



100 SW Market Street
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Pre-Sale Disclosure Statement

This disclosure will supplement your contract and summarizes many of the terms and conditions of our plans. If you have any questions, please call Customer Service at 1 (888) 675-6570 or visit our Web site at or.regence.com

How can I get a list of participating primary care and specialty care providers?

For the most up to date provider information, visit our Web site or, call Customer Service to request any provider directories.

How can I get a list of covered benefits, exclusions, reductions and limitations to covered benefits on Regence BlueCross BlueShield of Oregon plans?

For the most up to date plan (including prescription drug benefit and plan limitations and exclusions) summaries, visit our Web site or call Customer Service to request any plan summary.

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

A rate quote is sent with a proposal and at renewal. Your plan may have a deductible which is the dollar amount you pay in a calendar year before the plan pays covered benefits. Not all benefits apply to the deductible. Some benefits require a co-pay or other cost-sharing amount.

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

A POS plan option is not currently available through Regence BlueCross BlueShield of Oregon.

How do I consult a provider other than my Primary Care Provider (PCP)?

PCPs are not required on Engage, Activate, Regence HSA 2.0, or Regence Preferred plans.

Where can I find a summary explanation of 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 or call Customer Service to request information about the grievance process.

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

Regence BlueCross BlueShield of Oregon has a written policy to protect the confidentiality of health information. For more information, please refer to the Regence BlueCross BlueShield of Oregon Notice of Privacy Practices.

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 or.regence.com or, by US mail to the address below.

Regence BlueCross BlueShield of Oregon
ATTN: Vice President, Customer Service
PO Box 1271
Portland, OR 97207

How do I access and request copies of health disclosure information in other formats?

You may request copies of health disclosure information in paper or electronic form by calling Customer Service. You may also visit our Web site for disclosure information.

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 and other health care providers practicing in relevant clinical areas and any other relevant factors.

What does the term "formulary" mean?

Formulary means our list of selected prescription medications. We established our formulary and review and update it routinely. Medications are reviewed and selected for inclusion in the formulary by an outside committee of providers, including physicians and pharmacists. Members may be required to pay more if the drug does not appear in the formulary. The formulary is available on our Web site, or by calling Customer Service.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

Yes. For the most current listing of participating pharmacies, please visit regenceRx.com or call Customer Service.

How many days' supply of most medications can I get without paying another co-pay or other repeating charge?

Generally speaking, you may receive a 30-day supply for medications filled at a retail pharmacy and a 90-day supply for medications filled through a mail order pharmacy.

What other pharmacy services does my health plan cover?

Your health plan may cover any of the following services or supplies. However, your benefit booklet will include a list of the covered benefits of your plan.

- Oral contraceptives
- Smoking cessation
- Diabetic supplies
- Weight loss

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

- Any documents or other information referred to in the contract or benefit booklet.
- Annual accounting of all payments made by Regence BlueCross BlueShield of Oregon which counted against any payment limitations, visit limitations, or other overall limitations under the plan.

What procedures may require prior authorization from Regence BlueCross BlueShield of Oregon 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 Customer Service or ask your provider for a list of services that need to be preauthorized. Preauthorization is your assurance that medical services will not be denied because they are not medically necessary. In most cases, your provider will initiate the preauthorization process. You may also call Customer Service for additional information about the preauthorization process.

Description of any reimbursement or payment arrangements between Asuris Northwest Health and a provider or network.

Regence BlueCross BlueShield of Oregon pays an allowed amount to providers for covered services and supplies under the plan. For preferred and participating providers, the allowed amount is what the providers contractually agree to accept as payment in full for a service or supply. For nonparticipating providers who are not accessed through the BlueCard® Program, the allowed amount is an amount Regence BlueCross BlueShield of Oregon determines to be reasonable charges for covered services or supplies. The allowed amount may be based upon the billed charges for some services, as determined by Regence BlueCross BlueShield of Oregon or as otherwise required by law. For nonparticipating providers accessed through the BlueCard® Program, the allowed amount is the lower of the provider's billed charges and the amount that the on-site BlueCross and/or Blue Shield organization identifies to Regence BlueCross BlueShield of Oregon as the amount on which it would base a payment to that

provider.

Descriptions and justifications for provider compensation programs.

Regence BlueCross BlueShield of Oregon does not employ the providers within the Regence network. Providers are contracted to provide services on a fee-for-service basis and are paid from fee schedules for the services provided.

What is Regence BlueCross BlueShield of Oregon 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 BlueCross BlueShield of Oregon has not chosen to seek NCQA accreditation. Instead, as part of our quality improvement process, we calculate and utilize selected HEDIS rates. Additionally, as required by contract, we report specified HEDIS rates to NCQA Quality Compass, CMS [Center for Medicare & Medicaid Services] and the Washington Department of Social and Health Services. These organizations publish the rates accordingly. For more detailed information, contact Customer Service and ask to speak with our Quality Programs Department.

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 “generic” mean?

Generic medication means a prescription medication that is equivalent to a brand-name medication, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references (or specified by us) as a generic medication. For the purposes of this definition, "equivalent" means the U.S. Food and Drug Administration (FDA) ensures that the generic medication has the same active ingredients, meets the same manufacturing and testing standards and is absorbed into the bloodstream at the same rate and same total amount as the brand-name medication. If listings in widely accepted references are conflicting or indefinite about whether a prescription medication is a generic or brand-name medication, we will decide.

What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?

Contact your employee benefits administrator to discuss other coverage options if you receive your health care benefits through your employer group. Contact Customer Service if you are covered under an individual plan.

How much do I have to pay to get a prescription filled?

You may pay a portion of the cost in accordance with your benefits.

Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?

Coverage for medications will be described in your benefit booklet. As described, certain medications that your health care provider may prescribe are excluded or have limited coverage. Some examples of exclusions or limitations are:

- Compounded medications
- Medications used for cosmetic purposes
- Coverage for brand name medications when a generically equivalent medication is available
- Some medications may require preauthorization
- Medications with maximum quantity or dose limits
- Medications dispensed by non-participating pharmacies.

What are the general categories of drugs excluded from coverage?

Cosmetic medications and over-the-counter medications are not covered.