reimbursement using [this form](https://hrportal.ehr.com/LinkClick.aspx?fileticket=ixQtaQ9ca18%3d&portalid=270).

#### Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, home delivery pharmacy, or specialty pharmacy. Review the Surest prescription drug benefit below for more information on what is covered.

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| P1084C3T67#yIS1 | The pharmacy network may change from time to time, and the SPD might not show the latest changes that are in effect. For the most updated pharmacy network information, please refer to the Surest mobile app or the [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website, or call Surest Member Services at (866) 222-1298. |
|  | |

|  | Retail pharmacy | Home delivery | Specialty pharmacy |
| --- | --- | --- | --- |
| Coverage | Up to a 90-day supply for 26Tgeneric medications26T; all others are up to a 30-day supply\* | Up to a 90-day supply\* only when using Optum Home Delivery | Up to a 30-day supply\*  Additional clinical support for members using specialty drugs |
| In-network pharmacies | Optum Rx pharmacies bill the plan on your behalf  To find an Optum Rx retail pharmacy, refer to the Surest mobile app or [Benefits.Surest.com](https://benefits.surest.com/) website or call Surest Member Services | Optum Home Delivery Pharmacy\*\*\* will bill the plan on your behalf | Optum Specialty Pharmacy \*\* will bill the plan on your behalf |
| Out-of-network pharmacies | You will need to submit a prescription reimbursement form, with your receipt, for reimbursement | Not covered | Not covered |

\* Unless the drug maker’s packaging otherwise limits the supply.

\*\* Contact Optum Specialty Pharmacy at 1-855-427-4682 to get started.

\*\*\* Contact Optum Home Delivery at 1-800-356-3477 to get started.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable

|  |  |
| --- | --- |
| P3029C1T150#yIS1 | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Generic drugs** are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply. |

##### Prior Authorization

Prior Authorization, also referred to as a pre-service review, may be required for some services and prescriptions to determine that coverage is available before the service occurs. Where Prior Authorization is required but not obtained, coverage may be denied on that basis alone. In-Network Providers are required to obtain Prior Authorization on your behalf. For out-of-network Covered Health Services, however, you are required to ensure that Prior Authorization is obtained (either by yourself or the Provider on your behalf).

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is Medically Necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service. If you have questions or need to obtain Prior Authorization, please contact Surest Member Services at (866) 222-1298. | |  |
|  |  |  |  |

See below additional details about specific benefits coverage under the Surest Plan.

### What you pay

You pay nothing for preventive care when you use in-network Providers. When you receive care or prescription drugs for other, non-preventive care, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost as a copayment, up to an annual out-of-pocket maximum amount.

#### Copayments

A copayment is the amount you pay each time you receive certain Covered Health Services, until you reach the applicable out-of-pocket maximum under the Plan. The table below describes how your coverage works and includes copayments applicable to the Covered Health Services you receive. Some copayments for in-network Providers are listed as a range. Surest assigns Provider copayments within the ranges based on Surest’s analysis of treatment outcome and cost information that identifies Physicians, clinics, and hospitals that provide cost-efficient care.

**The full range of in-network copayments displayed may not be available in all geographic areas or for all services. You can find in-network Provider-specific copayment amounts by utilizing the ‘Search tool’ on the Surest mobile app or at** [[**Benefits.Surest.com**](http://benefits.surest.com/)](http://benefits.surest.com) **website, or by calling Surest Member Services at (866) 222-1298. If possible, you should confirm the specific copayment that applies before you receive any Covered Health Services from a Provider.**

The following chart shows the cost-sharing provisions that apply under the Surest Plan.

#### Benefit Features

|  |  |  |
| --- | --- | --- |
| The Surest Plan | In-Network | Out-of-Network |
| Deductible | $0 | $0 |
| Out-of-Pocket Maximum per calendar year | | |
| Employee Only (“Individual”) | $2,750 | |
| Employee + 1 | $5,500 | |
| Employee + 2 | $6,875 | |

If you enroll in individual coverage, once you reach the out-of-pocket maximum for a calendar year, benefits are payable at 100% of the Eligible Expense during the rest of that calendar year. If you have other family members enrolled (Employee + 1 or Employee + 2 coverage) in the Surest Plan, each family member must meet their own individual out-of-pocket maximum until the overall family out-of-pocket maximum has been met.

Once any enrolled family member has reached the applicable individual out-of-pocket maximum, the Surest Plan will pay 100% of that individual’s Eligible Expenses for Covered Health Services for the rest of the calendar year, even if the family out-of-pocket maximum has not been met.

You are responsible for paying for any Covered Health Services that exceed the day, visit, or other applicable maximums under the Surest Plan, and for health care services that are not Covered Health Services, even if you have already reached the out-of-pocket maximum.

Out-of-network Provider balance billing amounts will not apply towards satisfaction of the applicable out-of-pocket maximum.

Except as specifically noted in the schedule of benefits in the “**What the Plan Covers**” section below, the amount applied to your in-network out-of-pocket maximum also applies to your out-of-network out-of-pocket maximum and the amounts applied to your out-of-network out-of-pocket maximum also applies to your in-network out-of-pocket maximum.

#### Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

| Situation | Benefit coverage | What you need to do |
| --- | --- | --- |
| You are new to the Surest plan and actively receiving treatment from a Provider or facility who is not in-network (Transition of Care) | Transition of Care benefits allow you the option to request coverage from your current out-of-network Provider or facility on an in-network basis for a limited time, due to a qualifying medical condition, until the safe transfer to an in-network Provider or facility can be arranged. | To confirm this coverage is available and the length of available in-network coverage extension, and to request an application, contact Surest Member Services at (866) 222-1298 or Benefits.Surest.com.  The application must be completed and returned within 30 days of the effective date of coverage.  Transition of Care benefits are managed on a case-by-case basis. |
| Your provider’s contract with Surest is ending or changing in a way that affects your care (Continuity of Care) | If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days. | To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, and to request an application contact Surest at (866) 222-1298 or Benefits.Surest.com.  The application must be completed and returned 30 days of the Provider leaving the network or experiencing a change in its network agreement for existing members.  Continuity of Care benefits are managed on a case-by-case basis. |

### What the plan covers

The tables below summarize what the Surest Plan covers, including what the plan pays for in-network and out-of-network care.

**For some Covered Health Services, copayments may vary based on Provider and location and are displayed as a range below. Please refer to the Surest mobile app or the Benefits.Surest.com website, or call Surest Member Services (866) 222-1298, for more information and specific copayment amounts.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| P6564C1T307#yIS1 | Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest) [.](#_Exclusions_and_limitations_2) | | | |
| **Common benefits** | | | | | |
| These are the most commonly used benefits in the Surest Plan. | | | | | |
| **Benefit** | | | **In-network coverage** | **Out-of-network coverage\***  **(may be subject to balance billing)** | |
| [Preventive Care](#PreventiveCare_Surest)  Including well-child visits through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the [Preventive Drug list](https://hrportal.ehr.com/microsoftbenefits/shared/Surest-Plan/2024-Preventive-Medications-List)) | | | Preventive services: 100%  Preventive prescription drugs: 100% | Preventive services: $100 copay\*  Preventive prescription drugs: 100% of Eligible Expenses | |
| [Prescription drugs](#PrescriptionRx_Surest)  Including preventive, generic, and brand-name drugs. (see the Surest Prescription Drug List ([PDL](https://hrportal.ehr.com/microsoftbenefits/shared/Surest-Plan/Your-2024-Prescription-Drug-List)) or visit Benefits.Surest.com or the Surest mobile app | | | *Surest (Optum Rx) Retail (up to 90-day supply for generics, 30-day supply for all other medications): Generic $10 copay, Preferred Drugs $50 copay, Non-Preferred Drugs $90 copay*  *Optum Rx Mail Order Pharmacy (90-day supply): Generic $10 copay, Preferred Drugs $100 copay, Non-Preferred Drugs $180 copay* | *Retail (30-day-supply)\*: Generic $10 copay, Preferred Drugs $50 copay, Non-Preferred Drugs $90 copay*  26T\*Home delivery and Specialty medications are not covered26T | |
| [Physician Services – Office Visit](#OfficeVisit_Surest) | | | Primary care provider office visit: $20 - $75 copay  Specialist provider office visit: $20 - $75 copay | Primary care provider office visit: $120 copay\*  Specialist provider office visit: $120 copay\* | |
| [Diagnostic services](#Lab_Xray_Surest)  Including lab and imaging services  To see the cost of a specific diagnostic test, visit the Surest website (<https://benefits.surest.com>) or call member services at (866) 222-1298. | | | Routine diagnostic test (e.g. x-ray, blood work): $0 copay  Non-routine diagnostic test (e.g. sleep study $75 - $450 copay, cardiac stress test $50 - $310 copay): $10 - $750 copay  Imaging (CT/PET scans, MRIs): $60 - $450 copay | Routine diagnostic test (e.g. x-ray, blood work): $0 copay\*  Non-routine diagnostic test (e.g. sleep study, genetic testing): Up to $2,250 copay\*  Imaging (CT/PET scans, MRIs): up to $1,350 copay\* | |
| [Hospital inpatient care](#InpatientHosp_Surest)  Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care | | | $125 - $2,000 copay | Up to $2,500 copay\* | |
| [Hospital outpatient care/ambulatory surgical care center](#HospitalServices_Surest)  Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing | | | $15 - $2,000 copay | Up to $2,500 copay\* | |
| [Urgent Care](#UrgentCare_Surest) | | | $40 copay | $120 copay\* | |
| [Rehabilitation – Physical, Occupational and Speech Therapies](#Rehab_Surest) | | | $5 - $60 copay | Up to $180 copay\* | |
| Contraception  Contraceptive devices and injections administered by a physician. Prescription forms of contraception are covered under preventive care. | | | 100% | $100 copay | |
| [Maternity care](#Maternity_Surest) | | | Routine Prenatal and Postnatal Office Visits, including Labs and Tests - $0 copay  Inpatient Delivery: $500 - $1,300 copay/stay | Routine Prenatal and Postnatal Office Visits, including Labs and Tests - $100 copay\*  Inpatient Delivery: $2,000 copay/stay\* | |
| Family Planning and Menopause Support (Maven) | | | Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents as well as employees and their partners who are navigating perimenopause and menopause. | Not applicable | |
| [Behavioral Health: Mental Health and Substance Use Disorder treatment](#Behavioral_Health_Surest) | | | Outpatient services through [26TSpring Health (administrator for the employee assistance program](#_Section_VII:_Microsoft))26T:   * 100% of 24 sessions per calendar year | Not applicable | |
| Mental Health & Substance Use Disorder in an office setting: $20 copay  Mental Health & Substance Use Disorder in an outpatient setting: $75 copay  Mental Health & Substance Use Disorder in an inpatient setting: $1,300 copay | Mental Health & Substance Use Disorder in an office setting: $60 copay\*  Mental Health & Substance Use Disorder in an outpatient setting: $225 copay\*  Mental Health & Substance Use Disorder in an inpatient setting: $2,000 copay \* | |
| P7944C1T366#yIS1 | | \*If you use an out-of-network Provider, your costs generally will be higher. In addition to your higher out-of-network copayment, in many cases you may be responsible for the Provider’s total billed amounts that exceed the Eligible Expenses that the Surest Plan pays for a Covered Health Service (known as out-of-network Provider “balance billing”), which can be significant. | | | |

| **Other benefits** | | |
| --- | --- | --- |
| **Benefit** | **In-network coverage** | **Out-of-network coverage\***  **(may be subject to balance billing)** |
| [Ambulance](#Ambulance_Services_Surest) | $160 copay/transport | $160 copay\*/transport |
| [Chiropractic services and acupuncture](#Chiropractic_Surest) | $30 copay | $90 copay\* |
| Combined 24-visit limit per member per calendar year | |
| [Diabetes health education2](#Diabetes_Surest) | 100% | $210 copay\* |
| [Durable Medical Equipment (DME) and supplies](#DME_Surest) | $0 - $500 copay | Up to $1,000\* |
| [Emergency room care and professional services2](#EmergencyRoom_Surest) | $350 copay | $350 copay\* |
| [Hearing care and hardware26T](#Hearing_Surest) | Exams: $20 - $75 copay | Exams: $120 copay\* |
| Hardware: $10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options | |
| [Home Health Care](#HomeHealth_Surest) | $30 copay | $90 copay\* |
| [Hospice Care](#Hospice_Surest) | Home Hospice Visit: $30 copay  Inpatient Hospice Care: $1,300 copay | Home Hospice Visit: $90 copay\*  Inpatient Hospice Care: $2,000 copay\* |
| Nutritional therapy | 100% | $100 copay\* |
| 12-visit maximum, per member per calendar year, which is waived for nutritional therapy for a diagnosed eating disorder or diabetes. | |
| [Skilled nursing facility](#SkilledNursing_Surest) | $1,000 copay/stay | $2,000 copay\*/stay |
| 120-day limit per member per calendar year | |
| [Temporomandibular joint (TMJ) dysfunction surgery](#TMJ_Surest) | $350 copay | $1,050 copay\* |
| [Vision therapy](#VisionTherapy_Surest) | $20 copay | $120 copay\* |
| 32-visit maximum, per member, for the duration of the member’s continuous enrollment in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options | |

|  |  |
| --- | --- |
| P7944C1T366#yIS1 | \*If you use an out-of-network Provider, your costs generally will be higher. In addition to your higher out-of-network copayment, in many cases you may be responsible for the Provider’s total billed amounts that exceed the Eligible Expenses that the Surest Plan pays for a Covered Health Service (known as out-of-network Provider “balance billing”), which can be significant. |

| **Specialized benefits** | | |
| --- | --- | --- |
| Microsoft provides these unique benefits to you through the Surest Plan. | | |
| **Benefit** | **In-network coverage** | **Out-of-network coverage\*** (may be subject to balance billing) |
| [Autism/Applied Behavior Analysis (ABA) therapy](#Autism_ABA_Surest) | $20 copay | $100 copay\* |
| [Fertility and Family Building Benefit](#Fertility_Surest) | $50 - $2,000 copay  Must use the Plan’s fertility vendor (Progyny) provider network, of generally two Smart Cycles per household for the duration of continuous enrollment in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy | Not applicable |
| [Gender Affirming Surgical Services](#Gender_Affirming_Surest) | $20 - $1,300 copay | $60 - $2,000 copay\* |
| [Weight Management program](#Virta_Surest)  comprehensive and clinically based weight management program through Virta, a Surest provider. | 100% | Not applicable |

|  |  |
| --- | --- |
| P7944C1T366#yIS1 | \*If you use an out-of-network Provider, your costs generally will be higher. In addition to your higher out-of-network copayment, in many cases you may be responsible for the Provider’s total billed amounts that exceed the Eligible Expenses that the Surest Plan pays for a Covered Health Service (known as out-of-network Provider “balance billing”), which can be significant. |

### Plan benefits

|  |  |
| --- | --- |
| P3417C1T165#yIS1 | *The following pages provide details on what the Surest Plan covers, if Medically Necessary, subject to the* [*exclusions and limitation*](#Exclusions_Limitations_Surest) *section.* |

The SPD is intended to provide a summary of the Surest Plan’s coverage.

For some Covered Health Services copayments may vary based on Provider and location and are displayed as a range.

Please refer to the Surest mobile app, the [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website, or call Surest Member Services at (866) 222-1298 for specific copay amounts and additional coverage information.

#### 

#### Ambulance Services

**Ground or Air**

|  |  |
| --- | --- |
| **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| $160 copayment/transport | $160 copayment/transport |

Out-of-network Ambulance Services copayment applies to the in-network out-of-pocket maximum.

Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.

Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.

Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, the Claims Administrator may approve benefits for Emergency air transportation to a hospital that is not the closest facility to provide Emergency health services.

Ambulance services for non-Emergency: the Surest Plan also covers transportation provided by a licensed professional ambulance (either ground, water, or air ambulance, as Surest determines appropriate) between facilities when the transport is, as determined by Surest:

* + - From an out-of-network hospital to an in-network hospital
    - To a hospital that provides the required care that was not available at the original hospital
    - To a more cost-effective acute care facility
    - From an acute care facility to a sub-acute care setting

Non-Emergency air ambulance services require Prior Authorization and Medical Necessity review.

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  ***If you have questions about Prior Authorization or need to confirm whether or not Prior Authorization is required, please contact Surest Member Services at (866) 222-1298.*** | |  |
|  |  | |  |
|  |  |  |  |

For air ambulance services, please see [26TFederal No Surprise Billing Protection](#_Federal_No_Surprise)26T for special rules that apply to out-of-network air ambulance services.

#### Autism/Applied Behavior Analysis (ABA) therapy

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible Providers.

|  |  |
| --- | --- |
| **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| $20 copayment/visit | $100 copayment/visit |

The Surest Plan provides benefits for behavioral services for Autism Spectrum Disorder, including Intensive Behavioral Therapies (IBT) such as Applied Behavior Analysis (ABA) that are the following:

* Focused on the treatment of core deficits of Autism Spectrum Disorder.
* Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, property, or impairment in daily functioning.
* Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.

Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in members with Autism Spectrum Disorder.

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories as described in this section.

* Applied Behavioral Analysis for Autism Spectrum Disorder services require Prior Authorization and Medical Necessity review

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
|  |  | |  |
|  |  |  |  |

#### Behavioral Health: Mental Health and Substance Use Disorder Services

| **Type of care** | **You will be covered as follows** |
| --- | --- |
| Short-term counseling employee assistance program (EAP) as administered by Spring Health | * 100%, limit of 24 sessions per person per calendar year * A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour. |
| Inpatient and Outpatient benefits | * See chart below |

|  |  |  |
| --- | --- | --- |
| **Behavioral Health: Mental Health and Substance Use Disorder Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Mental Health Office Visit (including Telehealth Visit)** | $20 copayment / visit | $60 copayment / visit |
| **Mental Health Biofeedback** | $20 copayment / visit | $120 copayment/ visit |
| **Mental Health Habilitative, Cognitive, Occupational Therapy** | $10 copayment / visit | $30 copayment / visit |
| **Mental Health Physical Therapy** | $5 copayment / visit | $15 copayment / visit |
| **Mental Health Speech Therapy** | $10 copayment / visit | $30 copayment / visit |
| **Electroconvulsive Therapy (ECT)** | $75 copayment / visit | $225 copayment / visit |
| **Intensive Outpatient Treatment Program (IOP)** | $40 copayment / visit | $120 copayment / visit |
| **Outpatient Alcohol and Drug Treatment Program** | $75 copayment / visit | $225 copayment / visit |
| **Partial Hospitalization (PHP)/Day Treatment** | $75 copayment / day | $225 copayment / day |
| **Substance Use Disorder Medication Therapy** | $10 copayment / visit | $30 copayment / visit |
| **Transcranial Magnetic Stimulation (TMS) Therapy** | $75 copayment / visit | $225 copayment / visit |
| **Residential Treatment Facility Care** | $1,000 copayment / stay | $2,000 copayment / stay |
| **Outpatient Mental Health (in a hospital setting)** | $75 copayment / visit | $225 copayment / visit |
| **Inpatient Hospital** | $1,300 copayment / stay | $2,000 copayment / stay |
| **Virtual Care** | See Virtual Care section for details | Not Applicable |

The Surest plan provides benefits for Mental Health and Substance Use Disorder. Benefits under the Surest Plan include:

* Diagnostic evaluations, assessment, medication management and treatment planning.
* Individual, family, and group therapy.
* Provider-based case management services.
* Crisis intervention.
* Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
* Residential treatment.
* Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
* Other Outpatient treatment.

Mental Health Office Visit refers to a face-to-face visit with your Provider; Mental Health Telehealth visits refers to a non-face-to-face visit with your Provider.

All inpatient services require Prior Authorization if non-emergent or planned, and notification within 24 hours of admission if emergent.

Inpatient residential and partial hospitalization services require Prior Authorization and Medical Necessity review.

Refer to the Gender Affirming Care section for additional coverage information.

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
|  |  |  |  |

##### Additional exclusions and limitations for behavioral health benefits

The following additional exclusions and limitations apply to this benefit:

* Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
* Inpatient or intermediate or outpatient care services for which Prior Authorization was not obtained.
* Non-medical 24-hour withdrawal management which is an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
* Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, and paraphilic disorders.
* School-based Intensive Behavioral Therapies (IBT) service or services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA).
* Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
* Transitional living services.
* Tuition for services that are school based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
* Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas. This exclusion does not apply when required for the treatment of autism spectrum disorders.
* Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.

#### Chiropractic services and Acupuncture

|  |  |
| --- | --- |
| **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| $30 copayment/visit | $90 copayment/visit |
| Limited to 24 visits or services combined (chiropractic and acupuncture), per member per Plan Year for in-network and out-of-network Providers combined | |

These services must be performed by a Physician or by a licensed chiropractic or acupuncture therapy Provider. Benefits include services provided in a Physician’s office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are covered only as described under the Home Health Care section.

Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.

#### Clinical Trials

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of medicines or treatments against standard, accepted treatment, or against a [placebo](https://www.blueshieldca.com/bsca/health-wellness/health-library/article.sp?articleId=HWSTP1708#stp1708-sec) if there is no standard treatment.

Members in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention.

Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with federal law, the Surest Plan covers routine health care costs for qualifying individuals participating in certain qualifying, approved clinical trials relating to the treatment of cancer or another life-threatening disease of condition, even if the expenses otherwise would be considered Experimental or Investigational, if you have been properly referred the clinical trial by a participating Provider and can provide medical and scientific information establishing that your participation in the trial is appropriate. For more information call Surest Member Services at the number on your member ID card.

Clinical Trial services require Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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#### Colonoscopy – Non-Screening

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| **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| $125 to $850 copayment/visit | $2,000 copayment/visit |

A non-screening colonoscopy is a procedure performed to diagnose disease symptoms. Benefits include Physician services and facility charges. Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician’s office.

Services for preventive colonoscopy screenings are provided under the Preventive Care Services section.

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| Complex Imaging   |  |  |  | | --- | --- | --- | | **Complex Imaging** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) | | **MRI (Magnetic Resonance Imaging)** | $75 to $450 copayment / visit | $1,350 copayment / visit | | **CT (Computed Tomography)** | $60 to $450 copayment / visit | $1,350 copayment / visit | | **Nuclear Imaging (e.g., PET scan)** | $75 to $450 copayment / visit | $1,350 copayment / visit |   Complex Imaging benefits include Physician services and facility charges. If imaging occurs on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of services and using only one type of machine (*e.g.*, MRI or CT), one copayment applies. If imaging occurs using different types of imaging machines (e.g., MRI and a CT), on the same date of services, more than one copayment applies. If your Physician suggests a low-dose CT scan (LDCT) for lung cancer screening, refer to Preventive Care Services, in this section, for coverage notes. |

#### Dental Services

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| **Dental and Oral Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
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| **Orthognathic (Jaw) Surgery** | $1,800 copayment / visit | $2,250 copayment / visit |
| **Accidental Injury and Medical Dental – All Other Services** | | |
| **Office Visit** | $20 to $75 copayment / visit | $120 copayment / visit |
| **Outpatient Hospital Visit** | $75 to $525 copayment / visit | $1,575 copayment / visit |
| **Inpatient Hospital** | $1,300 copayment / stay | $2,000 copayment / stay |

The Surest Plan provides benefits for the treatment of serious dental issues, such as a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth, when not part of the dentition (gums, teeth, teeth supporting structure). Treatment and repair for services required due to an accidental injury must be started within six months and completed within twelve months of the date of injury.

The Surest Plan also covers dental services, required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.

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| P1582C1T91#yIS1 | Review the [26TDental plan](#_Section_V:_Dental)26T section for information on your dental benefits. |

Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service has a $0 copayment. Returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.

Eligible Expenses for hospitalizations are those incurred by a member who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided.

The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.

* Accidental injury dental services require Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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##### **Additional exclusions and limitations for dental services**

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Dental braces (orthodontics).
* Dental care (which includes dental x-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accidental-related dental services for which benefits are provided as described above. This exclusion does not apply to dental care (oral exam, x-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan.
* Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.
* Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums.
* Removal of erupted or impacted teeth.
* Mandibular staple implant provided the procedure is not done to prepare the mouth for dentures.
* The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
* Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly.
* Dental implants, bone grafts, and other implant-related procedures.
* Endodontics, periodontal surgery, and restorative treatment.
* Oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root (with or without removal of the whole tooth), and root canal therapy.
* Facility, Provider, and anesthesia services in conjunction with non-covered dental procedures.

#### Diabetes

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| **Diabetes** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| Diabetes Health Education | $0 | $210 copayment |
| Virta – Diabetes Management, Diabetes Prevention, and Weight Management Programs | $0 | n/a |

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

**Virta – Diabetes Management, Diabetes Prevention, and Weight Management**

The Virta digital program for diabetes management, diabetes prevention, and weight management offers a personalized virtual diabetes control program focused on nutritional changes, medication changes, and biomarker feedback with the goal of helping implement lifestyle changes to reverse diabetes. If you qualify and enroll in any of the programs, you will receive the following benefits:

###### Eligibility Criteria

* **Type 2 diabetes reversal**: available for members aged 18 and older with an A1c of 6.5 or higher and a diagnosis of type 2 diabetes
* **Prediabetes Reversal**: available for members aged 18 and older with an A1c between 5.7 – 6.4.
* **Obesity reversal and sustainable weight loss**: available for members aged 18 and older with a BMI of 25 or higher without a diagnosis of type 2 diabetes or prediabetes.

If you qualify and join one of the programs, you will get:

* 1:1 health coaching, motivational support, behavior-based guidance, personalized nutrition based on low-carb, moderate protein and high healthy fats, while customizing it to the member's individual budget, food preferences, cultural preference and lifestyle.
* A Virta provider supports and oversees intensive medication management, and the option to safely off-ramp medications while reversing their condition and sustaining weight loss.
* Bluetooth connected weight scale, Bluetooth connected glucometer, unlimited glucose and ketone strips, food scale, and recipe packet.
* 24/7 access to in-app texting, the Virta member community, resources, educational videos, and behavior change health content.

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to [Virta for Microsoft](https://www.virtahealth.com/join/microsoft) or call Surest Members Services at (866) 222-1298.

#### Dialysis (Outpatient and Home)

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| **Dialysis Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Outpatient Dialysis** | $30 to $200 copayment / visit | $600 copayment / visit |
| **Home Dialysis** | $40 copayment / visit | $120 copayment / visit |

The Surest plan provides benefits for therapeutic treatments received in an office, home, outpatient hospital, or alternate facility. This benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis. Benefit also includes training of the patient.

Dialysis Services require Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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#### Durable Medical Equipment (DME)

The Surest Plan benefit covers charges for durable medical and surgical equipment and supplies (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase.

Coverage is provided for eligible DME that meets the minimum medically appropriate equipment standards needed for the patient’s medical condition.

Select DME require Prior Authorization and Medical Necessity review. For more information, please refer to the Surest mobile app, the Benefits.Surest.com website, or call Surest Member Services at (866) 222-1298.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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All durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment as shown in the table below:

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| **Durable Medical Equipment (DME) and Supplies** | | | | |
| **DME Tier** | **In-Network** | | **Out-of-Network**  (may be subject to balance billing) | |
| **Purchase** | **Rental** | **Purchase** | **Rental** |
| **Tier 1** | $0 copay | $0 copay/month | $20 copay | $2 copay/month |
| **Tier 2** | $20 copay | $2 copay/month | $40 copay | $4 copay/month |
| **Tier 3** | $40 copay | $4 copay/month | $80 copay | $8 copay/month |
| **Tier 4** | $60 copay | $6 copay/month | $120 copay | $12 copay/month |
| **Tier 5** | $80 copay | $8 copay/month | $160 copay | $16 copay/month |
| **Tier 6** | $100 copay | $10 copay/month | $200 copay | $20 copay/month |
| **Tier 7** | $150 copay | $15 copay/month | $300 copay | $30 copay/month |
| **Tier 8** | $200 copay | $20 copay/month | $400 copay | $40 copay/month |
| **Tier 9** | $250 copay | $25 copay/month | $500 copay | $50 copay/month |
| **Tier 10** | $300 copay | $30 copay/month | $600 copay | $60 copay/month |
| **Tier 11** | $400 copay | $40 copay/month | $800 copay | $80 copay/month |
| **Tier 12** | $500 copay | $50 copay/month | $1,000 copay | $100 copay/month |

*The list and tiers of covered DME and supplies subject to periodic review and modification.*

A breakdown of the tiers and corresponding copayments can be found on the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website.

This list of covered DME includes, but is not limited to:

* Braces
* Crutches
* Wheelchairs
* Wheelchair seat lift mechanism and/or a power seat elevation device
* Prostheses
* Cochlear Implants and associated supplies
* Shoes as prescribed by a Provider for a member. Limited to one pair per Plan Year.
* Wigs (up to $2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
* Purchase of one standard breast pump, either manual or electric, per pregnancy. The member may have to pay a surcharge to the Provider if they purchase enhanced models.
* Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. *Enteral Nutrition that is administered at home will have multiple copayments (such as for formula, nursing visit and administration)*
* Vision hardware such as eyeglasses or contacts; limited to a $250 allowance for one frame and one pair of lenses and one pair of contact lenses, or a one-year supply of disposable contact lenses may be covered under the medical plan after cataract surgery or for aphakia.
* Prosthetics, orthotics, and supplies (subject to any limitations noted within Exclusions and Limitations)

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following durable medical equipment and supplies will not be covered by this plan when they are:

* Normally of use to persons who do not have an injury, illness, disease, or medical condition
* For use in altering air quality or temperature
* For exercise, training and use during participation in sports, recreation, or similar activities
* Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, jacuzzis, recliners, overbed tables, elevators, vision aids, and telephone alert systems
* Special or extra-cost convenience items and/or features
* Structural modifications to your home and/or private vehicle
* Replacement of lost or stolen equipment or supplies
* Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

#### Emergency Room Services

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|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Emergency Room Visit** | $350 copayment/visit | $350 copayment/visit |
| **Observation Stay** | $350 copayment/stay | $350 copayment/stay |

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status. The copayment applies to Emergency room facility, professional expenses, and includes related expenses. Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Emergency Room visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

If you are admitted as an inpatient directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.

If you are admitted to observation directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for the Observation Stay copayment.

Out-of-network Emergency Room Visit or Observation Stay copayment applies to the in-network out-of-pocket maximum.

Returning home from an Emergency Room visit with durable medical equipment, such as crutches, may result in an additional copayment.

Refer to Hospital Services section for additional coverage notes

Please see the [26TFederal No Surprise Billing Protection](#_Federal_No_Surprise)26T section for more information about certain legal protections when you receive emergency services provided by an out-of-network Provider.

#### Fertility

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| **Fertility Treatments – Designated Provider: Progyny** | **In-Network** | **Out-of-Network** |
| **Two (2) Smart Cycles per family (employee and spouse) & One (1) additional Smart Cycle if neither of the first two result in a pregnancy** | Progyny Network  Up to $2,000 copayment per Smart Cycle | Not Covered |
| **Two (2) Consultations per Plan Year** |
| **Fertility preservation – Egg and sperm freezing coverage** |
| **Tissue storage (specific treatment),** **included in treatment cycles for the first year** |
| **Progyny Rx – fertility medications** | $50 copayment/script |

*Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more of Microsoft’s Surest, Premera, or KFHPWA administered health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below*

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

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| P1797C1T99#yIS1 | *Members must contact their* ***Progyny Patient Care Advocate*** *at* ***(888) 203-5066*** *to confirm eligibility and utilize a Progyny Network Provider to access the benefit.* |

Members may also contact Surest Member Services (866) 222-1298 for additional coverage information regarding what specific services are covered and what copayment applies to a procedure/service or refer to the Surest mobile app for additional coverage information.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

* Two consultations per calendar year
* Diagnostic testing
* Transvaginal ultrasounds
* Intrauterine insemination (also known as artificial insemination)
* In vitro fertilization (IVF)
* Gamete intra-fallopian transplant (GIFT)
* Intracytoplasmic sperm injection (ICSI)
* Pre-implantation genetic screening (PGS)
* Pre-implantation genetic diagnosis (PGD)
* Embryo assessment and transfer
* Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
* Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
* Purchase of donor tissue (sperm, eggs) as follows:
  + Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes ¼ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible expenses, with appropriate supporting documentation, to Progyny for reimbursement.
  + A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible expenses, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

There are some services that are not covered by Progyny; however, they may be covered under the Surest Plan (e.g., corrective surgeries like hysteroscopies, laparoscopies, myomectomies, and testicular sperm extractions).

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered under the Surest Plan as described in this SPD.

##### Additional exclusions and limitations for infertility

The following exclusions apply to this benefit:

* Fees paid to donors for their participation in any service
* Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
* Home ovulation prediction kits
* Services and supplies furnished for a dependent child (under age 26) except for oncofertility preservation due to cancer or medical treatments
* Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
* Fertility Services following a voluntary sterilization procedure

#### Gender Affirming surgical services

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#PrescriptionRx_Surest) and [mental health](#Behavioral_Health_Surest) benefits.

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| **Gender Affirming Services** | **In-Network** | **Out-of-Network** (may be subject to balance billing) |
| **Mental Health Office Visit** | $20 copayment / visit | $60 copayment / visit |
| **Gender Affirming Voice Therapy** | $10 copayment / visit | $30 copayment / visit |
| **Gender Affirming Surgery** | $75 to $1,300 copayment / visit | $225 to $2,000 copayment / visit |
| **Gender Affirming Reconstructive** | $10 to $75 copayment / visit | $30 to $225 copayment / visit |

##### The Surest Plan covers the following service for Gender Dysphoria, in accordance with the current applicable medical standards of care:

* Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
* Hormone therapy as appropriate to the patient’s gender goals: Hormone therapy administered by a medical Provider (for example, during an office visit).
* Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient’s gender goals.
* Hair transplantation.
* Permanent hair removal for purposes of genital reconstruction.
* Laser or electrolysis hair removal not related to genital reconstruction
* Voice lessons and voice therapy.

##### Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria. Surgical treatment for Gender Dysphoria includes, when Medically Necessary:

* + Abdominoplasty
  + Calf augmentation
  + Gluteal augmentation
  + Liposuction
  + Genital surgeries
  + Chest surgeries
  + Face and neck surgeries

In addition to the Surest Plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following cosmetic procedures are excluded from this benefit:

* Buttock lift
* Dermabrasion
* Ear reduction (Otoplasty).
* Fertility preservation services
* Neurotoxins
* Scalp tissue transfer (scalp advancement)
* Treatment for hair growth
* Treatment received outside the United States

Services for the treatment of Gender Dysphoria require Prior Authorization and Medical Necessity review.

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#### Hearing care and hardware

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|  | **In-Network** | **Out-of-Network** (may be subject to balance billing) |
| **Hearing Exams and Testing (21 and older)** | Exams: $20- $75 copay | Exams: $120 copay\* |
| **Hearing Screening (up to age 21)** | Screening; $0 copay | Screening: $100 copay\* |

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

* Examination of the inner ear and exterior of the ear
* Observation and evaluation of hearing, such as whispered voice and tuning fork
* Case history and recommendations
* The use of calibrated equipment

##### Hearing hardware

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of $10,000 per maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

* The hearing aid(s) (monaural or binaural) prescribed as a result of an exam, or an FDA approved over-the-counter hearing aid(s) (monaural or binaural)
* Ear mold(s)
* Hearing aid rental while the primary unit is being repaired
* The initial batteries, cords, and other necessary ancillary equipment
* A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either the prescribing physician or audiologist
* Repairs, servicing, and alteration of hearing aid equipment

##### Additional exclusions and limitations for hearing care and hardware

In addition to the Surest Plan’s [exclusions and limiations6T](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Hearing aids purchased before your effective date of coverage under this plan
* A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options
* Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid

The Surest Plan will not pay for more than one bone-anchored hearing aid per member who meets the above coverage criteria during the entire period of time the member is enrolled in the Surest Plan. In addition, repairs and/or replacement for a bone-anchored hearing aid for members who meet the above coverage are not covered, other than for malfunctions.

* Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
* Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

#### Home Health Services

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| **Home Health Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Home Health Care Visit** | $30 copayment / visit | $90 copayment / visit |

This benefit covers home visits for short-duration, part-time intermittent care when services are received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or an independent Provider. The services must be ordered by a Physician and provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Home Health Care Visits do not have a visit limit.

For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula and nursing visit).

Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.

Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.

Select Home Health Services require Prior Authorization and Medical Necessity review.

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##### Additional exclusions and limitations for home health care

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Domiciliary Care
* Services of a doula not listed as covered in Covered Health Services. Examples include babysitting or doing household chores or travel time.
* Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
* Private Duty Nursing
* Respite care, except as defined under Hospice Care in Covered Health Services.
* Rest cures
* Services of personal care attendants
* Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

#### Hospice Care

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| **Hospice Care** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Home Hospice Visit** | $30 copayment / visit | $90 copayment / visit |
| **Inpatient Hospice Care** | $1,300 copayment / stay | $2,000 copayment / stay |

The hospice care benefit is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill.

Hospice care can be provided in the home or an inpatient setting and includes physical, psychological, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the member (terminally ill person) is receiving hospice care.

Benefits are only available when hospice care is received from a licensed hospice agency, which can include a hospital.

Inpatient Hospice Care requires Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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##### Additional exclusions and limitations for hospice care

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Bereavement or pastoral counseling
* Financial or legal counseling, including real-estate planning or drafting of a will
* Funeral arrangements
* Diversional therapy
* Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

#### Hospital Services - Other

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| **Hospital Services - Other** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Outpatient Hospital Visit** | $75 to $525 copayment / visit | $1,575 copayment / visit |
| **Inpatient Hospital** | $1,300 copayment / stay | $2,000 copayment / stay |

This benefit covers Hospital Services. The above copayments apply for Covered Health Services not otherwise listed in this SPD, Surest mobile app or Benefits.Surest.com website.

Multiple copayments may apply if more than one treatment or procedure is performed during a visit.

Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

Inpatient hospitalization/stay benefits include:

* Physician and non-Physician services, supplies, and medications received during an inpatient stay.
* Facility charges, including room and board in a semi-private room (a room with two or more beds).
* Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
* The Surest Plan will allow a private room and cover the cost difference from a semi-private room, only if a private room is Medically Necessary.
* If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment

Outpatient hospital care includes services such as Radiation Device Placement, Abdominal paracentesis, Peritoneal dialysis procedure, Thoracentesis, Percutaneous drain and stent placement, Surgical Biopsy of the Breast and Inferior Vena Cava Filter Placement (IVC).

* Returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.

All inpatient services **require Prior Authorization** if planned, and notification within 24 hours of admission if emergent

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#### Laboratory Services, X-Rays, and Diagnostic Tests – Outpatient

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|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $0 copayment / visit | $0 copayment / visit |
| **Non-Routine Tests** | $10 to $750 copayment / visit | $90 to $2,250 copayment / visit |
| Sleep Study | $75 - $450 copayment/visit | Up to $2,250 copayment/visit |
| Cardiac Stress Test | $50 - $310 copayment/visit | Up to $2,250 copayment/visit |
| Electroencephalogram (EEG). | $50 - $330 copayment/visit | Up to $2,250 copayment/visit |

The Surest Plan covers Routine Diagnostic services as well as Non-Routine tests.

Refer to the Surest mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.

Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

Routine diagnostic services received on an outpatient basis at a hospital, alternate facility or in a Physician’s office include:

* Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
* Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.

Non-Routine diagnostic testing services received on an outpatient basis at a hospital, alternate facility or in a Physician’s office including, but not limited to:

* Angiography (Arteriography).
* Cardiac Event Monitoring.
* Coronary Calcium Score (Heart Scan).
* Cystometrogram (CMG).
* Echocardiogram Exercise Stress Test.
* EKG Exercise Stress Test.
* Electroencephalogram (EEG).
* Electromyography (EMG) and Nerve Conduction Studies (NCS).
* Gastrointestinal Motility Testing.
* Genetic Testing
  + The following categories of Genetic Testing services are covered; genetic tests for cancer susceptibility, genetic tests for hereditary diseases, unspecified molecular pathology, and fetal aneuploidy testing
* Facility-based Sleep Study.
* Home-based Sleep Study.
* Non-cardiac Angiography, Arthrography, and Myelography.
* Tilt Table Testing.
* Transthoracic Echocardiogram (TTE).

If more than one type of imaging occurs (such as an x-ray and ultrasound), or more than one type of diagnostic testing occurs (such as an EKG exercise stress test and EEG) on the same date of service, more than one copayment may apply.

Select laboratory services and diagnostic testing require Prior Authorization and Medical Necessity review.

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#### Maternity care

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children.

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| **Maternity Care and Delivery** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Routine Prenatal and Postnatal Office Visits, including Labs and Tests** | $0 copayment / visit | $100 copayment / visit |
| **Newborn Nursery Care** | $0 copayment / test | $0 copayment / test |
| **Inpatient Delivery** | $500 to $1,300 copayment / stay | $2,000 copayment / stay |
| **Home Birth/Delivery** | $500 copayment / visit | $1,200 copayment / visit |
| **Amniocentesis** | $300 copayment / test | $900 copayment / test |
| **Chorionic Villus Sampling (CVS)** | $300 copayment / test | $900 copayment / test |

For women’s preventive care visits during and after pregnancy, see the preventive care benefit.

There will be one copayment for all Covered Health Services related to childbirth/delivery, including the newborn, unless the newborn is discharged after the mother. If a newborn baby is discharged after the mother, another copayment will apply to the baby’s services. See Hospital Services section for benefits.

Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

* Prenatal testing when required to diagnose conditions of the unborn child
* Services of a licensed nurse or midwife (non-medical service, such as non-medical services performed by a doula are not covered)
* Miscarriages and terminations of pregnancy
* Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
* Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
* One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
* Home births include an allowance of up to $500 for eligible supplies and/or equipment used for home delivery, for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn, including hospital services and professional services are covered under the hospital services and physician services benefit.
* Doula services covered include in-person, phone, and email support throughout the pregnancy and post-partum; birth support; and lactation support. Birth doula services coverage is limited to a maximum benefit of $1,000 per pregnancy. Members will be responsible for any amounts that exceed this limit. Before seeking doula services, you must be examined by a licensed Physician, registered nurse or midwife and have a confirmed pregnancy. Eligible doula providers: a doula who is state-licensed if the state requires a license. If the state does not require a license, then the doula must have a current certification under a recognized doula certification organization (e.g., DONA International and PALS Doulas).

Hospital visits or admissions that do not result in delivery including false labor and tests or services not considered “routine” will follow the inpatient or outpatient hospital services benefit.

Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours following normal cesarean section delivery. Stays beyond these time periods require Prior Authorization and Medical Necessity review.

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#### Medical Infusions, Injectables, and Chemotherapy

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|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Cancer Chemotherapy** | $15 to $520 copayment / visit | $105 to $1,560 copayment / visit |
| **Provider Administered Drugs** | $20 to $1,950 copayment / visit | $375 to $2,450 copayment / visit |

These copayments apply to specific drugs that must be administered in a medical setting or under medical supervision. Call Surest Member Services at (866) 222-1298 to learn which medical drug (e.g., infusions and injections) are subject to these copayments.

Benefits are available for certain medical infusions, injectables, and cancer chemotherapy administered on an outpatient basis in a hospital facility, alternate facility, in a Physician’s office, or in the home. This includes intravenous chemotherapy or other intravenous infusion therapy.

Medical Infusions and injectables require supervision and follow up with a medical professional. The Provider Administered Drugs will be dispensed and administered by a medical professional. Certain drugs are dispensed by a medical professional and may require special handling and storage and are generally considered Specialty Drugs.

If a mixture of drugs is needed for a chemotherapy visit, the copayment of the highest cost drug will apply to that visit.

Select Injectable Drugs (or their non-injectable equivalents) that can be safely self-administered may not be covered under the medical benefit but may be covered under the pharmacy. See the [pharmacy benefits](#PrescriptionRx_Surest) section for more information.

Select medical infusions and injectables and chemotherapy require Prior Authorization and Medical Necessity review.

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| |P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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#### Cancer Support (MyCancerJourney)

MyCancerJourney is a patient navigation service providing 1-on-1 support with an experienced advocate who guides and supports you every step of your cancer journey. The Cancer Patient Navigators are trained to identify and help resolve common frustrations and can help guide members throughout their cancer experience.

It is powered by PotentiaMetrics, a decision support service that helps people and their families understand survival statistics and the likely outcomes of different treatment options for a cancer diagnosis. MyCancerJourney’s big data platform leverages the largest cancer outcomes dataset of its kind to help cancer patients find answers to questions about cancer that can affect their quality of life.

This program is available to you and your eligible dependents who qualify. The full cost of this program will be covered by the Plan. For additional information, visit the Surest mobile app or website or call Surest Member Services (866) 222-1298, or go to [www.mycancerjourney.com/join-surest](http://www.mycancerjourney.com/join-surest)

#### Office Visit

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| **Visit Type** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Office Visit (including Telehealth Visit) – PCP & Specialist** | $20 to $75 copayment / visit | $120 copayment / visit |
| **Mental Health Office Visit (including Telehealth Visit)** | $20 copayment / visit | $60 copayment / visit |
| **Convenience Care / Retail Visit** | $20 copayment / visit | Not Covered |
| **Allergy Injection Visit** | $0 copayment / visit | $100 copayment / visit |
| **Allergy Testing and Treatment** | $70 copayment / visit | $210 copayment / visit |
| **E-Visit and Telephone Consult with Your Physician** | $20 copayment / visit | $120 copayment / visit |
| **Travel Vaccines** | $0 copayment / visit | $100 copayment / visit |

The Surest Plan provides benefits for services provided in an office for the diagnosis and treatment of an illness or injury.

Routine Diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Office Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment. Multiple copayments may apply if a treatment or procedure is also performed during a visit

Mental Health Office Visit refers to a face-to-face visit with your Provider.

Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.

Convenience Care/Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illnesses and injuries, and provide preventive care services.

If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply

#### Palliative Care

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|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Office Visit** | $20 to $75 copayment / visit | $120 copayment / visit |
| **Home Health Care Visit** | $30 copayment / visit | $90 copayment / visit |
| **Outpatient Hospital Visit** | $75 to $525 copayment / visit | $1,575 copayment / visit |

The Surest Plan provides benefits for palliative care for members with a new or established diagnosis of progressive debilitating illness. This includes services for pain management received as part of a palliative care treatment plan. The services must be within the scope of the Provider’s license to be covered.

Select services performed in the office and outpatient hospital setting require Prior Authorization and Medical Necessity Review.

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See the [Home Health Services](#HomeHealth_Surest) section for services related to Home Health Care.

See the [Hospice Care](#Hospice_Surest) section for services related to Hospice Care

#### Prescription drugs

Your prescription drug benefit under the Surest plan is operated by Optum Rx. This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member’s 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 included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit. Brand-name preventive medications with an available generic equivalent may be covered by the preventive care benefit. Review the [preventive care](#PreventiveCare_Surest) benefit for more information. The information in this section describes the benefits available under your prescription drug plan.

**Generic drug substitution**

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you’ll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you’ll be charged the difference in price between the brand name drug and the generic equivalent (called an “Ancillary charge”) along with the applicable brand name cost-share. In the event a generic drug becomes available for a brand drug, the tier placement of the brand drug may change, or you may no longer have access to that brand drug.

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| Title: Question icon - Description: P4059C1T184#yIS1 | A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.  **Brand drugs** are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.  **Generic drugs** are equivalent to brand-name drugs but typically available at a lower cost than brand-name prescriptions because the patent has expired.  **Specialty drugs** are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.  **Ancillary charges** are a charge, in addition to the Copayment, that you must pay when a covered drug is dispensed at your request, when a chemically equivalent drug is available. |

The Surest Plan includes coverage for prescription drugs dispensed at network pharmacies with the copayments listed below. A Formulary is used to determine which prescription drugs are covered. The Formulary is subject to regular review and modification. You can use the Surest mobile app or [Benefits.Surest.com](http://benefits.surest.com/) website or contact Surest Member Services to find network pharmacies, drug tiers, and Formulary medications and Specialty Drugs.

The Surest Plan works with the following vendors to administer the pharmacy Benefits.

* OptumRx is the Pharmacy Benefits Manager (PBM) for retail pharmacies.
* OptumRx is the specialty pharmacy.
* OptumRx is the mail-order pharmacy.

##### Prescription Drug Tiers

If your copayment is higher than the retail price, you pay the lower amount.

Use the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services to determine the tier of your drug or to learn more about preventive medications.

##### **Retail Drug Tiers**

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|  | **30-Day Supply** | | **90-Day Supply** | |
|  | **Network Pharmacies** | **Out-of-Network** | **Network Pharmacies** | **Out-of-Network** |
| **Preventive** | $0 copayment | $0 copayment | $0 copayment | $0 copayment |
| **Tier 1** | $10 copayment | $10 copayment | $10 copayment | $10 copayment |
| **Tier 2** | $50 copayment | $50 copayment | Not Covered | Not Covered |
| **Tier 3** | $90 copayment | $90 copayment | Not Covered | Not Covered |

##### **Mail Order Drug Tiers**

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| **OptumRx Home Delivery Pharmacy (In-Network Only)** | | |
|  | **30-Day Supply** | **90-Day Supply** |
| **Preventive** | $0 copayment | $0 copayment |
| **Tier 1** | $10 copayment | $10 copayment |
| **Tier 2** | $50 copayment | $100 copayment |
| **Tier 3** | $90 copayment | $180 copayment |

##### **Specialty Drug Tiers**

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| **OptumRx Specialty Pharmacy (In-Network Only)** | |
| **30-Day Supply** | |
| **Tier 1** | $10 copayment |
| **Tier 2** | $50 copayment |
| **Tier 3** | $90 copayment |

##### **Microsoft Onsite Pharmacy (Redmond Only) Drug Tiers**

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| **Living Well Health Center Pharmacy\*** | | |
|  | **30-Day Supply** | **90-Day Supply** |
| **Preventive** | $0 copayment | $0 copayment |
| **Tier 1** | $10 copayment | $10 copayment |
| **Tier 2** | $50 copayment | $100 copayment |
| **Tier 3** | $90 copayment | $180 copayment |

*\*Members can fill 30-day supplies of specialty medications at the Microsoft Onsite Pharmacy (Living Well Health Center)*

**Notes:**

* **General**
* There is no coverage for out-of-network pharmacies.
* You pay the listed copayment or price of the prescription, whichever is less.
* As written by the provider, members can receive up to a consecutive 90-day supply of a tier 1 Prescription Drug product at a retail pharmacy, unless adjusted based on the drug manufacturer’s packaging size, or based on supply limits. Tier 2 and Tier 3 Prescription Drug Products are limited to a 30-day supply at a retail pharmacy.
* You must present your Surest member ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your member ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy may charge you the full amount of the prescription drug as well as require payment prior to rendering a service. To request reimbursement, contact Surest Member Services.
* Prescription drugs and diabetic supplies are generally covered up to a 90-day supply. Some medications may be subject to a quantity limitation, per-day supply, or a maximum dosage per day. More information can be found on the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or by contacting Surest Member Services.
* Drugs that require the prescriber to submit a Prior Authorization are indicated as such within the Formulary. Use the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services to determine if a particular drug requires a Prior Authorization.
* Drugs that require step therapy or that may be subject to a quantity limitation, per-day supply, or a maximum dosage per day are indicated on the Formulary and can be also obtained by using the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services.
* When identical chemical entities are from different manufacturers or distributors, the PBM’s clinical coverage committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
* Surest applies health principles to prescription drug benefits with the objective of discounting copayments for the most appropriate medication(s) for a given member, based on the Surest Clinical Policy Committee review. The Surest Clinical Policy Committee reviews evidence-based guidelines, real-world evidence, peer-reviewed studies, etc., to determine treatment pathways that improve long-term health outcomes and target specific members.
* Members will see eligible benefit adjustments in the ‘search app’ on the Surest mobile app or at the pharmacy when picking up their prescription. Use the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services to learn more.
* **Specialty Drugs**
* OptumRx is the specialty pharmacy.
* In addition to OptumRx Specialty pharmacy, members may fill specialty prescriptions at the Microsoft Onsite Pharmacy (Living Well Health Center).
* Specialty Drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and/or dilution requirements, and include, but are not limited to, drugs used for growth hormone treatment, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.
* Specialty Drugs are generally only covered up to a 30-day supply.
* A current list of designated Specialty Drugs and suppliers is available on the Surest mobile app or the [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com/) website or call Surest Member Services.
* Members are allowed two retail grace fills for specialty drugs before being required to utilize OptumRx Specialty Pharmacy
* **Other Drugs/Supplies**
* Prescription Benefits will cover prescription tobacco cessation drugs and products, and over-the- counter (OTC) tobacco cessation drugs and products obtained with a Physician’s prescription at a $0-dollar copayment. Some quantity limitations may apply. Use the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services to learn more.
* OptumRx applies medical management in determining which contraceptives are included on your specified preferred drug list, as well as a subset of contraceptive medications where a $0 copayment applies as indicated on the Formulary. To view a current list of contraceptive medications that are eligible for coverage with $0 member cost-sharing under the Surest Plan use the Surest mobile app or [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services.
* When you pay for any reimbursement-eligible prescriptions yourself, you are required to submit the drug receipt(s) with the Claim form for reimbursement. For prescription drugs dispensed and used during a covered hospital stay, refer to Medical Infusions, Injectables, and Chemotherapy.
* Drugs that are excluded from the Formulary are not covered under the Surest Plan unless approved in advance through an exception to coverage process managed by OptumRx on the basis that the drug requested is (1) Medically Necessary and essential to the patient’s health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the patient. If approved through that process, the Tier 3 copayment would apply. Without this approval, if you or a covered dependent selects drugs excluded from the Formulary, you will be required to pay the full cost of the drug without any reimbursement under the Surest Plan. If your Physician believes that an excluded drug meets the requirements described above, your Physician should take the necessary steps to initiate an exception to coverage review.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

* The number of units and days' supply dispensed on the last fill or refill, and
* The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable.

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| *Title: Information icon - Description: P4100C5T186#yIS1* | Surest provides a customer service team dedicated to Microsoft employees and their dependents. You can use this service by calling member services at (866) 222-1298 with questions regarding:   * Status of mail order prescriptions * Plan design, including which medications are covered or not covered * Location of retail pharmacies |

**Covered drugs**

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a Prior Authorization.

Prescription drugs (Federal Legend 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.

Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to a standard supply limit.

Inhalation spacer devices and peak flow meters

Glucagon and allergy emergency kits

Prescribed injectable medications for self-administration (such as insulin)

Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications

Disposable diabetic testing supplies, including test strips, testing agents, and lancets

Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)

Human growth hormone

Prescription drugs for smoking cessation

Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the [preventive care](#PreventiveCare_Surest) benefit.

**Prior authorization**

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for certain prescription drug is available before prescription can be filled.

To determine if Prior Authorization is required for a particular drug, referto the Surest mobile app or the [[Benefits.Surest.com](http://benefits.surest.com/)](http://benefits.surest.com) website or call Surest Member Services (866) 222-1298.

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| *Title: Question icon - Description: P4123C1T187#yIS1* | [**Prior authorization**](file:///C:/Users/stevelam/Downloads/spd_corporate_2024%20(14).docx#priorauthorization) is an advance determination by Surest that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298. |

Prior Authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Surest reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

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

Be under the care of an appropriate medical specialist

Trying a generic drug or a specified brand name drug first

In making these determinations, Surest takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.

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| *Title: Information icon - Description: P4135C1T188#yIS1* | For questions about your pharmacy benefits or quantity limits, contact Surest Customer Service at (866) 222-1298 |

The table below provides information on how to submit information for a medical necessity review.

|  |  |
| --- | --- |
| **Drug** | **Information** |
| Certain drugs require Prior Authorization. Examples include but are not limited to rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications. | Have your provider call (800) 711-4555 to start or update the benefit review process for these or other drugs needing clinical review and Prior Authorization.  If you would like to find out if your drug requires Prior Authorization, refer to the https://benefits.surest.com website, call the telephone number on your ID card, or access the Surest mobile app |

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| *Title: Explanation icon - Description: P4152C3T190#yIS1* | Categories of drugs on the drug list may be added or deleted from time to time, based on factors including FDA approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process. |
|  |  |

**How to file a Pharmacy Claim**

Generally, you do not need to file a pharmacy Claim for services from in-network pharmacies, the pharmacy will handle the filing of the pharmacy Claim. If you receive Emergency care outside the United States and are seeking reimbursement from the Plan, you can submit a pharmacy Claim using the procedure below.

Please note, manual submission of pharmacy Claims does not guarantee reimbursement. If the prescription drug(s) is non-Formulary, has Prior Authorization, step therapy, quantity limit requirements, or is restricted in some other way, OptumRx will make a coverage determination according to the coverage determination and exceptions process. Requests which require an exception to coverage, such as Prior Authorization, should be submitted to OptumRx for review.

You can submit a post-service pharmacy Claim by mail or fax to OptumRx:

OptumRx

Claims Address

P.O. Box 650540

Dallas, TX 75265-0540

Online Claim Form (eForm): <https://dmrforms.optumrx.com/online-claim-form>

You will need to provide several pieces of information for OptumRx to be able to process your pharmacy Claim and determine the appropriate benefits:

* The Participant ID listed on the member ID card.
* Copies of receipts showing proof of out-of-pocket payment.
* Information about any other health coverage the Participant has.
* Proof of payment may be requested to substantiate your pharmacy Claim but is not required upon initial submission.

**Drug-usage patterns**

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this Plan and what coverage limitations are in your contract.

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| *Title: Information icon - Description: P4162C1T191#yIS1* | If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Surest customer service team at (866) 222-1298 |

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

The pharmacy plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), can be found in the [exclusions and limitations](#Exclusions_Limitations_Surest) section.

#### Preventive Care Services

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| --- | --- | --- |
|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Preventive Care Services** | $0 copayment / visit | $100 copayment / visit |
| **Preventive Drugs** | $0 copayment | $0 copayment |

Services include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.

This benefit covers routine exams, immunizations and health screenings, such as:

* Routine physicals for women and men
* Women’s preventive care including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)
* Mammograms, including 3D mammograms (routine)are considered routine diagnostic screening and the copayment/visit is $0 copayment for In-Network and $0 copayment for Out-of-Network (may be subject to balance billing)
* Contraception management office visits
* Well-child exams, including physical exams, tests, and immunizations, through age 18
* Hearing screening for children through age 18
* Routine prenatal and postnatal care
* Routine eye exams
* Flu shots
* Colorectal cancer screening
* Prostate cancer screening
* Lung cancer screening (Low dose CT Scan (LDCT) for lung cancer screening requires Prior Authorization and Medical Necessity review)
* Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

Preventive prescription drugs:

* This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence.
* This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.

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| P2220C3T114#yIS1 | For a complete list of what is considered preventive care and paid 100% by the plan see the Preventive Care list and the [Preventive Drug list](https://hrportal.ehr.com/microsoftbenefits/shared/Surest-Plan/2025-Preventive-Medications-List) , or contact Surest Member Services at (866) 222-1298.  For information on how to fill your prescription, see the [prescription drug](#PrescriptionRx_Surest) section. |
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#### Radiation Therapy and Other High Intensity Therapy

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| --- | --- | --- |
|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| Radiation Therapy & Other High Intensity Therapy | $10 to $1,400 copayment / visit | $30 to $2,000 copayment / visit |

The Surest Plan provides benefits for radiation therapy and other high intensity therapy services received on an outpatient basis. Benefits include Physician services and facility charges, and services such as, but not limited to:

* Apheresis.
* Blood Transfusion.
* Brachytherapy.
* Conventional External Beam Radiation Therapy (EBRT).
* Proton Therapy.

Select Radiation Therapies require Prior Authorization and Medical Necessity Review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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See [Hospital Servies – Other](#HospitalServices_Surest) for services related to Radiation Device Placement.

#### Reconstructive Surgery

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| --- | --- | --- |
| **Place of Service** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Office Visit** | $20 to $75 copayment / visit | $120 copayment / visit |
| **Outpatient Hospital** | $75 to $525 copayment / visit | $1,575 copayment / visit |
| **Inpatient Hospital** | $1,300 copayment / stay | $2,000 copayment / stay |

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore psychologic function of an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an illness, injury, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

This benefit covers services, supplies, and procedures for reconstructive surgery purposes, along with complications of these services, supplies, or procedures, for the following:

* Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
* Treatment for a congenital anomaly of a covered child
* Treatment of visible birth marks of a covered child
* All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
* Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.

Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay

##### Additional exclusions and limitations for reconstructive services

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following services and supplies are excluded from this benefit:

* Cosmetic services and surgery such as:
* Hair removal or replacement
* Removal of scar or tattoo
* Treatments for hair loss
* Treatment for spider veins, or varicose veins when considered cosmetic
* Breast reduction surgery that is determined to be a cosmetic procedure except as required by the Women’s Health and Cancer Rights Act of 1998
* Excision or removal of hanging skin on any part of the body, unless determined to be Medically Necessary. Examples include plastic surgery procedures called abdominoplasty, brachioplasty and panniculectomy
* Treatment for complications resulting from cosmetic surgery
* Complications of non-covered services
* Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
* Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
* Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity, except as described in the Virta Weight Management program.

Reconstructive Surgery requires Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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#### Rehabilitative/Habilitative Services

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| --- | --- | --- |
| **Type of Service** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Aural Therapy – Post Cochlear Implant** | $15 to $60 copayment / visit | $180 copayment / visit |
| **Cardiac Rehabilitation Therapy** | $30 copayment / visit | $90 copayment / visit |
| **Cognitive Therapy** | $10 to $55 copayment / visit | $165 copayment / visit |
| **Occupational Therapy** | $10 to $55 copayment / visit | $165 copayment / visit |
| **Physical Therapy** | $5 to $45 copayment / visit | $135 copayment / visit |
| **Pulmonary Rehabilitation Therapy** | $50 copayment / visit | $150 copayment / visit |
| **Speech Therapy** | $10 to $55 copayment / visit | $165 copayment / visit |

This benefit includes services provided in a Physician’s office or on an outpatient basis at a hospital or alternate facility. Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Refer to the Surest mobile app for additional coverage and copayment information.

The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupation, physical, and speech therapy).

Therapies provided in your home are provided as described under the Home Health Care section and will be assigned the home health care visit copayment. See Home Health Services for coverage notes.

Aural, Occupational, Cardiac Rehabilitation, Cognitive, Physical, Pulmonary Rehabilitation, and Speech therapy do not have visit limits.

Cognitive rehabilitation therapy following traumatic brain Injury or cerebral vascular accident is covered when Medically Necessary

Therapies related to the treatment of a mental health condition, such as [Autism Spectrum Disorder](#Autism_ABA_Surest), are provided under [Behavioral Health – Mental Health and Substance Use Disorder](#Behavioral_Health_Surest) services section.

#### Skilled Nursing Facility

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| **Skilled Nursing Facility Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Skilled Nursing Facility** | $1,000 copayment / stay | $2,000 copayment / stay |
| **Inpatient Rehabilitation Facility** | $1,000 copayment / stay | $2,000 copayment / stay |

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.

This benefit covers an Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.

All Skilled Nursing Facility and Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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Benefits are available only if both of the following are true:

* The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost- effective alternative to an inpatient stay in a hospital.
* You will receive skilled care services that are not primarily Custodial Care

Benefits include:

* Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
* Supplies and non-Physician services received during the inpatient stay.
* Room and board in a semi-private room (a room with two or more beds).
* Physician services for anesthesiologists, pathologists, and radiologists.
* Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

* Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
* Services are ordered by a Physician.
* Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
* Services require clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.

All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.

See Hospital Services for other coverage notes

##### Additional exclusions and limitations for skilled nursing facility

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Custodial care is not provided
* Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder
* Private Duty Nursing
* Services of personal care attendants

#### Temporomandibular joint (TMJ) dysfunction

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| --- | --- | --- |
| **TMJ Services** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Accidental and Medical Dental:** | | |
| **Temporomandibular joint (TMJ) dysfunction surgery** | $350 copayment / visit | $1,050 copayment / visit |
| **All Other Services:** |  |  |
| **Office Visit** | $20 to $75 copayment / visit | $120 copayment / visit |
| **Outpatient Hospital Visit** | $75 to $525 copayment / visit | $1,575 copayment / visit |
| **Inpatient Hospital** | $1,300 copayment / stay | $2,000 copayment / stay |

The Surest Plan provides benefits for services for the evaluation and treatment of TMJ and associated muscles. Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the TMJ copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

This benefit includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.

Orthognathic surgery and select services for TMJ Disorder Select services for TMJ Disorder require Prior Authorization and Medical Necessity review.

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| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
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Transplant Services

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| **Transplant Services** | **In-Network** | **Out-of-Network** |
| **Bone Marrow and Solid Organ Transplant** | $1,400 copayment / visit | Not Covered |
| **Corneal Transplant** | $1,600 copayment / visit | Not Covered |
| **Cellular and Gene Therapy** | $1,400 copayment / visit | Not Covered |

This benefit covers bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and corneal transplants. Procedures cannot be experimental or investigational.

All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants. The Transplant Resource Services program provides Benefits for travel and lodging expenses.

Benefits are available to the donor and the recipient when the recipient is covered under the Surest Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient’s coverage.

Copayments for outpatient hospital visits may vary based on Provider and location.

Benefits are also available for cellular and gene therapy received on an inpatient basis at a hospital or on an outpatient basis at an alternate facility

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| P4355C1T200#yIS1 | **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [26Tglossary](#_Glossary)26T for a full definition. |

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##### **Eligible providers**

Surest has identified quality Designated Providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services. ***Transplant services (except for corneal transplant) must be rendered at a Designated Provider***. All members undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants. The Transplant Resource Services program provides benefits for travel and lodging expenses. See Travel and Lodging Reimbursement Benefit section for more information

##### Additional exclusions and limitations for transplants

In addition to the plan’s [exclusions and limitations](#Exclusions_Limitations_Surest), the following exclusions and limitations apply to this benefit:

* Nonhuman or mechanical organs, unless they are not experimental or investigational
* Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
* Donor costs are not covered if the recipient of the transplant service is not a Microsoft enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
* Donor costs are not covered by Microsoft if benefits are available under other group or individual coverage
* Donor costs are not covered for transportation for typing or matching
* Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s medical coverage.)

#### Transplant Resource Services

For a solid organ and blood/marrow transplant to be a Covered Health Service, you must be enrolled in Transplant Resource Services and use a designated provider. Contact Surest Member Services at (866) 222-1298 for more information on Transplant Resource Services and access to designated providers.

Once you are enrolled in Transplant Resource Services, a dedicated nurse case manager who specializes in transplant cases will provide assistance in:

Selecting the transplant facility.

Scheduling your evaluation at the transplant facility.

Following up with you routinely while you are on the transplant list.

Discharge planning, post-transplant support, and ongoing help with your care needs.

Organs included in the program are heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and bone marrow (blood forming stem cell transplants). While corneal transplant is a solid tissue transplant, it is not considered part of the Transplant Resource Services program.

The Transplant Resource Services provides benefits for travel and lodging expenses.

#### Travel and Lodging Reimbursement Benefit

The Surest Plan provides you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the necessary distance from your residence to the facility is at least 100 miles. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call Surest Member Services at (866) 222-1298.

#### Travel and Lodging Expenses

**Travel Allowances:** Travel expenses are reimbursed between the member’s residence and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical and Dental expenses, for current mileage reimbursement rates.

**Lodging Allowances:** Hotel or motel stays (or similar accommodations) away from the geographic area of the member’s residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of $50 per night per person, or up to $100 per night total for the member and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

**Overall Maximum:** The travel and lodging reimbursement benefit is limited to a total of $10,000 per member per calendar year.

**Companions:** The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

* Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
* Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

**Limits:** Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit the IRS website, [**www.irs.gov**](http://www.irs.gov), for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice. Please consult with a personal legal or tax advisor for more information.

**Non-Covered Expenses:**

* Alcohol/tobacco
* Car rental expenses
* Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
* Baggage fees
* Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
* Expenses for persons other than the patient and an eligible companion
* Lodging at a residence owned by a family member or friend
* Costs for pets or animals, other than service animals
* Meals
* Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
* Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
* Telephone calls

#### Limitations/exclusions:

* The travel and lodging must occur, and the treatment must be provided, within the United States
* The patient must be currently covered by the Surest Plan at the time the treatment is provided and the travel and lodging expenses are incurred
* The medical treatment for which the patient is required to travel more than 100 miles from the patient’s residence must be a Covered Health Service.

Treatment/Test/Therapies

Treatment/test/therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.

The table below is illustrative of how treatment/test/therapies are tiered and the range of copayments assigned to them.

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| **Treatment / Tests / Therapies** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Level 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., biofeedback, needle biopsy, pain management procedures, etc.) | $15 to $1,800  copayment / visit | $105 to $2,250  copayment / visit |
| **Level 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, glaucoma surgery, etc.) | $0 to $1,950  copayment / visit | $525 to $2,450  copayment / visit |
| **Level 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.) | $125 to $2,000  copayment / visit / stay | $2,000 to $2,500  copayment / visit / stay |
| **Level 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.) | $125 to $2,000  copayment / visit / stay | $2,000 to $2,500  copayment / visit / stay |
| **Level 5:** Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain tumor surgery, coronary artery bypass graft surgery, etc.) | $500 to $2,000  copayment / visit / stay | $2,000 to $2,500  copayment / visit / stay |
| **Other Treatments/Tests/Therapies:** Refer to the Surest mobile app or [Benefits.Surest.com](http://benefits.surest.com/) website for coverage and copayment information or call Surest Member Services at (866) 222-1298. Copayments may vary based on Provider, location and treatment, test, or therapy. | | |
| Office Visits | $20 to $75  copayment / visit | $120  copayment / visit |
| Outpatient Hospital Visit | $75 to $525  copayment / visit | $1,575  copayment / visit |
| Inpatient Hospital | $1,300  copayment / stay | $2,000  copayment / stay |

Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.

Procedures in Level 1 - Level 5 may vary based on Provider and location.

* Level 1 is a category of minor procedures typically performed in an outpatient office setting.
* Level 2 is a category of minor surgeries and procedures or services typically performed in an outpatient hospital setting.
* Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
* Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.
* Level 5 is a category of major surgeries and procedures that require intensive monitoring and are typically performed in an inpatient hospital setting. Transplant services must be rendered at a location specified as a Designated Provider

Bariatric Surgery does not have a limit.

Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.

Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app or call Surest Member Services at (866) 222-1298 to determine the copayment assigned to your procedure/service.

Inpatient Hospitalization/Stay benefits include:

* Physician and non-Physician services, supplies, and medications received during an inpatient stay.
* Facility charges, including room and board in a semi-private room (a room with two or more beds).
* Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
* The Surest Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

All inpatient services require Prior Authorization if planned, and notification within 24 hours of admission if emergent.

Select office-based and outpatient procedures require Prior Authorization and Medical Necessity review.

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|  | |  | |
| P1129C3T70#yIS1 | [26T**Prior authorization**](#priorauthorization)26T is an advance determination by Surest that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.  **If you have questions about Prior Authorization, please contact Surest Member Services at (866) 222-1298.** | |  |
|  |  |  |  |

Urgent Care

|  |  |  |
| --- | --- | --- |
| **Urgent Care** | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Urgent Care Visit** | $40 copayment / visit | $120 copayment / visit |

Benefits include visits at a walk-in Urgent Care center that treats illnesses and injuries requiring immediate care, but not serious enough to require an Emergency department visit. If the Urgent Care facility is unable to treat you, you may be referred to the Emergency Room or other Provider, you will be responsible for both the Urgent Care and Emergency Room copayments. Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Virtual Care

|  |  |  |
| --- | --- | --- |
| **Virtual Care – Designated Provider** | **In-Network** | **Out-of-Network** |
| **Virtual Primary and Urgent Care** | $0 copayment / visit | Not Covered |
| **Virtual Mental Health and Substance Use Disorder Care** | $20 to $40 copayment / visit | Not Covered |
| **Virtual Specialty Care** | $0 to $75 copayment / visit | Not Covered |

The Surest Plan provides benefits for Virtual Care. Please visit the Surest mobile app or [Benefits.Surest.com](https://benefits.surest.com/) website or call Surest Member Services at (866) 222-1298 to locate a Designated Virtual Network Provider

Virtual Care is for Covered Health Services that includes the diagnosis and treatment of medical and mental health conditions for members that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner.

Copayments vary based on Provider. If you choose a Provider that is not a Designated Virtual Network Provider (Other Virtual Provider), see the Office Visit section for additional Telehealth Visit copayment information. Virtual Care benefits are available only when services are delivered through a Designated Virtual Network Provider that are specified by your Surest Plan. There is no virtual care coverage for out-of-network Providers.

Please note that not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.

#### Vision therapy

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| --- | --- | --- |
|  | **In-Network** | **Out-of-Network**  (may be subject to balance billing) |
| **Vision Therapy** | $20 copayment / visit | $120 copayment / visit |

This benefit covers vision training, eye training or eye exercises, up to a maximum of 32 treatment visits, for the duration of continuous enrollment in one or more of Microsoft’s Premera, Surest, or KFHPWA health plan options, for the following conditions only:

* Amblyopia
* Convergence insufficiency
* Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [26TVision plan](#_Section_IV:_Vision)26T. Costs of equipment and supplies associated with vision therapy are not covered.

### Exclusions and limitations

The Surest Plan does not provide benefits for the following services, treatments, or supplies (including items or services that are related to the services, treatments, or supplies listed below, but which are not specifically listed below) even if they are recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in ***What the Plan Covers***.

* Services or supplies that are not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following in accordance with the terms of the Surest Plan: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-childcare and adult physical exam benefits
* Charges in excess of eligible expenses, including out-of-network provider billed amounts over the allowable charges
* Expenses in excess of the applicable annual and lifetime benefit maximums
* Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements), and herbal or naturopathic/homeopathic medicine
* Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
* Devices and computers to assist in communication and speech except as described in the section for DME and Supplies. Examples of non-covered items include iPads and Android tablets.
* Charges for or in connection with services or supplies that are determined to be experimental or investigational
* Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers’ Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
* Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies.
  + This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
  + Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
  + If other insurance is available for medical benefits, the Participant must put other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to the Plan.
* Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits 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
* In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
* Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
* Services of a social worker except as provided in the hospice care benefit, the home health care benefit and the mental health, substance use disorder, and alcohol use disorder treatment benefit
* Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.
* Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
* Massage therapy that is not medically necessary or is furnished without a prescription
* Activity therapy such as art therapy, dance therapy, horseback therapy, music therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health
* Any benefits or services not specifically provided for in this SPD
* Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
* Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
* Services that are considered Experimental or Investigational as determined by Surest. The fact that a treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered Experimental or Investigational in the treatment of that particular condition. For additional information, call Surest Member Services at (866) 222-1298
* Procedures for sterilization reversals
* Hypnotherapy, regardless of provider
* Hippotherapy or other forms of equine or animal-based therapy
* Electronic services and/or consults, except as specifically described under the plan
* Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but is not limited to a provider who is a covered dependent under the plan (whether or not living in the household), 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 that are illegal, outside the scope of the provider’s license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
* Separate charges for records or reports, except those Surest requests for utilization review
* Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
* Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
* Private Duty Nursing.
* Respite care, except as provided under Hospice Care in the Plan Benefits section.
* 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 and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
* Wilderness, adventure, camping, outdoor, or other similar programs, provided that otherwise-covered services will not be excluded solely because they are furnished in a wilderness or outdoor setting.
* Residential facilities or programs that are not licensed as Residential Treatment Centers (RTC) facilities under state law.
* Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
* Investigational therapies for treatment of autism spectrum disorders.
* Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or congenital anomaly.
* Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices, unless otherwise provided under the DME and Supplies section.
* Services or supplies for any of the following:
  + Education and training programs including testing or supplies/materials, including vision training supplies
  + Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
  + Social, cultural, or vocational rehabilitation or vision training supplies
* Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
* Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
* Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums, unless otherwise explicitly provided in this SPD
* Routine eye exams (including refractions), eyeglasses, contact lenses and any fittings associated with them
* Surgery and other related treatment that is intended to correct farsightedness, nearsightedness, presbyopia, and astigmatism, including but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
* Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months
* Reversal of voluntary sterilization‍.
* Treatments considered Experimental by the American Society of Reproductive Medicine.
* Services for individuals not eligible for coverage under the Microsoft Plan will not be reimbursed except in the following circumstances:
  + Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
  + Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
* Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products)
* Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
* Transitional living services
* When Coordinating Benefits (COB) and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
* Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan
* Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in-network providers do not apply to services received in excess of the benefit limit.
* Health care services related to a non-Covered Health Service, unless the service treats complications that arise from the non-Covered Health Service. For the purpose of this exclusion a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.
* Items or services for which an out-of-network Provider waives, does not pursue, or fails to collect, copayments or other amount owed
* Charges for giving injections that can be self-administered.
* Drugs dispensed by a Physician or Physician’s office for outpatient use.
* Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by Surest), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to members for self-administration.
* Certain new prescription medications or products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, benefits may be available for the new prescription medications or product to the extent provided in the Plan Benefits section. Selected drugs or classes of drugs which have shown no additional benefit, with regard to efficacy, safety, or side effects, as compared to other covered drugs.

In addition, the exclusions listed below apply specifically to the pharmacy benefit.

When an exclusion applies to only certain Prescription Drug Products, you can contact Surest at <https://benefits.surest.com>, the telephone number on your ID card, or the Surest mobile app for information on which Prescription Drug Products are excluded.

* Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
* Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
* Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
* Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
* Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
* Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
* Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
* A Pharmaceutical Product for which benefits are provided under the medical benefits portion of the Plan in this SPD. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
* Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in this SPD. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies, including certain insulin pumps and related supplies for the management and treatment of diabetes and inhaler spacers specifically stated as covered.
* General vitamins, except the following, which require a Prescription Order or Refill:
* Prenatal vitamins.
* Vitamins with fluoride.
* Single entity vitamins.
* Certain unit dose packaging or repackaged prescription drugs.
* Medications used for cosmetic or convenience purposes.
* Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.
* Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
* Prescription Drug Products when prescribed to treat infertility.
* Certain Prescription Drug Products for tobacco cessation.
* Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.
* Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's PDL Management Committee.
* Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
* Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of sickness or injury.
* A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
* A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
* Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
* Certain Prescription Drug Products that have not been prescribed by a Specialist.
* A Prescription Drug Product that contains marijuana, including medical marijuana.
* Certain Prescription Drug Product with either:
* An approved biosimilar.
* A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
* For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
* It is highly similar to a reference product (a biological Prescription Drug Product).
* It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
* Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
* Diagnostic kits and products including associated services.
* Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
* Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

* [Behavioral Health](#Behavioral_Health_Surest)
* [Dental Services](#Dental_Surest)
* [Durable Medical Equipment (DME)](#DME_Surest)
* [Fertility](#Fertility_Surest)
* [Gender Affirming Services](#Gender_Affirming_Surest)
* [Hearing Care & Hardware](#Hearing_Surest)
* [Home Health Services](#HomeHealth_Surest)
* [Hospice Care](#Hospice_Surest)
* [Reconstructive Surgery](#Reconstructive_Surest)
* [Skilled Nursing Facility](#SkilledNursing_Surest)
* [Transplant Services](#Transplant_Surest)

### How to file a claim

#### Claims Procedures

This section summarizes the procedures you must follow to submit a medical Claim for payment, and the procedures the Surest Plan will use to determine whether and how much to pay for that medical Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Surest Member Services at (866) 222-1298.

Claims for medical (non-pharmacy) benefits will be reviewed by Surest and claims for pharmacy benefits will be reviewed by Optum.

All Claims should be submitted as soon as possible, in accordance with this section, and in all cases must be submitted within one year from the date you received the health care services. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the health care service for Claims submission purposes.

Separate schedules apply to the timing of benefit requests and medical Claim appeals, depending on the type of request. There are four types of requests:

|  |  |  |  |
| --- | --- | --- | --- |
| **Urgent Care Request for Benefits** | **Concurrent Care Requests** | **Pre-Service Request for Benefits** | **Post-Service Medical Claim Request for Benefits** |
| A request for benefits provided in connection with urgent care services  If your urgent care request for benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review, if applicable). | A request to extend an already approved ongoing course of treatment that was approved for a specific period of time or a specific number of treatments.  If the request is urgent, we will follow the urgent care request for benefits and appeals processes and timeframes, except that if the request was received at least 24 hours before expiration of the current approved course of treatment, we will decide the claim within 24 hours of receipt.  If it is not urgent, it will be treated like a new request for services and will follow the Pre-Service or Post-Service Request for Benefits and Appeal processes, as applicable. | A request for benefits for which the Surest Plan requires Prior Authorization.  If your pre-service request for benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review, if applicable). | A medical Claim for reimbursement of the cost of non-urgent care for which the Surest Plan does not require Prior Authorization.  You can submit a post-service medical Claim through the Surest website at <https://benefits.surest.com> or on the mobile app or by mail to the address on your member ID card |

#### Notice of Adverse Benefit Determination

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. The notice will be written in an understandable and, where required by law, in a culturally and linguistically appropriate manner and will include all of the following:

* Information sufficient to identify the medical Claim involved (including the date of service, the healthcare Provider, and the medical Claim amount (if applicable)).
  + The specific reason or reasons for the denial, the denial code and its meaning and a description of the Plan standard, if any, that was used in denying the Claim.
  + The specific reference to the relevant Plan provision on which the decision is based
* A description of additional information needed to support your medical Claim and an explanation of why it is needed.
* Information about to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
* A statement about available external review processes, including information on how to initiate the review.
* If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
* Either an explanation of the scientific or clinical judgement for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on Medical Necessity, Experimental or Investigational, or a similar limit or exclusion.
* A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If we tell you about our decision orally within the timeframes required, we will follow up within three business days with a written or electronic notice.
* A description of any voluntary dispute resolution processes the Plan offers.

#### **Denied claims notice**

##### If your Medical Claim is Denied

If a medical Claim for benefits is denied in part or in whole, you are encouraged to call Surest Member Services before requesting a formal appeal. If Surest Member Services cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit a medical Claim appeal:

1. Contact Surest Member Services to request a medical Appeal Filing Form or refer to the medical Appeal Filing Form included with your Explanation of Benefits.
2. Complete the medical Appeal Filing Form.
3. Submit the completed medical Appeal Filing Form along with your denial notice and any supporting documentation to:

Surest Consumer Affairs (Member Appeals)

P.O. Box 31270

Salt Lake City, UT 84131

##### Review of a Medical Appeal

Surest will conduct a full and fair review of your medical Claim appeal.

You can send written comments, documents, records, and any other information you think will help decide the medical Claim appeal.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s medical Claim for benefits.

When we review your medical Claim appeal, we will take into account all comments, documents, records, and other information you give, even if we did not have that information when we denied the medical Claim.

Surest adheres to the following review practices:

* The appeal will be reviewed by an appropriate individual(s) who did not make the initial benefit determination and who does not report to the person who did make the initial benefit determination.
* If your medical Claim involves a medical judgement or whether the medical Claim is about investigational or Experimental services, the appeal will be reviewed by a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.
* Surest will review all medical Claims in accordance with the rules established by the U.S. Department of Labor and applicable state law.
* Our reviewers avoid conflicts of interest and act independently and impartially.

Once the review is complete, if Surest upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you are not satisfied with the first-level medical Claim appeal decision, you have the right to request a second-level medical Claim appeal within 60 days of receipt of the first-level medical Claim appeal determination.

##### Access to New or Additional Information

If you ask us, we will give you the identification of any medical expert who gave an opinion – whether or not we used that opinion to decide your medical Claim. Any member will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required, with: (i) any new or additional evidence considered, relied upon, or generated by the Surest Plan in connection with the medical Claim; and (ii) a reasonable opportunity for any member to respond to such new evidence or rationale.

##### Timing of Medical Claim Appeals Determinations

You may have the right to external review through an Independent Review Organization (IRO) upon completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in a decision letter to you from Surest.

The tables below describe the time frames which you and Surest are required to follow.

##### Urgent Care Request for Medical Benefits and Appeal\*

| **Request for Urgent Care Benefits** | **Claims Timing** |
| --- | --- |
| If your request for medical benefits is incomplete, Surest must notify you within: | **24 hours**  and advise you what information is needed |
| You must then provide a completed request for medical benefits to Surest within: | **48 hours**  after receiving notice of additional information required |
| Surest must notify you of the medical benefit determination within: | **48 hours** of receiving the needed information, or of expiration of the 48-hour period for you to provide the completed request |
| If your request for medical benefits is complete when it is filed, Surest must notify you within: | **72 hours** |
| If Surest denies your request for medical benefits, you must appeal an Adverse Benefit Determination no later than: | **180 days**  after receiving the Adverse Benefit Determination |
| **Concurrent Care Benefits Claims** | **Claims Timing** |
| If Surest reduces or terminates an approved ongoing course of treatment before its expiration, Surest must notify you: | **Sufficiently in advance**  to allow you to appeal before the reduction or termination takes effect |
| If (i) you are requesting to extend an approved course of treatment beyond the approved period of time or number of treatments, (ii) your request is for urgent care, and (iii) your request is made at least 24 hours before expiration of the approved period of time or number of treatments, Surest must notify you within: | **24 hours**  after receipt of the claim |
| All other cases where you are requesting to extend an approved course of treatment beyond the approved period of time or number of treatments, Surest must notify you within: | **The urgent care, pre-service, or post-service timeframe**  as applicable, depending on the nature of the claim |
| **Expedited Appeals (Urgent Care or Concurrent Care)** | **Appeals Timing** |
| Surest must notify you of the medical Claim appeal decision within: | **72 hours**  after receiving the medical Claim appeal — if the medical Claim appeal is still urgent.  If services have already been provided, we follow the Post-service medical Claim appeals process. |

**\***Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.

##### Pre-Service Request for Medical Benefits and Appeal\*

| **Request for Pre-Service Benefits** | **Claims Timing** |
| --- | --- |
| If your request for medical benefits is filed improperly, Surest must notify you within: | **5 days** |
| If your request for medical benefits is incomplete, Surest must notify you within: | **15 days** |
| You must then provide a completed request for medical benefits information to Surest within: | **45 days** |
| Surest must notify you of the medical benefit determination: | |
| * If the initial request for medical benefits is complete, within: | **15 days\*** |
| * After receiving the completed request for medical benefits (if the initial request for medical Benefits is incomplete), within: | **15 days\*** |
| \*Surest may require a one-time extension for the request for Pre-Service benefits, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if we determine that additional time is needed before the 15 days expires. | |
| You must appeal an Adverse Benefit Determination no later than: | **180 days**  after receiving the Adverse Benefit Determination |
| **Appeals (Pre-Service)** | **Appeals Timing** |
| Surest must notify you of the first-level medical Claim appeal decision within: | **15 days**  after receiving a complete first-level medical Claim appeal |
| You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within: | **60 days**  after receiving the first-level medical Claim appeal decision |
| Surest must notify you of the second-level medical Claim appeal decision within: | **15 days**  after receiving a complete second-level medical Claim appeal |

##### Post-Service Medical Claim Request for Benefits and Appeal\*

| **Post-Service Claim** | **Claims Timing** |
| --- | --- |
| If your medical Claim is incomplete, Surest must notify you within: | **30 days** |
| You must then provide completed medical Claim information to Surest within: | **45 days** |
| Surest must notify you of the benefit determination: | |
| * If the initial medical Claim is complete, within: | **30 days\*** |
| * After receiving the completed medical Claim (if the initial medical Claim is incomplete), or at the expiration of the 45-day period if a completed medical claim is not received, within: | **30 days\*** |
| \*Surest may require a one-time extension for the initial Post-Service Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if we determine that additional time is needed before the 30 days expires. | |
| You must appeal an Adverse Benefit Determination no later than: | **180 days**  after receiving the Adverse Benefit Determination |

|  |  |
| --- | --- |
| **Appeals (Post-Service)** | **Appeals Timing** |
| Surest must notify you of the first-level medical Claim appeal decision within: | **30 days**  after receiving the first-level medical Claim appeal |
| You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within: | **60 days**  after receiving the first-level medical Claim appeal decision |
| Surest must notify you of the second-level medical Claim appeal decision within: | **30 days**  after receiving the second-level medical Claim appeal |

#### **Notice of Claim Denial on Appeal**

If your Claim is denied on review, the reviewer will provide you with a notice of the Adverse Benefit Determination that will:

* Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
* Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
* Include the specific reasons for Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
* Refer to the specific Plan provisions on which the determination was based.
* Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for benefits.
* Notify you of your right to bring legal action under ERISA
* Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
* Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
* Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
* Include a statement about voluntary appeal procedures your Plan may offer.

The reviewer’s decision on appeal is the final internal Adverse Benefit Determination.

#### **Federal External Review Program**

If, after exhausting your internal appeals, you are not satisfied with the determination made by Surest, and the Adverse Benefit Determination was based on any of the following, you may be entitled to request an external review. The process is available at no charge to you.

* Medical judgement and/or Clinical reasons - for example Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
* A determination that a treatment, service, drug, or device is an Experimental or Investigational Service(s) or Unproven Service(s).
* A determination as to whether a member is entitled to a reasonable alternative standard for a reward under a wellness program.
* A determination as to whether the Surest Plan is complying with federal mental health parity requirements regarding non-quantitative treatment limitations.
* A recission of coverage (generally, coverage that was cancelled or discontinued retroactively).
* Consideration of whether the Surest Plan is compliant with the federal rules relating to surprise billing for out-of-network Providers.
* As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, call Surest Member Services at (866) 222-1298 or by sending a written request to the address set out in the determination letter. A request must be made within 120 days after the date you received the final internal Adverse Benefit Determination letter from Surest.

An external review request should include all of the following:

A specific request for an external review.

The member’s name, address, and member ID number.

Your designated representative’s name and address, when applicable.

The service that was denied.

Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Surest has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available, and both are free to you.

#### Standard External Review

A standard external review comprises of all of the following:

A preliminary review by Surest of the request completed within five business days following Surest’s receipt of the request.

A referral of the request by Surest to the IRO.

A decision by the IRO.

Within the applicable timeframe after receipt of the request, Surest will complete a preliminary review to determine whether all of the following criteria are satisfied:

You are or were covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.

The denial does not relate to your eligibility to participate in the Plan.

You have exhausted the applicable internal appeals process or are deemed to have exhausted the internal appeals process.

You have provided all the information and forms required for Surest to process the request.

After completing the preliminary review, Surest will issue a notification in writing to you within one business day. If the request is eligible for external review, Surest will assign an IRO to conduct such review. Surest will assign requests by either rotating assignments among the IROs or by using a random selection process.

If the request is complete but not eligible for external review, Surest will provide notification that includes the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete; you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request.

The IRO will timely notify you in writing whether the request is eligible for external review. Within 10-business days following the date of receipt of the notice, you may submit in writing to the IRO additional information for the IRO to consider in conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10-business days.

Surest will provide to the assigned IRO the documents and information considered in making ‍the determination, including:

All relevant medical records.

All other documents relied upon by Surest.

All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Surest will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after receiving the request for the external review (unless they request additional time, and you agree). The IRO will deliver the notice of Final External Review Decision to you and Surest, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the determination made by Surest, the Surest Plan will immediately provide coverage or payment for the benefit Claim at issue, if applicable, in accordance with the terms and conditions of the Surest Plan, and any applicable law regarding Plan remedies. If the Final External Review decision is that payment or referral will not be made, the Surest Plan will not be obligated to provide benefits for the health care service or procedure.

#### Expedited External Review

An expedited external review is similar to a standard external review. The time for completing the review process is much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

An Adverse Benefit Determination of a Claim or appeal if the Adverse Benefit Determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and you have filed a request for an expedited internal appeal.

A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure, or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Surest will determine whether the individual meets both of the following criteria:

* Is or was covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.
* Has provided all the information and forms required so that Surest may process the request.

After completing the review, Surest will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Surest will assign an IRO in the same manner Surest utilizes to assign standard external reviews to IROs.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice the assigned IRO will provide written confirmation of the decision to you and to Surest.

**You may contact Surest Member Services (866) 222-1298 for more information regarding external review rights, or if you are making a verbal request for an expedited external review.**

#### Limitation on Your Right to Legal Action

#### You must follow the appeals process described above through the decision on the appeal (including external review, if applicable) before taking action in any other forum regarding a Claim or appeal under the Surest Plan. Any legal action initiated under the Surest plan must be brought no later than one year following the final adverse determination on the appeal. This one-year limitations period applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit Claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a Claim at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.

#### Right to Recover Benefits Paid in Error

If the Surest Plan makes a payment in error on your behalf to you or a Provider, and you are not eligible for all or a part of that payment, we have the right to recover payment, including deducting the mistaken amount paid from future benefits. Note: Neither Providers nor any other third-parties are “beneficiaries” of the Surest Plan, and although we may make direct payment to Providers in many instances, such payments shall not be considered “benefits” available under the Surest Plan or confer beneficiary standing upon a Provider or any other third-party.

# Section IV: Other health & wellness benefits

What is in this section

[Spring Health Employee Assistance Program (EAP) 311](#_Toc179829537)

[Expert Medical Opinion (Teladoc Health ) 314](#_Toc179829538)

[Be Well 318](#_Toc179829539)

[Family Health and Reproductive Support (Maven) 320](#_Toc179829540)

| **P** | COBRA enrollees – the Other health & wellness section applies |
| --- | --- |

## Spring Health Employee Assistance Program (EAP)

What is in this section

[[How the program works 311](#_Toc172480268)](#_Toc179829717)

[[What the plan covers 312](#_Toc172480268)](#_Toc179829718)

|  |  |
| --- | --- |
| **P** | COBRA enrollees – the Spring Health (EAP) section applies |

### How the program works

Spring Health is our confidential, free, short-term counseling and work-life resource and referral provider (employee assistance program).

**Eligibility:** Employees and their dependents (spouse/partner, children 6-26).

Note: for children under 6 Spring Health will help with referrals.

Create your online account at [aka.ms/SpringHealth](https://microsoft.sharepoint.com/teams/YearEndActivities/Shared%20Documents/Open%20Enrollment%202024/SPDs/aka.ms/SpringHealth) to access their services. You may add dependents under 18 to yours, or your spouse/partner’s account.

Adult dependents (spouse/partner, \*child 18+) can create accounts in one of two ways:

* From your Spring Health account you can send your adult dependent (spouse/partner, child 18+) an invitation to create their own Spring Health account. Login to your account and to your profile and settings to send the invitation.
* Adult dependents (spouse/partner, \*child 18+) can create their own accounts by going to www.microsoft.springhealth.com. They will need your full name and full email with your alias to creat an account.
* You will not have access to or know if your adult dependent has created an account, as it’s confidential.

Note: In some states, dependents *under* 18 may be able to create their own accounts based on local state law regarding parental consent.

| P9046C1T436#yIS1 | Microsoft respects your right to privacy in your personal and family life. No record of your use of the Spring Health program will be kept or made available to anyone within Microsoft. This also applies to your health care plans. |
| --- | --- |

|  |  |
| --- | --- |
| P9051C1T437#yIS1 | * To schedule an appointment with a Spring Health counselor, call (855) 629-0554. You can also visit Spring Health. * If you leave Microsoft or otherwise become ineligible, you will continue to have access to Spring Health, short-term counseling, resource & referral (EAP) benefits if you elect to continue your coverage. For more information, see the [When coverage ends](#_When_benefit_coverage) section. |

### What the plan covers

Spring Health short-term counseling, work-life resources and referrals, access to the Spring Health Platform and services.

#### Counseling services

The short-term counseling services covered through Spring Health are described below.

| **Service** | **Description** | **Coverage** |
| --- | --- | --- |
| Individual, couples, or family counseling | Emotional, psychological, social, or work-related stress; brief problem resolution and/or referral for behavioral health treatment. For couples and/or families, issues related to relationship building, conflict resolution, and decision making within the family unit. You can choose in-person or video/virtual-based therapy. | Up to 24 sessions per calendar year. |

| P9070C1T439#yIS1 | Additional mental health coverage may be available under your [medical plan](#_Section_III:_Medical). The Spring Health EAP is separate from the mental health services covered under Microsoft’s medical plans. |
| --- | --- |

Counseling services include:

| **Type of counseling** | **Description** |
| --- | --- |
| Child counseling | You can get help for a child who needs to adapt more effectively within the family, at school, and with friends. Experienced child counselors lead individual and group sessions. |
| Domestic violence treatment program | Education and support is available for women or men trying to overcome the cycle of violence and abuse. Classes and group sessions focus on assessing domestic violence issues, changing abusive behaviors, and learning nonviolent relationship skills. |
| Grief counseling | Counseling is available for adults and children who have experienced the death of a loved one. Support groups and referral sources are also available. |
| Work-related and onsite resources | Manager Consultation or Critical incident Stress Management support is available for HR and managers who may be dealing with difficult situations in their work environment, including conflict resolution, communicating sensitive messages, and dealing with deaths in the workplace. Call 1(855)629-0554 (option 4) |
| Child counseling | You can get help for a child who needs to adapt more effectively within the family, at school, and with friends. Experienced child counselors lead individual and group sessions. |

Access to Spring Health includes the following:

* Access to Spring Health via Web and App (microsoft.springhealth.com)
* Personalized care plan: 5-minute mental health assessment creates a customized care plan
* Counseling: 24 free counseling sessions per calendar year (12 sessions in 2022) with a Spring Health provider per year​.
* Care Navigator (Concierge) Support: Unlimited appointments with Care Navigators who are licensed clinicians to help you determine the best care options for you
* ​Mental & Emotional Wellbeing Coaching
* Moments: self-guided exercises for mental wellbeing, covering topics like anxiety, burnout, better sleep, and more in an on-demand library. You have unlimited access to Moments which are wellness exercises for everyone, for your continued overall wellbeing from anywhere at any time.
* Work-life Resources & Referrals: Covers a variety of childcare, eldercare, financial, legal, and daily life topics. Spring Health will do the research for you to find options, including a list of referrals for childcare, eldercare, pet care, and more.  Browse thousands of articles, talk/chat with a work-life consultant and connect with subject-matter experts. Use online tools, articles, audio/video information, resources, and skill builders that provide practical tips on parenting, aging, balancing, thriving, working, living, as well as U.S./international immigration/relocation.
* Monthly and on demand webinars based an various mental and emotional wellbeing topics.
* Access to Gottman Institute to attend one of the following (limited to one of the below sessions per member, per year):
  + [Art and Science of Love](https://www.gottman.com/product/the-art-and-science-of-love-virtual-event/) couples virtual or online relationship workshop (up to USD599 towards 1 virtual weekend workshop, or one online workshop with or without the DVD per employee per calendar year). If you want to attend the Art and Science of Love workshop in person, you may work with the Gottman institute directly to cover the additional cost from your own funds; or
  + [Emotion Coaching](https://www.gottman.com/product/emotion-coaching-the-heart-of-parenting-online/) online course (up to USD99 online or DVD, per employee, per calendar year), or
  + [Bringing Baby Home workshop/New Parents relationship workshop](https://www.gottman.com/parents/new-parents-workshop/), virtual or in-person, (up to USD400, per employee, per calendar year)
  + To learn more about how to get access to the Gottman Institute options view the options under, “Access Spring Health” [here](https://aka.ms/mscares) or ask your Spring Health Care Navigator.

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| --- | --- |
| P9112C1T442#yIS1 | * For more information on Spring Health services and resources, or to schedule an appointment, go to [microsoft.springhealth.com](https://microsoft.sharepoint.com/teams/YearEndActivities/Shared%20Documents/Open%20Enrollment%202024/SPDs/microsoft.springhealth.com), or call (855) 629-0554. |

## Expert Medical Opinion (Teladoc Health )

What is in this section

[[How the plan works 314](#_Toc423613701)](#_Toc179829887)

|  |  |
| --- | --- |
| **P** | COBRA enrollees – the Expert Medical Opinion section applies |

### How the plan works

Microsoft's Expert Medical Opinion Program, administered by Teladoc Health, an independent third-party vendor, offers expert medical advice when you or a family member is facing an important medical decision. The program is a voluntary and confidential service provided at no additional cost to all Microsoft U.S. benefits-eligible employees, along with their spouses, domestic partners, children, and extended family members. The Expert Medical Service is ideally suited to help complex patients with conditions such as cancer, surgical candidates, and those with complicated or sensitive medical questions.

Teladoc Health is a global health services provider of physician-driven programs offering advocacy and support to employees experiencing medical confusion and/or crisis. The Expert Medical Service is delivered only by actively practicing, board certified physicians with access to 50,000 leading consulting experts worldwide.

Teladoc Health Medical Experts will support all medical specialties including but not limited to:

* Orthopedic Surgery
* Oncology
* Psychiatry
* Cardiology
* Internal Medicine
* Radiology
* Obstetrics/Gynecology
* Nephrology
* Urology
* Ophthalmology
* Emergency Medicine
* Pediatrics
* Family Medicine
* Mental Health
* Hematology
* Pulmonology
* Critical Care
* Pathology

#### To get started

* Contact Teladoc Health in one of three ways:
* Call (800) 676-1411 and follow the prompts to speak with a Teladoc Health Medical Experts representative. Calls are answered by live representatives twenty-four hours a day, seven days a week, 365 days a year. Any non-covered dependents or extended family members will need to provide a Promo Code (Promo Code is **MSFT-Family**) to access this service.
* Register on the [teladochealth.com/microsoft](https://urldefense.com/v3/__https:/teladochealth.com/microsoft__;!!KmjVaS9Yw9I!1U0TLpY_0v_0Nvv_uMYw2nHR5aa6fMltGjmumPHPWq54TW0dUI5L1jULqCPJsxT42WcqPd_SzUwsdD2W1TyZnrGV028$) and receive a response the same day or next business day.
  + Send an email to [memberservices@Teladochealth.com](mailto:memberservices@Teladochealth.com) and receive a response the same day or next business day.
* A dedicated Teladoc Health representative will verify your eligibility, collect all necessary authorizations and consents, and open a case to be reviewed.
* Within one business day of verifying your eligibility, a Physician Case Manager will be assigned to you, and they will contact you to:
* Discuss Teladoc Health Medical Experts Services
  + Review your medical history including current and previous treating provider’s information
  + Clarify and document your questions and concerns
  + Offer treatment decision support as needed
  + Determine gender, language, preferred contact times and other personal preferences
* After the discussions with you, your new Physician Case Manager will develop an initial report based on the information gathered.
* Your Physician Case Manager will then determine whether to initiate an Expert Medical Opinion, Coaching or Physician Navigation services.

|  |  |
| --- | --- |
| Additional information | Each person’s case is unique, and the components of the services provided by Teladoc Health Medical Experts may vary. The exact service that any eligible employee or family member receives will be determined by a mix of the following: your preferences and objectives, the amount of data available for expert review, and the medical necessity determined by the Medical Directors. |

#### Expert Medical Opinion

When you need a second medical opinion from an expert regarding a recent, complex diagnosis or treatment plan.

* If determined your case needs an expert medical opinion, a Physician Navigation Associate will initiate the collection of medical records for your entire medical history, from all of your providers. Teladoc Health Medical Experts will use their best efforts to collect all necessary records for you within three (3) business days. Collected Records will include, but are not limited to:
  + Physician notes
  + Consult reports
  + Imaging, labs and testing
  + Pathology tissue and reports
* Your Physician Case Manager will consolidate and review your records for any gaps in care and significant medical issues to be explored while working with you and the medical expert that is assigned to your case.
* All collected medical records will be uploaded to your Teladoc Health Medical Experts Microsite member portal for easy access by you.
* Once the Teladoc Health Medical Experts Clinical Committee has reviewed your medical records, they will evaluate your case, determine the appropriate medical expertise to engage, and assign the appropriate expert(s).
* The expert(s) assigned will then review your case, make their assessment and create your final report within a few weeks; depending on the complexities of your case.
* Your Physician case manager will call you every week to update you on the progress and status of your case.
* After your final report is created, your Physician Case Manager will call you on your preferred day and time to discuss the results.
* With your consent, your Physician Case Manager will also contact your treating physician(s) to discuss the final report.
  + The expert(s) and Physician Case Manager will not serve as treating physicians, but only serve as a resource for you and your treating physician(s).
* Your Physician Case Manager will follow up with you within six (6) months of the final report review to discuss and initiate activity as needed to support:
  + Implementation of expert recommendations
  + Resolution and/or ongoing nature of medical concerns
  + New symptoms, conditions, testing, or records requiring expert review
  + Interest in pursuing new or additional treating physicians (via Physician Navigation)
  + Anecdotal data about participation satisfaction recorded

#### Coaching

When you need additional help navigating the medical system or want answers from a specialist physician to basic questions about health conditions and treatment options.

* After an in-depth discussion with you over your current care and treatment, your Physician Case Manager will coach you on how to interact with the medical system and/or discuss other programs available to you.
* Some or all your medical records may be collected depending on the needs and complexities of your case.
* Teladoc Health Medical Experts will provide direct and unlimited access for you to get questions and answers from your Physician Case Manager by phone, email, video and chat.
* Your Physician Case Manager will recommend and/or provide articles, books, and medical literature relevant to your reported condition. Such information may be provided through the Microsite, direct email and mail.

#### Physician Navigation

When you need additional help finding a leading, recognized physician in your local area network.

* Teladoc Health Medical Experts will deliver Physician Navigation support upon your request. After collecting your preferences, a Physician Navigation Associate will compile a “Physician Navigation List” of physicians close to you that are best suited for your situation. This list includes the physician’s certifications, patient satisfaction, education, training, practice area, a sanctions/malpractice check, contact information, in-network status, and availability to see new patients.
* Your Physician Navigation Associate will call all identified physicians to confirm the doctor’s specialty, sub-specialty, acceptance of new patients, acceptance of member’s insurance, appointment availability, referral requirements, contact info and the new patient process, including what to bring to the first appointment, and update the Physician Navigation List accordingly.
* The finalized Physician Navigation List, typically including three physicians, will be reviewed by your Physician Case Manager for quality assurance and then provided to you. Your Physician Case Manager will then verbally review the results on the Physician Navigation List with you.
* At your request, the Physician Navigation Associate will provide appointment facilitation by documenting your preferred appointment days and times and setting up an appointment on your behalf with the newly identified treating physician. Upon your request and permission, your Physician Case Manager will communicate with your new treating physician.

| Additional information | *Although the Teladoc Health Expert Medical Opinion Services are provided at no additional cost to you, any treatment or services obtained in accordance with your Teladoc Health Medical Experts report will be subject to the terms, conditions, and provisions of your selected medical plan. Prior to receiving any additional treatment or service, review the coverage details of your medical plan or contact Premera at (800) 676-1411, Kaiser Foundation Health Plan of Washington at (888) 901-4636 or Kaiser Permanente at (800) 464-4000.* |
| --- | --- |

#### Eligibility

All U.S. benefits-eligible employees as well as their spouses, domestic partners, and children (regardless of age or eligibility for other coverage under the Plan), and extended family members (who are otherwise ineligible for benefits under the Plan) may participate in the Expert Medical Services Program. For this purpose, extended family members include siblings, parents, grandparents, aunts, uncles, nieces, nephews or cousins of a U.S. benefits-eligible employee or the employee’s spouse or domestic partner. Any non-covered dependents or extended family members will need to provide a Promo Code (Promo Code is **MSFT-Family**) to utilize this service.

Participants who are eligible at the initiation of their case will receive full service throughout the program regardless of their eligibility status (i.e., if an eligible employee uses the services but then terminates their employment at Microsoft before completion of the case, they would still be permitted to use the services until their case is completed).

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| --- | --- |
| Additional information | For more information about the Teladoc Health Expert Medical Services or if you are unsure if your case can be reviewed by Teladoc Health, call (800) 676-1411, and follow the prompts to speak with a Teladoc Health representative. |

| Additional information | *Teladoc Health will NOT share your medical records, medical information or the contents of your Teladoc Health report with anyone, including Microsoft or your health plan, unless you specifically authorize such disclosure. In addition, Teladoc Health endeavors to comply with all relevant state, national, and international laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Unless required by law, your specific name and medical information will NOT be shared with anyone, including Microsoft, without your written consent. Only de-identified and aggregate information will be used for program evaluation and improvement purposes.* |
| --- | --- |

## Be Well

What is in this section

[[How the plan works 319](#_Toc517773395)](#_Toc179830135)

|  |  |
| --- | --- |
| **P** | COBRA enrollees – the Be Well section applies |

### How the plan works

The Be Well program offers programs, activities and resources that support your physical, mental and financial wellbeing.

#### Flu Shots

Microsoft provides an annual flu shot program where US benefits-eligible employees and their spouses/domestic partners can receive a flu shot, free of charge. Flu shots are offered through a voucher that can be used at a retail location, or through onsite events at various Microsoft office locations.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Additional information | Vouchers to obtain a flu shot offsite from a specific provider, at no charge, are also available for the duration of the Flu Shot Program, which occurs in the fall. Dependent children (regardless of age) are not eligible to participate in the Flu Shot Program, either onsite or with a voucher. To obtain a voucher:   |  |  | | --- | --- | | **Active employees** go here… | **COBRA enrollees** go here… | | [Be Well](http://aka.ms/BeWell) or email [benefits@microsoft.com](mailto:benefits@microsoft.com) | Email [benefits@microsoft.com](mailto:benefits@microsoft.com) | |

The Flu Shot Program generally runs in the fall and is separate from the medical coverage offered under the plan. As a reminder the medical coverage also covers flu shots (subject to the terms and conditions of the medical coverage).

#### Biometric Screenings

Microsoft provides an annual biometric screening program where US benefits-eligible employees and their spouses/domestic partners can receive a biometric screening, free of charge. Biometric screenings are offered through the Be Well program site and employees can choose the option of a home test kit, a voucher, or book an appointment for a biometric screening through an onsite event at on one of the various Microsoft office locations.

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| Additional information | Dependent children (regardless of age) are not eligible to participate in the Biometric Screening Program, either onsite or home test kit. |

The Biometric Screening program generally runs in the fall and is separate from the medical coverage offered under the plan, which also covers biometric screenings (subject to the terms and conditions of the medical coverage) typically through an appointment with your primary care provider.

#### Other Programs and Activities

The Be Well platform offers physical, mental, and financial wellbeing activities, programs and resources, as well as Be Well seminars on topics that support your wellbeing. Log into your Be Well to learn more to help you care for your body, nurture your mind, and invest in your future.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Additional information | The Be Well online platform is available to employees, spouses, domestic partners and children age 18 and over.   |  |  | | --- | --- | | **Active employees** go here… | **COBRA enrollees** go here… | | [Be Well](http://aka.ms/BeWell) or email [benefits@microsoft.com](mailto:benefits@microsoft.com) | Email [benefits@microsoft.com](mailto:benefits@microsoft.com) | |

## Family Health and Reproductive Support (Maven)

What is in this section

[[How the program works 321](#_Toc52788930)](#_Toc179830242)

### How the program works

Microsoft provides access to Maven to all employees and their dependents who are covered under a Microsoft U.S. health plan (including all Premera and Kaiser plans). Maven is a digital health platform to help navigate preconception, pregnancy, postpartum, adoption, surrogacy, parenting, menopause, and returning to work.

#### Family Health Support

This program provides support on family planning and parenthood:

* Meet with a Care Advocate 24/7, who can answer questions about your benefits, recommend the best practitioners on Maven for your needs, and refer you to in-person, in-network doctors.
* Get on-demand support from providers and coaches across 35+ specialties, including midwives; doulas; mental health providers; nutritionists; reproductive endocrinologists; egg donor consultants; lactation consultants; infant sleep coaches; adoption and surrogacy specialists; parenting coaches, and many others.
* Receive clinically informed content tailored to your journey, take classes with Maven experts, and connect with other working parents through supportive community forums.

#### Menopause Support

This program provides support for menopause education and care:

* Meet with a Care Advocate 24/7, who can help address symptoms and will provide specialized virtual care and personalized guidance.
* Book video appointments or chat with providers spanning 35+ specialties, including gynecologists, sex therapists, mental health providers, career coaches, and more.
* Connect with others going through menopause.
* Learn more about perimenopause and menopause with access to clinically-approved education resources.

To enroll:

1. Go to [Maven](https://mavenclinic.com/join/msft) (((https://mavenclinic.com/join/msft)
2. Set up an account (you and/or your spouse/partner will need your Microsoft employee ID number).
3. Complete a health assessment to create a specialized care team based on you (or your partner’s) needs and interests.

# Section V: Coverage if you leave Microsoft

What is in this section

[When benefit coverage ends 324](#_Toc179830452)

[Continuation of coverage for health benefits (COBRA) 326](#_Toc179830453)

## When benefit coverage ends

What is in this section

[Medical and prescription drugs 324](#_Toc179834089)

[Other health & wellness benefits 325](#_Toc179834090)

| does not apply | COBRA enrollees – the When benefit coverage ends section does not apply |
| --- | --- |

| Additional information | Microsoft reserves the right to [terminate or amend](#_Right_to_Amend) these plans at any time and for any reason. |
| --- | --- |

### Medical and prescription drugs

#### For employees

Your benefit coverage ends when any one of the following occurs:

* The date this plan is terminated
* The date you no longer qualify as an eligible employee

The first day following the maximum length of an applicable leave of absence, should you not return to work

#### For dependents

Coverage for dependents will end on the earliest of the following dates:

* The date your coverage ends
* The date the plan is terminated
* The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
  + Divorce, legal separation, or annulment (for spouses)
  + The dissolution of a domestic partnership
  + The end of the month in which a child no longer meets the age requirement for dependent status

The date coverage for all dependents under the plan is cancelled

| Additional information | If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. If your coverage terminates as a result of your death Microsoft will provide your covered dependents, who elect COBRA a subsidy for 365 days from the date of their medical coverage ends. |
| --- | --- |

You may be eligible to continue your medical coverage after you leave Microsoft. See the [Continuation of coverage for health benefits](#_Continuation_of_coverage_1) section for more information.

#### If you live in Hawaii

If your principal residence is in Hawaii and you would otherwise lose medical coverage under the Hawaii Only Plan (Premera) while hospitalized or otherwise prevented by sickness from working, your medical coverage will not be terminated before whichever occurs later:

* The end of the third month following the month in which you first became unable to work due to hospitalization or sickness
* The date Microsoft ceases to pay you regular wages in such a case

During such period of continued coverage, Microsoft will contribute the same amount per month toward your cost of medical coverage that it contributed per month for you before you became sick.

#### Proof of coverage

Following the end of your employment from Microsoft, you will receive proof of your health coverage under the Microsoft plan in the mail. If you enroll in another health plan that has an exclusion period for preexisting conditions, you may need this proof of coverage to reduce the exclusion period. Your new plan will let you know if your new plan's exclusion period can be shortened and, if so, by how much.

### Other health & wellness benefits

Your benefit coverage for other health and wellness benefits (the Microsoft Cares Employee Assistance Program (EAP), Expert Medical Opinion service, onsite Flu Shot and/or biometric Programs, and Be Well) ends when any one of the following occurs:

* The date this plan is terminated
* The date you no longer qualify as an employee eligible for the benefit
* The first day following the maximum length of an applicable leave of absence, should you not return to work

#### For dependents

Coverage for dependents, if applicable, will end on the earliest of the following dates:

* The date your coverage ends
* The date the plan is terminated
* The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
  + Divorce, legal separation, or annulment (for spouses)
  + The dissolution of a domestic partnership
* The date coverage for all dependents under the plan is cancelled

| Additional information | If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. |
| --- | --- |

You may be eligible to continue your other health & wellness benefits coverage after you leave Microsoft. See the [Continuation of coverage for health benefits (COBRA)](#_Continuation_of_coverage_1) section for more information.

## Continuation of coverage for health benefits (COBRA)

What is in this section

[How COBRA works 326](#_Toc179834215)

[Who is eligible 326](#_Toc179834216)

[How to start COBRA coverage 327](#_Toc179834217)

[Cost of COBRA coverage 328](#_Toc179834218)

[Filing an appeal for COBRA coverage 330](#_Toc179834219)

[Extending COBRA coverage 330](#_Toc179834220)

[When COBRA coverage ends 331](#_Toc179834221)

| **P** | COBRA enrollees – the Continuation of coverage for health benefits (COBRA) applies |
| --- | --- |

### How COBRA works

If you are no longer eligible for benefits under the Plan, you may be able to continue coverage of the following benefits on a self-pay basis under COBRA:

* Medical and prescription drugs
* Employee Assistance Program (EAP)
* Wellness; Expert Medical Services (ATeladoc Health) and Be Well

Note: You may also have other health coverage options available to you through the Health Insurance Marketplace. Visit <http://www.healthcare.gov> for further information.

You can continue coverage under COBRA for up to 18 months, or, for dependents who are eligible for COBRA other than due to an employee’s termination of employment, up to 36 months. In some cases, you may have the option to extend COBRA coverage.

With regard to benefits, COBRA participants have the same rights as employees. COBRA coverage is administered by the Microsoft COBRA Service Center.

| Additional information | Your rights to COBRA coverage may change as further amendments to COBRA are made by Congress or as interpretations of COBRA are made by the courts and by federal regulatory agencies. |
| --- | --- |

### Who is eligible

COBRA coverage is available for you (and your dependents, if applicable) **if**:

* You (and your dependents, if applicable) were covered by Plan benefits on the day before a qualifying event occurs (or, for dependents in particular, you removed your dependents from coverage at Open Enrollment in anticipation of a future qualifying event), or

A child is born to you or adopted by you, or you are named the legal guardian of the child, while you are covered under COBRA

**And** a qualifying event (described above) occurs which results in the loss of benefit coverage for you or for your dependents under the Plan. The qualifying events include:

* The end of your employment with Microsoft (not including transfers to US Microsoft subsidiaries) for any reason other than gross misconduct
* Additional qualifying events for dependents only:
  + Your death (if your coverage terminates as a result of your death Microsoft will provide your covered dependents who elect COBRA a subsidy for 365 days from date their medical coverage ends)
  + Your divorce, legal separation, or annulment
  + The legal dissolution of your domestic partnership
  + The fact that the dependent is no longer an eligible dependent as defined by the Plan

You may elect separate COBRA coverage for you and each of your eligible dependents. If elected, separate coverage will apply to all of your COBRA benefits and separate premiums will apply to each member. If you are interested in this alternative, contact the [Microsoft COBRA Service Center](http://cobra.me.microsoft.com/) at (833) 253-4929 for more information.

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| Additional information | For active employees, removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the removed dropped dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be **deemed** to have been enrolled in Microsoft benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event. |

### How to start COBRA coverage

If your employment with Microsoft is ending and you or your dependents are eligible for COBRA coverage, the Microsoft COBRA Service Center will send you or your dependent a notice about your right to COBRA coverage as well as an election form and instructions to elect COBRA coverage. This notice and form will be mailed to your last known address or the last known address of your dependent within 44 days of your last day of employment (or the notification of your death, if applicable).

If coverage for you or your dependents is ending due to any other qualifying event (including divorce, legal separation, dissolution of a domestic partnership or dependent becoming ineligible), or your dependent was removed from coverage at Open Enrollment in anticipation of a future qualifying event, you or your dependent must inform Microsoft no more than 60 days\* after the latest of any one of the following events:

* The date of the qualifying event
* The date that benefits would be terminated as a result of the qualifying event

The date you or your dependent is informed, through the SPD, the general COBRA notice, or otherwise, of the obligation to provide this notice to Microsoft and the procedures for providing such notice (stated below)

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| Additional information | To notify Microsoft of a qualifying event contact Benefits at (833) 253-4929 or go to the [Microsoft COBRA Service Center](http://cobra.me.microsoft.com/). |

If you report a qualifying event to Microsoft, but COBRA coverage is not made available at that time, either due to late reporting by you or your termination of employment due to gross misconduct, the Microsoft COBRA Service Center will send you a notice of unavailability of COBRA coverage within 14 days of receiving your notice of the event (or your termination of employment, as applicable).

You must enroll for COBRA coverage within 60 days\* of the date your benefits end with Microsoft, or the date you are mailed your COBRA notification and enrollment form, whichever date is later. Through COBRA, you can continue coverage for yourself and any eligible dependent in your current COBRA-eligible plan(s). You do not have to cover the same dependents as you had as an active employee.

| Additional information | If you do not notify Microsoft within the 60-day period\*, you and your covered dependents will lose your right to elect COBRA coverage. If you do not choose COBRA coverage or do not pay for COBRA coverage within the time limits set by COBRA, you may not be eligible for COBRA coverage in the future for the same qualifying event. |
| --- | --- |

### Cost of COBRA coverage

If you enroll for COBRA coverage, you must pay the full cost of the coverage plus an administrative fee. Generally, this cost is 102% of the cost of coverage for similarly situated active full-time employees and/or dependents. The cost is actuarially determined based on the level of coverage. Separate rates are established for:

* A single employee or single spouse/domestic partner, or a child who enrolls in COBRA after “aging out” of coverage at age 26
* An employee and spouse/domestic partner
* An employee and children

An employee, spouse/domestic partner, and children

A child only (other than a child who enrolls in COBRA after aging out of coverage at age 26).

If the cost of active employee coverage changes after your COBRA coverage starts, the cost of COBRA coverage may also change.

If you are disabled and qualify for an additional 11 months of coverage, the cost for those extra 11 months of coverage is 150% (instead of 102%) of the cost of coverage for similarly situated active full-time employees and/or dependents.

You must send your first COBRA payment to the Microsoft COBRA Service Center postmarked within 45 days\* following the date you elect COBRA coverage.

| Additional information | After you have elected and paid your initial COBRA premium payment, your subsequent monthly COBRA payments must be postmarked no more than 30 days following the due date. If your payments are late, you could lose COBRA coverage retroactive to the last payment date.  In the event of your death, Microsoft will provide your covered dependents a COBRA subsidy for medical coverage for up to the first 365 days from the date that they lose such coverage. Your dependents must elect COBRA continuation coverage under a Microsoft health care plan in order to avail of this benefit. |
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| Additional information | For more information about COBRA rates, contact Benefits at (833) 253-4929 or go to the [Microsoft COBRA Service Center](http://cobra.me.microsoft.com/). |

The following table summarizes the monthly COBRA rates for 2025. These rates are subject to change. (All currency amounts are expressed in U.S. dollars.)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2025 COBRA Rates** | | | | | | | |
| Type of coverage | Employee or spouse / domestic partner | Employee and spouse / domestic partner | Employee and children | Employee and spouse / domestic partner and children | Spouse Only | Children Only | Family Only |
|  |
| Medical and prescription drugs | | | | | | | |  |
| Health Savings Plan (Premera) | $696.66 | $1,393.32 | $1,045.50 | $2,020.62 | $696.66 | $348.84 | $1,045.50 |  |
| Health Connect Plan (Premera) | $781.32 | $1,562.64 | $1,171.98 | $2,265.42 | $781.32 | $390.66 | $1,171.98 |  |
| Hawaii Only Plan (Premera) | $746.64 | $1,493.28 | $1,119.96 | $2,165.46 | $746.64 | $373.32 | $1,119.96 |  |
| Surest PPO Plan (Surest) | $780.30 | $1,581.00 | $1,253.58 | $2,185.86 | $780.30 | $473.28 | $1,253.58 |  |
| HMO Plan (Kaiser Foundation Health Plan of Washington) | $679.32 | $1,358.64 | $1,018.98 | $1,969.62 | $679.32 | $339.66 | $1,018.98 |  |
| HMO Plan (Kaiser Permanente CA) | $786.60 | $1,573.21 | $1,179.91 | $1,966.51 | $786.60 | $393.30 | $1,179.91 |  |
| EAP & Wellness | | | | | | | |  |
| Employee Assistance Program (Spring Health) | $36.15 | $36.15 | $36.15 | $36.15 | $36.15 | $36.15 | $36.15 |  |
| Wellness (Limeade, Second Opinion, Biometrics and Flu Shots) | $5.46 | $5.46 | $5.46 | $5.46 | $5.46 | $5.46 | $5.46 |  |

Benefit coverage is subject to the terms and conditions set forth by Microsoft corporate policies, benefit plan documents, and summary plan descriptions.

### Filing an appeal for COBRA coverage

If you believe your right to enroll in COBRA coverage should not have been denied, you may file an appeal as follows:

1. Write an appeal in which you explain why you believe your right to COBRA coverage was improperly denied. Include your name, address, and the names of other covered individuals you wish to include in your appeal, along with any additional information you wish to be reviewed.
2. Send your written appeal within 30 days of your receipt of the declination to:

Microsoft (c/o Businessolver, Inc.)

ATTN: COBRA Administration

P.O. Box 310512

Des Moines IA 50331-0512

(833) 253-4929

The Microsoft COBRA Service Center will respond within 30 days after the receipt of your written appeal. This is the exclusive process for appeals of COBRA rights declinations. Appeals for COBRA coverage are not subject to the general plan and ERISA rules for benefit claims and appeals. The Microsoft COBRA Service Center’s determination is final. You cannot appeal further.

### Extending COBRA coverage

If a second qualifying event occurs during the 18-month COBRA period that results from the loss of coverage due to your termination of employment (other than for gross misconduct), your covered dependents may continue their coverage for a maximum of 36 months from the date of your termination of employment (i.e., first qualifying event). Your dependents must notify Microsoft of this change within 60 days\* of the second qualifying event.

If the initial qualifying event is your termination of employment and you or a covered dependent become disabled during the first 60 days of your 18-month COBRA period, COBRA coverage may be extended for up to 29 months total for you and your dependents if you or a covered dependent receive a determination of disability from the Social Security Administration within this timeframe. You must send this Social Security Administration notice indicating the disability onset date to the Microsoft COBRA Service Center no more than 60 days after the latest of any one of the following events:

* The date of the notice from the Social Security Administration
* The date of the qualifying event
* The date benefits are terminated

The date you are informed, through the SPD or the general COBRA notice, of the obligation to provide this notice, and the procedures for providing such notice

* Note: If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment, your eligible dependents can elect COBRA for a period of not more than 36 months from the date you became entitled to Medicare.

In addition, individuals enrolled in the Kaiser Permanente HMO Plan for California employees may be eligible for an extended COBRA coverage period, in accordance with California state law (“Cal-COBRA”). For more information, please see:

|  |  |
| --- | --- |
| **Active employees/dependents** go here… | **COBRA enrollees** go here… |
| * [Evidence of Coverage – Northern California](https://microsoft.sharepoint.com/sites/HRweb/HRweb/Country/US/EOC_KaiserPermanente_NorthernCA_2023.pdf) * [Evidence of Coverage – Southern California](https://microsoft.sharepoint.com/sites/HRweb/HRweb/Country/US/EOC_KaiserPermanente_SouthernCA_2023.pdf) | Go to [http://cobra.me.microsoft.com](http://cobra.me.microsoft.com/) > Reference Center > Kaiser CA Evidence of Coverage (EOI) Documents |

### **When COBRA coverage ends**

COBRA coverage ends on the date of the earliest of the following events:

* The date the maximum COBRA coverage period ends, as described above
* The last date for which premiums were paid, in the event that you fail to make the next required premium payment either in full or within the grace period required by COBRA
* The date you become covered under another group plan, or the effective date of your enrollment under Medicare Part A or B, after the date of your COBRA election
* The date Microsoft ceases to offer the plan in which you are enrolled. However, COBRA coverage may be available under other Microsoft plans. If all Microsoft plans are terminated, all COBRA coverage is also terminated

If you add dependents to your coverage while on COBRA, their coverage ends when your coverage ends

| Additional information | If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, they must notify the Microsoft COBRA Service Center of that fact within 30 days after the Social Security Administration’s determination. All other rules still apply. COBRA qualified beneficiaries will be notified of their COBRA termination date. |
| --- | --- |
| Additional information | If the qualified beneficiary becomes covered under another group health plan or covered by Medicare Parts A or B, they must notify the Microsoft COBRA Service Center of that fact within 30 days of being so enrolled. All other rules still apply. COBRA qualified beneficiaries will be notified of their COBRA termination date. |
|  |  |

# Section VI: Additional resources

What is in this section

[Glossary 333](#_Toc179831416)

[How to get help 352](#_Toc179831417)

| **P** | COBRA enrollees – the Additional resources section applies |
| --- | --- |

## Glossary

What is in this section

[General terms 333](#_Toc179831172)

[Health plan terms 334](#_Toc179831173)

[Coordination of benefits terms 350](#_Toc179831174)

General terms

**Eligible employee**—For purposes of determining eligibility to participate in the plan under this SPD, an eligible employee is an individual who has been designated by Microsoft as a benefits-eligible intern or visiting researcher and is on the Microsoft U.S. payroll.

You are on the Microsoft U.S. payroll if you are paid from the Microsoft payroll department located in the United States, and Microsoft withholds and pays U.S. employment taxes on your payroll amounts. For purposes of eligible employee status, the term Microsoft includes those subsidiaries and affiliates of the Microsoft Corporation that participate in the Plan. The current participating employers are listed in the [Administrative Information](#_Administrative_Information) section of this Summary Plan Description. Contact Benefits if you would like a current list of the Microsoft subsidiaries and affiliates that participate in the Plan.

Notwithstanding the above, the following persons are not eligible employees and are not eligible to participate as employees in the plan under this SPD, even if they meet the definition of a regular employee of Microsoft:

* Cooperatives
* Apprentices
* Nonresident aliens receiving no U.S. source income from Microsoft
* Employees covered by a collective bargaining agreement resulting from negotiations with Microsoft in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
* Persons providing services to Microsoft pursuant to an agreement between Microsoft and any other individual or entity, such as a staff leasing organization (leased employees)
* Temporary workers engaged through or employed by temporary or leasing agencies
* Temporary employees of Microsoft. For purposes of the plan, a temporary employee of Microsoft is one who is hired by Microsoft as an employee to work on a specific project or series of projects that in the aggregate is not expected to exceed six months.
* Workers who hold themselves out to Microsoft as being independent contractors or as being employed by or engaged through another company while providing services to Microsoft
* Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.

All other workers who Microsoft does not classify as being an intern or a visiting researcher eligible to participate in the plan under this SPD, even if that classification is later determined to be incorrect or is retroactively revised.

**Dependent children under age 26**—Includes your:

* Biological child and/or your spouse’s/domestic partner’s biological child
* Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence)
* Legally adopted child, or child who has been placed with you for adoption, but not a foster child
* A child’s eligibility as a dependent does not rely on the child’s financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors.

**Incapacitated dependent children age 26 or over**—An incapacitated dependent is unable to sustain employment due to a developmental or physical disability that existed before the child reached age 26. The individual is chiefly dependent on the member for support.

**Spouse**—You must be married (whether same or opposite sex) under the laws of any state, possession, or territory of the U.S. in which the marriage is entered into, regardless of domicile, and not legally separated

**Domestic Partner**—You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:

* You are each other's sole domestic partner and intend to remain so indefinitely
* Neither of you is legally married
* You are both at least 18 years of age and are mentally competent to consent to contract
* You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
* You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes)
* You are mutually responsible (financially and legally) for each other's common welfare

For life and accidental death & dismemberment (AD&D), a domestic partner includes any person who satisfies the requirements for being a domestic partner, registered domestic partner, or civil union partner of an eligible employee under the law of your jurisdiction of residence.

### Health plan terms

#### Medical Care

**Adverse Benefit Decision -** An Adverse Benefit Determination is a denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity, as well as any coverage rescission.

**Ancillary Charge** - a charge, in addition to the Copayment, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

* The Prescription Drug Charge for the Prescription Drug Product; and
* The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

**Ancillary Services** - Items and services provided by out-of-network Providers at an in-network facility that are any of the following, as defined under federal law (the federal No Surprises Act):

* Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
* Provided by assistant surgeons, hospitalists, and intensivists;
* Diagnostic services, including radiology and laboratory services; and
* Provided by an out-of-network Provider when no other in-network Provider is available at the facility

**Approved transplant center**—A hospital or other provider, located in the United States, that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by your insurance plan. Your plan has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, they will direct you to an approved transplant center with which they have a contract. Of course, if neither a plan-approved transplant center nor a network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by the plan.

Authorized Representative - A person you revocably appoint to assist you in submitting a Claim or appealing a Claim denial, in a form and manner prescribed by the applicable Component Plan. However, for urgent care Claims and expedited appeals, a treating Provider may act as your Authorized Representative without your designation.

Bluecard - BlueCardÒ Program and other inter-plan arrangements (Premera Plans Only)

Premera Blue Cross has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program," negotiated National Account arrangements, and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Washington and Alaska or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of these Inter-Plan Arrangements when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the “Host Blue” in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you’re used to from Premera Blue Cross. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

BlueCard in California

We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross. In order for you to maximize your in-network savings under the BlueCard Program, you will need to choose only Anthem Blue Cross network providers for services received in California. Note: Blue Shield of California network providers are not considered in-network for purposes of the Health Savings Plan, unless (and to the extent) they are also Anthem Blue Cross network providers.

Negotiated National Account Arrangement in Arizona

Members' claims for covered healthcare services in Arizona are processed through an Inter-Plan Program called a negotiated National Account arrangement with the Host Blue in Arizona. Our responsibilities and those of the Arizona Host Blue and its network providers under this arrangement are the same as under the BlueCard Program.

Allowable charge calculations under the negotiated National Account arrangement are the same as described above in the "Network Providers" section for the BlueCard Program.

Non-Network Providers

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

* An amount that is no less than the lowest amount 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

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law.

Exceptions Required by Law

In some cases, federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If either federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible.

Blue Cross Blue Shield Global Core (Premera Plans Only)

If you’re outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you’ll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

If you have questions or need more information about Inter-Plan Arrangements, including the BlueCard Program, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the back cover of your booklet. You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

**Brand-name prescription drug**—A prescription drug that is sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

**Brand formulary (KFHPWA)** —The brand-name prescription drugs that are covered under the KFHPWA HMO Plan.

**Chemical dependency**—This is an illness characterized by a physiological or psychological (or both) dependency on a controlled substance and/or on alcoholic beverages, and where the member's health is substantially impaired or endangered or their social or economic function is substantially disrupted.

**Claim (Surest)** - A request for Benefits made by a member or his/her Authorized Representative in accordance with the procedures described in this SPD. A Claim includes Prior Authorization requests for Benefits and appeals; urgent care requests for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims and appeals

**Claims Administrator (Surest)** - Surest, in its role of administering and deciding Claims and Appeals under the Surest Plan, for which Surest acts as a fiduciary that has been delegated final discretionary authority.

**Congenital anomaly**—A marked difference from the normal structure of a body part that is physically evident from birth

**Continuous care (Premera Plans Only)** —Skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill member at home

**Cosmetic** - Services, medications, and procedures that improve physical appearance but are not Medically Necessary.

**Covered Health Service (Surest)** - Health care services, including supplies or pharmaceutical products, which are determined to be all of the following:

* Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, illness, disorder, condition, disease or its symptoms, whether medical/surgical or behavioral health
* Medically Necessary
* Described as a Covered Health Service in this SPD
* Not excluded in this SPD

**Custodial care**—Any service, procedure or supply that is provided primarily:

* For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
* To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such services and supplies are regarded as custodial without regard to the following:

* Who prescribes the service and supplies
* Who recommends the service and supplies
* Who performs the service or the method in which such services are performed

**Designated Provider (Surest)** - A provider and/or facility that:

* Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Service for the treatment of specific diseases or conditions; or
* The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all network hospitals or network physicians are Designated Providers.

**Designated Virtual Network Provider (Surest)** - A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator’s behalf, to deliver Covered Health Services through live audio with video technology or audio only, and/or through federally compliant secure messaging applications.

**Domiciliary Care** - Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

**Durable Medical Equipment (DME)** - Medical equipment that is all of the following:

* Ordered or provided by a Physician for outpatient use primarily in a home setting.
* Used for medical purposes.
* Not consumable or disposable except as needed for the effective use of covered DME.
* Not of use to a person in the absence of a disease or disability.
* Serves a medical purpose for the treatment of a sickness or injury.

**Eligible Expenses (Surest)** – The amount of charges that the Claims Administrator determines to be reimbursable under the Surest Plan for Covered Health Services that are provided while the Surest Plan is in effect. Eligible Expenses are determined solely in accordance with the Claims Administrator’s reimbursement policy guidelines.

Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

**Note:** Out-of-network Providers may bill you for any difference between the Provider’s billed charges and the Eligible Expense described above, except as required under the No Surprises Act or other applicable law, or provided in this SPD.

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

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

For more information on eligible providers, refer to the section of this SPD describing the specific benefit and plan at issue.

**Emergency** - The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

1. Placing the health of the member’s health(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

3. Serious dysfunction of any bodily organ or part

**Emergency Health Care Services** - With respect to an Emergency:

* An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
* Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
* Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

a) The attending Emergency Physician or treating Provider or facility determines the patient is able to travel using non-medical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c) The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law.

d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e) Any other conditions as specified by the Secretary of the U.S. Department of Health and Human Services.

**E-Visit and Telephone Consult** - Services provided by a Physician without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages

**Experimental or investigational**—

**Premera Experimental or investigational:**

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 (“FDA”) 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).

**Kaiser Experimental or investigational services:**

KFHPWA consults with KFHPWA’s medical director and then uses the criteria described below to decide if a particular service is experimental or investigational.

a. A service is considered experimental or investigational for a Member’s condition if any of the following statements apply to it at the time the service is or will be provided to the Member:

1) The service cannot be legally marketed in the United States without the approval of the FDA and such approval has not been granted.

2) The service is the subject of a current new drug or new device application on file with the FDA.

3) The service is the trialed agent or for delivery or measurement of the trialed agent provided

as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of

a Phase III clinical trial.

4) The service is provided pursuant to a written protocol or other document that lists an

evaluation of the service’s safety, toxicity or efficacy as among its objectives.

5) The service is under continued scientific testing and research concerning the safety, toxicity or

efficacy of services.

6) The service is provided pursuant to informed consent documents that describe the service as

experimental or investigational, or in other terms that indicate that the service is being

evaluated for its safety, toxicity or efficacy.

7) The prevailing opinion among experts, as expressed in the published authoritative medical or

scientific literature, is that (1) the use of such service should be substantially confined to

research settings, or (2) further research is necessary to determine the safety, toxicity or

efficacy of the service.

b. The following sources of information will be exclusively relied upon to determine whether a service

is experimental or investigational:

1) The Member’s medical records.

2) The written protocol(s) or other document(s) pursuant to which the service has been or will

be provided.

3) Any consent document(s) the Member or Member’s representative has executed or will be

asked to execute, to receive the service.

4) The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.

5) The published authoritative medical or scientific literature regarding the service, as applied to the Member’s illness or injury.

6) Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding KFHPWA denial of coverage can be submitted to the Member Appeal Department, or to KFHPWA's medical director at P.O. Box 34593, Seattle, WA 98124-1593.

**Surest Plan Experimental or investigational services:**

A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if it is any of the following criteria/guidelines is met, unless otherwise provided in the Surest Plan:

* It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments.
* It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
* Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.
* The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
* It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).
* It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
* It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
* Except as otherwise provided in this SPD, it is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
* It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition – unless otherwise provided under the Surest Plan.

**Generic maintenance medications** have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

**Generic drugs** are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

**Hospice care**—**(Kaiser Plan):** A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the Member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member’s provider must certify that the Member is terminally ill and is eligible for hospice services.

**(Premera Plan)** A coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member’s home.

**Independent Freestanding Emergency Department** - A health care facility that:

* Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and
* Provides Emergency Health Care services

**Intermittent care**—Care provided due to the medically predictable recurring need for skilled home health care services.

**Maintenance Medication** (Surest) - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at <https://benefits.surest.com>, the telephone number on your ID card, or the Surest mobile app.

**Network Provider (Kaiser Plan):** A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other health care provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please visit ww.kp.org to find a Kaiser Pharmacy.

**Network Hospital (Kaiser Plan):** A licensed hospital that provides inpatient, outpatient and ambulatory surgical care and other related services for surgery, acute medical conditions, or injuries usually for a short-term illness or condition, and which is owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services. Note: Ancillary providers at Kaiser owned facilities are always in-network providers**.**

**Network Pharmacy (Premera and Surest)** - A retail or mail order pharmacy that has:

* Entered into an agreement with an organization contracting on its behalf to dispense prescription drugs to members
* Agreed to accept specified reimbursement rates for dispensing prescription drugs
* Been designated by the Plan Administrator as a Network Pharmacy

**Network Pharmacy (Kaiser Plan):** A pharmacy owned and operated by Kaiser Permanente or another pharmacy that Kaiser Permanente designates.

**Network Physician (Kaiser Plan):** A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services.

**Network Ancillary Providers (Kaiser Plan):** Non-MD providers such as Psychologists, Marriage Family and Child Counseling (MFCC), Licensed Clinical Social Worker (LCSW), Optometrists, Physical, Speech, and Occupational Therapy. Such providers will be subject to the primary care Cost Share. Verify referral requirements at KP.org in the How to Obtain Services section.

**Network Primary Care Provider (Kaiser Plan):** Family Practice, Internal Medicine and Pediatrics. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based the supervising physicians’ provider status.

**Network Specialist (Kaiser Plan):** Medical Doctor with a specialty not considered primary care. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based the supervising physicians’ provider status.

**Network Skilled Nursing Facility (Kaiser Plan):** A licensed facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services that contracts with Kaiser Permanente to provide Covered Services. The facility’s primary business is the provision of 24-hour-a-day skilled nursing care. The term “Skilled Nursing Facility” does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A “Skilled Nursing Facility” may also be a unit or section within another facility if it continues to meet the definition.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

* The date it is placed on a tier by the Claims Administrator PDL Management Committee.
* December 31st of the following calendar year.

**Observation Stay** – Observation Stay care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.

**Out-of-network**—Physicians, hospitals and other providers who have not contracted with Premera, Surest, or KFHPWA. If you receive services from an out-of-network provider or facility, then you will typically have a higher coinsurance and you are responsible for the difference between the provider's billed charge and the allowable charge.

**Physical functional disorder**—A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

**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 treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing a service for which benefits are specified in this SPD and 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.)
* Advanced Registered Nurse Practitioner (A.R.N.P.)
* Nurse (R.N.)
* Naturopathic physician (N.D.)

**Preventive Care**—This plan covers preventive care as described below. “Preventive care” is a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies as required under the Affordable Care Act.

Preventive services have limits on how often you should get them and many of these limits are specific to gender, age or your personal risk factors for disease or condition. These limits are based on your age and gender. Some of the services you get as part of a routine exam may not meet preventive guidelines and would be covered as part of medical benefits.

The plan covers the following as preventive services:

* Covered preventive services include those with a Services with an “A” or “B” rating by the United States Preventive Task Force (USPTF);
* immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and
* preventive care and screening recommended by the Health Resources and Services Administration (HRSA).

**Prescription drug**—Any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

**Prescription Drug Charge** (Surest) - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

**Prescription Drug List** (Surest) - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at <https://benefits.surest.com>, the telephone number on your ID card, or the Surest mobile app.

**Prescription Order or Refill** (Surest) - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

**Private Duty Nursing** - Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or an office/home setting when any of the following are true:

* Services exceed the scope of intermittent care in the home.
* Skilled nursing resources are available in the facility.
* The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose
* The service is provided to a member by an independent nurse who is hired directly by the member or his/her family. This includes nursing services provided on an inpatient or a home care basis, whether the services is skilled or non-skilled independent nursing.

**Provider Administered Drug –** Medications that are typically given by a healthcare professional in a clinical setting, such as a physician’s office or outpatient clinic. These drugs often require special handling, complex dosing regimens, or specific administration methods, such as injections or infusions.

**Reconstructive** - Surgery or procedure to restore or correct:

* A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part.
* A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician.
* A physical defect that directly adversely affects the physical health of a body part, and the restoration of correction is determined by the Claim Administrator to be Medically Necessary

**Respite care**—Continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers.

**Skilled home health care (Premera Plan)**—Skilled home health care is reasonable and necessary care for treatment of an illness or injury that requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the member. Services are performed directly by an appropriately licensed professional provider.

**Skilled home health care (Kaiser Plan)**—Covered Services for skilled home health care may include the following when rendered pursuant to a KFHPWA-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment; medical social worker and limited home health aide services.

**Skilled nursing care (Premera Plan)** —Care provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

**Skilled nursing facility** - A hospital or nursing facility that is licensed and operated as required by law. Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.

**Specialist** - A Physician who has a majority of their practice in areas other than those practicing in the areas of family practice, general medicine, internal medicine, obstetrics/gynecology or general pediatrics

**Specialty drugs**—High-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

**Surest Plan** -The Surest health plan option described in the applicable sections the SPD.

**Telehealth visit** - Live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

**Therapeutically Equivalent** (Surest) - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Unproven Services (Surest)** - Services, including medications and devices regardless of U.S. Food and Drug Administration (FDA) approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

* Well-conducted randomized controlled trials, (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
* Well-conducted cohort studies from more than one institution, (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Surest has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time-to-time Surest issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can [contact](http://contact) Surest Member Services for additional information.

**Please note:** If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), Surest may, at its discretion, consider an otherwise Unproven service to be a Covered Health Service for that sickness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that sickness or condition.

**Urgent care**—

* In the Premera health plans, a visit that is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:
  + Requires prompt medical attention to avoid serious deterioration of the member’s health
  + Does not require the level of care provided in the emergency room or a hospital
  + Cannot be postponed until the member’s physician is available
* In the KFHPWA plan, inside the KFHPWA Service Area, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Network Provider’s office. Outside the KFHPWA Service Area, urgent care is covered at any medical center.
* **Usual and Customary Charge (Surest)** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

**Value-based drugs**—Drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

#### Plan Management

**Allowable charge or allowed amount**—

* In the Premera health plans, the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. The allowable charge for Washington or Alaska providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below:
  + An amount that is no less than the lowest amount 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

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. In the Premera medical plans, only the allowable charge will be applied to your deductible, coinsurance maximum, and out-of-pocket maximum, as applicable.

* In the KFHPWA HMO plan, where expenses incurred from a non-KFHPWA provider or facility are covered under this SPD and the EOC, the negotiated amount that KFHPWA providers and facilities have agreed to accept as payment in full for those same services. The charges must be consistent with those normally charged to others by the provider or organization for the same services or supplies, and within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be responsible to pay any difference between the non-KFHPWA provider’s or facility’s charge for the services and the allowed amount.

**Annual maximum (Premera Plans)**—is the most the plan will pay for services for a member within a calendar year. If your employment or dependent status under the plan ends and you are hired or rehired within the same calendar year, the accumulated amount for that benefit carries over to your new enrollment.

**Appeal**—A written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to, and continued stays in, a facility. The process does not apply to appeals of denied COBRA eligibility claims.

**Coinsurance**—The percentage of the allowable charge that you are required to pay for certain covered services.

**Coinsurance maximum**—The maximum amount that you could pay each year in coinsurance amounts for covered services. If you seek care with out-of-network providers, only the allowable charge applies to the coinsurance maximum.

**Copayment**—A fixed, up-front dollar amount that you're required to pay for certain covered services.

**Deductible**—The amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

**Evidence of Coverage (EOC)**—A document outlining details of benefits coverage under the Kaiser Permanente HMO Plan.

**Explanation of benefits statement (EOB)**—The statement you receive from Premera Blue Cross, Surest, KFHPWA, or Kaiser Permanente detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

**Health Maintenance Organization (HMO)**—A health care plan such as Microsoft offers with KFHPWA or Kaiser Permanente that covers only those services and supplies that are received from in-network providers and facilities. Out-of-network care is covered only under a few circumstances. Providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about care.

**Independent review organization (IRO)**—An independent organization of medical experts who are qualified to review medical and other relevant information.

**In-network**—Physicians, hospitals and other providers who have contracted with your plan administrator (Premera, Surest, KFHPWA or Kaiser Permanente) to provide services at a negotiated discount rate. In-network providers agree to accept network rates and will not bill you for any amount in excess of those rates. In-network providers also agree to bill your medical plan directly, so you will not have to pay up front and submit your own claim to Premera or Surest for reimbursement.

**Lifetime benefit maximum**—Generally the maximum amount a plan will pay toward a benefit for a member. For more information, please refer to the section of this SPD describing the specific benefit and plan at issue.

**Medically necessary**—A covered service or supply that meet certain criteria including:

* It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the enrollee's life or health, unless it is provided for preventive services when specified as covered under this plan.
* It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice.
* It is a medically effective treatment of the diagnosis as demonstrated by the following criteria:
  + There is sufficient evidence to draw conclusions about the positive effect of the health intervention on health outcome
  + The evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
  + The expected beneficial effects of the health intervention on health outcomes outweigh the expected harmful effects of the health intervention.
* It is cost-effective, as determined by being the least expensive of the alternative supplies or levels of service that are medically effective and that can be safely provided to the enrollee. A health intervention is cost-effective if no other available health intervention offers a clinically appropriate benefit at a lower cost.
* It is not primarily for research or data accumulation.
* It is not primarily for the comfort or convenience of the enrollee, the enrollee's family, the enrollee's physician or another provider.
* It is not recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions.

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

**Other benefit maximum**—is the most the plan will pay for services for a member within the time specified for that benefit. If your employment or dependent status under the plan ends and you are hired or rehired within such specified time, the accumulated amount for that benefit carries over to your new enrollment.

**Out-of-pocket maximum**—The maximum amount that you could pay each plan year for covered services and supplies, including deductibles, copayments, and coinsurance, as applicable, unless otherwise provided in this SPD.

**Personal Health Support (Premera Plan)**—The plan offers participation in Premera's personal health support services to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:

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

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

**Plan Year** - The calendar year.

**Prior Authorization (Surest)** – Pre-service, urgent care request, pre-admissions notification, concurrent care benefit coverage decision for a service, procedure or test that has been subject to an evidence-based review resulting in a Medical Necessity determination. Select services require Prior Authorization.

**Prior authorization (Premera, Kaiser)**—An advance determination by Premera, or KFHPWA that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Although not required, prior authorization is available, and strongly recommended to ensure that coverage will be provided, for services that include (but are not limited to) the following:

* Scheduled admission into hospitals or skilled nursing facilities
* Advanced imaging, such as MRIs and CT scans
* Some planned outpatient procedures, such as facility sleep studies and varicose vein treatment
* Some injectable medications you get in a health care provider’s office, such as Interferon, Synagis and Xolair
* Knee arthroscopy or knee arthroplasty
* Home medical equipment costing $500 or more

**Qualified Medical Child Support Order (QMCSO)**—An order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law.

**Residential Treatment (Surest)** - Treatment in a facility which provides Mental Health or Substance Use Disorder treatment. The facility must meet all of the following requirements:

* It is established and operated in accordance with applicable state law for Residential Treatment programs.
* It provides a program of treatment under the active participation and direction of a Physician.
* It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
* Room and board.
* Evaluation and diagnosis.
* Counseling.
* Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a hospital is considered a hospital

**Residential treatment center or services**—Facility-based treatment providing active Residential Treatment in a controlled environment. At least weekly physician visits are required, and services must offer treatment by a multi-disciplinary team of licensed professionals.

**Standard reference compendia**—Refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia—Drug Information, or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

**Urgent situation**—When an appeal is under consideration, a situation in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment.

### Coordination of benefits terms

**Coordination of benefits (COB)**—A process where you or your covered dependents who have health benefit coverage through another employer, a government plan, or other motor vehicle or liability insurance, combine coverage to maximize benefits. All of your Microsoft health benefits—medical are subject to COB. The two plans coordinate their payment of benefits to ensure the total paid by both plans will not exceed the total amount charged.

**Primary plan**—The health plan that pays benefits first when a member has coverage from more than one health plan.

**Secondary plan**—The health plan that pays benefits second when a member has coverage from more than one health plan. The secondary plan pays the balance for eligible expenses, subject to its plan benefits and limitations.

## How to get help

[[General benefits questions 352](#_Toc52188256)](#_Toc179831033)

[[Medical 352](#_Toc52188256)](#_Toc179831034)

[[Spring Health employee assistance program (EAP) 353](#_Toc52188256)](#_Toc179831035)

### General benefits questions

| Benefits contact information | Active employees/dependents | COBRA enrollees |
| --- | --- | --- |
| Email address | [benefits@microsoft.com](mailto:benefits@microsoft.com) | [n/a](mailto:benefits@benefits.microsoft.com) |
| Website | <http://benefits.me.microsoft.com> | <http://cobra.me.microsoft.com> |
| Telephone number | (425) 706-8853 | (833) 253-4929 |

### Medical

#### Premera plans

| Premera plans contact information | |
| --- | --- |
| Email address | [microsoft@premera.com](mailto:microsoft@premera.com) |
| Website | <https://www.premera.com/> |
| Telephone number | (800) 676-1411 |
| Group Number | 1000010 |

#### Surest

|  |  |
| --- | --- |
| Surest plans contact information | |
| Website | https://benefits.surest.com |
| Telephone number | 1-866-222-1298 |
| Group Number | 78800680 |

#### HMO plan (Kaiser Foundation Health Plan of Washington)—Washington only

| Kaiser Foundation Health Plan of Washington contact information | |
| --- | --- |
| Email address | [Email Member Services](https://wa.kaiserpermanente.org/html/public/forms) |
| Website | [Kaiser Foundation Health Plan of Washington](https://wa.kaiserpermanente.org/) |
| Telephone number | (206) 630-4636 or (888) 901-4636 |
| Group Number | 172300 |

#### HMO plan (Kaiser Permanente)—California only

| Kaiser Permanente California contact information | |
| --- | --- |
| Website | [Kaiser Permanente](https://healthy.kaiserpermanente.org/health/care/consumer/member-assistance) |
| Telephone number | (800) 464-4000 |
| Group Number | Northern California 603873 Southern California 231325 |

### Spring Health employee assistance program (EAP)

| Spring Health contact information | |
| --- | --- |
| Website | <https://microsoft.springhealth.com/> |
| Telephone number | (855) 629-0554 |

# Section VII: Important notices

What is in this section

[Administrative information 355](#_Toc179830905)

[Participant rights under ERISA 358](#_Toc179830906)

[Special notice about Newborns' and Mothers' Health Protection Act 359](#_Toc179830907)

[Special notice about Women's Health and Cancer Rights Act 359](#_Toc179830908)

[The Health Insurance Portability and Accountability Act (HIPAA) of 1996 360](#_Toc179830909)

[HIPAA Notice of Privacy Practices 361](#_Toc179830910)

[CHIP Notice 367](#_Toc179830911)

[Notice of Creditable Coverage 372](#_Toc179830912)

[Summary Annual Report for Microsoft Corporation Welfare Plan 375](#_Toc179830913)

| **P** | COBRA enrollees – the Important notices section applies |
| --- | --- |

### Administrative information

ERISA requires that certain information be furnished to each participant in an employee benefit plan.

* **Plan name**  
  Microsoft Corporation Welfare Plan
* **Plan number**  
  501
* **Plan year**  
  January 1 to December 31
* **Plan sponsor**  
  Microsoft Corporation
* **Employer identification number**  
  91-1144442
* **Type of plan**  
  Welfare benefit plan providing health and welfare benefits
* **Plan administrator and named fiduciary**  
  Microsoft Corporation  
  One Microsoft Way  
  Redmond, WA 98052-6399  
  (425) 882-8080
* **Participating employers**

| **Participating employer name** | **Company code** |
| --- | --- |
| Vexcel Corporation | 1693 |
| Microsoft Payments, Inc | 1888 |
| Microsoft Open Technologies, Inc | 1899 |
| Microsoft Operations Licensing Corporation | 1654 |
| Microsoft Online, Inc | 1548 |
| Microsoft Technology Licensing | 1988 |

* **Source of contributions**  
  Pre-tax and after-tax employee contributions, and employer contributions
* **Funding**

| **Health benefits** | Funded from the general assets of Microsoft Corporation and employee contributions |
| --- | --- |
| **Employee assistance benefits** | Funded through the employer’s general assets |

* **Type of administration**  
  The Plan is administered by Microsoft according to the terms of the plan documents. Under the terms of the plan, Microsoft has the authority to delegate the day-to-day administrative duties to a third party. Microsoft shall have complete discretion to interpret and construe the provisions of the plan options, programs, and policies described in this SPD, to determine eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations Microsoft made pursuant to the plan options, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious, or unless found by an independent medical review organization, after external review, to be made in error. Microsoft may delegate this discretionary authority to select service providers, and hereby delegates such authority to each service provider to the extent that the service provider is responsible for reviewing and issuing claims and appeals determinations under the respective plan options, programs, and policies described in this SPD.
* **Agent for legal process**  
  Senior Vice-President, Law and Corporate Affairs  
  Microsoft Corporation  
  One Microsoft Way  
  Redmond, WA 98052-6399   
  Service of process may also be made upon the Plan Administrator.

Microsoft, as plan sponsor, has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. See[Right to amend or terminate plan](#_Right_to_Amend) section for more information.

|  |  |
| --- | --- |
| Additional information | If you have questions regarding the Plan's administration, contact Benefits by e-mail at [benefits@microsoft.com](mailto:benefits@microsoft.com) or by phone at (425) 706-8853. |

#### False or misleading statements

Any falsification, misrepresentation, or omission of facts or information by you on your enrollment form, benefits enrollment tool, or claim form may result in your loss of coverage and in disciplinary action, up to and including your dismissal from employment at Microsoft. Electronic communications on enrollment or claims are considered written and signed representations. If you lose your coverage, you will not be eligible for any continuation of coverage except to the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.

#### Fraud and abuse

Any participant who willfully and knowingly engages in an activity intended to defraud the plan will face disciplinary action that may include Microsoft rescinding the participant's coverage under this plan, the termination of employment, and prosecution. Examples of fraud include falsifying a claim to obtain benefits or trying to obtain services for someone who is not an eligible dependent or who is no longer enrolled in the plan. The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, to deny coverage for any dependents if such confirmation is not provided, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Additional information | If you have questions regarding the Plan's administration, contact Benefits.   |  |  | | --- | --- | | **Active employees/dependents** go here… | **COBRA enrollees** go here… | | e-mail [benefits@microsoft.com](mailto:benefits@microsoft.com)  phone (425) 706-8853 | e-mail [benefits@benefits.microsoft.com](mailto:benefits@benefits.microsoft.com)  phone (833) 253-4929 | |

##### Right to review

The plan may have any patient examined by an appropriate health care professional when there is a question of fraud or abuse of plan benefits.

##### How to report suspicious activity to Premera, Surest, or Kaiser Foundation Health Plan of Washington

If you suspect fraud or abuse, there are several reporting options available to you. All reports are confidential and can be anonymous if you choose. You are not required to include your name, address, or other identifying information.

For Premera, you may contact the Special Investigations Unit 24 hours a day by leaving a telephone message on the confidential fraud hotline or by mail.

Hotline: (800) 848-0244

Mailing address:

Attention Special Investigations Unit  
Premera Blue Cross  
7001 220th Street SW  
Mail Stop 219  
Mountlake Terrace, WA 98043

For Kaiser Foundation Health Plan of Washington, you may contact the Fraud, Waste and Abuse (FWA) Department by e-mail, phone or mail.

E-mail: FWA@kp.org

Confidential, toll-free hotline: (888) 774-9100

FWA Department: (206) 988-2967

Mailing address:

Kaiser Foundation Health Plan of Washington  
Regional Fraud Control  
PO Box 9813  
Mailstop RCP-C3W-08  
Renton, WA 98057-9813

Surest

PO Box 211758

Eagan, MN 55121

Member Services: (866) 222-1298

When reporting suspected fraud, please remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud, identify the dates of service or issues in question, and describe in detail why you believe a fraudulent act may have occurred. If possible, please include your name and telephone number so Premera Surest, or Kaiser Foundation Health Plan of Washington may contact you if they have any questions during their investigation.

#### Right to amend or terminate plan

Microsoft has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. Payment of claims incurred at the time of such amendment or termination will not be adversely affected.

### Participant rights under ERISA

The Employee Retirement Income Security Act (ERISA) provides that all plan participants are entitled to the following:

* Examine, without charge, all documents that govern the plan including insurance contracts and a copy of the latest annual report (Form 5500 Series), which the plan files with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security. Administration, at the plan administrator's office, and at other specified locations, such as worksites
* Obtain, upon written request to the plan administrator, copies of documents that govern the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
* Receive the [Summary Annual Report](#_Summary_Annual_Report) for Microsoft Corporation Welfare Plan. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.

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

In addition to creating rights for plan participants, ERISA imposes obligations on those responsible for the operation of an employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries.

No one, including Microsoft or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents that relate 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 previously stated rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to US$110 a day until you receive the materials, unless the plan administrator did not send the materials because of reasons beyond the control of the administrator.

If you have a claim for benefits that 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 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 plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person 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 the claim to be frivolous.

If you have any questions about your plan, you should contact Microsoft. If you have any questions about this statement or about your rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor that your telephone directory lists, or you can contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.

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| Additional information | To access plan administrator information, see [Administrative Information](#_Administrative_Information) or contact Benefits. |

### Special notice about Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers that offer group insurance coverage generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, 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). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This plan complies with these requirements.

### Special notice about Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. You can contact Benefits or call (425) 706-8853 for more information.

### The Health Insurance Portability and Accountability Act (HIPAA) of 1996

##### Notice of your right to documentation

Prior to the Patient Protection and Affordable Care Act (ACA), federal law allowed employers to apply limitations on paying benefits for preexisting medical conditions for newly hired or newly eligible employees and covered family members. The ACA outlawed this practice as of 1/1/2014 for most health insurance plans. If you terminate employment with Microsoft and begin to work for another employer, you should receive the full benefit for any covered condition subject to your new plan’s standard cost sharing or other limitations, as applicable once you meet the employer’s eligibility criteria and enroll in benefits. Should you need a statement confirming you previously had coverage under a Microsoft plan, you can obtain one by contacting Benefits.

##### Notice of your special enrollment rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days\* after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or any of your dependents were covered under a Medicaid or State child health plan and you or your dependents lose eligibility for that coverage, or if you or any of your dependents become eligible for assistance with respect to coverage under this plan due to a Medicaid or State child health plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends, or within 60 days\* of becoming eligible for assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or legal guardianship, or establishment of a domestic partnership you may be able to enroll yourself and your dependents. However, you must request enrollment within 90 days after the marriage, birth, adoption, or placement for adoption or legal guardianship.

|  |  |
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| Additional information | To request special enrollment or obtain more information, see the [Life event enrollment](#_Life_event_enrollment) section or contact Benefits. |

### HIPAA Notice of Privacy Practices

#### Microsoft Corporation Welfare Plan HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully.

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| --- |
| Effective Date: April 14, 2003, revised effective August 1, 2024  This Notice is from the Microsoft Corporation Welfare Plan (the "Plan"), which is sponsored by Microsoft Corporation. A federal regulation, known as the HIPAA Privacy Rule, requires that a health plan provide detailed notice in writing of its privacy practices. You may receive other notices of privacy practices from other parties that are considered “covered entities” under HIPAA (for instance, physicians, the Living Well Health Center, Kaiser Permanente).  The Microsoft Corporation Welfare Plan includes health care benefits, making it a health plan covered by the HIPAA Privacy Rule. Health care benefits under the Plan include the medical and prescription drug benefits; the employee assistance program. Non-health care benefits under the Plan, including long-term and short-term disability plans, are not covered by the HIPAA Privacy Rule.  I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU  The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a participant or beneficiary under the Plan, or where there is a reasonable basis to believe the information can be used to identify a participant or beneficiary under the Plan. This information is called "protected health information" or "PHI." Generally, PHI also includes genetic and demographic information, collected from you or created or received by the Plan, that relates to (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.  This Notice describes your rights as a health plan participant and our obligations regarding the use and disclosure of PHI. We are required by law to comply with all of the following:   * Maintain the privacy of PHI about you * Provide you with certain rights with respect to your PHI * Give you this Notice of our legal duties and privacy practices with respect to PHI * Comply with the terms of our Notice of Privacy Practices that is currently in effect * Notify you of a breach of your unsecured PHI   In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose that specially protected PHI. Examples of PHI that is sometimes specially protected include PHI involving mental health, HIV/AIDS, reproductive health, or chemical dependency. We may refuse to disclose the specially protected PHI, or we may contact you for the necessary authorization.  We reserve the right to make changes to this Notice, which will be incorporated and published in the Plan’s SPD as soon as reasonably practicable, and to make such changes effective for all PHI we may already have about you.  II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU  We may use or disclose your PHI under certain circumstances as permitted or required by law or if you (or your authorized representative) give us permission. Any such PHI that we disclose under these circumstances may be subject to redisclosure by the recipient and no longer protected by HIPAA. The following describes the different ways we may use and disclose your PHI.  **Treatment:** We may use and disclose PHI about you to assist your health care provider in coordinating or managing your health care and related services. For example, a doctor may send us information about your diagnosis and treatment plan, so we can arrange additional services.  **Payment:** We may use or disclose PHI to pay or deny your claims, to collect premiums, or for the payment activities of your health care providers or your other insurer(s). For example, we may use and disclose PHI to tell you, your health care providers, or your other caregivers whether a particular type of health care service is covered under your policy.  **Health Care Operations:** We may use and disclose PHI in performing business activities that are called "health care operations." For example, we may use and disclose PHI about you in reviewing and improving the quality, efficiency, and cost of our operations, or for purposes of analyzing the quality and effectiveness of different Plan benefits in which you may or may not participate. We may disclose PHI to other entities, if any, in an organized health care arrangement with the Plan. For example, if a health care provider, company, or other health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company.  **Business Associates:** We may contract with individuals or entities known as "business associates" to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a business associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.  **Individuals Involved in Your Care or Payment for Your Care:** If you do not object after an opportunity to do so, or if you are incapacitated or if it is an emergency situation, we may disclose to your family member, close friend, or any other person identified by you, PHI about you that is directly relevant to that person's involvement in your care or payment for your care. We may also use and disclose PHI necessary to notify these persons of your location, general condition, or death. State laws will vary, but in many states a teenage minor must consent to use, or disclosure of PHI related to their mental health, chemical dependency, HIV/AIDS, or sexual health. Therefore, the Plan may require the child's authorization before releasing PHI to anyone, including their parents.  **Disaster Relief**: We also may share PHI about you with disaster relief agencies such as the Red Cross for disaster relief purposes.  **Required by Law:** We may use and disclose PHI to the extent required by law.  **Incidental Disclosures:** Disclosures that are incidental to permitted or required uses or disclosures under HIPAA are permissible so long as we implement safeguards to avoid such disclosures and limit the PHI exposed through these incidental disclosures.  **Health Plan Sponsor:** Under certain conditions, we may disclose PHI to the Plan Sponsor of this Plan (Microsoft Corporation), but only after it certifies to us that it will take certain steps to protect the confidentiality of your PHI.  **Public Health or Oversight Activities:** We may use and disclose PHI to authorized persons to carry out certain activities related to public health. We may disclose PHI to a health oversight agency to monitor the health care system, government health care programs, and compliance with certain laws. If the PHI is potentially related to health care that affects an individual’s health in any matter relating to the reproductive system and its functions and processes (“reproductive health care”), we must first obtain a valid attestation from the PHI recipient to verify that the use or disclosure is permitted under HIPAA.  **Abuse, Neglect, or Domestic Violence:** We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a participant has been a victim of domestic violence, abuse, or neglect.  **Lawsuits and Other Legal Proceedings:** We may use or disclose PHI when required by a court order, administrative agency order, subpoenas, discovery requests, or other lawful process, when efforts have been made to advise you of the disclosure or to obtain an order protecting the information requested. If the PHI is potentially related to reproductive health care, we must first obtain a valid attestation from the PHI recipient to verify that the use or disclosure is permitted under HIPAA.  **To Law Enforcement or to Avert a Serious Threat to Health or Safety:** Under certain conditions, we may disclose PHI to law enforcement officials. We may use and disclose your PHI under limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public.  **Coroners, Medical Examiners, Funeral Directors:** We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death, or to funeral directors, as authorized by law, so that they may carry out their jobs. If the PHI is potentially related to reproductive health care, we must first obtain a valid attestation from the PHI recipient to verify that the use or disclosure is permitted under HIPAA.  **Organ and Tissue Donation:** If you are an organ donor, we may use or disclose PHI to facilitate an organ, eye, or tissue donation and transplantation.  **Research:** We may use and disclose PHI about you for research purposes under certain limited circumstances.  **Specialized Government Functions:** Under certain conditions, we may disclose PHI for military activities, national security, or other specialized government functions.  **Workers’ Compensation:** We may disclose PHI to the extent necessary to comply with laws that provide benefits for work-related injuries or illness.  **Disclosures Required by HIPAA Privacy Rule:** We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.  **Other Uses and Disclosures:** All other uses and disclosures of your PHI will be made only with your written permission (an "authorization"). We generally may not use or disclose your PHI for marketing purposes or sell your PHI without your authorization. If you have given us authorization to use or disclose your PHI, you may later take back ("revoke") your authorization at any time, except to the extent we have already acted based on your permission.  **Genetic Information:** We may not use or disclose PHI that is genetic information for underwriting purposes.  Reproductive Health Care: We may not use or disclose PHI related to any individual who seeks, obtains, provides, or facilitates reproductive health care that is lawful – or is protected, required, or authorized by federal law – in the state and under the circumstances in which it is furnished, for the purpose of conducting a criminal, civil, or administrative investigation or imposing criminal, civil, or administrative liability on any person (or identifying any person for those purposes) merely for their seeking, obtaining, providing, or facilitating the reproductive health care. For example, if a local law enforcement agency requests PHI from the Plan related to a participant’s obtaining of reproductive health care that was legal in the state and under the circumstances it was provided, solely for the purpose of investigating that participant for criminal or civil liability for obtaining that reproductive health care, we will not use or disclose the PHI to the agency for that purpose.  III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU  Under federal law, you have the following rights regarding PHI about you. Unless otherwise noted, you may exercise any of these rights by contacting the Privacy Operations Official or Privacy Official identified in Section V below.  Right to Request Restrictions: You have the right to request additional restrictions on the use of your PHI for treatment, payment, and health care operations, or on the disclosure of your PHI to individuals involved in your care. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment), and the PHI pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.  Right to Receive Confidential Communications: If you tell us that disclosure of your PHI could endanger you, you have the right to request in writing that we communicate your PHI to you in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. We are required to meet only reasonable requests.  Right to Inspect and Copy: You can request the opportunity to inspect and receive a copy of your PHI in certain records that we maintain. We may charge you reasonable fees for the cost of providing a copy.  Right to Amend: You have the right to request that we amend your health plan PHI if you give us an appropriate reason for the request.  Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years prior to the request, other than disclosures made for treatment, payment, and health care operations; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative; for certain notification purposes (including national security, intelligence, and law enforcement purposes); of a "limited data set" in compliance with our policies and procedures for this kind of data; or incidental to otherwise permitted or required uses and disclosures. The first list you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.  Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time even if you agreed to receive this notice electronically. Please email Benefits@Microsoft.com or call 425-706-8853 for a paper copy.  IV. COMPLAINTS  If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Operations Official. You may also file a complaint directly with the Office for Civil Rights of the United States Department of Health and Human Services ("OCR"). We will not retaliate or take action against you for filing a complaint.  V. PRIVACY OPERATIONS OFFICIAL AND PRIVACY OFFICIAL CONTACT INFORMATION  If you have questions, you may contact our Privacy Operations Official or Privacy Official at the following addresses and phone numbers:  **HIPAA Privacy Operations Official** C/O Benefits  Microsoft Corporation One Microsoft Way Redmond, WA 98052 (425) 707-0531  **HIPAA Privacy Official** C/O Benefits  Microsoft Corporation One Microsoft Way Redmond, WA 98052 (425) 421-4459 |

### CHIP Notice

**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [**www.healthcare.gov**](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [**www.insurekidsnow.gov**](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [**www.askebsa.dol.gov**](http://www.askebsa.dol.gov) or call **1-866-444-EBSA** **(3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –**

|  |  |
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| **ALABAMA – Medicaid** | **ALASKA – Medicaid** |
| Website: <http://myalhipp.com/>  Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program  Website: <http://myakhipp.com/>  Phone: 1-866-251-4861  Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  Medicaid Eligibility: [https://health.alaska.gov/dpa/Pages/default.aspx](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhealth.alaska.gov%2Fdpa%2FPages%2Fdefault.aspx&data=05%7C01%7CBerman.Nathaniel%40dol.gov%7Ca5722ebf007e4847fe8808da69a45fb9%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C637938452103798639%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=A5Fggwg0lR2c%2FOwofWNVpVk8b5%2FFX1kaOQNuuEwAAAE%3D&reserved=0) |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: <http://myarhipp.com/>  Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:  <http://dhcs.ca.gov/hipp>  Phone: 916-445-8322  Fax: 916-440-5676  Email: [hipp@dhcs.ca.gov](mailto:hipp@dhcs.ca.gov) |
| **COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website: <https://www.healthfirstcolorado.com/>  Health First Colorado Member Contact Center:  1-800-221-3943/State Relay 711  CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>  CHP+ Customer Service: 1-800-359-1991/State Relay 711  Health Insurance Buy-In Program (HIBI):  <https://www.mycohibi.com/> HIBI Customer Service: 1-855-692-6442 | Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>  Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: [https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp](https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmedicaid.georgia.gov%2Fhealth-insurance-premium-payment-program-hipp&data=02%7C01%7Cstashlaw%40dch.ga.gov%7C98b18a96ce1b49d087f708d709449652%7C512da10d071b4b948abc9ec4044d1516%7C0%7C0%7C636988062560854968&sdata=7rziGawQfBKcW1N2%2Bdi2j8cyHpaCYURGdtF8Hk%2By6FM%3D&reserved=0)  Phone: 678-564-1162, Press 1  GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>  Phone: 678-564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64  Website: <http://www.in.gov/fssa/hip/>  Phone: 1-877-438-4479  All other Medicaid  Website: <https://www.in.gov/medicaid/>  Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:  <https://dhs.iowa.gov/ime/members> Medicaid Phone: 1-800-338-8366  Hawki Website:  <http://dhs.iowa.gov/Hawki>  Hawki Phone: 1-800-257-8563  HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>  HIPP Phone: 1-888-346-9562 | Website: <https://www.kancare.ks.gov/>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660 |

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| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>  Phone: 1-855-459-6328  Email: [KIHIPP.PROGRAM@ky.gov](mailto:KIHIPP.PROGRAM@ky.gov)  KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>  Phone: 1-877-524-4718  Kentucky Medicaid Website: [https://chfs.ky.gov/agencies/dms](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fchfs.ky.gov%2Fagencies%2Fdms&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Cceea86848e7e41f7dd9008db83d50dfb%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638248724653548159%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=DJ8rl0bkdcKwMIE92YY23XQc%2FZI71iLtdbD0L2XkS38%3D&reserved=0) | Website: [www.medicaid.la.gov](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  Phone: 1-888-342-6207 (Medicaid hotline) or  1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website: [https://www.mymaineconnection.gov/benefits/s/?language=en\_US](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.mymaineconnection.gov%2Fbenefits%2Fs%2F%3Flanguage%3Den_US&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Cb96a31a5c25e4e1da49908daf4ae9bf1%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638091328210827160%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=GeBtSEsUoaCw5ukO%2F6O2IUy%2B9FzGqgY%2FJ2C9OgAhxE4%3D&reserved=0)  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <https://www.maine.gov/dhhs/ofi/applications-forms>  Phone: 1-800-977-6740  TTY: Maine relay 711 | Website: <https://www.mass.gov/masshealth/pa>  Phone: 1-800-862-4840  TTY: 711  Email: [masspremassistance@accenture.com](mailto:masspremassistance@accenture.com) |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp>  <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>  Phone: 1-800-657-3739 | Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  Phone: 1-800-694-3084  Email: [HHSHIPPProgram@mt.gov](mailto:HHSHIPPProgram@mt.gov) | Website: <http://www.ACCESSNebraska.ne.gov>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178 |

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| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: <http://dhcfp.nv.gov>  Medicaid Phone: 1-800-992-0900 | Website: [https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.dhhs.nh.gov%2Fprograms-services%2Fmedicaid%2Fhealth-insurance-premium-program&data=05%7C01%7CGoodwin.Carolyn%40dol.gov%7C6aa7b22dba29413479c108da73eb96c6%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C637949752922233349%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=mUgACydlz9JGXnHMgi%2FUkDGD0QyTI1U6Tjwue%2Bq8D0Q%3D&reserved=0)  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:  [http://www.state.nj.us/humanservices/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  [dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)  Medicaid Phone: 609-631-2392  CHIP Website: <http://www.njfamilycare.org/index.html>  CHIP Phone: 1-800-701-0710 | Website: <https://www.health.ny.gov/health_care/medicaid/>  Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: <https://medicaid.ncdhhs.gov/>  Phone: 919-855-4100 | Website: [https://www.hhs.nd.gov/healthcare](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hhs.nd.gov%2Fhealthcare&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7C64da7b9f730b4fb2467608db7fe082e3%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638244374885371946%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=RO%2BrOZKJxqNsa0Ewzhle%2FkVaDGnl7hpPQnJUnW1mwDU%3D&reserved=0)  Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid** |
| Website: [http://www.insureoklahoma.org](http://www.insureoklahoma.org/)  Phone: 1-888-365-3742 | Website: <http://healthcare.oregon.gov/Pages/index.aspx>  Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>  Phone: 1-800-692-7462  CHIP Website: [Children's Health Insurance Program (CHIP) (pa.gov)](https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx)  CHIP Phone: 1-800-986-KIDS (5437) | Website: <http://www.eohhs.ri.gov/>  Phone: 1-855-697-4347, or  401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: <https://www.scdhhs.gov>  Phone: 1-888-549-0820 | Website: [http://dss.sd.gov](http://dss.sd.gov/)  Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: [Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services](https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program)  Phone: 1-800-440-0493 | Medicaid Website: <https://medicaid.utah.gov/>  CHIP Website: <http://health.utah.gov/chip>  Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: [Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdvha.vermont.gov%2Fmembers%2Fmedicaid%2Fhipp-program&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7C3daa411d0e934769e75c08daf4bf842e%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638091400777632051%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=7ao%2BrltzkBEMojzmZ9O8UllrAdaRI%2Fmzhq3FE%2Bf%2B2nk%3D&reserved=0)  Phone: 1-800-250-8427 | Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>  [https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcoverva.dmas.virginia.gov%2Flearn%2Fpremium-assistance%2Fhealth-insurance-premium-payment-hipp-programs&data=05%7C01%7CClinton.Latisha.M%40dol.gov%7Caa3a5092aeb14ed08af708db81758880%7C75a6305472044e0c9126adab971d4aca%7C0%7C0%7C638246115240341681%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=rI%2BZX53PVAmr9gcvTJt3KrfWxCtIx6VIxQ36deaOXTs%3D&reserved=0)  Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: <https://www.hca.wa.gov/>  Phone: 1-800-562-3022 | Website: <https://dhhr.wv.gov/bms/>  <http://mywvhipp.com/>  Medicaid Phone: 304-558-1700  CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:  <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>  Phone: 1-800-362-3002 | Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>  Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services

[**www.dol.gov/agencies/ebsa**](https://www.dol.gov/agencies/ebsa)[**www.cms.hhs.gov**](http://www.cms.hhs.gov/)

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

### Notice of Creditable Coverage

**Important Notice from Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington and Kaiser Permanente About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington and Kaiser Permanente and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:**

* + 1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
    2. **Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington and Kaiser Permanente have determined that the prescription drug coverage offered by them, under the Microsoft Corporation Welfare Plan, is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington or Kaiser Permanente coverage will not be affected. You can keep your current coverage, and Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington or Kaiser Permanente will coordinate benefits with your Medicare Part D coverage so as not to duplicate payments. If you do decide to join a Medicare drug plan and drop your current Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington or Kaiser Permanente coverage, be aware that you and your dependents will be able to get this coverage back, but only during limited specified times.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Premera Blue Cross, Surest, Kaiser Foundation Health Plan of Washington or Kaiser Permanente and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage…**

For further information, contact:

* Premera: (800) 676-1411
* Kaiser Foundation Health Plan of Washington (206) 630-4636 or (888) 901-4636
* Kaiser Permanente: (800) 464-4000
* Surest (866) 222-1298

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if coverage through Premera Blue Cross, Surest, Surest, Kaiser Foundation Health Plan of Washington or Kaiser Permanente changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

* Visit [**www.medicare.gov**](http://www.medicare.gov)
* Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
* Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [**www.socialsecurity.gov**](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

### **Summary Annual Report for Microsoft Corporation Welfare Plan**

This is a summary of the annual report for Microsoft Corporation Welfare Plan (the “Plan”), Plan Number 501, EIN: 91-1144442 for the period 01/01/2023 to 12/31/2023. This is a welfare benefit plan offering Health (other than vision or dental), Life Insurance, Dental, Vision, Prepaid legal, Long-term disability, Accidental Death & Dismemberment, Paid Leave, Employee Assistance plan and Death benefits (including travel accident but not life insurance).

The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Microsoft Corporation has committed itself to pay all medical claims incurred under the terms of the plan.

**Insurance Information**

The Plan has contracts with Arag Insurance Company, Kaiser Foundation Health Plan Inc, and Prudential Insurance Company of America to pay certain health, life insurance, long-term disability, group legal plan, AD&D and paid leave claims incurred under the terms of the Plan. The total premiums paid for the Plan year ending 12/31/2023 were $157,029,883.

**Your Rights to Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

* Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Microsoft Corporation, Microsoft Corporation Welfare Plan Sponsor, One Microsoft Way, Redmond, WA 98052, and at the main office phone of (425) 882-8080.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan One Microsoft Way, Redmond, WA 98052, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs.

**Requests to the Department should be addressed to:**

Public Disclosure Room, N1513

Employee Benefits Security Administration

U.S. Department of Labor

200 Constitution Avenue, N.W.

Washington, DC 20210

OMB Control Number 1210-0040 (expires 03/31/2026)

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL\_PRA\_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040. (expires 1/31/2026)