
Post-Sale Disclosure Statement

Health Care Patient Bill of Rights

This Q & A summarizes many of the terms and conditions of our plans and supplements your member benefits booklet. **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.

What additional information can I get from Regence BlueShield upon request?

- Any documents or other information referred to in the contract or benefit brochure.
- Annual accounting of all payments made by the company which have been counted against any payment limitations, visit limitations, or other overall limitations under the plan.

What is Regence BlueShield’s accreditation status with national managed care accreditation organizations, including effectiveness performance using HEDIS? Is the HEDIS data published and how can I access HEDIS data?

Regence BlueShield has not sought NCQA accreditation. As a result, HEDIS rates are not reported to Quality Compass. However, HEDIS reporting is mandated by government programs contracts. (Medicaid). HEDIS rates are reported annually to DSHS/HCA, per contract requirements. This data is publicly reported. HEDIS data is reported as aggregate data by product. Individual providers and members remain confidential. Some large employee groups may also require HEDIS measurements.

How do I, if necessary, consult a provider other than your Personal/Primary Care Provider (PCP)?

PCP’s are not required on Innova, Engage, Activate, Preferred or Traditional plans. Members on Selections plans may go outside the Selections Network to a Selections, Preferred Plan, or participating provider in the “extended network”, however, out-of-pocket costs may be higher. All care must be coordinated by the member’s Person Care Provider for the member to qualify for the highest level of benefits, with the exception of self-referral benefits and for emergency services.

Descriptions of and justifications for provider compensation programs.

Regence BlueShield does not employ the physicians within the Regence network. Physicians are contracted to provide services on a fee-for-service basis and are paid from fee schedules for the services provided.

What procedures may require prior authorization from Regence BlueShield and how do I obtain that authorization?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact our Customer Service department at the phone number on the back of your Member card, or ask your 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.

Description of any reimbursement or payment arrangements between the company and a provider or network.

Regence BlueShield reimburses physicians and other providers using the Resource Based Relative Value Scale, (RBRVS). Reimbursement conversion factors are reviewed and updated annually. Hospitals are reimbursed using Diagnostic Related Groups, (DRGs). DRG weights and conversion factors are reviewed and updated periodically as hospital contracts are renewed. These reimbursement methodologies are based on national standards for reimbursement as developed and maintained by the Centers for Medicare and Medicaid Services, (CMS). Commercial reimbursement for provision of healthcare services is almost always based on these methods, both locally and nationally.

What is the plan’s appeal / grievance process, including appeals / grievances for claim or service denial and for dissatisfaction with care?

For the most up to date copy of the plan’s appeal / grievance process, visit our Web site at www.myRegence.com.

What are the limitations and exclusions to my medical benefit plan?

The following list is representative of the limitations and exclusions to the benefit plans we offer. It is not a complete list. For a complete list, see your group contract and/or member booklet. The following services and supplies are not covered or are limited:

- Acupuncture for smoking cessation
- Benefits covered by government programs
- Charges for services or supplies that are above the allowed amount, except as required by law for emergencies
- Charges that in the absence of the plan there would be no obligation to pay
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies; 3) for reconstructive breast surgery following mastectomies to the extent required under federal and state law
- Custodial care
- Dental services, except as provided under the Repair of Teeth and Hospitalization for Dental Services benefits (*Preferred, Selections, & Traditional plans only*)
- Dental services (*Innova, Engage & Activate plans only*)
- Dyslexia treatment, except as required for Neurodevelopmental Therapy
- Eyeglasses and contact lenses and the fitting, except for the first intraocular lenses following cataract surgery (optional Vision Hardware or Vision Care benefit is available)
- Hearing aids.
- Hospitalization for conditions for which the member is not usually hospitalized, such as common colds, minor cuts or bruises, removal of small tumors, and similar minor conditions
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest
- Investigational services or supplies
- In-vitro fertilization, artificial insemination, embryo transfer, or other artificial means of conception, including any expenses for fertility drugs
- Marital counseling; family counseling, except as specified in the Mental Disorders or Mental Health Services benefit
- Over-the-counter contraceptive supplies and devices
- Physical or psychiatric exams to obtain or continue employment, licensure, legal proceedings, insurance, school admission, sports activities, or for purposes of medical research
- Private duty nursing or hourly nursing charges
- Routine eye exams, except on Selections plans (Optional Vision Care benefit including exams available on Traditional, Preferred, Innova & Engage Plans)
- Services and supplies payable under Medicare, when by law Medicare is primary, regardless of whether the member had properly enrolled when first eligible
- Services or supplies covered by auto insurance, personal injury protection insurance, homeowner insurance, or commercial premises coverage
- Services or supplies not medically necessary for illness, injury, or physical disability
- Services provided by a family member (spouse, parent, or child), the group, or any of the group's employees or agents
- Surgery (including reversals), treatment, programs, or supplies that are intended to result in weight reduction, regardless of diagnosis
- Surgery or treatment for sexual dysfunction/impotence or transsexualism
- Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection
- Treatment of any condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States
- Visual analysis, therapy, training, or orthoptics
- Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except telemedicine in remote locations, as approved by the Company (*Preferred, Selections and Traditional plans only*) and except where otherwise provided under the Telemedicine benefit of the *Innova, Engage & Activate* plans), whether initiated by the member or the member's provider