

Supplemental Information

about Premera Blue Cross

Individual Health Care Coverage Plans

About This Brochure...

This brochure is designed to inform and assist you in understanding the services, features and benefits of Premera Blue Cross health plans. Enclosed you will find information about:

- our products and benefits
- our providers and how we pay them
- how to access care, including specialty care
- additional information available to members
- confidentiality policies
- how to share your comments and complaints
- our commitment to quality

We have made every effort to ensure the accuracy of this brochure. However, as plans vary, you may find differences between how you understand your plan and this brochure. If so, please talk to your broker, agent or Premera Blue Cross representative. If you are a member, refer to your benefit booklet for more detailed information.

Our Product Offerings

Our health plans are offered through Premera Blue Cross—throughout Washington State, excluding Clark County.

We offer the following type of plan:

Preferred Provider Organization

Preferred Provider Organization (PPO) plans provide you with significant choice and access to doctors. You may select providers from our Heritage provider network. Coverage is based on a percentage of allowed medical expenses after an annual deductible is satisfied. To receive the highest level of benefits on a PPO plan, you should seek care for medically necessary covered services from Heritage network providers. However, you may choose to use non-network providers, at a lower benefit level in most cases.

Our Prescription Drug Plans— The Preferred Drug List

Certain Premera Blue Cross individual plans offers a 3-Tier Pharmacy Benefit that provides choice and helps manage costs. This benefit program utilizes a Preferred Drug List that contains the generic and brand-name drugs we recommend to prescribing providers.

If you are a member under the 3-Tier Pharmacy Benefit, you pay the lowest out-of-pocket amount when you request generic equivalents to brand-name medications. If you request a preferred brand-name

drug when a lower-cost generic equivalent is available, you pay a higher amount plus the cost difference between the two. (Your pharmacist will inform you if you are required to pay anything above your regular cost share.) However, if your doctor or practitioner requires that you use a preferred brand-name drug for medical reasons, you will only be required to pay the applicable cost share.

All drugs on the Preferred Drug List are FDA-approved, and the list is regularly reviewed and updated by a committee of providers and pharmacists. Drugs on the Preferred Drug List are as effective as non-preferred drugs, but are generally less expensive.

The Premera Blue Cross Pharmacy and Therapeutics Committee makes decisions about which brand-name drugs are preferred and non-preferred. This group includes doctors, practitioners and pharmacists from the community. This group uses current medical studies and facts to choose safe and effective drugs for the Preferred Drug List.

The Preferred Drug List is reviewed and updated regularly with the addition of the latest FDA-approved drugs, and the removal of those that are considered less effective than the new ones. If two or more prescription drugs are found to have the same level of effectiveness, then the one that is most cost-effective is selected for the Preferred Drug List.

Premera Blue Cross provides our network doctors and practitioners with a copy of the Preferred Drug List and encourages its use when prescribing. But coverage for your prescriptions is not limited to the drugs on the list. Non-preferred drugs are also covered at a higher out-of-pocket expense. Drugs may be non-preferred for a variety of reasons:

- there are generic equivalents available
- there are preferred brand-name alternatives available at a lower cost
- the Pharmacy and Therapeutics Committee has concerns about their side-effect risks and effectiveness.

The Preferred Drug List applies only to members who have the 3-Tier Pharmacy Benefit. If you are a member and would like to find out whether you are covered under this program, please check your contract or call the Customer Service number listed on the back of this brochure.

The Preferred Drug List is available at **www.premera.com** for your convenience. Additionally, a printed version of the Preferred Drug List is available by calling Customer Service.

Benefit Exclusions

Benefit plans typically have exclusions—what the plans do not cover. The following are general exclusions that apply to most of our plans. Your specific individual plan may have other benefit exclusions.

What is not covered:

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

- Chemical dependency
- Cosmetic services (except as specifically provided)
- Dental care (except as specifically provided)
- Experimental or investigative services and drugs
- Hearing examinations or hardware
- Infertility
- Mental or psychiatric conditions
- Obesity services
- Orthodontia
- Orthognathic surgery
- Over-the-counter or non-prescription drugs
- Personal comfort or convenience items
- Routine foot care
- Services in excess of specified benefit maximums
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal

Services that are not “medically necessary” are not covered. Medically necessary services are those services, drugs, and supplies which we determine to meet all of the following requirements. They are:

- essential to and consistent with the establishment of a diagnosis or the direct care and treatment of an illness, accidental injury, or condition harmful or threatening to the member’s life or health, unless provided for preventive services
- appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature

- effective treatment for the medical condition as demonstrated by:
 - sufficient evidence exists to draw conclusions about the effect of the health intervention on health outcomes
 - 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 its expected harmful effects
- the least costly available level of service, supply, or setting which can be safely and appropriately provided for the member
- not primarily for research or data accumulation
- not primarily for the convenience of the member, the member’s family, the member’s physician, or another provider.

The fact that services were furnished, prescribed or approved by a physician or other qualified provider does not in itself mean that services were medically necessary.

Our Care Management provisions and your eligibility can also affect benefits. In addition, some benefits have their own specific limitations.

Please note that this is a general summary. Your individual health plan contract will set out the actual terms, conditions and exclusions of coverage.

Our Provider Directories

An online Provider Directory is available at **www.premera.com** for your convenience. Additionally, a printed Provider Directory is available by calling Customer Service at the number listed on the back of this brochure.

How We Pay Providers

Premera Blue Cross uses several methods of paying health care providers, depending on the plan:

Fee-for-Service

Premera Blue Cross pays the full bill or an agreed amount. For example, a provider may charge \$100 for an office visit, but Premera Blue Cross negotiates with the provider to accept \$80 per visit. Because Premera Blue Cross has the potential to bring many patients to a provider, the provider agrees to lower his or her usual fee. Premera Blue Cross also sets a maximum amount it will pay by comparing services and supplies for professional services, with one or more of the following factors: complexity of the service; degree of provider liability; use of the provider's resources; health plan data. These payment methods apply to hospitals, skilled nursing services, primary care providers and specialists.

Per case rate

Providers receive a fixed-rate payment for each procedure or service, which helps to maintain medical costs. This payment method usually applies to facility costs, such as those for hospitals.

Per Diem

Providers are paid a fixed rate for each day an enrollee or member is hospitalized or in another type of institution.

Referral Information

Individual plan enrollees do not need to obtain a referral in order to receive benefits. Remember that you typically realize the highest benefits available under those plans when you seek care from a provider within your plan's network.

Benefits Advisories and Notification

Whenever a member needs hospitalization or surgery, we encourage the member's doctor or hospital to contact us first. Each request triggers a review by our care management staff to verify eligibility, benefits and medical necessity on selected procedures. Through this clinical review, we can confirm coverage prior to treatment to provide our members with greater peace of mind. If a benefit advisory is not requested in advance, we conduct a clinical review upon billing to determine medical necessity and to ensure that medical costs are applied to the appropriate benefit.

Additional Information—

Documents Referenced in Subscriber Contract

If you are a member and you are interested in receiving any of the documents, instruments or other infor-

mation that is referenced in the member benefit booklet, please call Customer Service at 1-800-722-1471.

Additional Information— Annual Accounting

Members on our plans may receive an annual accounting of all payments made by Premera Blue Cross that have been counted against any payment limitations, visit limitations, or other overall limitations. If you are a member and would like to request annual accounting information, please call Customer Service for instructions on how to do so.

Our Confidentiality Policies

At Premera Blue Cross, we have policies regarding your health information—how we may use it and how we protect your confidentiality.

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security Number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- underwriting and determining your eligibility for benefits and paying claims
- coordinating benefits with other health care plans
- conducting care management, case management or quality reviews
- fulfilling other legal obligations that are specified under the group contract or individual contract.

This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and procedures.

If a disclosure of PPI is not related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

Our Grievance Process

Our members have the right to offer ideas, ask questions, voice complaints, and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

Complaints

A complaint is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but do not require, that you take advantage of this process when you are not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, they will tell you.

Appeals

An appeal is an oral or written request that we reconsider:

- 1) our decision on a complaint, or
- 2) our decision to deny, modify, reduce, or end payment, coverage, or authorization of coverage. This includes admissions to, and continued stays in, a facility.

When we receive your appeal, we will provide to you detailed information about the appeals process, including the timeframes for each step of the process.

If you are not satisfied with the outcome of our internal appeals process, you may ask for an independent review.

Independent Review

Independent reviews are conducted by an independent review organization (IRO), which consists of a team of outside medical experts qualified to review your appeal. We will use an IRO that has been certified by the state's Department of Health. We will submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We will implement the IRO's determination promptly.

The complaints and appeals process, including Independent Review, is described in detail in the Contract.

Our Accreditation Status and Performance

Our goal at Premera Blue Cross is to set the standard of excellence in the communities we serve. For many years, Premera was accredited by the National Committee for Quality Assurance (NCQA). An "Excellent"

accreditation status was achieved for our managed care products in recent years.

We attribute our success in meeting NCQA's rigorous standards to:

- excellent care provided by our contracted practitioners and providers
- high standards of our company
- strength of our clinical programs

Effective 4/30/03, Premera's NCQA accreditation expired. The decision not to seek reaccreditation after 4/30/03 was made after careful analysis and consideration. Premera Blue Cross is committed to continuing to meet NCQA Standards as required by public products and valued by many purchasers of health care coverage. Premera will continue to measure and report results from the Health Employer Data Information Set (HEDIS).

Please note that this is not a contract. The complete terms of coverage are determined by the contract for your individual health plan. If you would like a sample contract, please contact your broker, agent or Premera Blue Cross representative.

Premera Blue Cross

Members call: 1-800-722-1471

TDD 1-800-842-5357

Others call: 1-800-PLAN ONE

P.O. Box 327

Seattle, WA 98111-0327

www.premera.com