
DISCLOSURE STATEMENT

Health Care Patient Bill of Rights

Senate Bill 6199 (also known as the Health Care Patient Bill of Rights) was passed by the 2000 Washington State Legislature to assure that patients and providers are fully informed about the benefits and policies of their health insurance plans.

As a means of informing our members, Regence BlueCross BlueShield of Oregon has put together this Q & A outlining many of the terms and conditions of our plan.

Please note: As you read this information, keep in mind that the references to “you” refer to both you and your enrolled dependents (if applicable), unless specifically noted otherwise.

How can I get a list of Preferred and Participating Physicians and Specialists?

Call Customer Service at 1 (800) 777-3168 to request any provider directories. For the most up-to-date provider information, visit our Web site at www.or.regence.com.

How will I know if my benefits change or are terminated?

If you have an individual policy, we will send you notification of any benefit change(s) through the mail. In addition, you can always contact Customer Service and ask a representative about your current benefits.

What is the agent/broker compensation on my plan?

For a description of agent/broker compensation, please visit www.or.regence.com, or contact Customer Service at 1 (800) 777-3168.

How can I find out what my copayments and/or coinsurance responsibilities are for my health benefits plan?

Refer to your benefit summary, your contract or benefits booklet that outlines your health benefits. Customer Service is also available to answer your benefit questions. They may be reached Monday through Friday from 7:30 am to 6 p.m. by calling 1 (800) 777-3168.

What are your Prior Authorization criteria?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact Customer Service at the phone number on the back of your identification card, or ask your physician or medical provider for a list of services that need to be preauthorized. Many types of treatment may be available for certain conditions. The preauthorization process helps your provider work together with you, other providers, and us to determine the treatment that best meets your medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, preauthorization is your assurance that your medical services won't be denied because they don't meet the contract definition of "medical necessity."

What does the term "medical necessity" mean?

Medical necessity means those services and supplies required for the diagnosis or treatment of an illness or injury and which, in our judgment, are:

- Appropriate by treatment setting and level of care in amount, duration, and frequency of care and consistent with the symptoms or diagnosis and treatment of your or your enrolled dependent's condition;
- Appropriate with regard to widely accepted standards of good medical practice;
- Not primarily for the convenience of you or your enrolled dependent or a provider of services or supplies; and
- The least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to a patient.

This means, for example, that care rendered in a hospital inpatient setting or by a nurse in the patient's home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.

With respect to treatment of chemical dependency, medical necessity means the level of care indicated in the most current version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

Please note: The fact that a professional provider furnished, prescribed, ordered, recommended, or approved a service or supply does not, in itself, make the service or supply medically necessary. We will determine whether the services are necessary. We will consult with professional consultants, peer review committees, or other appropriate sources for recommendations regarding the necessity of the services or supplies received by enrollees.

What is Provider Risk-Sharing?

Your plan includes certain risk-sharing arrangements with providers. A risk-sharing arrangement is one in which the physician, physician organization, or hospital that is responsible for delivering health care services bears some financial risk or reward for the services they deliver. An example of a risk-sharing arrangement is a contract between an insurer and a group of heart surgeons in which the surgeons agree to provide all of the heart operations needed by plan members and the insurer agrees to pay a fixed monthly amount for those services.

For additional information about our risk-sharing arrangements, contact Customer Service.

How are important documents (such as my medical records) kept confidential?

Regence BlueCross BlueShield of Oregon has a written policy to protect the confidentiality of health information. Only employees who have a need to know in order to do their jobs may access enrollee personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Washington law requires insurers to obtain a written authorization from the enrollee or his or her representative before disclosing person information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

If I am not satisfied with my health plan or practitioner/provider, what can I do to voice a complaint or appeal my issue?

At any time, you may receive assistance filing your grievance. You also have the right to name someone you trust to file and appeal for you. However, you must give your permission in writing.

There are three steps to our grievance and appeal process. The first level of review is filing a grievance. You may file your grievance by writing us a letter, filing out a grievance form, or by contacting Customer Service to provide your information over the phone. We'll send you an acknowledgement letter outlining your issues, as well as advising you of your rights. Within 30 days, you'll receive a response from our grievance coordinator.

After the initial grievance review, you have the right to file and appeal verbally or in writing within 180 days of our decision. Your issue will be reviewed by someone not previously involved in your case. For clinical issues, a practitioner that specializes in your medical condition or procedure will be involved in the review or your appeal. A panel of representatives will evaluate your case and your appeal coordinator will notify you of the outcome in writing within 30 days, or less.

The third and final level of appeal may be filed verbally or in writing within 180 days of our decision. You have the right to an independent review of final decisions made by us. The appeal will be conducted by an independent review organization (IRO). An IRO is not connected in any way with Regence BlueCross BlueShield of Oregon and you are not responsible for the costs of the independent review. A written response to your appeal will be sent to you within 20 days. If you are not sure whether your appeal is eligible or you want more information, please contact Customer Service a 1 (800) 777-3168.

If your or your representative believes that a decision denying preauthorization or a referral for a service will jeopardize your life, health or ability to regain maximum function, you or your representative may request an expedited appeal. You can do this by contacting Customer Service and requesting an expedited review of your case. A decision will be made with 72 hours or less.

You also have the right to file a complaint and seek assistance from the Office of the Insurance Commissioner. You can write to the Insurance Commissioner at:

Office of the Insurance Commissioner

ATTN: Consumer Advocacy
P.O. Box 40256
Olympia, WA 98504-0256

Or call: 1 (800) 562-6900 (toll-free in WA only) (360) 407-0409 (TDD)
Or visit their Web site at www.insurance.wa.gov

How can I participate in the development of your corporate policies and practices?

Your feedback is very important to us. If you have suggestions for improvements about your plan or our services, we would like to hear from you.

We've formed several advisory committees – the Member Advisory Committee for enrollees, the Marketing Advisory Panel for employers, and the Provider Advisory Committee for health care professionals – to allow participation in the development of corporate policies and to provide feedback. If you would like to become a member of any of the advisory committees, send your name, identification number, address, and phone number to the Vice President of Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon
ATT: Vice President, Customer Services C7A
P. O. Box 1271
Portland, OR 97207-1271

Or send your comments to us over the internet at: www.or.regence.com.

Please note that the size of the committees may not allow us to include all those who indicate an interest in participating.

What additional information can I get from you upon request?

The following documents are available by calling Customer Service:

- Rules related to our drug formulary, including information on whether a particular medication is included or excluded from the formulary.
- A description of our risk-sharing arrangement with physicians and other providers consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services.
- Information about our prior authorization procedures.
- A list of covered benefits, including prescription medication benefits.
- A list of the limitations and exclusions of your contract.
- A statement of premium costs and cost-sharing requirements.
- A more detailed notice regarding information practices is available upon request.

Prescription medication plan information. 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 rights to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us at 1 (800) 452-7390.

If you would like to know more about your rights under the law, or if you think anything you received from this plan, may not conform to the terms of your contract, you may contact the Washington State Offices of Insurance Commissioner at 1 (800) 562-6900. If you have a concern about the pharmacists or pharmacies service you, please call the State Department of Health at (360) 236-4825.

Does my prescription plan limit or exclude certain medications that my health care provider may prescribe, or encourage substitutions for some medications?

Coverage for medications is described in your contract. As described, certain medications that your health care provider may prescribe are excluded or have limited coverage. Some examples of exclusions or limitations are:

- Compounded medications
- Medications used for cosmetic purposes
- Coverage for brand name medications when a generically equivalent medication is available
- Some medications may require preauthorization
- Medications with maximum quantity or dose limits
- Medications dispensed by non-participating pharmacies.

What is the process for developing coverage standards, formularies and preferred medications?

Information from practicing physicians and pharmacist, established national treatment guidelines, widely accepted medical literature and cost are all used to determine which medications will be included on the Preferred Medication List (PML). Medications which are recognized as a first choice or first step are included on the PML. Sometimes scientific information demonstrates that two or more products have similar effectiveness. When these choices exist, the medication products which are the best value are available on the PML for the preferred copayment. Physicians and pharmacists at Regence BlueCross BlueShield of Oregon make the final decisions for the medication products included on the PML. Please visit our Web site at www.or.regence.com for the most current PML.

What are preauthorization requirements or quantity or dose limits?

Certain medications may need to be preauthorized. This means we will need to review information from your physician before the medication is covered. For a list of medications which need to be preauthorized, please visit our Web site at www.or.regence.com or contact our Customer Service department at the telephone number listed on the back of your medical identification card.

Medications may require preauthorization if:

- The medication is not a first step in therapy or is a secondary choice.
- The medication is part of a group of medications that have been clinically proven to work very similarly, but differ considerably in cost.
- The medication is prone to use which is longer in duration or in doses/quantities that are higher than recommended.

What does the term “medical necessity” mean?

Coverage for medications which require preauthorization is based on medical necessity and any applicable terms of your benefit plan. Medical necessity means the medication is required for the diagnosis or treatment of an illness or injury and in the judgment of Regence BlueCross BlueShield of Oregon is:

- In an amount, duration, and frequency that is consistent with the symptoms or diagnosis and treatment of your condition.
- Appropriate with regard to widely accepted standards of good medical practice.
- Not primarily for convenience.
- The least costly, safe alternative.

What are the coverage standards for substitute medications (generic, therapeutic)?

Your contract and/or benefit summary describes your coverage, copayments/coinsurance for generic, brand name, preferred, and non-preferred medications.

Generic medications are medications that are equivalent to the brand name version, are marketed and sold by more than one source, and are listed in widely accepted references as a generic product. The US Food and Drug Administration (FDA) makes sure that the generic product is equivalent to the brand name version. The FDA ensures that the generic product:

- Has the same active ingredients found in the brand name version.
- Meets the same manufacturing and testing standards as the brand name version.
- Has the same amount of active ingredients absorbed into the bloodstream over the same amount of time as the brand name version.

Under most benefit plans, if a generic equivalent is available,, but you obtain the brand name version, you will be responsible for paying the difference between the price of the generic medication and the price of the brand name medication in addition to the applicable copayment.

When can my plan change the approved medication list?

Changes to the medication list will be made annually. An annual notification will be sent to members, agents, employee benefits administrators, physicians and pharmacist.

If my health plan makes a changes to the approved medication list, will I have to pay more to use a prescription medication I'm already taking?

Yes, if you continue taking the same prescription medication. Member copayments are driven by the benefit you and/or your employer selected. Medications that were removed from the PML are either now available generically or have one or more less costly alternatives available. We suggest you review the PML with your physician or other medical provider to determine if another medication would be appropriate for you.

What should I do if I want a change from the limitations, exclusions, substitutions or cost increases for medications specified in this plan?

If you receive your health care benefits through your employer group, contact your employee benefits administrator to discuss other coverage options.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

Yes. There are 914 participating pharmacies in Washington. For the most current listing of participating pharmacies, please visit our Web site at www.or.regence.com

How many days supply of most medications can I get without paying another copayment?

According to the benefits of our prescription plans, members are allowed to purchase up to a 34-day supply of a medication for one copayment. Our group only plans allow for a vacation supply one time per year. You or your pharmacist will need to call us for authorization for up to a 3-month supply of a medication for a vacation. You would be required to pay one copayment for each month's supply of the medication.

What other pharmacy services does my health plan cover?

Your health plan may cover any of the following services or supplies. However, please refer to your benefits booklet for a list of the covered benefits of your plan.

- Oral contraceptives
- Smoking cessation
- Diabetic supplies*
- Weight loss

Please note: Cosmetic medications and over-the-counter medications are not covered.

* Outpatient diabetic instruction is a medical benefit of your plan, and is not considered a pharmacy service.

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 IT CAREFULLY.

We, at Regence BlueCross BlueShield Insurance Company, know **you** value **your** privacy. That is why **we** are committed to the confidentiality and security of **your** personal information. **We** maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of **your** personal information.

We collect personal information, such as **your** name, contact information, and health information, from **you**, **your** health care providers, and other insurers that provide **you** coverage. **We** are required by law to maintain the privacy of this protected health information and to explain **our** legal duties and privacy practices. **We** provide the protections and apply the practices described in this notice to all personal information that **we** maintain, including to personal information of former members who are no longer covered by **us**. **We** hope this notice will clarify **our** responsibilities to **you** and give **you** an understanding of **your** rights. **We** abide by the notice that is currently in effect. This notice is in effect as of April 1, 2006.

Your Rights

Inspection and Copies

You have the right to request an inspection or copies of protected health information that **we** maintain about **you** in a “**designated record set**” except psychotherapy notes and information that **we** compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A “**designated record set**” is a group of records that is used to administer **your** health benefits, including enrollment information and claims. **We** may limit the information that **you** can inspect or copy if **we** have reason to believe that is necessary to protect **you** or another person from harm. If **we** limit **your** right to inspect or copy, **you** can ask for a review of that decision.

Amendment

If **you** believe that protected health information **we** maintain about **you** in a designated record set is inaccurate or incomplete, **you** have the right to request an amendment to correct or complete the information. **You** must submit **your** request in writing and explain the reason for the amendment. If the amendment is made, **we** will make reasonable efforts to inform others, including people **you** identify, that the information has been amended and **we** will use **our** best efforts to include the amendment with any future disclosure. **We** may decline to amend information under certain circumstances. This is likely to occur if **we** did not create the original record. If **we** decline to amend the information, **you** have the

right to submit a statement of disagreement. **You** should know that **we** are allowed to attach a rebuttal statement in response to **your** statement of disagreement.

Notice

You have the right to receive a paper copy of this notice upon request.

Accounting

You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to **us**). **We** will supply this list free of charge once a year at **your** request. If **you** request an accounting more than once in a 12-month period, **we** may charge a reasonable fee.

Special Handling

You have the right to request restrictions on **our** use or disclosure of protected health information in addition to the restrictions imposed by law. **We** are not required to agree to **your** request and **we** may be unable to do so. If **we** do agree, **we** will comply with **your** request except in the case of emergency. **You** also have the right to request that **we** communicate with **you** in confidence. **We** will make every effort to accommodate **your** request if it is reasonable and **you** provide an alternate means to communicate. **You** should know that redirecting communication may not prevent others on **your** policy from discovering that **you** sought medical care. Accumulated deductibles and co-payment information may reveal that **you** obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

Complaints

You have the right to submit a complaint if **you** believe **we** have violated **your** privacy rights. To submit a complaint, write to: The Regence Group, Privacy Office, P.O. Box 1271, Mail Stop E12B, Portland, OR 97207 or call **our** Customer Service department at the phone number provided at the end of this notice. **You** also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that **we** will not retaliate against **you** for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, **we** collect, use and disclose protected health information for a variety of purposes:

Treatment

We may disclose protected health information to a health care provider in order for the provider to treat **you**. **We** may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

Payment

We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying **your** claims.

Health Care Operations

We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

Business Associates

Occasionally, **we** contract with business associates to perform insurance-related functions on **our** behalf. **We** may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on **our** behalf. **We** contractually obligate **our** business associates to provide the same privacy protections that **we** provide.

Plan Sponsors and Group Health Plans

If **you** are enrolled in a group health plan, **we** may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, **we** supply enrollment lists so that premiums can be paid appropriately.

As Permitted or Required by Law

We use or disclose protected health information as permitted or required by law. For example, some laws require that **we** disclose protected health information to **your** personal representatives or to certain government agencies.

Public Health Activities

We may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers' compensation benefits.

Health Oversight

We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

Health Related Service

We may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to **you**. This may include enhancements to **your** health plan and health related products or services available only to health plan members that add value to, but are not a part of, **your** benefit plan.

Legal Proceedings

We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement

We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. **We** also may disclose protected health information for the purpose of reporting a crime on **our** premises.

Military and National Security

We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution

If **you** are an inmate, **we** may disclose protected health information to **your** correctional institution for treatment purposes or to ensure the safety of **yourself** and others.

Marketing

We do not use or disclose protected health information for marketing purposes without **your** authorization. However, **we** may communicate with **you** face-to-face about products or services that may interest **you** or **we** may send **you** a promotional gift of nominal value.

Others Involved in Your Health Care

We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if **you** give **us** verbal permission or if **your** permission can be implied (for example, while **you** are unconscious during an emergency), **we** may disclose protected health

information to family members or others who call on **your** behalf. This permission is valid only for a limited time. If **you** want to authorize on-going disclosures to family members or friends, **you** must submit written authorization.

Authorizations

You may give **us** written authorization to use protected health information or disclose protected health information about **yourself** to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or **you** revoke it. **You** may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for **us** to use or disclose **your** protected health information for purposes other than those described in this notice.

Future Changes

We reserve the right to change **our** privacy practices and this notice at any time without advance notice. If **we** make a material change to **our** privacy practices, **we** will send a new, updated notice. The new notice will apply to all protected health information in **our** possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach **us** during regular business hours by calling **our** Customer Service department at (800) 458-3523. For more information about this notice or to file a written privacy-related complaint, **you** may write to: Privacy Official, The Regence Group, P.O. Box 1271, MS E12B, Portland, OR 97207.