

# Provider Agreements

As a participating provider with Regence BCBSO, you have signed one or more of the following *Physician and Other Health Care Professional Provider Agreements*:

- **Participating**
- **Preferred Provider Plan (PPP)**
- **Regence Access**
- **Regence First Choice Sixty-Five**
- **Regence Preferred Choice Sixty-Five**
- **Regence MedAdvantage**

These networks participate in the national BlueCard® Program (refer to Section “G” *Filing Claims* for more BlueCard information). All providers must be Regence BCBSO Participating providers in order to be considered for the other networks. If you are not participating on any of the above networks and would like to be considered, contact your provider relations representative for more information.

## **Benefits of Participation**

- Regence BCBSO members have financial incentives to seek health care from you because their expenses will be limited to deductible, copayment and coinsurance amounts and charges for non-covered items.
- Regence BCBSO members with Preferred or Access coverage may have financial incentives to seek health care from you because they may pay a lower rate of deductible, copayment and/or coinsurance if care is provided by a Preferred or Access provider.
- You are listed in the Regence BCBSO provider directories (depending on the agreements you signed), which are made available to our members.
- Claim payments are made to you directly on a weekly basis.
- You may provide input on our policies in a variety of ways. See chapter “K” *Medical and Reimbursement Policy* for more information.
- Provider relations representatives and provider consultants are available to assist you and your staff.

## **Responsibilities of Participation**

As a physician, other health care professional or facility on Regence BCBSO’s networks, you have agreed to:

- Accept Regence BCBSO Maximum Allowable Fees (depending on which agreements you have signed) as payment in full for covered services for all Regence BCBSO and affiliated members. Your patient is only responsible for copayment, coinsurance and deductible amounts and for services not

- covered by their benefit contract. Refer to Section “H” *Payment* for more information on Maximum Allowable Fees.
- Bill Regence BCBSO directly for covered services. Patients should not be asked to bill Regence BCBSO.
  - Direct patients to other physicians, other health care professionals and facilities participating on the network used by the member’s plan (e.g., Participating, Preferred, Access, First Choice Sixty-Five, Preferred Choice Sixty-Five, Regence MedAdvantage) whenever possible. Refer to current copies of the various provider directories for a list of these providers.
  - Cooperate with Regence BCBSO’s Member Grievance and Appeal Procedures.

## **Confidentiality Requirements**

As a Regence BCBSO participating physician, other health care professional or facility, it is your responsibility to abide by all applicable provisions of the law concerning the confidentiality of patient information and records. Regence members are informed through member materials of our commitment to protecting the confidentiality of their information and records. The following is Regence’s policy regarding patient confidentiality.

### ***Right to Approve Release of Information***

Disclosure outside of Regence is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law. Subject to certain exceptions, Oregon law requires insurers to obtain a written authorization from the member or their representative before disclosing personal information.

### ***Routine Consent***

By signing the enrollment form, members are authorizing Regence to obtain health information about them and their dependents as necessary:

- To determine eligibility for coverage
- To pre-authorize or process claims for benefits
- To perform provider credentialing, utilization management or quality assurance reviews
- To conduct audits

### ***Access to Records***

Members have the right to obtain and inspect a copy of their personal information for as long as our business associates or we maintain it. Members can submit a request in writing identifying the information requested. Requests should be sent to the address on the member card.

### ***Use of Measurement Data***

Regence collects and analyzes claim information to perform utilization management, case management and other clinical activities. The data is used to identify areas of improvement for the care and service members receive.

### ***Protection of Privacy***

Our staff is committed to assuring personal information is kept confidential. Only Regence and employees who need information in order to do their jobs (e.g., process claims) may access member information. In addition, Regence requires persons and entities with whom it contracts to maintain the confidentiality of our members' health information.

### ***Members Unable to Give Consent***

There are situations when a member cannot give an authorization for the release of information. An adult or emancipated minor who is legally authorized to act on behalf of an individual for health care decisions can act as a legal representative. If not already on file, Regence will request proof of the members' legal representative.

### ***Information and Employers***

We will not disclose personal information to any employer, union or other entity that sponsors the group health plan without the individual's authorization. Only minimum necessary patient de-identified information may be released as long as the employer signs a privacy protection agreement with us.

## **Medical Records Standards**

Standards for physician and other health care professional's office medical records have been developed to promote a consistent basis for quality care. Physicians and other health care professionals must maintain a medical record-keeping system that conforms with professional medical practice, permits internal and external medical audit, permits encounter claim review, and facilitates an adequate system for follow-up treatment. All medical records must be maintained for at least six years after the date of medical services.

The physician or other health care professional shall maintain the confidentiality of the medical record information, ensuring the contents of the medical record will be released to authorized personnel only. This includes our medical director, his/her designee or persons as authorized by the member in the *Release of Information form*. The physician or other health care professional shall cooperate with Regence and our representatives in the inspection and examination of medical records for the purpose of audits. All efforts to maintain confidentiality will be applied.

Due to state and federal requirements, medical records supplied to us during the appeals process will be released, upon request, to the member as part of their appeal file. See chapter L, *Quality Programs*, for specific medical record documentation requirements for all Regence members.

## Provider Appeal Procedures

### Overview of Appeals, Disputes and Complaints

From time to time, you may feel that a claim has been adjudicated incorrectly, or there may be extenuating circumstances you believe would make a difference in the outcome of claims payment. In other instances, you may disagree with our interpretation of the participating provider agreement or our decision to terminate our relationship with you.

The vast majority of your questions and concerns can be resolved quickly and efficiently by contacting provider customer service or your provider relations representative. If, after talking with a customer service or provider relations representative, you are not satisfied with the outcome you may initiate the formal internal provider appeals process as described herein. If the matter you wish to dispute involves a decision to terminate your status as a participating provider or relates to external audit findings, you will proceed directly to the internal provider appeals process. If the matter you wish to dispute involves billing issues, you must first go through the billing dispute process. Please refer to the information within the subsequent pages to determine what steps are necessary to initiate the appropriate appeal process.

We know that when these types of situations occur, you may not know exactly how to proceed or who to contact for help. If you are having difficulty determining which process to invoke, please contact your provider relations representative or provider customer service. If you are unsure of whom your provider relations representative is, see our *Provider Web Site* at [www.or.regence.com/provider](http://www.or.regence.com/provider) or contact Customer Service at 1 (800) 722-5086.

The disputes subject to appeal typically fall into one of the following categories: billing disputes/claims reviews; external audit findings; and contract terminations.

**Note:** *In most cases where the provider wishes to appeal a matter in which a member has an interest, the **Member Appeals** process must be used. Please refer to the Member Appeals section beginning on page D-9 for additional information.*

## Billing Disputes

If you feel a claim has been paid incorrectly or improperly denied, please initiate the billing dispute process by submitting a written request via regular mail to your provider relations representative *or* to the following address:

Regence BlueCross BlueShield of Oregon  
Attn: Provider Services - Billing Dispute  
P.O. Box 12625, M/S S3J  
Salem, OR 97309

Please send all pertinent information, including copies of original payment vouchers and other documents that will help us investigate the claim in question. To ensure that the documents are handled appropriately, please include “billing dispute” on all documents submitted. After we review the information, we will make our decision within sixty (60) days of the complaint. If you disagree with our decision, you may invoke the Internal Provider Appeals Process as set forth below.

**Note:** If a physician or other health care professional requests an appeal within 30 days of receipt of a request for repayment of an overpayment, Regence BCBSO shall not require the physician or other health care professional to repay the alleged overpayment before the appeal is concluded.

## Internal Provider Appeals Process

If your dispute regarding any Company action or determination cannot be resolved through communications with provider customer service or your provider relations representative, you may utilize the internal provider appeals process. This formal process is used to adjudicate disputes between providers and Regence. You must exhaust the internal provider appeals process before seeking arbitration or mediation, as set forth in your participating provider agreement with Regence. As a reminder, claims adjudication issues must go through the billing dispute process set forth above before proceeding to the internal provider appeals process.

### Level One Appeal

To request a Level One Appeal, please submit a written, detailed “Request for Internal Provider Appeal” within thirty (30) business days of the action or decision you want to dispute. Send the request via certified mail, return receipt requested, to your provider relations representative *or* to the following address:

Regence BlueCross BlueShield of Oregon  
Attn: Provider Services - Appeals

P.O. Box 12625, M/S S3J  
Salem, OR 97309

Also include, at a minimum, a detailed description of the disputed issues, the basis for your disagreement, all evidence and documentation supporting your position (except in the case of an audit dispute where submission of records not made available to the auditors will not be considered) and the action you desire from us.

We will reconsider the disputed issue and notify you of our determination within thirty (30) business days of our decision, unless otherwise provided herein. If additional documentation is requested for the Level One Appeal, you must submit this information within fifteen (15) business days of your receipt of the written request for information. If no documentation is received within this time period, the initial adverse decision stands and you will be so notified in writing. If the documentation is timely received, the new information will be considered during the Level One Appeal. You will receive written notification of the Level One Appeal decision within thirty (30) business days of such decision being reached. At our discretion, the internal provider appeal may include a review of the materials by a peer review body.

If the dispute involves billing or claims issues, the documentation submitted by you should include copies of original payment vouchers and other documents that will help us investigate the claim in question.

**Note:** If a physician or other health care professional requests an appeal within 30 days of receipt of a request for repayment of an overpayment, Regence BCBSO shall not require the physician or other health care professional to repay the alleged overpayment before the appeal is concluded.

*If the appeal involves Utilization Management issues, please note that you may only appeal an individual utilization management and medical necessity decision if you believe additional information, not previously reviewed by Regence, will impact our original decision or an error was made in the decision-making process. Standard provider utilization management appeals are retrospective in nature, with prospective appeals handled through the Member Appeals Process. Utilization Management appeals should be accompanied by supporting medical information indicating why the original decision should be overturned. Appeals based on a denial of claim as investigational follow the standard appeal processes as set forth herein, but decisions are made within thirty (30) calendar days of our receiving the necessary information.*

## Level Two Appeal

If you are not satisfied with the results of the Level One Appeal, you may submit a written “request for an in-person meeting” to Regence via certified mail, return receipt requested, to your provider relations representative *or* to the following address:

Regence BlueCross BlueShield of Oregon  
Attn: Provider Services – Request for In-Person Meeting  
P.O. Box 12625, M/S S3J  
Salem, OR 97309

This request must be postmarked no more than thirty (30) business days after the date of our response. The request for an in-person meeting must identify in detail all issues for which you request re-evaluation. Within thirty (30) business days of our receipt of the request for a Level Two Appeal, we will notify you of the date, time and place of your requested meeting.

The Level Two Appeal process is divided into two distinct subcategories: Those appeals involving contract terminations that may be reportable to the Healthcare Integrity and Protection Data Bank (HIPDB), and all other appeals. Due to the HIPDB reporting requirements, certain additional procedural rights are afforded to providers whose contract terminations may be reportable. These additional procedures are set forth below, under the heading of “Reportable Contract Terminations.” At each Level Two Appeal, you will have the opportunity to provide additional evidence (except in the case of an audit dispute where submission of records not made available to the auditors will not be considered), to make an oral statement and respond to questions raised by the panel. You may be represented by counsel at this meeting if you so choose.

The Level Two Appeal panel is comprised of various individuals affiliated with Regence that have not been directly involved in the First Level Appeal. The individuals chosen to participate in the Level Two Appeal will include individuals who we believe have appropriate levels of knowledge and training to understand the issues presented at the appeal.

After the Level Two Appeal, we will consider the issues and send you our determination within fifteen (15) business days of the in-person meeting. If we cannot reach a decision within fifteen (15) business days or if additional information is needed from you, we will notify you of this delay within the fifteen (15) business day timeframe and we will agree upon a new time for each party to respond.

Decisions of the Level Two Appeal panel are deemed final on all appeals, including but not limited to appeals related to contract terminations which may be reportable to the HIPDB. Once a decision has been made by the Level Two Appeal panel, you have completed the internal provider appeals process.

## **Reportable Contract Terminations**

Regence is required by law to report certain contract terminations to the Health Care Integrity and Protection Data Bank (“HIPDB”). These required reports include terminations that are based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service. These acts or omissions include but are not limited to improper billing practices, sexual misconduct, and billing members in a manner that violates state law. You will be notified if your contract termination relates to an act or omission that Regence considers reportable.

In light of the reporting requirements, certain additional procedural rights are afforded at the Level Two Appeal for those providers whose contract terminations may be reportable to the HIPDB. These additional rights are as follows:

- Regence will provide a list of witnesses expected to testify on behalf of the Company.
- The provider will be apprised as to the names of the Level Two Appeal panel members, and will be given the opportunity to request refusal of members of the panel based upon conflict of interest.
- The provider may request a record of the hearing.
- The provider has the right to call witnesses, the right to examine and cross-examine witnesses and the right to provide evidence.
- The provider is allowed to submit a written statement at the close of the hearing or to provide an oral closing statement.

Please note that the above-mentioned rights are afforded only to those providers whose contract terminations are identified by Regence as reportable to the HIPDB.

## **Additional Information Regarding the Internal Provider Appeals Process**

### ***Failure to Timely Appeal***

If you fail to submit a complete and timely appeal, you will be deemed to have accepted the Company’s last determination of the issues raised by you and to have waived all further internal, external, judicial, or arbitral process regarding the issues.

### ***Provider Status During Appeal Process***

Generally, on receipt of an appeal meeting the criteria set forth herein, you will continue in your prior status, and any pending action by the Company is put in abeyance until the appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the safety or welfare of our members, the status of your license, or if we have exercised our right to

immediately terminate as set forth in your contract, your participating status may be suspended for the duration of the appeals process.

***Effect of Appeals Process:*** *This process is not intended to create any substantive rights for you or to guarantee participation with the Company. Just as you remain free to choose not to contract with Regence, the Company is free to decide whether to enter into or maintain a contract with a provider.*

## **Regence Member Appeal Policy and Procedures**

The Regence Member Appeal Policy applies to all insured group and individual contracts issued by Regence Plans, with the exceptions of Federal Employee Program (FEP), Medicare A & B, Medicaid and certain other government programs. The first two levels of regular appeal and the first level of Expedited Appeal procedures will apply to self-funded accounts unless otherwise agreed to by the Plan sponsor and the Regence Plan. An appeal must be initially submitted to the Regence Plan within 180 days of the claim denial or other action giving rise to the complaint or grievance. Failure to initiate appeal within this time period (absent the Plan's finding, in its sole discretion, of acceptable extenuating circumstances) will preclude all further rights to appeal and may jeopardize the member's ability to contest the denial or other action in any forum. All applicable non-optional appeal levels must be exhausted before the member may contest the action in any forum, including through filing a lawsuit.

"Appeal" includes any grievance, complaint, reconsideration or similar terms as used in some jurisdictions, and is a written or oral request from a member, their personal representative, treating provider or appeal representative, to change a previous decision (Adverse Benefit Determination) made by the Regence Plan concerning:

- a. access to health care benefits, including an adverse determination made pursuant to utilization review;
- b. claims payment, handling or reimbursement for health care services;
- c. matters pertaining to the contractual relationship between a member and the Plan; or
- d. other matters as specifically required by law or regulation.

"Appeal representative" is a representative of the member for the purpose of the appeal. The appeal representative may be the member's personal representative, a treating provider, or another party, such as a family member, for whom the member or their personal representative has signed a valid authorization. If no such authorization exists and is not received in the course of the appeal, the determination and any personal information will be disclosed to the member, their personal representative or treating provider only.

“Personal representative” means a person who is legally authorized to act on behalf of an individual for health care decisions. For example: parents of a minor; a person holding a power of attorney; conservator; or person appointed by a court; so long as the power granted to the person includes managing the individual’s health care affairs.

“Authorization” is an individual’s written permission for use and disclosure of their personal information for a specific purpose and timeframe in accordance with the Regence Corporate Privacy Policy.

“Adverse benefits determination” means any of the following; a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- a. eligibility to participate in a plan
- b. application of utilization review
- c. determination that a treatment is experimental or investigational
- d. determination that a treatment is not medically necessary or
- e. contractual exclusion or limitation

“Urgent care request” is any pre-service or concurrent care claim for medical care or treatment for which the application of the time periods for making regular appeal determinations:

- a. could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function or
- b. in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment.

An individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may determine whether a request is an urgent care request. However, the determination by a physician with knowledge of the member’s medical condition that a request is an urgent care request is binding.

Regence members are entitled to three levels of review. At any time during the process, members may file a complaint with the Department of Consumer and Business Services:

Oregon Insurance Division; Consumer Protection  
Unit 350 Winter Street NE, Room 440-2  
Salem, OR 97310

Washington-based members (Clark County) may file a complaint with the Washington Office of Insurance Commissioner:

P.O. Box 40256  
Olympia, WA 98504-0256

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### **Level One Appeal – Grievance, Complaint, Reconsideration**

The member or member representative has the right to request an appeal within 180 days of receipt of the written notification of an adverse benefit determination. If a member chooses to file an appeal, Customer Service will provide assistance to the member by accepting information about the member's appeal over the phone or will provide the member with a form for a written appeal.

A Customer Service grievance coordinator will acknowledge receipt of the appeal, advise the member of all member rights and gather the necessary information to thoroughly investigate the issue. Upon completion of the review, the grievance coordinator will send a written response to the member. Appeals involving pre-service issues are responded to within 14 calendar days; investigational post-service issues are responded to within 20 working days; and other post-service issues are responded to within 30 calendar days. Expedited reviews are responded to within 72 hours from the receipt of the review. If the decision is not in the member's favor, the member or member representative will be informed of their right to further appeal.

### **Level Two**

The member or member representative may file a Level Two appeal. Requests for a Level Two appeal must be submitted within 180 days of the receipt of an adverse determination at the first level. The member or member's representative may appear before the panel at this level of review. The appeal coordinator/specialist acknowledges the receipt of the appeal by the fifth day. The acknowledgement must be in writing and must state all member rights. Documentation is compiled by the appeal coordinator/specialist then presented to an internal appeal panel. The panel is comprised of three voting members not previously involved with the case. A written response is sent to the member in:

- Fourteen days for pre-service issues
- Twenty working days for post-service investigational procedures
- Thirty days for all other appeals

If the decision is not in the member's favor, the member is informed of the next level of appeal and again informed of their right to file a complaint with the Oregon Insurance Division or the Washington Insurance Division (members residing in Clark County). For issues related to medical necessity, investigational, or continuity of care, the member is informed of the right to file the appeal with an Independent Review Organization (IRO) within 180 days. For all other issues, the member is informed of their right to file a final appeal to be considered by another internal three-member panel.

### **Level Three Appeals**

External appeal with an Independent Review Organization (IRO) The appeal is filed and acknowledged within five days. The appeal coordinator/specialist

requests regulator appointment of the IRO as mandated by state specific regulations. All documentation, including a written summary of the facts, is delivered to the IRO.

IRO is an independent organization employing physicians and other medically-qualified individuals or experts, which acts as the decision maker for external appeals (regular or expedited), either through an independent contractor relationship with the Plan, and/or through assignment to the Plan via state regulatory requirements.

Regence will provide to the member and/or appeal representative in writing:

- the decision by the IRO
- a list of the IRO reviewer title(s) and qualifications

Regence agrees to bound by the decision of the IRO.

### **Level Three Internal Appeal**

All benefit administration appeals are handled through a third level internal review panel. The member or their representative has the right to appear in person at this level of review. Documentation is compiled by the appeal coordinator/specialist and presented to an internal appeal panel. The panel is comprised of representatives not involved in prior decisions. A written response is sent to the member or member representative within 14 days for pre-service appeals or 30 days for post-service appeals. Our response will remind the member that they may also file a complaint with the Oregon Insurance Division or the Washington Insurance Division (members residing in Clark County).

### **Expedited Appeals**

A Regence member may request an expedited appeal if:

- the member or the member's physician reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent issue could jeopardize the member's life, health or ability to regain maximum function
- a physician with knowledge of the member's medical condition reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent care issue could subject the member to severe pain that cannot be adequately managed without the disputed care or treatment.

The member, their representative or the physician may request an expedited appeal either verbally or in writing. The member, provider or member representative may provide additional written documentation and may attend by telephone.

Expedited appeals are responded to within 72 hours by telephone, facsimile or other available similarly expeditious methods. Written notification follows.

As a participating physician, you can minimize the complaints and appeals by:

- Acknowledging and upholding members' right to complaints, grievances and appeals
- Explaining these rights to members who contact you to express a concern or dissatisfaction
- Assisting Regence in timely resolution by submitting requested records or input within seven days of the request

## Member Rights and Responsibilities

Regence is committed to providing our members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

Providing the best possible health care coverage requires more than comprehensive benefit packages, prompt claims processing and efficient customer service. It also includes notifying our members of their rights and responsibilities and conscientiously protecting these rights. Therefore, we have developed a written policy that addresses members' rights and responsibilities. This policy is revised based on regulatory requirements for entities such as: Centers for Medicare & Medicaid Services (CMS) and Federal and State Patient Protection Acts.

Each individual within the health plan is responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to preserve and respect these rights.

## Rights for Members Enrolled in Commercial Group Plans

Subscribers and their enrolled dependents have the right to make their own health care decisions. Although we must set guidelines that affect how benefits are paid, these guidelines merely dictate whether the cost of care is eligible for reimbursement.

Members of Regence have the right to:

### ***Timely and Quality Care***

- timely access to their physicians and other health care professionals and referrals to specialists when medically necessary
- continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care
- receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury

- have their physicians and health care professionals tell them about their diagnosis, the prognosis of their condition, and instructions required for follow-up care
- participate with physicians and health care professionals in decision-making regarding their health care and treatment planning;
- a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

***Treatment with Dignity and Respect***

- be treated with respect, dignity, compassion and the right to privacy
- exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect these rights by both the Plan and contracting physicians.
- expect consideration of privacy concerning their care and confidentiality in all communications and in their medical records
- extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care
- know why they are given various tests, treatments or procedures, who the persons are who give them, and what risks are involved for any procedure or treatment prescribed
- refuse treatment and to be informed of the medical consequences of this action
- refuse to sign a consent form if they feel they do not clearly understand its purpose, or to cross out any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent
- be informed of policies regarding Advance Directives (living wills) as required by state and federal laws

***Health Plan and Other Important Information***

- receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements
- expect a clear explanation regarding benefits and exclusions of their policy
- know by name the physicians, nurses, or other health care professionals providing care
- information about medications – what they are, how to take them and possible side effects
- information regarding how medical treatment decisions are made by the health plan or contracted medical groups, including payment structure
- be advised if a practitioner proposes to engage in experimentation affecting care or treatment. They have the right to refuse or participate in such research projects

### ***Solving Problems in a Timely Fashion***

- present questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed
- the right to voice a complaint about their health plan or the care provided including the right to appeal an action or a denial, and the process involved
- make recommendations regarding the health plan members' rights and responsibilities policies

## **Responsibilities for Members Enrolled in Commercial Group Plans**

In addition to their rights, subscribers and their enrolled dependents have the responsibility to:

- identify themselves as a Regence enrollee and present their identification card when requesting health care services
- be on time for appointments and contact the physician or other health care professional at once if there is a need to cancel or if they are going to be late for an appointment; if the physician, other health care professional or facility has a policy for assessing charges regarding late cancellations or "no shows," they will be responsible for such charges
- provide, to the extent possible, information that their health care organization and its physicians and other health care professionals need in order to provide care
- do their part to improve their health condition by following the plans, instructions, and care that they agreed upon with the physician or health care professional
- act in a manner that supports the care provided to other patients and the general functioning of the office or facility
- to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals
- review their employee benefit booklet to make sure services are covered under the plan
- follow Plan requirements to have services properly authorized before receiving medical attention
- to participate, to the degree possible, in understanding their health problems including behavioral health, and developing mutually agreed upon treatment goals
- inform Customer Service if they feel they or their family members are not receiving adequate care
- check their benefit booklet and follow proper procedures for illness after business hours
- review information and all materials concerning health benefits and educate other covered family members

- provide identification cards to family members to be presented at the time of service
- accept the financial responsibility for any co-payment or coinsurance associated with services received while under the care of a physician or other health care professional or while a patient at a facility
- let us know if they have concerns, or if they feel their rights are being compromised so we may act on their behalf

## **Access and Availability Standards**

Regence's commitment to its membership is that they will have the necessary information to be able to use their health plan benefits and that health services will be reasonably accessible to satisfy their health care needs.

Annually, Regence monitors and evaluates compliance and develops strategies to improve system performance. Various divisions of Regence will collect data measuring the accessibility and availability standards.

### ***Accessibility***

To ensure that Regence members have equal access to informational services, the following are minimum standards for access:

#### **1.0 Informational**

- 1.1 The length of wait time to reach a live person when contacting Regence's Customer Service department should not exceed an average of 40 seconds.
- 1.2 The abandoned call rate for members calling Regence's Customer Service department should not exceed an average of five percent.

### ***Availability***

To ensure that Regence members have services they need at any given time, the following are minimum standards for availability:

#### **1.0 Cultural**

- 1.1 Regence members will have access to informational services in their primary language.

#### **2.0 General Hospital**

- 2.1 Hospitals with emergency care capabilities shall be available within 10 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in an urban area.
- 2.2 Hospitals with emergency care capabilities shall be available within 30 miles for 90% of Regence BCBSO Participating, Preferred and Access members in rural areas.

### **3.0 Primary Care Providers**

- 3.1 Primary care physicians (FP, GP, Internal Medicine, Pediatrics, Obstetrics, Gynecology, Nurse Practitioner) shall be available within 10 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in an urban area.
- 3.2 Primary care physicians (FP, GP, Internal Medicine, Pediatrics, Obstetrics, Gynecology, Nurse Practitioner) shall be available within 30 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in a rural area.

### **4.0 Specialty Care**

- 4.1 General surgery, and some specialized medical/surgical care (ENT, Ophthalmology, Orthopedic Surgery) shall be available within 10 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in an urban area.
- 4.2 General surgery, and some specialized medical/surgical care (ENT, Ophthalmology, Orthopedic Surgery) shall be available within 30 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in a rural area.
- 4.3 Obstetrics/Gynecology (OB/GYN) services shall be available within 10 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in an urban area.
- 4.4 Obstetrics/Gynecology (OB/GYN) services shall be available within 30 miles for 90% of Regence BCBSO Participating, Preferred and Access members living in a rural area.

## **Code of Business Conduct**

Regence and its affiliates have worked hard to earn and maintain a reputation for high ethical business practices. These practices are based on fairness, integrity and honesty. We are committed to strict compliance with all of the federal, state and local laws and regulations that apply to our business. We expect the same of those with whom we do business.

Our ethics and compliance standards are expressed in our Code of Business Conduct. Among other subjects, the Code addresses the following:

- |                                 |  |                      |
|---------------------------------|--|----------------------|
| ✓ Core values                   | ✓ Confidential information and trade secrets | ✓ Improper payments  |
| ✓ Making good decisions         | ✓ Dealing with customers/suppliers           | ✓ Honorariums        |
| ✓ Reporting issues and concerns | ✓ Gifts, gratuities and entertainment        | ✓ Books and records  |
| ✓ Conflicts of interest         | ✓ Federal programs                           | ✓ Proper accounting  |
| ✓ Reciprocity                   | ✓ Political activity and contributions       | ✓ Member information |

- ✓ Payments to agents, representatives, providers and consultants
- ✓ Safety, health and environment
- ✓ Employee information

We are committed to conducting business only with physicians and other health care professionals, facilities, agents, consultants, contractors and suppliers who support our employees' compliance with our Code. We appreciate your full cooperation with this commitment so that our relationship with you will be built on the same high ethics and compliance standards. If at any time you become aware of a situation or practice that may not comply with these standards, please contact any one of Regence's Ethics and Compliance Officers. Their contact information is listed below.

### **Ethics and Compliance Officers' Contact Information**

If at any time you become aware of a situation or practice that may not comply with high ethics and compliance standards, please contact any one of Regence's Ethics and Compliance Officers.

- Idaho: **Eddy Chapman** (208) 798-2122
- Oregon: **Jackie Yerby** (503) 226-8769
- Utah: **Randy Romrell** (801) 333-5691
- Washington: **Harry Carstens** (206) 464-3653

If you wish to remain anonymous, you may also contact a Compliance Officer through one of the Ethics and Compliance Resource lines:

- Idaho: **1 (800) 438-1608**
- Oregon: **1 (800) 308-1228**
- Utah: **1 (800) 377-8446**
- Washington: **1 (888) 809-2334**

We will attempt to protect the confidentiality of anyone who reports suspected misconduct, but some circumstances may make that impossible. Choosing to make an anonymous report may limit the Company's ability to conduct an investigation and may result in no corrective action being taken. No employee who is accused of a violation will be disciplined solely on the basis of an anonymous report.