

How to get the most out of your medical plan



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Welcome to Premera Blue Cross

We're always looking for ways to give you greater peace of mind about your health-care coverage. Please refer to this booklet for general information on how to get the most from your health plan.

As a Premera Blue Cross health-plan member, you can:

- Reduce your out-of-pocket expenses and paperwork by using our network of doctors, hospitals and other health-care providers
- Use a variety of benefits, including worldwide emergency care and specialist care without referral
- Take advantage of helpful customer service and quick claims processing
- Actively participate in your health care by using our Web site to learn about your benefits, check claims, find specific health information, locate a provider and more.

Please don't hesitate to share your questions, comments and suggestions with us so we can ensure that we're meeting your needs and expectations. We look forward to serving you!



Your member packet offers valuable information

You're bound to have plenty of questions about your health-care coverage:

- Who do I contact when I have a question or problem, and how? *(page 3)*
- What do I do in case of an emergency? *(page 5)*
- Do I need a referral to see a specialist? *(page 5)*
- Where can I get my prescriptions filled? *(page 7)*

You'll find answers to these questions, and many others, in this booklet.

For information about your specific benefits, take time to review your Benefit Highlights sheet and Benefit Booklet.

And for a complete list of doctors and other providers in your plan's network, refer to your Provider Directory. You can also access the most up-to-date provider directory information online.

Glossary of terms

Here are some key terms that will help you in understanding your health plan. You'll find a comprehensive list of defined terms ("Definitions") in your Benefit Booklet.

Allowable charge: the amount that network doctors and other contracted health-care providers have agreed to accept as full payment for covered health-care services and supplies.

Balance billing: additional charges for which a non-network provider (one who's not in your plan's network) may hold you responsible.

Benefit: the portion of the cost for covered health-care services and supplies that your health plan is responsible for paying.

Coverage: the range of health-care services and supplies for which your health plan provides benefits.

Network: a group of doctors, hospitals and other health-care providers that have been contracted to provide health-care services and supplies at agreed amounts called "allowable charges."

Out-of-pocket expenses: costs that are paid by you, not your health plan—such as the following:

Coinsurance: the percentage of the cost you will pay for a covered medical service, after your health plan has paid its portion.

Copayment (copay): a set fee your health plan may require you to pay your doctor or other health-care provider at each visit for certain covered services.

Deductible: a fixed amount your health plan may require you to pay for certain covered services and supplies each year before your health plan starts paying specified benefits. Copays are not credited toward your deductible.

Provider: a doctor, hospital or other medically-licensed or medically-certified person or facility that provides health-care services or supplies.

If you need answers

Visit www.premera.com 

Instant information and services

- **Provider Directory**—Search for a physician or other provider in your plan's network.
- **Pharmacy**—Locate a network pharmacy, order prescription refills through the Medco® mail pharmacy service and learn how our prescription benefits can save you money.
- **Using Your Health Plan**—Find information on our provider networks and benefits—plus a list of common health-care terms and their definitions.
- **Staying Healthy**—Find information here to help you take charge of your health. Learn more about getting active, handling stress, making healthy food choices and many other health and wellness topics.
- **Extras!**—Discover the valuable discount programs available to Premera Blue Cross members for eyewear, hearing aids and more.
- **Care Facilitation**—Take a look at how we support the doctor-patient relationship and positive health outcomes.
- **Member Forms**—Download and print forms on demand such as mail pharmacy service order forms.

Secure member portal—www.premera.com

To protect your privacy, you'll receive a special Personal Identification Number (PIN) in the mail that will allow you to register and log in for the first time to access:

- **My Information**—Check eligibility, view and update personal information, order ID cards and review benefit information.
- **Claim Center**—Easily check on the status and details of your claims.

- **Coverage AdvisorSM**—Compare the financial and tax impact of your plan choices so you can decide which plan best meets your needs.
- **Healthcare AdvisorSM**
 - Find easy-to-understand information about your condition or recommended procedure.
 - Get a list of key questions to ask your doctor.
 - Get connected with other people who share your health issue.
 - Find an online medical encyclopedia.
 - Use the hospital comparison tool to view comparison data to help you in choosing a hospital.
 - Use the **Treatment Cost AdvisorSM** tool to help you estimate the costs of specific health-care services to aid you in making informed and educated decisions.

If you don't use the Web, call us instead at 1-800-722-1471

- Our Customer Service staff is here to help you between 8 a.m. and 5 p.m. PST weekdays.
- To get around-the-clock benefit, eligibility and claim information, call Customer Service anytime at 1-800-722-1471 and respond to the prompt that leads you to our Quick Response interactive phone system.
- You'll be asked for your member ID number in order for us to provide information or direct your call to the appropriate representative.

Need a new card?

If your ID card is lost, you can request a replacement card at www.premera.com or by calling Customer Service at 1-800-722-1471.



Choosing a provider

When you're at home

Save time and money with network doctors, hospitals and other health-care providers

Your health plan offers you access to a state-wide network of doctors, hospitals and other health-care providers.

Our network providers have agreed to bill us directly and accept our allowable charges for covered services. Providers who are not in our network (non-network providers) may bill over our allowable charges and hold you responsible for the additional costs.

To ensure that you receive the highest level of benefits, check to make sure both your doctor and the clinic where you wish to receive care are in your health plan's network.

- You get the highest level of benefits and lowest out-of-pocket costs when you use a network provider. If you use a network provider you're responsible for your coinsurance, copayment, deductible and any charges not covered by your plan.
- You rarely have to worry about filing a claim because network providers have agreed to submit your claims directly to us. We send claim payments directly to the provider.

You'll find network providers listed in our Provider Directory at www.premera.com. You also can request a copy of the Provider Directory by contacting Customer Service at 1-800-722-1471.

If you need care that you or your doctor believes is not available in your plan's network, please call Customer Service.

When you're traveling or living out-of-state

The BlueCard® Program offers you access to a network of contracted Blue Cross Blue Shield providers across the nation. Just like at home, these networks can save you time and money.

If you need care outside Washington or Alaska, other than emergency care:

1. To find a nearby Blue Plan provider, visit our Web site at www.premera.com and click the **Provider Directory** link. Choose the type of provider you need. Then choose "Other States" and select the correct network option for your plan—either **BlueCard PPO** or **BlueCard Traditional**.* Or call the BlueCard Provider Locator number on the back of your member ID card (1-800-810-2583).
2. Visit the Blue Plan provider and show your member ID card.
3. At the time of service, you're responsible only for the applicable copays. The provider will file a claim with the local Blue Cross or Blue Shield plan who will route it directly to us. Once we have processed the claim, we'll send you an Explanation of Benefits detailing any coverage amounts owed.**

* See your Benefit Booklet to determine which network is offered by your plan.

** Deductible and/or coinsurance.

For covered benefits that are available to you outside Washington or Alaska, please refer to your Benefit Booklet or call us at 1-800-722-1471.



Worldwide provider networks

When you travel overseas or are living abroad, you enjoy the added advantage of BlueCard Worldwide®. This program offers access to an international network of participating doctors and hospitals for a broad range of medical services. Check your Benefit Booklet to find out what benefits your plan covers when you are outside the United States and follow these simple steps:

1. If you need non-emergency medical care, call BlueCard at 1-804-673-1177. The BlueCard Worldwide Service Center is available 24 hours a day, 7 days a week and is staffed with multilingual representatives. They can help coordinate hospital care or make an appointment with a doctor for you.
2. Visit the BlueCard Worldwide provider and show your member ID card.
3. For all outpatient care or office visits, you pay the provider and submit a claim to Premera Blue Cross.
4. For inpatient hospital care that was arranged by the BlueCard Worldwide Service Center, the provider will file the claim. You only pay the out-of-pocket expenses required by your plan (deductible, copayments, coinsurance, and any non-covered services). If the hospitalization was not arranged by BlueCard Worldwide, you pay the provider and submit a claim to Premera Blue Cross.

Note: For emergency care outside the U.S., go to the nearest hospital. Call BlueCard at 1-804-673-1177 if you're admitted.

Need to see a specialist?

No referrals necessary.

As a Premera Blue Cross member, you have the freedom to see specialists without referrals. Our provider network includes a wide variety of specialists. Just like our other network providers, they bill us directly and accept our allowable charges as full payment, saving you time and money.

What to do in a medical emergency

Call 911 or seek help immediately!

Emergency care is always covered at the highest benefit level, regardless of whether or not the facility is part of your health plan network. A sudden illness or injury is considered to be a medical emergency if it causes severe pain, and/or a prudent layperson believes it's life threatening or it places your health in serious jeopardy. Examples of medical emergencies include suspected heart attacks, strokes and broken bones.

For a complete definition of "emergency" and your related coverage, please see your Benefit Booklet.

24-hour NurseLine

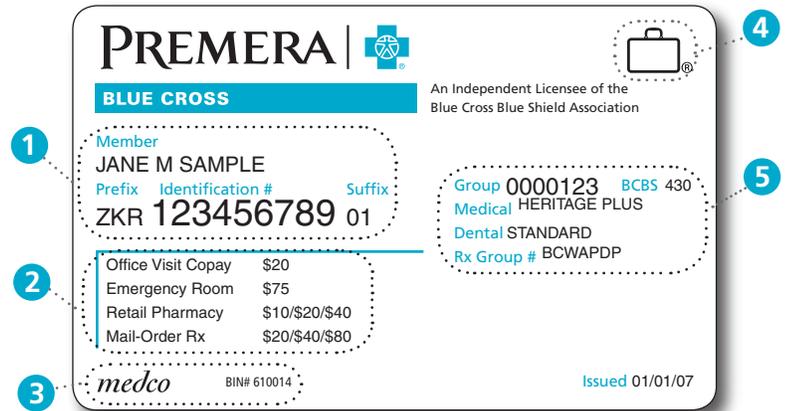
To discuss symptoms you may have and whether or not you should seek care for them, call our experienced NurseLine staff. Our NurseLine registered nurses can answer your questions and help facilitate the right care, at the right time, in the right setting.

The 24-hour NurseLine staff is available at 1-800-841-8343.

Using your ID card

Take your “passport to care” with you everywhere

Your Premera Blue Cross Member ID card is your direct link to care. Always carry your card and show it to physicians, other providers and pharmacists whenever you need care or prescriptions. To help ensure that your claims are paid properly, encourage physicians and other providers to make a copy of the front and back of your card each time you visit.



Note: This sample card may show features that don't appear on your card, depending on your health plan.

Understanding your ID card

- 1 Member**—person eligible for covered services.
Identification #—helps us verify your eligibility and coverage when you call Customer Service. The three letters in front of your Identification Number are required to process your claims.
- 2 Office Visit Copay**—a set fee you pay a provider at each visit for certain covered services.
Emergency Room—a set fee you pay for each emergency room visit.
Retail Pharmacy*—the amount you pay for a prescription (up to a 30-day supply) when you visit a pharmacy. From left to right, “generic” is the least expensive, followed by “preferred brand.” “Non-preferred” is the most expensive.
Mail-Order Rx*—the amount you pay for a prescription (up to a 90-day supply) when you use the Medco mail pharmacy service. This amount depends on which tier your medication is in, as stated in the Retail Pharmacy description above.
- 3 medco***—this pharmacy service symbol and BIN# lets pharmacists know where to send your pharmacy claim for processing.
- 4 Suitcase symbol or PPO**—this suitcase symbol indicates that your plan participates in the BlueCard Program, which provides coverage worldwide through a provider network.
- 5 Group**—this number identifies your particular plan's benefits.
BCBS—helps your claims get processed through the BlueCard Program when you're outside of Washington or Alaska.
Medical—name of your provider network.
Dental—name of your dental plan, if applicable.
Rx Group #*—pharmacists use this number to process your prescriptions.

The back of your card provides additional information, including important phone numbers you and your providers may need.

* These features apply only if your Premera Blue Cross plan includes prescription coverage.

Your prescription benefits

Some Premera Blue Cross plans may not cover prescription drugs. Please call 1-800-722-1471, or check with your company's benefit administrator to find out if your plan does.

Tiered prescription drug programs designed for cost savings

Your prescription benefits are covered through either our 2- or 3-Tier Prescription Drug Program. Both offer coverage for a wide choice of generic and brand-name prescription medicines, and both can help you save money. With either program, you pay a designated copay or coinsurance amount, depending on the drug's category. Generic drugs provide the best value in most cases. In the 2-Tier program you pay a higher copay or coinsurance for all brand-name drugs, while your copay or coinsurance for generics is charged at the lower tier. A description of the 3-Tier program and associated costs is detailed in the table below. The dollar copay or coinsurance amount for each drug tier will depend on your plan's specific benefit design.*

3-Tier Program	Cost	Drug definition
Generic	\$	FDA-approved; as safe and effective as brand-name alternative
Preferred brand-name	\$\$	Cost-effective and effective for treatment
Non-preferred brand-name	\$\$\$	Generic / preferred alternative is equally or more effective

If a generic equivalent is available and you or your provider request the pharmacy to fill the prescription with the brand-name drug, you may be responsible for paying the difference between the cost of the brand-name drug and the generic, plus the applicable copay/coinsurance.

Filling your prescriptions

To receive the highest level of prescription benefits, fill your prescriptions at any of more than 60,000 participating Medco network retail pharmacies or through Medco's mail service. If you go to a pharmacy not in the network, your out-of-pocket expense may be higher. Virtually all pharmacies in the United States are part of the Medco network. Call Medco's toll-free 24-hour Pharmacy Locator number on the back of your ID card (1-800-391-9701) to locate a network pharmacy near you or visit our Provider Directory at www.premera.com. Specialty drugs used to treat rare or complex conditions are available through one of our two contracted specialty pharmacies, Accredo Health Group™ (a Medco company) or Caremark.® Specialty drugs will not be covered unless purchased through Accredo or Caremark.

Mail pharmacy service for greater savings: Medco By Mail

Medco's mail pharmacy service can provide greater savings on long-term medications. With the mail service you can receive prescriptions up to the supply maximum allowed by your plan—typically 90 days—at a lower out-of-pocket cost than what you would pay for an equal supply at a retail pharmacy. Please check your Benefit Booklet or front of your ID card for the mail pharmacy service copay or coinsurance amounts for your plan. Please check your Pharmacy Packet for more details on using Medco By Mail.

Mail-order refills

If refills on your prescriptions are allowed, be sure your doctor indicates that on the prescription. You can order refills by phone at 1-800-4-REFILL or through MyPharmacyPlus™ in the Pharmacy section at www.premera.com. Have your member ID, prescription numbers and credit card ready.

*Coinsurance amounts vary based on actual drug cost.



How to use a Specialty Pharmacy

Specialty drugs are high-cost drugs used to treat rare or complex conditions. These drugs are available through one of our two contracted specialty pharmacies, Accredo Health Group (a Medco company) and Caremark Specialty Pharmacy Services. These pharmacies not only dispense specialty drugs but also provide extra clinical services to help you manage your illness at no additional cost. Specialty drugs will not be covered unless purchased through Accredo or Caremark.

To get started using Caremark or Accredo specialty pharmacy services, call CaremarkConnect[®] at 1-800-237-2767 or Accredo at 1-877-244-2995. You also can visit the Pharmacy link at www.premera.com to learn more about other ways to contact either specialty pharmacy.

Member-centered pharmacy programs

Generics—Yes!

Generic drugs generally cost less but they are identical to their brand-name equivalents. They also can save you money. Whenever your doctor writes a prescription, be sure to ask whether a generic equivalent is available. Always requesting a generic drug is one simple way help minimize your health-care costs while maintaining the same level of care.

Therapeutic Alternative Program*

When a generic is not available, you can still save money with a generic alternative. A generic alternative falls into the same drug class as a brand-name medication. It can provide a similar

therapeutic benefit as the brand-name drug, even though it contains different ingredients. Ask your doctor if a generic alternative is right for you. You can also avoid copay charges on your first 90-day supply when you fill your prescription with selected generic alternatives.

Cut the Pill, Cut Your Bill Program*

Many medications are available in different dosages, but the out-of-pocket costs to you are the same regardless of the dosage strength. If you take lower dosage of a medication that also is available in higher dosages, have your doctor prescribe the higher dosage and take half of a higher dosage pill rather than a full lower dosage one. This program is voluntary, but can save you up to 50% on your prescription costs. Talk to your doctor about the pill-splitting alternatives available to you.

Find out more about your Premera prescription benefits

To get the best value from your prescription coverage, please review your Benefit Booklet for details about your specific plan's coverage, and your Pharmacy Packet for information about filling prescriptions and our preferred drug list.

To learn more

about these pharmacy programs and view a list of qualifying drugs, refer to the Pharmacy section of our Web site at www.premera.com or contact Customer Service.



* Not all plans offer this program. Please check with your Benefits Coordinator or your Benefit Booklet to determine if you qualify for this program under your current plan.

Information about claims payments



How to read an Explanation of Benefits

You receive an Explanation of Benefits (EOB) from us each time we process a claim sent by you or your health-care provider. The EOB is not a bill.

The information on the EOB helps you understand how your benefits were applied to that particular claim. It includes the service date, provider's name, amount billed, amount covered, amount we paid and any balance you're responsible for paying the provider. It also tells you how much has been credited toward any required deductible.

Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider. If you have any concerns or questions, please call Customer Service at 1-800-722-1471. We recommend that you keep all EOBs for at least two years.

EXPLANATION OF BENEFITS

June 01, 2006

SAMPLE

Group Number: 12345678
 Member: John Sample
 Member's ID: 10000017-01
 Claim Number: 8000000001
 Provider: Smith, Robert
 Payment Reference ID: 2002062510100013

(This is NOT a bill)

1	2	3	4	5	6	7	8	9	10	11
Service/ product description	Dates you received service/product (m/d/y to m/d/y)	Charges billed by provider	Minus provider's fee adjustment (*)	Minus your copay (C), deductible (D) or amount not covered (**)	Total amount eligible for benefits	%	Minus your coinsurance amount	Plus or (minus) adjustment	Total paid by your plan	Amount you're responsible for
OFFICE VISIT	05/15/06 05/15/06	75.00	12.00 PDC	15.00 C	48.00	100%			48.00	15.00
LAB	05/15/06 05/15/06	89.12	15.36 PDC	50.00 D	23.76	100%			23.76	50.00
X-RAY	05/15/06 05/15/06	100.00	20.00 PDC		80.00	80%	16.00		64.00	16.00
SURGERY	05/15/06 05/15/06	50.00		50.00 575	0	0%			0.00	50.00
Totals		\$314.12	\$47.36	\$115.00	\$151.76		\$16.00		\$135.76	\$131.00
Amount you're responsible for:			\$131.00							
Your 2006 Plan Year Medical Deductible satisfied so far:			\$100.00							
Your 2006 Plan Year Family Medical deductible satisfied so far:			\$300.00							
Amount you're responsible for:			\$131.00							

Message Codes:

PDC AGREEMENT DISCOUNT

575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

Z48 NOTE: WHEN YOU RECEIVE SERVICES FROM A NON-PREFERRED PROVIDER, WE MAY PAY BENEFITS DIRECTLY TO YOU. IF SO, YOU WILL NEED TO MAKE ARRANGEMENTS TO REIMBURSE THE PROVIDER.

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Definitions of terms on your EOB

The numbers on the sample EOB refer to the definitions below.

- 1 **Service/product description**—what you received from your provider.
- 2 **Dates you received service/product**—when you saw your provider (month/day/year to month/day/year).
- 3 **Charges billed by provider**—amount billed to you and your health-care plan(s).
- 4 **Provider's fee adjustment**—difference between "charges billed by provider" and the amount providers have agreed to accept as full payment; see message codes at the bottom of your EOB for details.
- 5 **Your copay, deductible or amount not covered**—"copay" is a set fee you pay a provider at each visit; "deductible" is how much you pay each year before your benefits start; "amount not covered" applies to services/products not covered by your plan; see "Message Codes" at the bottom of your EOB for details.
- 6 **Total amount eligible for benefits**—"charges billed by provider" minus "provider fee adjustment" minus "your copay, deductible or amount not covered."
- 7 **%**—percentage level of benefits for covered services/products.
- 8 **Your coinsurance amount**—what you must pay the provider after we pay the covered percentage.
- 9 **Adjustment**—see explanation(s) at the bottom of your EOB for details.
- 10 **Total paid by your plan**—"total amount eligible for benefits" minus "your coinsurance amount."
- 11 **Amount you're responsible for**—what you must pay of the billed charges after plan benefits are paid.

If you need to file a claim

When a provider doesn't file a claim for you

Network providers process your claims directly with us so you don't have to. However, if you receive care from a non-network provider, you may have to pay the provider for the service and file a claim for reimbursement.

To file a claim:

1. Complete and sign a claim form. If you don't have one, you can print one from our Web site or request one by calling Customer Service at 1-800-722-1471.
2. Attach an itemized bill from the provider for the covered service.
3. Make a copy for your records.
4. Mail your claim to the address shown on the Claim Form.

When you receive your Benefit Booklet, look for more details on filing claims.

If you disagree with how a claim was paid

How to request a review of your claim.

If you have questions or disagree with how your claim was processed as shown on your Explanation of Benefits (EOB), please call Customer Service at 1-800-722-1471. We will do our best to resolve your concerns.

In the event you wish to request a formal review of your claim, you may do so by telephone or by mail. Filing by mail allows you to keep a written

request for your records. If requesting a review by mail, please include a copy of your EOB and any other documentation that may help resolve the claim to your satisfaction.

Please note that we must receive your request to review a claim within 180 days after you receive your EOB.

Send your request to:

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

After we receive your request, we'll send you detailed information about the appeals process, including the time frame for each step of the process.

What to do if you suspect fraud in the processing of your claim

If you feel that payments were made for services you didn't receive, please call the Anti-Fraud Hotline at 1-800-848-0244.

Filing a prescription drug claim

Always present your member ID card at a participating retail pharmacy for direct reimbursement of your prescription drugs. If you need to file a prescription drug claim, refer to your pharmacy packet included in your member packet. Your pharmacy packet contains a prescription drug reimbursement form. Complete all information and carefully follow the instructions on the form. If you have questions, or need additional claim forms, call the customer service number listed on the back of your member ID card or visit www.premiera.com.

Steps towards better health

Five steps to safer medical care*

1. Ask questions if you have doubts or concerns.

Ask questions and make sure you understand the answers. Choose a doctor you feel comfortable talking to.

2. Keep and bring a list of ALL the medicines you take.

Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines. Tell them about any drug allergies you have. Ask about side effects and what to avoid while taking the medicine. Read the label when you get your medicine, including all warnings. Make sure your medicine is what the doctor ordered and know how to use it. Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

Ask your doctor when and how you will get the results of tests or procedures. Call your doctor and ask for your results. Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from. Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

Make sure you, your doctor and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, “Who will manage my care when I am in the hospital?” Ask your surgeon:

- Exactly what will you be doing?
- About how long will it take?
- What will happen after the surgery?
- How can I expect to feel during recovery?

Tell the surgeon, anesthesiologist and nurses about any allergies, bad reaction to anesthesia and any medications you are taking.

*Source: Quality Interagency Coordination Task Force, July 2003

Take Care of Yourself...

...With a FREE Online Personal Health Assessment

to evaluate your lifestyle and health risks. More than 50% of chronic health conditions are preventable and are linked to everyday nutrition, activity and other lifestyle habits. Learn what your risk factors are and how you can take steps to reduce or eliminate those risks. It's fast, easy and free.

- ✓ Get a personal health report by simply answering questions about your lifestyle and medical history.
- ✓ Complete the questionnaire, view and print your results—all on online.
- ✓ Completely confidential; your employer will never see your individual results.

Ask your employer for more information about how to take advantage of the online personal health assessment and Guidance Resource programs. Some Premera Blue Cross plans may not include these programs. Please call 1-800-722-1471, or check with your company's benefit administrator to find out if your plan does.

...With Help When You Need It

GuidanceResources® provides counseling and support to help you cope with everyday stress and unexpected situations. It can help you manage the problems that affect your health, work and family.

- ✓ Unlimited, confidential toll-free telephone support.
- ✓ Referral to helpful community resources.
- ✓ Follow-up with participating members.

Preventive health gu

You can make a difference in your health

Lifestyle choices and health behaviors directly impact your health, well-being and the quality of your life. Positive lifestyle choices include a balanced diet, weight management, stress management and staying physically active. The following preventive care services and immunizations are recommended by the U.S. Preventive Services Task Force. We hope you find these guidelines useful when you schedule appointments with your provider.

Routine physicals/ wellness exams	Recommended schedule
0–18 months	2–7 days of age and at 2, 4, 6, 9, 12 and 15 months of age
2–6 years	Annually
7–18 years	Every 2 years
19–64 years	Every 1–3 years
65+ years	Annually

Regular screenings	Recommended schedule
Blood pressure	Every 1–3 years for adults age 18 and older
Breast cancer screening	Every 1–2 years for women beginning at age 40
Cervical cancer screening	Begin when sexually active, but no later than age 21, every 1–3 years. Routine screening may discontinue: <ul style="list-style-type: none"> • At age 65 if pap results have been normal <i>or</i> • If you have had a hysterectomy for benign disease.
Cholesterol screening	Men—Beginning at age 35, every 1–5 years Women—Beginning at age 45, every 1–5 years
Colon cancer screening	All men and women beginning at age 50. Screening options include: fecal occult blood test, sigmoidoscopy, double-contrast barium enema or colonoscopy. Ask your doctor what is best for you.
Depression screening	All adults
Obesity screening	All adults

Be informed and involved.

- Set a regular schedule for your routine exams and screening tests.
- Work with your provider to decide the best combination of services and activities to meet your lifestyle and health needs.
- Enlist the support of friends, family and colleagues when making lifestyle changes. They can provide help and encouragement.



Recommended immunization schedule

The following vaccines covered by your health plan are listed under the routinely recommended ages. Light blue boxes indicate range of acceptable ages for vaccinations. Darker blue boxes indicate catch-up vaccinations.

Vaccines	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12-15 mos.	15-18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	13-18 yrs.	19-26 yrs.	27-49 yrs.	50+ yrs.
Hepatitis B (Hep B)	✓ 1st shot		✓ 2nd shot			✓ 3rd shot			✓ if missed earlier					
Tetanus/ Diphtheria (Td), Pertussis (DTaP)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot		✓ 4th shot		✓ 5th shot	✓ DTaP	✓ if missed earlier		✓ Td booster every 10 years	
H. influenzae type B (Hib)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot	✓ 4th shot		✓ if missed earlier (18 mos–5 yrs)						
Polio (IPV)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot				✓ 4th shot	✓ if missed earlier				
Pneumonia (PCV or PPV)			✓ 1st shot PCV	✓ 2nd shot PCV	✓ 3rd shot PCV	✓ 4th shot PCV								✓ (PPV)
Measles, Mumps, Rubella (MMR)						✓ 1st shot			✓ 2nd shot	✓ if missed earlier			✓ 1–2 doses	
Varicella¹ (Chicken Pox)						✓ 1st shot		✓ if missed earlier, consult health-care provider						
									✓ 2nd shot					
Influenza (Flu)					✓ yearly during flu season									✓ yearly
Hepatitis A					✓ 2 doses									
Quadrivalent HPV (females only)										✓ 3 doses	✓ if missed earlier			

¹ Varicella vaccine is recommended for all individuals 13 years of age or older that do not have a reliable history of chicken pox.

This schedule is based on recommendations made by the U.S. Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices (ACIP), and is endorsed by Premera Blue Cross. This schedule may change. Check with your health-care provider regarding new recommendations.

Quick reference

www.premera.com

- Search for a physician or other health-care provider in the online Provider Directory
- Order replacement ID cards
- View your claims
- Update personal information and more

Customer Service 1-800-722-1471

TDD: 1-800-842-5357
8 a.m. to 5 p.m. PST weekdays.
Please have your Member ID number handy.

BlueCard® & BlueCard Worldwide®

Nationwide provider locator toll-free number:
1-800-810-2583

Outside the United States, call collect:
804-673-1177

**For a medical emergency—
call 911 or seek help
immediately**

24-hour NurseLine 1-800-841-8343

Talk to a registered nurse for non-emergency health matters.

Available toll-free 24 hours a day, every day.

Medco Pharmacy Locator 1-800-391-9701

Call this toll-free number to find a network pharmacy near you (if applicable).

Please note that this booklet is not a contract. For more information about the full terms and conditions of your health plan, including benefits, limitations and exclusions, please see your Benefit Booklet.

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