
Pre-Sale Disclosure Statement

Health Care Patient Bill of Rights

The Patient Bill of Rights was passed, among other things, 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 BlueShield has put together this Q & A summarizing many of the terms and conditions of our plans. This Q & A supplements the group contract.

How can I get a list of Preferred, Selections and Participating providers?

For the most up to date provider information, visit our Web site at www.wa.regence.com or, call Customer Service at 1 (800) 458-3523 to request any provider directories.

How can I get a list of standard covered benefits on Regence BlueShield plans?

For the most up to date plan and prescription drug summaries, visit our Web site at www.wa.regence.com or, call Customer Service at 1 (800) 458-3523 to request any plan summary.

How can I find out what the rates and any enrollee cost-sharing requirements are?

A rate quote is sent with this proposal / renewal.

Is a Point of Service (POS) plan option available and how does the plan operate?

Point of Service plans are available through Regence BlueShield. The following is a brief explanation of how point-of-service works. For full coverage provisions, including a description of waiting periods, limitations, exclusions, and referral requirements, please refer to your group contract.

Upon enrollment on a RegenceBlueShield Selections product, members are encouraged to select a Personal Care Provider (PCP) from the provider network. Each family member may choose his or her own PCP. To receive the highest level of benefits, members need to consult with their PCP upon first seeking medical care. Members may also self-refer for certain covered services. Women may self-refer for covered women's health care services, to a women's health care provider within the network. When specialty care is recommended, the PCP will coordinate treatment by handling hospital admissions or referrals to appropriate network specialists.

Members are also free to use any Regence BlueShield approved health care provider who is outside your plan's network, in what is called the extended network. Members can bypass their PCP and self-refer directly to a specialist, either in the plan's network or in the extended network. In these cases, members will still have coverage; however, they may be required to pay a deductible and may receive a lower level of benefits. In emergencies, benefits will be provided even if members do not receive a referral from their PCP.

How can I be involved in decisions about benefits?

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. Send your comments to us over the internet at www.wa.regence.com or, by US mail to the address below.

Regence BlueShield
ATTN: Vice President, Customer Service
PO Box 21267
Seattle, WA 98111-3267

What is Regence BlueShield's statement of carrier confidentiality policies?

Regence BlueShield has a written policy to protect the confidentiality of health information. Only employees who 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.

What does the term "brand-name" mean?

The reference to brand-name drugs means drugs included in the current formulary that are under patent and are generally marketed and sold by only one source.

What does the term “medically necessary” mean?

Medically necessary means health care services or supplies that a physician or other health care provider exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are: 1) in accordance with generally accepted standards of medical practice; 2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease; and 3) not primarily for the convenience of the member, physician or other health care provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

What does the term “formulary” mean?

A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. Members will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company’s formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost effective ones. For convenience, the formulary is available on our Web site at www.regencrx.com.

What does the term “generic” mean?

The reference to generic drugs means drugs included in the current formulary 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 drug based on manufacturer and price. Equivalent means the U.S. Food and Drug Administration (FDA) ensures that the generic must: a) have the same active ingredients found in the brand-name version; b) meet FDA specifications for quality, purity, and potency; and c) have the same medical effect as the brand-name version.

When can the plan change the approved drug list (formulary)?

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