

WASHINGTON INDIVIDUAL CONTRACT CHANGES, EFFECTIVE AUGUST 1, 2009

This comparison summarizes the revisions that will be made to individual policies beginning August 1, 2009.

Please note: This list does not include minor grammatical or cosmetic modifications and previously filed amendments.

BENEFIT / REGULATORY / LEGISLATIVE CHANGES		
COMPONENT / CONTRACT(S) AFFECTED	EXISTING CONTRACT / BOOKLET / REASON FOR CHANGE	NEW CONTRACT / BOOKLET LANGUAGE
<p>BENEFIT PORTABILITY</p> <p>Applies to all individual products except DentalOne and Conversion (change applies to contracts with effective dates prior to 11/1/08).</p>	<p>As required by the Washington State Office of Insurance Commissioner (OIC), members must be allowed to keep their prior equal or greater creditable coverage while remaining eligible for the preexisting condition waiting period credit.</p>	<p>Revised the Preexisting Condition Waiting Period Credit provision in the Benefit Portability section.</p>
<p>CERTIFICATES OF CREDITABLE COVERAGE</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>As required by the OIC, the Certificate of Health Coverage provision must include the mailing address where members can obtain certificates of creditable coverage. The provision also must clarify the meaning of the phrase "as required by law."</p>	<p>Added the full mailing address where the member can request a certificate of creditable coverage. Removed the phrase "as required by law" so that the provision reads as follows: When coverage under this Contract ends, the Company automatically will send the Member a "Certificate of Health Coverage." The Company will also issue a certificate upon the Member's request, within 24 months of cessation of coverage. The certificate will provide information about the Member's length of coverage under this Contract. The Member should verify the accuracy of the information on the certificate.</p>
<p>CESSATION OF BENEFITS</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>As required by the OIC, the Cessation of Benefits provision must clarify the meaning of the phrase "as required by law."</p>	<p>Removed the phrase "as required by law" so that the first sentence of the provision reads as follows: No person shall have or acquire a vested right to receive Benefits after the date this Contract is terminated.</p>
<p>DENTAL CARE RESPONSIBILITY</p> <p>Applies to DentalOne_individual products only.</p>	<p>As required by the OIC, the Dental Care Responsibility provision must clarify the meaning of the phrase "as required by law."</p>	<p>Removed the phrase "as required by law" so that the provision reads 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>DIABETES SUPPLIES AND EQUIPMENT</p> <p>Applies to Comprehensive individual products only.</p>	<p>As required by the OIC, diabetic supplies cannot be subject to any Prescription Drugs or Home Medical Equipment maximums.</p>	<p>Revised the Home Medical Equipment and Prescription Drugs benefits. Each benefit now states that the yearly maximum for Home Medical Equipment and Prescription Drugs does not apply to diabetic equipment and diabetic supplies.</p>

<p>DIABETES SUPPLIES AND EQUIPMENT</p> <p>Applies to Comprehensive individual products only.</p>	<p>As required by the OIC, a Diabetes Supplies and Equipment benefit must be added to the Contract to clarify the benefits that are provided for the treatment of diabetes.</p>	<p>Added a Diabetes Supplies and Equipment benefit, which reads as follows: The Benefits of this Article will be provided for supplies and equipment for the treatment of diabetes. For Professional, Diabetes Care Training, Home Medical Equipment, Prostheses and Orthotics, and Prescription Drugs Benefits, see those Benefits of this Article.</p>
<p>ELIGIBILITY FOR COVERAGE</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>As required by the OIC, health insurers cannot require a dependent child to be financially dependent upon the subscriber, subscriber's spouse, or legal parent as a condition of eligibility.</p>	<p>Revised dependent eligibility language accordingly.</p>
<p>FACE PAGE</p> <p>Applies to all individual products except DentalOne and Conversion.</p>	<p>As required by the OIC, the contract for each individual product must be labeled as either catastrophic or comprehensive.</p>	<p>Added the following to the face page of all catastrophic contracts: This Contract is classified as a Catastrophic Health Plan. Coverage under this Contract is not considered to be Creditable Coverage as outlined in the Benefit Portability Section of Article 6 of this Contract.</p> <p>Added the following to the face page of all comprehensive contracts: This Contract is classified as a Comprehensive Health Plan. Coverage under this Contract is considered to be Creditable Coverage as outlined in the Benefit Portability Section of Article 6 of this Contract.</p>
<p>FIRST AND THIRD PARTY PAYMENTS</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>As required by the OIC, revise subrogation language relating to legal fees and expenses.</p>	<p>Added language to the First and Third Party Payments section which reads in part: The Member may incur attorney's fees and costs in connection with obtaining recovery. If this Contract is not subject to ERISA, the Company shall pay a proportional share of such attorney's fees and costs incurred by the Member at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to the Company to less than the full amount of Benefits paid by the Company.</p>
<p>GENERAL EXCLUSIONS</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>As required by the OIC, excluding services and supplies that would have been covered if the member had enrolled in Medicare when eligible is not allowed under Washington State law.</p>	<p>Deleted the following exclusion: Services and supplies for which Benefits are or would have been payable to a Member eligible and enrolled under Medicare Parts A and B regardless of whether the Member actually enrolled.</p>
<p>GENERAL EXCLUSIONS</p> <p>Applies to Catastrophic individual products only.</p>	<p>As required by the OIC, the exclusion for Routine Newborn Care cannot apply to newborn or adoptive children added to the Contract as a dependent within 60 days of birth or adoption.</p>	<p>Revised exclusion for routine newborn care accordingly.</p>
<p>GENERAL EXCLUSIONS</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>Federal law prohibits benefit exclusions based on the source of injury.</p>	<p>Revised the introduction to the exclusions section to read as follows: No Benefits will be provided for any of the following conditions, treatments, services, or supplies, or for any direct complications or consequences thereof, unless otherwise specified. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury.</p>

<p>HEALTH CARE RESPONSIBILITY</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>As required by the OIC, the Health Care Responsibility provision must clarify the meaning of the phrase “as required by law.”</p>	<p>Removed the phrase “as required by law” so that the provision reads 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>HOSPITAL FACILITY</p> <p>Applies to all individual HSA products.</p>	<p>As required by the OIC, the Contract must clearly identify the payment level for emergency room services.</p>	<p>Revised the Hospital Facility benefit on the payment schedules to clarify that coverage for services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits, as listed in the Medical Emergency Coverage benefits section in the Contract.</p>
<p>INELIGIBLE PERSONS</p> <p>Applies to all individual, Conversion and DentalOne products.</p>	<p>As required by the OIC, the Ineligible Persons provision must clarify the meaning of the phrase “as required by law.”</p>	<p>Removed the following sentence from the provision: Any ineligible person enrolled under this Contract will not be entitled to Benefits, except as required by law.</p>
<p>MENTAL HEALTH DISCLOSURES</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>The OIC repealed the state regulation that required disclosure of Mental Health Services and Member Rights.</p>	<p>Removed the Mental Health Services and Members’ Rights language under the Mental Disorders benefit.</p>
<p>NONSMOKER DISCOUNT</p> <p>Applies to all individual products except Conversion and DentalOne.</p>	<p>As required by the OIC, a member may not be terminated for failure to notify the Company that he or she no longer qualifies for the non-smoker discount.</p>	<p>Added the following language to Section 3.3 of the Contract: If the person fails to notify the Company, the Company shall be entitled to change the discount Periodic Rate to the regular Periodic Rate retroactive to the date that use of the substance commenced and to recover any payments due.</p>
<p>PRESCRIPTION DRUGS</p> <p>Applies to all Comprehensive individual products except HSA Healthplan Comprehensive.</p>	<p>As required by the OIC, the Pharmacy Benefits provision of the Prescription Drugs benefit must clarify the day supply dispensed per retail copay.</p>	<p>Added language to the Pharmacy Benefits provision as follows: The Member is responsible to pay the applicable Copay amount / Coinsurance percentage for each prescription dispensed (up to a 34-day supply). The applicable Copay amount / Coinsurance percentage will not vary as a result of the day supply prescribed.</p>
<p>PRESCRIPTION DRUGS</p> <p>Applies to all Comprehensive individual products except HSA Healthplan Comprehensive.</p>	<p>As required by the OIC, the Mail Order Service provision of the Prescription Drugs benefit must clarify the day supply dispensed per mail order copay.</p>	<p>Added language to the Pharmacy Benefits provision as follows: The Member is responsible to pay the applicable Copay amount / Coinsurance percentage for each prescription dispensed (up to a 90-day supply). The applicable Copay amount / Coinsurance percentage will not vary as a result of the day supply prescribed.</p>
<p>TERMINATION OF COVERAGE</p> <p>Applies to DentalOne products only.</p>	<p>As required by the OIC, carriers may not terminate coverage for a subscriber or dependent if there is a documented inability to establish or maintain a member/provider relationship.</p>	<p>Revised the Termination of Coverage provision. The provision now states only that coverage may terminate with notice if there is legal cause for termination.</p>

<p>VISION CARE</p> <p>Applies to Comprehensive individual products with vision care benefits only.</p>	<p>As required by the OIC, clarify that vision hardware provided by both participating and non-participating providers accrues to vision hardware limit.</p>	<p>Updated Vision Care benefit in the Contract and payment schedule.</p>
<p>VOLUNTARY SECOND SURGICAL OPINION</p> <p>Applies to all individual products except Conversion, HSA plans and DentalOne.</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 the provision to clarify that members may use one of the physicians referred by the Company 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>

DOCUMENT LANGUAGE CLARIFICATIONS		
COMPONENT / CONTRACT(S) AFFECTED	EXISTING CONTRACT / BOOKLET / REASON FOR CHANGE	NEW CONTRACT / BOOKLET LANGUAGE
<p>ALLOWED AMOUNT EXAMPLES</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>Changing the first sentence of the Preferred Plan or Participating Providers paragraph in the "Allowed Amount" definition.</p>	<p>Change to: For services or supplies covered under this Contract, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement...</p>
<p>BILLED CHARGES</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>Submission of Claims and Reimbursement: Contracts 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>Added the following to the "Allowed Amount" definition: The Member will be responsible for the total billed charges for services or supplies in excess of lifetime or per Year Benefit maximums, if any, and for charges for any other service or supply not covered under this Contract, regardless of the provider rendering such service or supply.</p>
<p>GUIDE TO USING YOUR BENEFITS</p> <p>Applies to all individual and DentalOne products.</p>	<p>Customer service TTY number has been changed from 1- 877-727-4357 to 711.</p>	<p>Revised the TTY number in "When to Call Customer Service" and the "Customer Service Directory" sections.</p>
<p>INDIVIDUAL BENEFITS MANAGEMENT</p> <p>Applies to all individual and Conversion products except DentalOne.</p>	<p>Clarified provisions relating to alternative services and supplies.</p>	<p>Added language as follows: If the Member or the Member's Attending Provider does not agree with the alternative Benefits as determined by the Company, Benefits will be provided by the Company in accordance with the other provisions of this Contract.</p>
<p>WAITING PERIODS</p> <p>Applies to Conversion only.</p>	<p>Clarified provisions relating to benefit portability and waiting period credits for members who directly transfer from group coverage.</p>	<p>Revised the last sentence of the Direct Transfers from Prior Group Coverage provision to read as follows: Such Subscribers and Dependents will be required to satisfy only the unsatisfied waiting periods, if any, of the prior group Contract.</p> <p>Revised the second sentence of the benefit portability provision to read as follows: Coverage under an immediately preceding contract must have ended no later than the date coverage under this Contract began for portability provisions to apply.</p>



Regence

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