Supplemental Information

about Premera Blue Cross Blue Shield of Alaska

Small Group Healthcare Coverage Plans
(2–50 employees)

About this Document...

This document is designed to help you understand the services, features and benefits of Premera small group health plans. Here you will find information about:

- our products and benefits
- our providers and how we pay them
- how to access healthcare
- how we protect your privacy
- our key utilization management procedures
- our pharmaceutical management procedures
- how to share your comments and complaints
- our commitment to quality

We make every effort to ensure that this information is correct. However, because health plans vary, you may find differences between this information and how you understand your plan. If so, please talk to your Premera producer. If you are already a member, see your contract for the most accurate information.

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PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Our Product Offerings

Our menu of benefit plans gives you the flexibility to choose the coverage and the price that meet your needs. You'll find that each plan offers great coverage, available in a choice of benefit levels.

Preferred Provider Organization Plans

Preferred Provider Organization (PPO) plans give you lots of choices and make it easy to see doctors. Your plan pays a set percentage of the allowed amount for covered services after you pay the annual deductible. On a PPO plan, you pay less if you see in-network hospitals for covered services that are medically necessary. You can also choose an out-of-network hospital, but you'll pay more.

Our Provider Directory

You can use our Provider Directory online at **premera.com** or call Customer Service. Customer Service phone numbers are listed at the end of this document.

Our Prescription Drug Plans

Premera small group plans offer prescription drug or pharmacy benefits utilizing a formulary. Your formulary is shown on your ID card. Members can find out how much their plan covers for different medications using the list on our website. All drugs on the Formulary Drug List are approved by the Food and Drug Administration (FDA). These drugs are just as effective as drugs that are not on the list, but are usually less expensive.

The Premera Pharmacy and Therapeutics Committee reviews and updates the Formulary Drug Lists regularly. This committee is made up of doctors, pharmacists, and other providers from the community. The committee uses current medical studies and information to choose safe and effective drugs. They add new FDA-approved drugs to the list, and remove drugs they find to be less effective than new ones. If the committee finds that two or more drugs have the same effectiveness, they put the most cost-effective one on the list.

Certain plans will only cover prescription drugs that are in the formulary. Refer to your plan benefit booklet to see if your plan limits drugs to those in the formulary. There is an exception process where you or your provider may request a drug not in the formulary. You can access this exception process by contacting Customer Service or checking **premera.com.**

Premera makes the Formulary Drug Lists available to all of our in-network providers. We strongly encourage them to use it when prescribing drugs. Depending upon your plan, you may be limited to the drugs in the formulary. Refer to your plan benefit booklet for coverage details.

If you are a member and want to find out if this program covers you, please check your plan benefit booklet or contact our Customer Service department.

Generic Drugs

Some Premera small group plans offer coverage for generic drugs only. According to Consumer Reports magazine, "Generics are every bit as pure, potent, and safe as brands."[1] Because the FDA regulates generic drugs just as it does brand-name drugs, you can be sure that generic drugs offer the same level of quality, strength, effectiveness and purity as their brand-name equivalents. By law, a generic drug must have the same active ingredients as the brand-name version.

There are two kinds of generic drugs you might use: a generic equivalent and a generic alternative:

- A generic equivalent has the same active ingredients, strength and dosage form (pill, capsule, liquid) as the brand-name drug.
- A generic alternative has different active ingredients than the brand-name drug but has a similar effect.

Why do generic drugs cost less than brand-name drugs? Generic drugs don't have the research, development and marketing expenses that brand-name drugs have. Buying generic drugs can save you money because they offer you the lowest cost share as a Tier 1 drug.[2] The average Premera member can save about $192 a year by using a generic drug instead of a brand-name drug. Your plan may also cover certain generic preventive drugs in full.

Talk with your doctor to see if a generic drug is right for you.

Pharmaceutical Prior Authorization

Premera needs to approve some drugs before you can fill your prescription. These drugs are part of our Prior Authorization Program (formerly called Point of Sale). Drugs for migraines, diabetes, high blood pressure, asthma, and certain other health problems need prior authorization. See if your medicine is on our *prior authorization drug list* before going to your pharmacy.

Use our online *Rx Search* tool to see if your drug needs prior authorization.

1. Go to the Rx Search tool on our website
2. Choose formulary name as shown on your ID card.

[1] Consumer Reports Best Buy Drugs. "Shopper's Guide to Prescription Drugs—Number 2. Generic Drugs."Consumers Union. 2006. **http://www.consumerreports.org/health/resources/pdf/best-buy-drugs/money-saving-guides/english/GenericDrugs-FINAL.pdf**

[2] Your plan classifies a drug as truly generic if a generic product is available at a lower cost than the brand-name version. Sometimes, the pharmacy will label a product with a similar cost to a brand-name product as "generic." The plan does not classify this as a true generic drug. You may still have a higher cost share for that product.

3. Follow the directions to search for your drug.
4. Choose the drug that you want information on.
5. Click on the "PA" symbol. A text box will appear that tells about the Prior Authorization criteria for that drug.

For more information on our prior authorization drug list, click p*rior authorization drug list* or go to **premera.com**.

How We Pay Providers

Premera pays health care providers in three different ways, depending on the type of service provided.

Fee-for-Service

Premera uses a fee-for-service payment method for many types of health care providers. With this method, Premera pays a set amount for a service. This amount may be based on a fee schedule, a percentage of a fee schedule, a percentage of the typical provider charges, or other method. In setting our allowed amounts, we compare costs in the same general location. We also look at how complex the services are.

Providers contracted with us agree to accept this amount as full payment. You will not have to pay anything other than costs such as your deductible, coinsurance or copayment. Providers who are not contracted with us are not required to accept our amounts, and may bill you for anything not paid by us.

Fixed Rate

We use fixed rate pricing for facility costs, such as costs for procedures and services in a hospital. We pay providers a fixed rate for each procedure or service, which helps to control medical costs.

Per Diem

Premera pays a hospital or other healthcare facility a set amount for each day a member spends there.

Diagnostic Related Group

Inpatient services are paid based on a specific medical condition or part of the body being treated.

Self-Referral

Premera members can go to any licensed provider for most medically necessary services that we cover. Remember that you will usually pay less when you use an in-network provider.

Prior Authorization

Certain medical procedures, services and supplies may require approval by Premera before you can receive them. This is called "prior authorization." If you do not receive approval before receiving these services, you will be liable for the full cost of the service.

Refer to your plan benefit booklet for details regarding prior authorization.

The types of services that may require prior authorization include:

- Inpatient admissions to health care facilities, including hospitals, skilled nursing facilities, hospices and rehabilitation facilities
- Non-emergency ambulance transportation
- Transplants
- Certain outpatient surgeries and medical procedures
- Home medical equipment, prosthetics and orthotic purchases of $500 or more
- Certain injectable drugs

You can get a detailed list of procedures, services and supplies that require prior authorization on our web page at **premera.com**.

Utilization Management

Utilization Management is what we call things we do to make sure medical resources get used in the best way. Here are some examples.

Prospective Review. Premera reviews some medical services before you receive them to make sure they are medically necessary. This is called "Prospective Review." Premera gives your provider a list of these services to check before providing the services to you. A list of the services that require this type of review is available at: *Clinical Review Code List*

Concurrent Review. Premera reviews some medical services while you are getting them. This is called "Concurrent Review."

Retrospective Review. Premera reviews some medical services after you get them. This is called "Retrospective Review."

We tell you about our decisions. Premera tells you and your healthcare provider if we do not approve a medical service.

You can appeal the decisions we make. You or your provider may appeal any decision Premera makes about your care. This applies whether we deny a request for a medical service before you receive it or after you receive it. Your doctor may discuss your case with a Premera Medical Director. If necessary, we may refer your appeal to an independent doctor or specialist.

We manage the use of prescription drugs. Premera works with Express Scripts to manage your prescriptions. We use advice from independent community doctors and pharmacists to help us set our policies for members. These policies include quantity limits, dollar amount limits, and prior authorization criteria.

Through utilization management, Premera reviews the following types of care:

- Preventive care and symptom-based care
- Specialty care
- Referrals
- Urgent care, emergency care, and hospital care
- Out-of-area coverage
- 24-Hour NurseLine
- Use of in-network and out-of-network providers

To find out how to better use your benefits, visit **premera.com**.

Medical Exclusions and Limitations

Benefit plans typically have exclusions and limitations—what the plans do not cover. The following are general exclusions and limitations for the Premera benefit plans:

What is not covered

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:

- Assisted Reproduction
- Cosmetic or reconstructive surgery (except as specifically provided)
- Dental services (except as specifically provided)
- Experimental or investigative services
- Hearing examinations or hardware (unless included in plan purchased by the group)
- Learning disorders (except as specifically provided)
- Obesity/morbid obesity surgery and pharmaceuticals
- Orthognathic surgery (except when repairing a dependent child's congenital abnormality)
- Over-the-counter or nonprescription drugs, except as specifically provided
- Services in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal
- Temporomandibular joint (TMJ) disorder

Services that are not "medically necessary" are not covered. We consider a service to be medically necessary for covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

The fact that a doctor or other qualified provider gave, prescribed, or approved a service does not, in itself, mean that the service was medically necessary.

Our Utilization Management rules and your eligibility can also affect benefits, and some benefits have their own specific limitations.

Please note that this is a general summary only. Your health plan contract will determine the actual terms, conditions, and exclusions of your coverage. For a complete list of medical exclusions and limitations visit ***premera.com****.*

Our Confidentiality Policies

At Premera, we have policies for handling your personal information. These policies cover how we may use your information and how we protect your privacy.

We may collect, use or release certain information about you. This Protected Personal Information (PPI) may include health information and other personal information such as your address, telephone number or Social Security Number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources. We collect, use or release this information when we conduct routine business operations such as these:

- underwriting and determining your eligibility for benefits
- paying claims
- coordinating benefits with other healthcare plans
- conducting utilization management, case management or quality reviews
- fulfilling other legal obligations described in your group contract

We may also collect, use or release this information for other purposes as required or allowed by law. When we do this, we make sure that your information stays private by following our confidentiality policy and procedures. If a release of PPI does not relate to a routine business function, we remove anything that could easily identify you, or we get your permission in writing.

For details of our Privacy Policy, go to *Privacy Policy* at **premera.com**.

Our Appeals Process

Our members have the right to offer ideas, ask questions, make complaints and submit appeals. Our goal is to listen, resolve your problems and improve our service to you. We recommend that you take advantage of our grievance process when you are not happy with a decision about services, benefits, or coverage.

Call Customer Service when you have a complaint or appeal

Customer Service can quickly correct errors, explain decisions or benefits, or take steps to improve our service. If Customer Service finds that you need to submit your complaint as a formal appeal, they will explain how to do that.

When we receive your appeal, we will send you details about the appeals. Then we begin our internal appeals process.

Independent Review

If you are not satisfied with the result of your appeal, you can ask for an independent outside review. Independent reviews are done by an independent review organization, or IRO.

An IRO is a team of outside medical experts qualified to review your appeal. Premera only uses IROs that are certified by the state Department of Health. If you ask for an independent review, we will send your file to the IRO for you. We also pay for the review. The IRO will send you its decision in writing, and we act on that decision right away.

Your member benefit booklet describes the complaints and appeals process in detail, including Independent Review. For more details on our Grievance Process and contact information, click on *Member Complaint and Appeal Rights* or visit **premera.com**.

Please note that this is not a contract. Your contract determines the complete terms of your coverage. If you would like a sample contract, please contact your Premera representative.

The National Committee for Quality Assurance has awarded an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement.

Premera Blue Cross Blue Shield of Alaska

P.O. Box 327
Seattle, WA 98111-0327

Customer Service

800-508-4722
TDD/TTY: 800-842-5357

premera.com

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