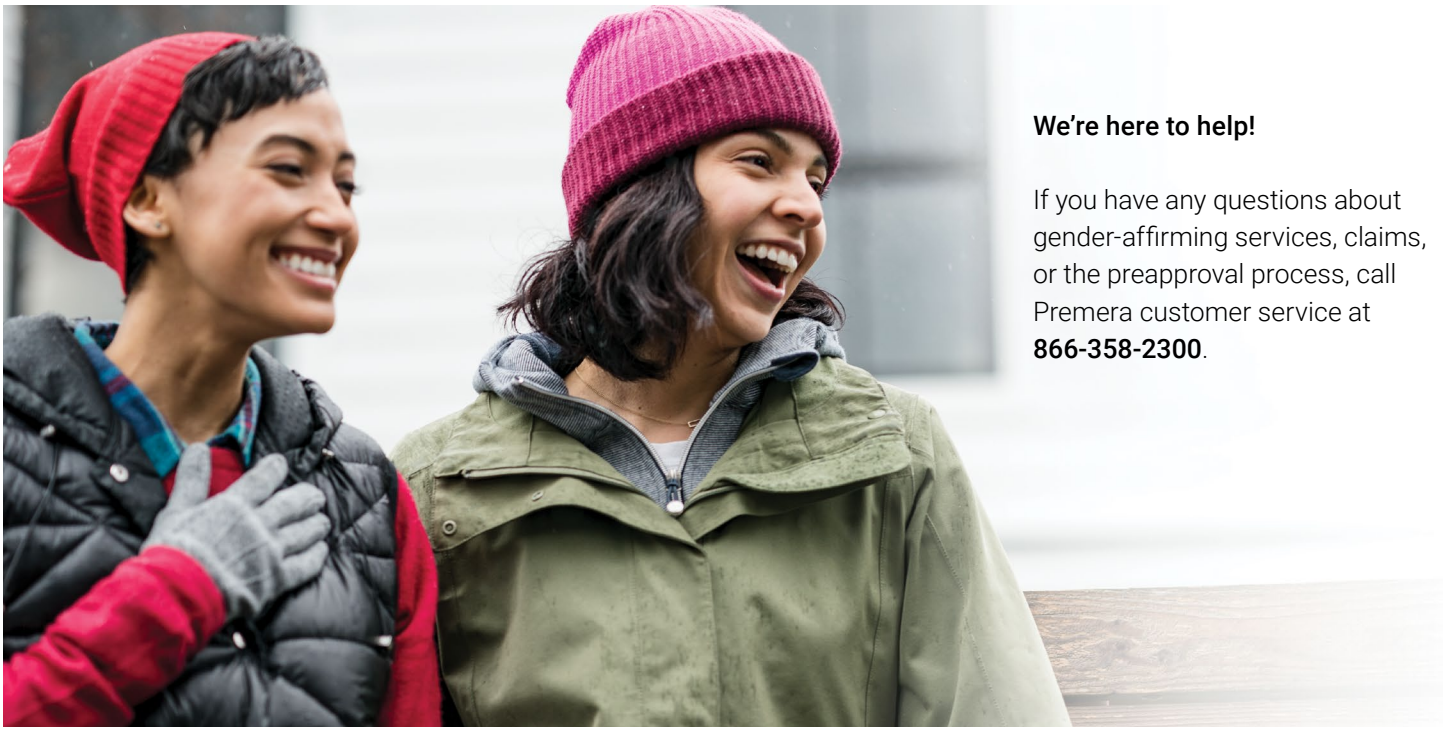
T-Mobile Gender-Affirming Benefit information

Premera Blue Cross administers the gender-affirming benefit for eligible T-Mobile members.

This benefit provides medically necessary coverage for gender affirmation only when certain criteria are met. This document provides you with a general description of benefit eligibility and coverage. We also include information on how to access doctors and services, and how to receive reimbursement for your treatment cost.

The criteria are outlined in the Premera Gender Transition/Affirmation Surgery medical policy available on **premera.com/t-mobile**.

Gender-affirming benefits may change based on the most current clinical guidelines.



We're here to help!

If you have any questions about gender-affirming services, claims, or the preapproval process, call Premera customer service at **866-358-2300**.

Make sure to bring this information to appointments with your providers so they are aware of your coverage.

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Description of the gender-affirming benefit

This benefit covers medically necessary gender-affirming surgical services, including facility and anesthesia charges related to the surgery. Coverage for mental health treatment associated with gender reassignment surgery is also available. Prescription drugs are available through your prescription drug plan with CVS Caremark.

Health Reimbursement Account (HRA) Plan

In network	Out of network
The plan pays 80% once you meet your deductible. • $35 copayment for primary care provider (PCP) and mental health office visits • $50 copayment for specialist office visits	Once you meet the deductible, the plan pays 60% of allowable charges.* • $35 copayment for out-of-network mental health office visits

Exclusive Provider Organization (EPO)

In network	Out of network
The plan pays 80% once you meet your deductible. • $20 copayment for primary care provider (PCP) and mental health office visits • $30 copayment for specialist office visits	There is no out-of-network coverage on the EPO plan except for hair removal. Out-of-network hair removal services are covered at the in-network benefit level. For all other out-of-network services, you will be responsible for 100% of the cost.

Health Savings Account (HSA) Plan

In network	Out of network
The plan pays 80% once you meet your deductible.	Once you meet the deductible, the plan pays 60% of allowable charges.*

Who is eligible?

Surgical gender reassignment services are considered medically necessary and are covered for employees, spouses/domestic partners, and dependents enrolled in a Premera medical plan if they meet the criteria for the procedure outlined in the Gender Transition/Affirmation Surgery medical policy.

*You may be billed for costs exceeding the allowable charges when using an out-of- network provider. Any amounts you pay for services in excess of allowable charges will not count toward satisfying any deductible requirements or out-of-pocket maximums on this plan.

Covered procedures

Examples of covered services include, but are not limited to, the following when medical necessity and plan requirements are met. A preapproval is recommended for a majority of the procedures. Letters of recommendations from mental health professionals as noted below are required for procedures including but not limited to the following:

Breast/Chest

- Breast augmentation
- Mastectomy
- Nipple reconstruction
- Rib excision

Genital

- Clitoroplasty
- Labiaplasty
- Metoidioplasty
- Orchiectomy
- Penectomy
- Phalloplasty
- Scrotoplasty
- Vaginectomy
- Vaginoplasty
- Vulvectomy

General surgical procedures

- Blepharoplasty
- Chin augmentation
- Face lift
- Facial bone reduction
- Hair removal
- Laryngoplasty
- Lip reduction
- Liposuction
- Rhinoplasty
- Tracheal shave

Additional surgical services may be considered for preapproval, using the most current Gender Transition/ Affirmation Surgery medical policy and chart notes from your provider.

Mental health professional:

A mental health professional is defined as any mental health practitioner with a master's degree or higher level of education. Evaluations and recommendations must be performed by professionals who are licensed by the state in which they provide services as master's level mental health clinicians, doctoral level mental health clinicians, psychiatric nurse practitioners, or physicians (in which case they must also be board-eligible or board-certified in psychiatry).

The required minimum content of the mental health evaluation and recommendation is as follows:

- Confirmation of the diagnosis of gender dysphoria.
- Recommendation or support for surgery and the rationale for the recommendation.
- Confirmation of the member's capacity to make a fully informed decision and to consent to treatment.
- Verification that the decision is current, well thought out, not impulsive, and not due to any other treatable mental disorder.
- Refer to the medical policy for the complete requirements.

Note:

- The mental health evaluation and recommendation letters are required at the beginning of the gender reassignment surgical process. If the surgery is not performed within 12 months, then a new mental health evaluation and recommendation letter will be required.
- Additional mental health recommendations are not required for all subsequent gender-affirming surgeries that are done within 2 years of when the first surgery that required a mental health recommendation is approved.

Preapproval (prior authorization) process

It is strongly recommended that your provider submits a preapproval request to Premera to find out if your plan will cover your surgery. A preapproval is recommended to determine whether benefits are available before the service occurs.

A preapproval confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on the criteria outlined in the Gender Transition/Affirmation Surgery medical policy. Premera and T-Mobile reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

These reviews take up to 15 days to be completed. The preapproval should be submitted by the physician who is performing the service(s).

A preapproval 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 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.

When services are covered

Surgical gender reassignment services for breast/chest ("top") and genital ("bottom") surgery, will be considered medically necessary and covered if you are diagnosed as having gender dysphoria and the following criteria are met:

For genital surgery:

- Are 18 years of age or older.
- One letter of recommendation from a licensed mental health professional based on either a pre-surgery evaluation conducted within the last 12 months, or pre-surgery psychotherapy or mental health treatment within the last 12 months.

For other procedures:

- The surgery is medically necessary according to the most current Premera medical policy.

Female-to-male breast/chest surgery:

- Are 17 years of age or older.
- One letter of recommendation from a licensed mental health professional based on either a pre-surgery evaluation conducted within the last 12 months, or pre-surgery psychotherapy or mental health treatment within the last 12 months.

Male-to-female breast/chest surgery:

- Are 18 years of age or older.
- One letter of recommendation from a licensed mental health professional based on either a pre-surgery evaluation conducted within the last 12 months, or pre-surgery psychotherapy or mental health treatment within the last 12 months.

Your provider can submit prior authorization online through Availity or fax to 800-843-1114.

In-network vs. out-of-network providers

Use in-network providers when possible to maximize your benefits.

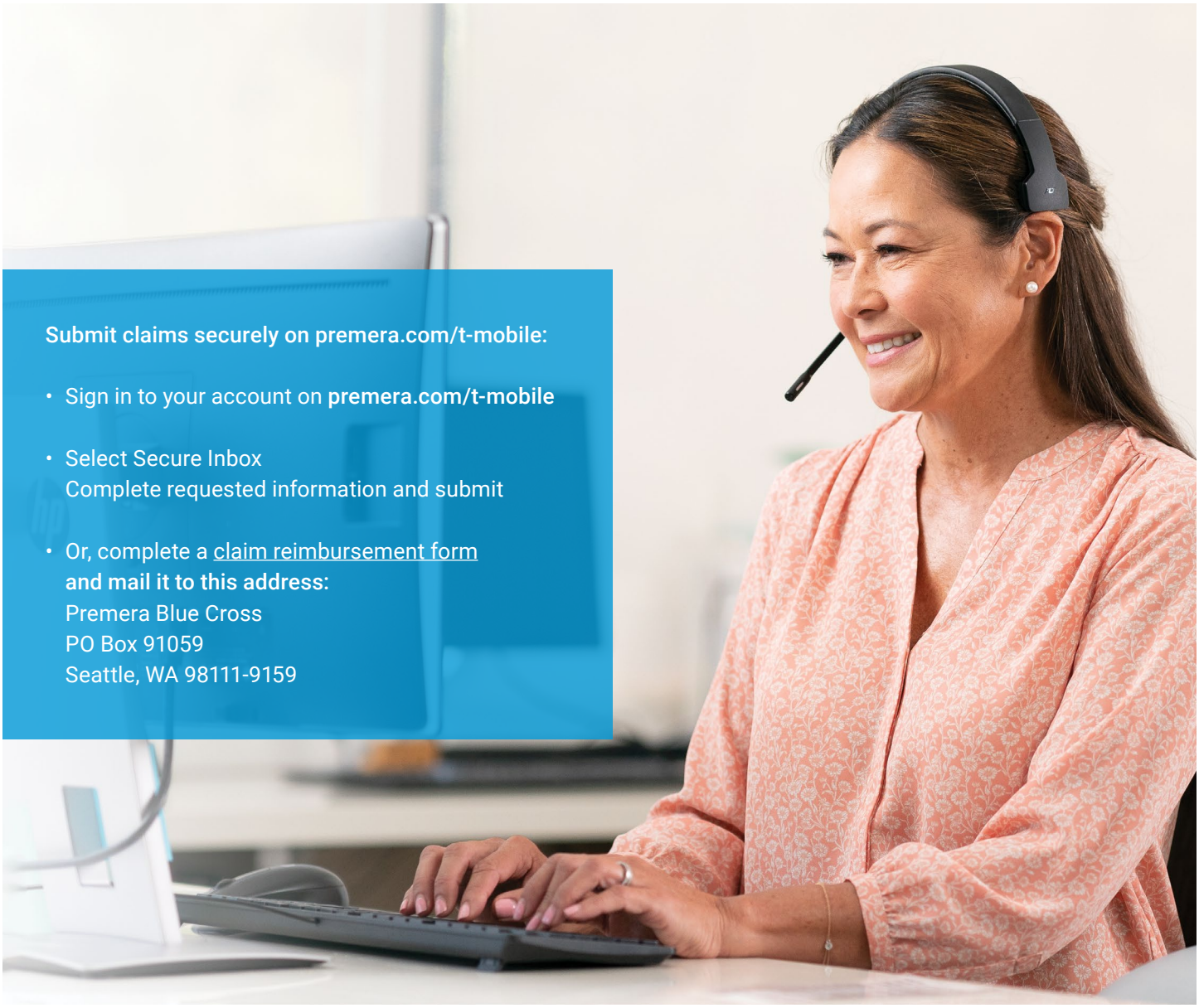
In network	Out of network
We encourage you to use an in-network provider to help protect yourself against high, unexpected, out-of-pocket costs while receiving the highest level of coverage. Premera network providers can be found online at **premera.com/t-mobile** using the Find a Doctor tool. Or you can call Premera Customer Service at **866-358-2300** for help. If you have already found a provider, visit **premera.com/t-mobile** to confirm the provider is in network. Remember, you have access to the entire Blue Cross Blue Shield national network of providers.	Many gender reassignment surgery doctors are out of network. In those cases, the medical plan would pay at the out-of-network benefit level up to the allowable amount. When you use an out-of-network provider, you may be responsible for the difference between the allowed charge and the provider's billed amount—this is referred to as balance billing. Out-of-network providers may require up-front payment for their services. Premera may be able to work with the provider on a Letter of Agreement. A Letter of Agreement will state the intent to pay for the mutually agreed upon charges covered under the preapproval. When using an out-of-network provider, be sure to advocate for yourself. Ask the provider for pricing and any estimated out-of-pocket costs up front. Do not sign private payment forms or else Premera will not be able to assist you with pricing. Call Premera Customer Service if the provider will not provide you with pricing for services. We may be able to help you reduce your out-of-pocket costs when using an out-of-network provider.

Premera recommends knowing the requirements of the benefit when seeking surgical services. Take copies of the benefit language and required letters from the mental health professionals when you see the surgeon, so that they can submit them with the clinical information.

Claims processing and reimbursement

You or your provider will need to complete and submit claim forms to Premera. Claims are processed differently if you are using coordination of benefits (when you use another health plan as your primary coverage and your T-Mobile plan as your secondary coverage). You will need to provide either an explanation of benefits (EOB) statement or a denial from your primary health insurance company if they don't cover gender-affirming services. This will allow Premera to process your claims as your secondary health plan.

To submit your own claims for services received by an out-of-network provider, be sure to include your chart notes and operative reports with your claim form, as well as all the necessary requirements of the benefit including mental health letters.



Submit claims securely on premera.com/t-mobile:

- Sign in to your account on **premera.com/t-mobile**
- Select Secure Inbox
  Complete requested information and submit
- Or, complete a claim reimbursement form
  and mail it to this address:
  Premera Blue Cross
  PO Box 91059
  Seattle, WA 98111-9159

Commonly asked questions

What procedures are excluded under this benefit?

Requests for procedures that are not specifically listed in the current version of the Gender Transition/ Affirmation Surgery medical policy will be reviewed for medical necessity based on clinical information sent by your provider during the preapproval process.

Does my plan cover gender-affirming treatment for children?

Yes, the plan will cover non-surgical medical treatment, such as mental health care, for minors seeking gender-affirming services. Please refer to page four of this document for additional information on when surgical interventions are covered.

Is hormone therapy covered?

Yes, some hormone therapy is covered subject to the plan's pharmacy benefit administered by CVS Caremark. Please contact CVS for therapy-specific coverage information.

The Premera medical necessity criteria will be applied to two types of hormones that are administered in a provider's office:

- Gonadotropin-releasing hormone analogs, which are used to suppress puberty in adolescents
- Testosterone formulations other than gels

Please review the medical policy for the complete criteria.

What does Premera consider to be a mental health professional?

For the gender-affirming services benefit, a mental health professional is defined as any mental health practitioner with a master's degree or higher level of education. Evaluations and recommendations must be performed by professionals who are licensed by the state in which they provide services as master's level mental health clinicians, doctoral level mental health clinicians, psychiatric nurse practitioners, or physicians (in which case they must also be board-eligible or board-certified in psychiatry).

Are the mental health visits covered by the plan?

Yes, the plan covers any of the associated mental health visits. Please refer to page two of this document for mental health visit cost share information for the plan you are enrolled in.

Can I receive services outside of the United States?

The only services covered outside of the U.S. are those that are due to an emergency or illness where immediate care is necessary. The plan doesn't provide international coverage for any pre-planned elective services. This is true for all types of medical care, not specific to gender-affirming services.

CVS Caremark is an independent provider of pharmacy benefits that does not provide Blue Cross Blue Shield products or services. CVS Caremark is solely responsible for their products and services.

This document represents a summary of the T-Mobile gender-affirming benefit. It is not intended to provide a complete description. For full information on your benefits, including any limitations that may apply, please see the official Summary Plan Description (SPD).

Although every effort has been made to ensure information in this document is accurate, the provisions of the official SPD will govern in case of any discrepancy.