



Regence

Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association

1800 Ninth Avenue
Seattle, WA 98101

ANNUAL DISCLOSURE NOTICE

Breast Reconstruction (medical plans only)

Health plans are required by federal law to inform you upon enrollment and annually thereafter about the presence of a breast reconstruction benefit in your plan. This update includes such information, along with information regarding the Act described below.

The Women's Health and Cancer Rights Act of 1998 established federal standards for the coverage of breast reconstruction following a mastectomy. This law requires that health plans that include coverage for mastectomy must also include coverage of the following (in a manner determined in consultation with the attending physician and the member):

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive surgery may be subject to annual deductibles, if any, and coinsurance consistent with those established for other benefits. Health plans and employers may not deny a member eligibility to enroll in or to renew coverage solely for the purpose of avoiding coverage of breast reconstruction following a mastectomy. If you would like more information regarding your cancer rights, contact your Plan Administrator.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We, at Regence BlueShield, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. We are required by law to maintain the privacy of this protected health information and to explain our legal duties and privacy practices. We provide the protections and apply the practices described in this notice to all personal information that we maintain, including personal information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We abide by the notice that is currently in effect. This notice is in effect as of April 1, 2006.

Your Rights

Inspection and Copies. You have the right to request an inspection or copies of protected health information that we maintain about you in a "designated record set" except psychotherapy notes and information that we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A "designated record set" is a group of records that is used to administer your health benefits, including enrollment information and claims. We may limit the information that you can inspect or copy if we have reason to believe that it's necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to amend

information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: The Regence Group, Privacy Office, P.O. Box 1071, Mailstop E12B, Portland, OR 97207 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

Business Associates. Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates to provide the same privacy protections that we provide.

Plan Sponsors and Group Health Plans. If you are enrolled in a group health plan, we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists so that premiums can be paid appropriately.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws require that we disclose protected health information to your personal representatives or to certain government agencies.

Public Health Activities. We may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers' compensation benefits.

Health Oversight. We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

Health Related Services. We may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

Marketing. We do not use or disclose protected health information for marketing purposes without your authorization. However, we may communicate with you face-to-face about products or services that may interest you or we may send you a promotional gift of nominal value.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. If we make a material change to our privacy practices, we will send a new, updated notice. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling our Customer Service department at 1 (888) 367-2112. For more information about this notice or to file a written privacy-related complaint, you may write to: Privacy Official, The Regence Group, P.O. Box 1071, MS E12B, Portland, OR 97207.

Newborns' and Mothers' Health Protection Act (medical plans only)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). State law may permit even longer lengths of stay.

The regular benefits of your contract will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under your contract. Such benefits will not be subject to enrollment requirements for a newborn as specified in your benefit booklet, or the payment of a separate premium for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of your contract. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn. When delivery of a child is not covered under your contract, benefits will be provided for routine care for that newborn child while hospitalized for up to the first 72 hours following birth, not subject to the enrollment requirements for a newborn specified in your benefit booklet.

Notice of Preexisting Condition Exclusion Period (medical plans only)

This plan imposes a preexisting condition exclusion period. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion period applies only where there was a recommendation or receipt during the plan's look-back period of medical advice, diagnosis, care, or treatment for the condition (under federal law, the look-back period can be no longer than six months). Generally, the look-back period ends the day before your coverage becomes effective. However, if you have a waiting period for coverage, the look-back period ends the day before the waiting period begins. For fully-insured group plans, this preexisting condition exclusion period may not exceed 9 months for groups of 2-50 or 3 months for groups of 51+ from your enrollment date, according to state and/or federal law.

A preexisting condition exclusion does not apply to a child who becomes covered on a group or individual health plan within 60 days after birth, adoption, or placement for adoption, unless a period of at least 63 consecutive days without creditable coverage has elapsed. A preexisting condition exclusion cannot apply to pregnancy on a group health plan, and may not apply to members under the age of 19 in most plans. A preexisting condition exclusion applies to members age 19 or older in all plans. If you need to confirm the exclusion period applicable to your health coverage, please give us a call using the contact information shown below.

You can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage. Under federal law, you are allowed a credit against the exclusion period for the combined amount of prior creditable coverages that you have had, except that, if you have had a break in coverage of 63 days or more, no credit is given for any creditable coverages prior to that break. Alternatively, under state law, if you had coverage at the time you applied for this plan and that coverage terminated no more than 90 days before you applied, you are allowed credit against this plan's exclusion period.

To reduce the exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have from previous plans (or from plans that were in force at the time of your enrollment in this plan). If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from

your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to: Regence BlueShield, P.O. Box 1271 MS C7A, Portland, OR 97207 or by calling 1 (888) 367-2112.

Appeals Process

You or your representative may initiate the member appeal process described in your benefit booklet if you or your representative has a concern regarding a claim denial or other action by us under the contract and wish to have it reviewed.

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 benefit 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 booklet.
- Annual accounting of all payments made by Regence BlueShield which have been counted against any payment limitations, visit limitations, or other overall limitations under the plan.

What is Regence BlueShield 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 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.

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

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

Descriptions of and justifications for provider compensation programs.

Regence BlueShield 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 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. 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 the company and a provider or network.

Regence BlueShield 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 BlueShield 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 BlueShield 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 BlueShield as the amount on which it would base a payment to that provider.

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 myRegence.com or review the member appeal process described in your benefit booklet.

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 website at www.wa.regence.com for disclosure information.

Your Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (the health carrier) at the phone number on the back of your Member card.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

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 at www.myRegence.com, or by calling Customer Service.

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.

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

Coverage for medications is 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 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 as described in your benefit booklet.

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. See your benefit booklet for more information.

What other pharmacy services does my health plan cover?

Your health plan may cover any of the following services or supplies. However, please refer to your benefit booklet for a list of the covered benefits of your plan.

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

What are the general categories of drugs excluded from coverage?

Cosmetic medications and over-the-counter medications are not covered. Please refer to your benefit booklet for a list of the exclusions under your plan.