

SUMMARY OF CHANGES

Regence BlueShield has made some benefit and provision changes. The following changes will be made as groups renew, and will apply to all groups regardless of number of employees, unless otherwise specified. Note that this is only a summary; refer to the brochure or contract for more detailed information.

BENEFIT / REGULATORY / LEGISLATIVE CHANGES		
COMPONENT / CONTRACT(S) AFFECTED	EXISTING CONTRACT / BOOKLET / REASON FOR CHANGE	NEW CONTRACT / BOOKLET LANGUAGE
CERTIFICATES OF CREDITABLE COVERAGE Applies to all <u>group</u> medical products.	Our contracts currently do not have language explaining this process.	Added new language for receiving/obtaining certificates of creditable coverage to the booklet.
MENTAL HEALTH DISCLOSURES Applies to all <u>group</u> products.	The OIC issued a rule making order repealing WAC 284-43-810 for Mental Health Services and Your Rights.	Removed the MH Services & Your Rights, and the Mental Health Questions (if applicable).
WHCRA NOTICE Applies to all <u>group</u> medical products.	WHCRA is not listed in the member brochure.	Add the WHRCA (Women's Health and Cancer Rights) to the end of the brochure.
CHEMICAL DEPENDENCY Applies to all <u>group</u> products.	As required by Washington Stat law, the Chemical Dependency benefit limit must increase each year in increments of \$500.	Increased the Chemical Dependency benefit maximum to \$14,500.
COLORECTAL CANCER SCREENING Applies to all <u>group</u> medical products.	Colorectal cancer screening is now a covered benefit for all members as the result of the passage by the Washington Legislature of Substitute Senate Bill 1337 requiring colorectal cancer screening coverage in all health plans.	If a plan covers Preventive Care, then routine colorectal cancer screenings will be covered like any Preventive Care condition. If a plan does not cover Preventive Care, then routine colorectal cancer screenings will be covered like any Professional or Hospital benefit of the plan. Colorectal cancer screenings covered under the Preventive Care benefit are not subject to any Preventive Care maximums.
INELIGIBLE PERSONS Applies to all <u>group</u> medical products.	As required by the OIC, the Ineligible Persons provision must be revised to clarify what is meant by "as required by law".	Revised to delete the following statement: Any ineligible person enrolled under this Contract will not be entitled to Benefits, except as required by law.

<p>TERMINATION FOR SUBSCRIBER OR DEPENDENT COVERAGE</p> <p>Applies to <u>group</u> Columbia Dental products only.</p>	<p>As required by the OIC, carriers may not terminate coverage for a subscriber or dependent coverage if there is a documented inability to establish or maintain a member/provider relationship.</p>	<p>Revised to clarify that Coverage for a subscriber or dependent may terminate with notice only on the date of written notice, if there is legal cause for termination.</p>
<p>VOLUNTARY SECOND SURGICAL OPINION</p> <p>Applies to all <u>group</u> medical products, except Regence HSA Healthplan and HSA-Qualified Preferred Plan 80/80/60.</p>	<p>As required by the OIC, members may obtain second surgical opinions from a qualified participating provider of the member's choice.</p>	<p>Revised to clarify that members may use one of the physicians referred by Regence BlueShield to take advantage of the copay and deductible waiver, but if the member chooses not to use one of the physicians referred by Regence BlueShield, the benefits will still be paid under the contract, but at the Professional Services payment level.</p>
<p>DIABETES SUPPLIES AND EQUIPMENT</p> <p>Applies to all <u>group</u> medical products.</p>	<p>As required by the OIC, a Diabetes Supplies and Equipment benefit must be added to clarify where benefits are provided for the treatment of diabetes.</p>	<p>Added a Diabetes Supplies and Equipment benefit, which reads as follows: The benefits of this plan will be provided for supplies and equipment for the treatment of diabetes. For Professional Services, Diabetes Care Training, Home Medical Equipment, Prostheses and Orthotics, and Prescription Drugs Benefits, see those benefits of this plan.</p>
<p>PRESCRIPTION DRUGS</p> <p>Applies to all <u>group</u> medical products, except Regence HSA Healthplan and HSA-Qualified Preferred Plan 80/80/60.</p>	<p>As required by the OIC, the Getting Your Prescription Filled provision of the Prescription Drugs benefit must be revised to clarify the number of days supply that the copay covers.</p>	<p>Revised to clarify that members will need to pay their applicable copay amount as outlined in the Copays section for each prescription (up to a 34-day supply) and that the applicable copay amount will not vary as a result of the day supply prescribed.</p>
<p>PRESCRIPTION DRUGS</p> <p>Applies to all <u>group</u> medical products, except Regence HSA Healthplan and HSA-Qualified Preferred Plan 80/80/60.</p>	<p>As required by the OIC, the Using Our Mail Order Service provision of the Prescription Drugs benefit must be revised to clarify the number of days supply that the copay covers.</p>	<p>Revised to clarify that members will need to pay their applicable copay amount as outlined in the Copays section for each prescription (up to a 90-day supply) and that the applicable copay amount will not vary as a result of the day supply prescribed.</p>
<p>MEDICARE PARTS A AND B</p> <p>Applies to all <u>group</u> medical products.</p>	<p>As required by the OIC, carrier contracts may not contain exclusions for services and supplies to the extent payable under Medicare Part A or B, when by law, the plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether the member actually enrolled.</p>	<p>Deleted the following exclusion: Services and supplies to the extent payable under Medicare Parts A or B when, by law, this plan would not be primary to Medicare had the member properly enrolled in Medicare when first eligible regardless of whether the member actually enrolled.</p>
<p>HOSPITAL SERVICES</p> <p>Applies to <u>group</u> medical Regence HSA Healthplan and HSA-Qualified Preferred Plan 80/80/60 products only.</p>	<p>As required by the OIC, carriers must clearly identify which benefit emergency room coverage falls into.</p>	<p>Revised the Hospital Services benefit on the payment schedule to clarify that services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits as specified in the Emergency Care provision in the What Do I Do When I Need Care? section.</p>

<p>HEALTH CARE RESPONSIBILITY</p> <p>Applies to all <u>group</u> medical products.</p>	<p>As required by the OIC, the Health Care Responsibility provision must be revised to clarify what is meant by “as required by law”.</p>	<p>Revised to read as follows: All health care services are provided by facilities and professionals who are neither employees nor agents of the Company. The fact that a provider is listed in the Company’s provider directory does not mean the provider is the Company’s employee or agent. Providers are responsible for the quality of care they render.</p>
<p>DENTAL CARE RESPONSIBILITY</p> <p>Applies to all <u>group</u> dental products.</p>	<p>As required by the OIC, the Dental Care Responsibility provision must be revised to clarify what is meant by “as required by law”.</p>	<p>Revised to read as follows: All dental services are provided by facilities and professionals who are neither employees nor agents of the Company. The fact that a provider is listed in the Company’s provider directory does not mean the provider is the Company’s employee or agent. Providers are responsible for the quality of care they render.</p>
<p>CESSATION OF BENEFITS</p> <p>Applies to all <u>group</u> products.</p>	<p>As required by the OIC, the Cessation of Benefits provision must be revised to clarify what is meant by “as required by law”.</p>	<p>Revised the first sentence of the provision to read as follows: No person has a right to receive benefits of this plan after the date this plan terminates.</p>
DOCUMENT LANGUAGE CLARIFICATIONS		
COMPONENT / CONTRACT(S) AFFECTED	EXISTING CONTRACT / BOOKLET / REASON FOR CHANGE	NEW CONTRACT / BOOKLET LANGUAGE
<p>BILLED CHARGES</p> <p>Applies to all <u>group</u> products.</p>	<p>Submission of Claims and Reimbursement: Booklets do not describe the fact that once a calendar or lifetime limit is met, a provider can bill the member for more than the allowed amount.</p>	<p>Add: You will be responsible for the total billed charges for benefits in excess of lifetime or Calendar Year Maximum Benefits, if any, and for charges for any other service or supply not covered under this plan, regardless of the Provider rendering such service or supply.</p>
<p>ALLOWED AMOUNT EXAMPLES</p> <p>Applies to all <u>group</u> products.</p>	<p>Changing the first sentence of the Preferred Plan or Participating Providers paragraph in the "Allowed Amount" section.</p>	<p>Change to: For services or supplies covered under this plan, the amount these providers have agreed to accept as payment in full pursuant to applicable agreement.....</p>

Unique Self-Funded Employer Plans

BENEFIT / REGULATORY / LEGISLATIVE CHANGES

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<p>NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT</p> <p>Applies to all State's Self-Funded groups.</p>	<p>Federal mandate requiring specific language be added to all self-funded contracts.</p>	<p>Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.</p> <p>Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.</p> <p>In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.</p>
DOCUMENT LANGUAGE CLARIFICATIONS		
<p>RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY</p> <p>Applies to Washington & Oregon State's Self-Funded groups.</p>	<p>Request from the Subrogation Department.</p>	<p>Revised language to remove made whole provision.</p>