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Telephone Numbers You Will Need

Seattle:

Conversion Plans	
Member inquiries.....	1(888)344-8234
Regence Life & Health...Washington Office	(206) 464-3744 or1(800)621-3330
Life; Accidental Death & Dismemberment (AD&D);	
Short-Term Disability (STD); Long-Term Disability (LTD); Voluntary Life;	
Voluntary AD&D, LTD and STD	
Marketing Communications	(206) 464-3782
Public Relations	(206) 289-6630
Group Marketing, Account Services	
Contracts, brochures	(206) 464-3833 or 1(800)653-1125
Fax	1(800)770-5644 or (206) 389-5669
Individual Plans (under age 65)	
Member inquiries.....	1(888)344-8234
Medicare Supplement Plans	
Member inquiries.....	1(888)344-8234
Member Services	
Member inquires	(206) 464-3663 or 1(800)458-
3523	
(have Member's Identification number available)	
For Other Departments Not Listed	(206) 464-3600

Telephone Numbers You Will Need (continued)

Tacoma:

Customer Service	
Broker and member inquiries.....(253) 597-6557 or	(253) 597-7015
(have member's identification number available).....	1(800)458-3523
Individual Plans (under age 65)	
Member inquiries	1(888)344-8234
Group to Individual Conversion Plans	
Member inquiries	1(888)344-8234
Medicare Supplement Plans	
Member inquiries	1(888)344-8234
Communications	(206) 464-3782
Public Relations	(206) 389-6630
Group Marketing, Account Services	
Contracts, brochures.....	1(800)653-1125
Forman & Associates Inc.	
Long-Term Care.....	1(800)742-9444
Fax	(425) 462-9839
Personal Choice Accounts (Section 125 Administration)	1(800)334-4340
For Other Departments Not Listed	(253) 597-6500

Telephone Numbers You Will Need (continued)

Burlington

Customer Service (360) 755-4100 or 1(877)276-5906
Individual Sales..... 1(888)344-8234
Medicare Supplement Plans Sales 1(888)344-8234
Group Sales (360) 755-4000 or 1(800)659-7229
Group Sales Fax (360) 755-4591
Group Membership Services..... (360) 755-4000 or 1(800)659-7229
Membership fax (360) 755-4594 or 1(800)208-4555

Everett

Customer Service (425) 348-8160 or 1(800)548-8385
Fax..... (425) 348-8167 or 1(888)233-7660
Individual Sales..... 1(888)344-8234
Medicare Supplement Plans Sales 1(888)344-8234
Group Sales (425) 348-8124 or 1(800)328-7273
Group Sales Fax (425) 513-8581
Group Membership Services..... (425) 348-8100 or 1(800)328-7273
Membership fax (425) 348-8183 or 1(800)233-7660

Yakima - Sales Office

Group Sales 1(888)344-
5582
Group Sales Fax (509) 573-6818
Individual Sales..... 1(888)344-8234
Medicare Supplement Plans Sales 1(888)344-8234

Office Locations

Regence BlueShield has offices in Burlington, Everett, Seattle, and Tacoma.

Regence BlueShield Locations:

Burlington

333 Gilkey Road
Burlington, WA 98233-2823
(360) 755-4100 or 1(877)276-5906

Everett

7600 Evergreen Way
Everett, WA 98203
(425) 348-8100 or 1(800)328-7273

Seattle

PO Box 21267
1800 Ninth Avenue
Seattle, WA 98111-3267
(206) 464-3600

Tacoma - Market Street

1501 Market Street
Tacoma, WA 98402-3333
(253) 597-6500

Tacoma - Broadway Plaza

1148 Broadway Plaza
Tacoma, WA 98402
(253) 573-3203

Federal Legislation Affecting Benefit Plans

The burden of compliance with most of the laws and regulations described in this section rests with the employer. We are not legal experts and do not presume to give legal advice. We urge you to contact your legal counsel regarding any questions about your responsibilities under these laws.

Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) became law September 2, 1974. The law provides protection for employees covered by private benefit plans, including both pension plans (which provide retirement benefits) and welfare plans (which provide other kinds of benefits such as health, dental, life and accident).

ERISA provisions applying only to pension plans include eligibility and vesting rules, funding rules and plan termination insurance. ERISA provisions applying to both pension and welfare plans include standards for governing plan administration, reporting requirements to the Department of Labor, disclosure information to plan participants and enforcement provisions for compliance with ERISA.

ERISA regulations applying to welfare plans require that certain information be distributed to plan participants. This information is called the "summary plan description." It is the basic document that informs participants of the terms of their plan. In addition, for self-insured plans, ERISA usually pre-empts any state insurance laws and regulations.

Medicare Secondary Payer Provisions

Medicare secondary payer rules fall into several categories and determine the circumstances under which an employer health plan must provide benefits primary to Medicare. The significant provisions are outlined below. Note that the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) made revisions to the methodology by which employer groups determine their size for compliance; Employers who are unclear about how they are affected should contact their legal counsel.

- ***The "Working Aged" (TEFRA)***

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), amended by the Deficit Reduction Act (DEFRA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA), has significant provisions affecting health care coverage for employees age 65 and over—commonly referred to as the "working aged"—working for employers with 20 or more full-time or part-time employees.

Specifically, TEFRA amends the Age Discrimination in Employment Act of 1967 so that employers must offer active employees age 65 and over, and their spouses age 65 and over, the same group health care plans as offered to younger workers. Medicare "carve-out" plans, which allowed the employer plan to pay only to the extent not covered by Medicare, are no longer permitted if the group is subject to TEFRA.

See Members Eligible for Medicare in Administrative Information section of this guide (C-9) for more information about TEFRA-eligible employees.

- ***Disabled Beneficiaries on Large-Group Health Plans***

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86), amended by OBRA 93, provides that employer groups with 100 or more full-time or part-time employees during 50% or more of their business days in the previous calendar year must pay benefits primary to Medicare benefits for disabled beneficiaries. This applies to all group coverage that the beneficiary may have as a result of his or her own current employment or the current employment of a family member.

- ***End-Stage Renal Disease (ESRD)***

Medicare provisions for end-stage renal disease patients were most recently amended by OBRA 93 and require that Medicare be the secondary payer for a specific time period for any individual eligible for Medicare due to end-stage renal disease. The Medicare Secondary Payer requirement applies to active and retiree plans, regardless of the beneficiary's original entitlement reason. For example, a Medicare beneficiary over age 65 who has end-stage renal disease would receive group benefits as primary for a specified time period from the date of the kidney transplant or the first dialysis treatment.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) amends the Internal Revenue Code, ERISA and other legislation and contains provisions that significantly affect employers with 20 or more employees in the preceding calendar year. Its provisions have been amended on several occasions.

Effective July 1, 1986, the Act requires employer-sponsored group health plans to provide certain employees and their dependents the opportunity to continue to participate in the employer-sponsored health benefit plans after their coverage would otherwise cease. Coverage may continue for up to 18, 29, or 36 months, depending on the status of the beneficiary.

In 1987, the IRS issued proposed regulations in a question-and-answer format to provide further guidance in COBRA issues. These proposed regulations continue to be helpful to employers, but it is important to note that they have never been adopted in final form and that they have not been amended in light of later changes to the COBRA statute. The employer may require the qualified beneficiary to pay both the employer and member share of the rates. **All rate payments must continue to be submitted to us through your group's representative.** Each member and his or her spouse must be notified of the continuation coverage options.

COBRA also extended the "working aged" health benefits rules mandated by the Age Discrimination in Employment Act and TEFRA to employees over age 70.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Individual plans will not have to be administered differently than they are under current state law as a result of the implementation of HIPAA in Washington state. Below is a comparison of Washington state's current individual portability provisions and HIPAA's individual portability provisions. The federal law replaces existing state law unless state law is more generous to consumers. This comparison shows that all of Washington state's provisions in this area are more favorable to the consumer than HIPAA's:

- Under HIPAA, one must have an aggregate of 18 months of continuous coverage to be eligible for Individual Plan portability. Washington law requires only three months or nine months depending on group size.
- Under HIPAA, breaks of coverage must not exceed 63 days. Washington allows breaks in coverage of up to three months.
- Under HIPAA, the prior coverage must have been under a group plan. Washington law allows prior coverage to be credited from either a group or Individual Plan.

HIPAA Portability Changes Effective July 1, 2005

Clarifications to HIPAA's portability rules went into effect on July 1. These rule clarifications were issued by the federal government and intended to improve the continuity of health coverage for members. Three areas of coverage are affected by these clarifications: pre-existing condition exclusions, creditable coverage and special enrollment.

Regence implemented the necessary administrative changes for all group members on July 1, 2005. However, existing group contracts will not be updated until the group's first renewal that falls on or after July 1, 2005.

The federal Health Insurance Portability and Accountability Act, or HIPAA, established rules to streamline health care administration and improve privacy and security protection for personal health information.

Portability was implemented in 1997 as the first part of HIPAA. The Department of Labor, Centers for Medicare and Medicaid Services, and Health & Human Services released clarifications to the portability rules at the end of 2004.

What changes under these clarifications?

The HIPAA Portability rules primarily affect three areas of coverage:

- Pre-existing condition exclusions
- Creditable coverage
- Special enrollment

How is coverage affected?

Area of Coverage	Effective July 1, 2005
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Pre-existing condition exclusions	<ul style="list-style-type: none"> • A pre-existing condition exclusion is allowed on a condition if medical advice, diagnosis, and/or treatment for the condition was received during the allowable “look-back” period prior to the enrollment date. Taking a prescription medication during the look-back period constitutes receiving treatment. • If a member’s benefit packages or payers change, the member’s enrollment date remains the same. • Prior to enrollment (or as soon as possible thereafter), the group or Plan must provide a written notice explaining the terms of the pre-existing condition exclusion. This notice must include the length of the exclusion period, steps the enrollee can take to shorten the period, and a person to contact with questions. • If an evidence of current or prior coverage is provided, the Plan (Regence) must provide a second notice that includes the remaining amount of waiting period, and the last day of the waiting period. If the evidence offsets the remaining waiting period, then no notice is required.
Creditable coverage	<ul style="list-style-type: none"> • The definition of creditable coverage expands to include the State Children’s Health Insurance Program and any health coverage provided by a government entity (including self-insured coverage) or foreign government health system (such as Canada’s national health system). • The Certificate of Creditable Coverage (COCC) now includes an educational statement explaining rights provided under the HIPAA Portability rule. • In addition to established loss of coverage events, a COCC must be issued when a claim is denied due a lifetime limit on all benefits being reached.
Special enrollment	<ul style="list-style-type: none"> • Prior to enrollment, the group or Plan (Regence) must provide a written notice explaining special enrollment rights. This notice must be provided to all employees, not just to those who decline coverage. See our website at www.regence.wa.com for copies of the notice.

SPECIAL ENROLLMENT PERIOD RIGHTS

For individuals who are eligible for enrollment in a group health plan:

If an employee is declining enrollment for himself or herself or dependents (including his or her spouse) because of other health insurance or group health plan coverage, he or she may be able to enroll himself or herself and his or her dependents in this plan if the employee or his or her dependents lose eligibility for that other coverage (or if, in the case of group health plan coverage, the employer stops contributing toward his or her, or the dependents' other coverage.) In addition a special enrollment period triggered by a dependents loss of coverage provides a right for those already enrolled to change plans as long as it is offered by the group. However, the employee must request enrollment within "30 days" after his, her or the dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if an employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her dependents. In addition, a special enrollment period triggered by a new dependent provides a right for those already enrolled to change plans as long as it is offered by the group. However, the employee must request enrollment within "31 days" after the marriage, or within 60 days after a birth, adoption, or placement for adoption. To request special enrollment or obtain more information, please contact, your Regence BlueShield Membership Analyst or visit our website at www.regence.wa.com

Washington state law ESHB 2460 exemptions for groups of less than 20

Exemption #1:

(e) If a person is seeking an individual health benefit plan and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of standard health questionnaire shall not be a condition of coverage if: (i) the person has at least 24 months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health questionnaire from a person with at least 24 months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within 90 days thereafter.

There are seven qualifying events:

1. termination of a covered employee's employment (other than for gross misconduct);
2. a reduction in a covered employee's hours of employment;
3. the death of a covered employee;
4. a divorce or legal separation from the covered employee;
5. ceasing to be a dependent child under the terms of the plan;
6. the covered employee's becoming entitled to Medicare; and
7. employer bankruptcy (this relates only to retiree plans).

Exemption #2:

If an applicant is applying for Individual coverage because their current group conversion contract is being discontinued by their insurance carrier, the applicant will not be required to fill out the standard health questionnaire provided they apply for Individual coverage within 90 days of the date that the coverage under the current conversion contract terminates. A copy of the letter the applicant receives from the carrier giving the effective date of the termination must be included with the application.

The Mothers and Newborns Health Protection Act

A federal law called The Mothers and Newborns Health Protection Act, was passed to extend the usual length of a hospital stay for a new mother from 24 hours to two days. The law, effective January 1, 1998, is intended to ease concerns about "drive-through deliveries."

At Regence BlueShield, we believe that the decision to discharge a new mother from the hospital should be made by the patient and her provider. There is nothing in our contracts that states hospitals must discharge mothers and babies after a certain amount of time.

A Washington State law, often referred to as the “Erin Act” of June 1996, also states that the decision about how much time a mother spends in the hospital is up to the patient and her provider. The federal Mothers and Newborns Health Protection Act will not have any impact in Washington state because the Erin Act is already in effect.

Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act (FMLA) was signed into law in February 1993. The law took effect on August 5, 1993, and guarantees up to 12 weeks of unpaid leave each year to workers who:

- Need time off for birth or placement of a child for adoption or foster care.
- Need to care for a spouse or immediate family member with a serious illness, or
- Are unable to work because of a serious physical or mental health condition.

The FMLA is an employer law—it covers employers with 50 or more employees and affects many job-related rights of employees. Among other things, this law also affects the health benefit plans maintained by employers that are required to comply.

Employers are required by FMLA to continue to provide group health benefits at the same level and under the same conditions as if the person had continued to be actively at work. A person entitled to COBRA continuation as a result of not returning to active employment following FMLA leave will be entitled to COBRA continuation coverage, the duration of which shall be calculated from the date the person fails to return from the FMLA leave.

For specific questions, call your account executive or contact the Department of Labor for a complete copy of the FMLA law and Department of Labor interim final rules.