

Disclosure Documents for Washington Traditional/PPO

Date

name
address
city,state,zip

Re: group-id

Dear salutation:

Thank you for your recent request for the information available to you as stipulated in the Washington Patient Bill of Rights disclosure statement.

Enclosed you will find documents relating to the additional items you have the right to obtain as disclosed in the statement.

I hope you find this information helpful. Please contact our Customer Service Department at phone number if we can assist you further.

Sincerely,

Vivian Taunton
Customer Service Specialist

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Description of Prior Authorization and Utilization Review procedures

Prior Authorization

Regence BlueCross BlueShield of Oregon only preauthorizes services on our Focused Notification List. Our participating physicians and providers receive a list of those services or supplies requiring preauthorization approximately twice a year. This list is also located on our website at www.or.regence.com.

- Enclosed is a list of those services requiring preauthorization. We do not preauthorize services or supplies, which are not listed.

Utilization Review

Utilization review criteria is developed to help us review proposed or rendered treatment. Using the criteria and the information from your doctor, we can then determine whether the treatment meets the contract requirement of medical necessity for payment of benefits. There are many services and supplies for which no medical criteria has been developed. These would be services or supplies so commonly done and accepted by the medical community as a whole they would not be questioned, or services and supplies which may be new or still in an experimental or investigational status. Utilization review criteria developed by Regence BlueCross BlueShield of Oregon for a specific service or supply will be sent to you upon request.

Disclosure Documents for Washington Traditional/PPO Reimbursement Arrangements

Participating and Preferred Provider Networks

Regence BlueCross BlueShield of Oregon has no compensation programs, provider incentives or penalties in place that would encourage a provider on our participating or preferred provider networks to withhold services. We do not require you to see a primary care physician before you can see a specialist, nor do we require any kind of referral be made before you can see a specialist.

Following are explanations of the different types of reimbursement arrangements that may be used to provide payment to our participating and preferred hospitals, physicians, and other professional medical providers for services rendered to our members.

- **Diagnosis Related Group (DRG) reimbursement.** Payment to a hospital at a pre-determined dollar amount based on the patient's admitting diagnosis. The DRG rate covers the entire inpatient stay from admission to discharge, except for personal convenience items and durable medical equipment.
- **Per Diem Reimbursement Payment.** to a hospital at a pre-determined daily rate based upon the number of days the patient is in the hospital. This daily rate covers the patient's entire inpatient stay from admission to discharge, except for personal convenience items and durable medical equipment.
- **Outlier Reimbursement.** Additional payment which may be made to a hospital when charges for DRG or Per Diem reimbursement exceed a pre-determined charge threshold. The charge threshold is negotiated between the hospital and Regence BlueCross BlueShield of Oregon when they contract with us and is specific to a diagnosis.
- **Discount to Charges.** This reimbursement method is used for outpatient charges. Payment is made to the hospital at a certain percentage discount from the hospital's actual charges. This pre-determined percentage is negotiated between the hospital and Regence BlueCross BlueShield of Oregon when they contract with us.
- **Fee for Service Reimbursement.** This reimbursement method assigns a specific dollar amount for each procedure code used by the provider to describe the service performed. Payment is calculated by multiplying a dollar conversion factor set by Regence BlueCross BlueShield of Oregon by unit values found in the Resource Based Relative Value Scale (RBRVS). RBRVS is a reimbursement system developed by the federal government. RBRVS takes into consideration the work involved by the provider for a specific procedure, their malpractice costs and overhead facility costs to establish a unit value for each procedure.

There are some procedures and supplies that do not have established unit values. In these instances, Regence BlueCross BlueShield of Oregon looks to see if the regional Medicare carrier or other Regence plan have a payment allowance that could be used to determine a payment amount. If we are unable to find anything then we review similar procedures that already have a unit value established to determine our payment amount.

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Member Grievance and Appeal process

Health plan member appeals should be easy to understand. So we're sharing this brief summary to make you aware of important steps and critical time frames if you choose to use this process. A new Washington State law, The Patient Bill of Rights, requires health plans to tell you about this, and other member rights and responsibilities, when you enroll, every year and/or as often as you request it. Please call ... if you have questions or want a complete member appeal policy.

The "How To" of Member Appeals

Regular appeal process

First Step: The Complaint

What the member must do: You, or someone representing you, tells Regence BlueCross BlueShield of Oregon about your complaint in writing or verbally within 180 days of receiving something in writing from Regence BlueCross BlueShield of Oregon—such as an Explanation of Benefits or letter denying a preauthorization request. Explain what you're dissatisfied with based on a previous decision or action by Regence BlueCross BlueShield of Oregon. You may give Regence BlueCross BlueShield of Oregon written materials supporting your complaint. If you or your provider is asking Regence BlueCross BlueShield of Oregon to reconsider a previously denied preauthorization, it's possible that your provider may talk directly with a Regence BlueCross BlueShield of Oregon Medical Director.

What Regence BlueCross BlueShield of Oregon does: A benefits administration representative (Regence BlueCross BlueShield of Oregon Customer Service Specialist with contract benefits, enrollment and claims processing expertise) working together, as needed, with a Regence BlueCross BlueShield of Oregon Medical Director, the medical services, legal and/or communications departments, accepts and logs the complaint and notifies you of receipt within seven days. The representative investigates the complaint, gathers facts and prepares a "complaint package" of detailed information. The representative makes a decision, records it in writing and sends it to you within 30 days of first receiving your complaint. It must be understandable, describe how you may appeal the decision and the timing required, list the people at Regence BlueCross BlueShield of Oregon who helped make the decision, state the facts and refer to support documents. At this point, you may ask Regence BlueCross BlueShield of Oregon to change its mind by appealing the decision (see second step, below).

Second Step: Internal Appeal

What the member must do: Tell Regence BlueCross BlueShield of Oregon you want to appeal its decision (based on your complaint) in writing or verbally within 180 days of receiving notification from Regence BlueCross BlueShield of Oregon that they won't take further action on your complaint. You may give Regence BlueCross BlueShield of Oregon written materials supporting your appeal and are invited to appear in person.

What Regence BlueCross BlueShield of Oregon does: A "panel," made up of Regence BlueCross BlueShield of Oregon representatives, reviews your appeal and makes a decision. Panel members are new to the case and haven't been involved in any previous decision Regence BlueCross BlueShield of Oregon made regarding your original complaint. The panel includes an appeal coordinator who is Registered Nurse, a Vice President, and a Medical Director. The panel may work with Regence BlueCross BlueShield of Oregon medical services, legal and/or communications departments. The Medical Director may also confer with an independent physician with medical training related to your appeal. The appeal coordinator accepts and logs your appeal and notifies you within five days that it was received. The coordinator investigates the complaint, gathers facts and prepares an "appeal package" of detailed information.

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The panel makes a decision on the appeal and records it in writing. A written decision is sent to you by certified mail within 30 days of first receiving your appeal.

You'll get the decision within 20 days if it's about an investigational medical procedure, and within 14 days if it's about a service that your provider wants for you but needs approval from Regence BlueCross BlueShield of Oregon to perform. The written decision must be understandable, describe how you may request another appeal and the timing required, list the people at Regence BlueCross BlueShield of Oregon who helped make the decision, state the facts and refer to support documents.

Third Step: External Appeal

What the member must do: Tell Regence BlueCross BlueShield of Oregon you want to appeal their decision, in writing or verbally within 180 days of receiving notification from Regence BlueCross BlueShield of Oregon that it won't take further action on your internal appeal.

What Regence BlueCross BlueShield of Oregon does: A Regence BlueCross BlueShield of Oregon appeal coordinator accepts and logs your appeal and notifies you within five days that it was received. The coordinator gathers all facts and supporting documents together with the previous internal appeal packet, and delivers it to the Independent Review Organization (IRO) within three days of receiving your request for an external appeal. An IRO is made up of physicians not associated with Regence BlueCross BlueShield of Oregon with medical training in the area of your appeal, reviews your case and makes a decision. These physicians are new to the case and have not been involved in any previous decision Regence BlueCross BlueShield of Oregon made about your complaint or internal appeal. The IRO makes a decision, records it in writing and sends it to you and Regence BlueCross BlueShield of Oregon by certified mail within 20 days of receiving your external appeal packet. It must be understandable, describe the next appeal level, if any, and the timing required, list the independent physicians who made the decision, state the facts and refer to support documents.

Expedited appeal process

For members who need a faster process because of a life-threatening medical condition, there is an expedited appeal process. In this case, you go through an Internal Appeal process similar to the one outlined above. The difference is the reviewing Regence BlueCross BlueShield of Oregon "panel" is new to the case, and they make a decision in one working day or 72 hours, whichever is less after you tell Regence BlueCross BlueShield of Oregon that you want an expedited appeal. If you aren't satisfied with that decision, you may ask for an expedited, second level appeal similar to the External Appeal process described above. The difference is the IRO is new to the case, and it makes a decision in one day or 72 hours, whichever is less after you tell Regence BlueCross BlueShield of Oregon that you want another expedited appeal.

A grievance that has been rejected by us following final review through our appeals and grievance process may be submitted to nonbinding mediation.

Disclosure Documents for Washington Traditional/PPO Limitations and Exclusions

Note: This list is a representative of the limitations and exclusions to the benefit plans we offer. It is not a complete list. For a complete list, see your benefit booklet. The following services and supplies are not covered:

- Services and supplies for which payment could be obtained in whole or in part if you had applied for payment under any city, county, state, or federal law except for Medicaid coverage
- Services and supplies you could have received in a hospital or program operated by a government agency or authority, unless reimbursement under the contract is otherwise required by law
- Charges for services and supplies for which you cannot be held liable because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply
- Services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance
- Service-related conditions
- Third party liability
- Motor vehicle coverage
- Work related conditions
- Experimental or Investigational services
- Care of inmates
- Expenses incurred before coverage begins or coverage ends
- Services provided by a member of your immediate family
- Treatment not medically necessary
- Growth hormones
- Surgery to alter refractive character of the eye
- Cosmetic/reconstructive services and supplies
- Orthognathic surgery
- Paraphilia
- Gender identity disorders
- Treatment of mental illness for which there is no effective cure
- Benefits not stated
- Impotence medications
- Routine services and supplies
- Treatment for obesity or weight control
- Orthopedic shoes
- Family planning
- Dental examinations and treatments
- Physical exercise programs
- Custodial care
- Developmental disabilities/learning disabilities/autism
- Personality disorders
- Behavior modification
- Counseling or treatment in the absence of illness
- Charges over the amount allowed under the plan
- Services rendered by non participating providers

Disclosure Documents for Washington Traditional/PPO Consumer Privacy Notice

We are committed to protecting the privacy of your personal information. The purpose of this notice is to inform you of the types of personal information we obtain and how we protect that information.

What is personal information?

We treat any information that is identifiable to you as your personal information, whether or not it may be otherwise available to the public. We collect personal information related to your:

- Health condition, including health care treatment and payment;
- Identity, such as your name, age, or address; and
- Income, when necessary for coverage.

Why do we collect your personal information?

We collect personal information from you to help us:

- Determine the appropriate products to offer you;
- Pay claims;
- Provide case management services; and
- Provide quality improvement services.

How do we collect your personal information?

We collect your personal information through you and your health care providers. For example, we receive personal information from you on your insurance application and from your health care providers through insurance transactions, such as the submission of a claim for reimbursement of covered benefits.

To whom do we disclose your personal information?

We will not disclose your personal information unless we are allowed or required by law to make the disclosure, or if you give us permission. Following are some examples of disclosures we may make as allowed or required by law:

- To health care providers (doctors and others who provide you with care) in connection with an insurance transaction, such as verifying that you have coverage;
- To service companies that perform insurance functions on our behalf, such as third party administrators, insurance agents, auditors, benefit consultants, or care management specialists for utilization management and quality improvement;
- To an insurance regulatory authority; or
- To respond to legal requests such as a subpoena.

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We will not disclose your personal information to any non-affiliated company for that company's marketing purposes.

We may share your financial information with our affiliated companies for marketing purposes to better serve your needs as one of our customers. Financial information means information about your income or your identity, such as your name, age, or address. An affiliated company means a company owned or controlled by us. For example, if you choose to purchase insurance from us, we may share your financial information with an affiliated life insurance company to make our full range of insurance products and services available to you. Also, when you reach a certain age, we may share your financial information with an affiliate to alert you of additional products or programs for which you may become eligible, such as Medicare or Medicaid.

How do we protect your personal information?

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices in our employee handbooks as well as disciplinary measures for privacy violations;
- Restricting access to your personal information only to those employees who need to know your personal information in order to provide our services to you, such as paying a claim for a covered benefit;
- Only disclosing your personal information that is necessary for a service company to perform its function on our behalf, and the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

Can I “opt out” of certain disclosures?

You may have received notices from other organizations that allow you to “opt out” of certain disclosures. The most common type of disclosure that applies to “opt outs” is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. As a health plan, we must follow many federal and state laws that prohibit us from making these types of disclosures. Because we do not make disclosures that apply to “opt outs,” it is not necessary for you to complete an “opt out” form or take any action to restrict such disclosures.

How can you reach us?

- Visit our Web site at www.or.regence.com; or
- Contact your Customer Service Department at 1 (888) 437-1503

Revisions

We may amend this notice at any time and will inform you of changes as required by law.

**Disclosure Documents for Washington Traditional/PPO
Note to Customer Service Specialist:**

Enclose applicable pharmacy information (i.e. Preferred Drug List, Choices brochure etc..)