

## ENDORSEMENT TO THE CONTRACT

Regence BlueCross BlueShield of Utah ("Regence BCBSU") agrees to provide Members the following benefits in accordance with and subject to the provisions, terms, conditions, limitations and exclusions set forth in this Endorsement and the Contract to which this Endorsement is attached. If there is any inconsistency between this Endorsement and the Contract, the terms of this Endorsement will prevail.

*The following modifications are effective: July 1, 2011.*

The **APPEAL PROCESS** section shall be replaced in its entirety with the following:

## APPEAL PROCESS

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wishes to have it reviewed, You may Appeal. There are two levels of Appeal, as well as additional voluntary Appeal levels You may pursue. Certain matters requiring quicker consideration may qualify for a level of expedited Appeal and are described separately later in this section.

### APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Utah, P.O. Box 4208, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 367-2119.

Each level of Appeal, including expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the first level, within 180 days of Your receipt of Our original Adverse Benefit Determination that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, You or Your Provider may specifically request an expedited Appeal. Please see Expedited Appeals later in this section for more information.

### First-Level Appeals

First-level Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, We will send a written notice of the decision within 20 working days of receipt of the Appeal.

### Panel-Level (Second-Level) Appeals

Second-level Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the previous decisions. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony on Your behalf. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Appeal. For Post-Service Appeals involving a service or supply determined to be Investigational, We will send a written notice of the decision within 20 working days of receipt of the Appeal.

## **VOLUNTARY EXTERNAL APPEAL - IRO**

For information regarding a voluntary external Appeal, refer to the Your Right To An Independent External Review - Notice provision below.

## **EXPEDITED APPEALS**

An expedited Appeal is available for an Urgent Care Claim.

### **Panel-Level (First-Level) Expedited Appeal**

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level Expedited Appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, the initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals timeframe) to provide written materials, including written testimony on Your behalf, or to participate via telephone. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within three calendar days of the verbal notice.

### **Voluntary Expedited Appeal - IRO**

For information regarding a voluntary expedited Appeal, refer to the Your Right To An Independent External Review - Notice provision below.

## **YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW - NOTICE**

Please read this notice carefully. It describes a procedure for review of an Adverse Benefit Determination by a qualified professional who has no affiliation with Us. If You request an independent external review of Your claim, the decision made by the independent reviewer will be binding and final, except to the extent that federal or state law makes available additional remedies.

You must first exhaust Our internal Appeal process. Exhaustion of that process includes completing all levels of Appeal, or unless You requested or agreed to a delay, Our failure to respond to a standard Appeal within 30 days in writing or to a request for an Urgent Care Claim within three working days of the date You filed Your Appeal. However, You may request an external review of a final Adverse Benefit Determination before You have exhausted Our internal grievance and Appeal process, if:

- We agree to waive the exhaustion requirement for an external review request; or
- We have not complied with Our requirements for the internal Appeal process; or
- the Appeal concerns a request for an Urgent Care Claim that involves a medical condition for which the time frame for completion of Our internal Appeal process would seriously jeopardize Your life, health or ability to regain maximum function, and You have applied for an expedited external review at the same time as applying for an expedited internal review, as further detailed under the expedited external review request provision below.

You may submit a written request for an external review to: Utah Insurance Department, ATTN: External Review, State Office Building, Room 3110, Salt Lake City, Utah 84114-6901. For more information and for an external review request form see the department's web site at [www.insurance.utah.gov](http://www.insurance.utah.gov), or call the Utah Insurance Department's (the "Department") telephone number at 1 (801) 538-3800 or toll-free in Utah at 1 (800) 439-3805.

If Your request qualifies for external review, Our final Adverse Benefit Determination will be reviewed by an IRO selected by the department. We will pay the costs of the review. In order to have the Appeal reviewed by an IRO, You may be required to sign a waiver granting the IRO access to medical records.

### **Standard External Review Request**

If We issue a final Adverse Benefit Determination of Your request to provide or pay for a health care service or supply that is a Covered Service under the Contract, You may have the right to have Our decision reviewed by health care professionals who have no association with Us. You have this right only if Our denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of Your health care service or supply, as follows:
  - Upon the Department's receipt of Your request, the Department will send a copy to Us for preliminary review.
  - Within five working days after We receive Your request from the Department, We will review Your request for eligibility. Within one working day after We complete that review, We will notify You and the Department in writing whether Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility in writing. You may Appeal that determination to the Department.
  - If Your request is eligible for review, the Department will assign an IRO to Your review upon receipt of Our notice. The Department will also notify You in writing.
  - Within five working days of the date You receive the Department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.
  - The IRO must provide written notice of its decision to You, to Us and to the Department within 45 calendar days after receipt of an external review request.
  
- Our determination that Your health care service or supply was Investigational, as follows:
  - Upon the Department's receipt of Your request, the Department will send a copy to Us for preliminary review. Such request to the Department must include certification from Your Physician that: 1) standard health care services or treatment have not been effective in improving Your condition; 2) standard health care service or treatment is not medically appropriate for You; or 3) there is no available standard health care service or treatment covered by Us that is more beneficial than the recommended or requested health care service or treatment.
  - Within five working days after We receive Your request from the Department, We will review Your request for eligibility. Within one working day after We complete that review, We will notify You and the Department in writing whether Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility in writing. You may Appeal that determination to the Department.
  - If Your request is eligible for review, the Department will assign an IRO to Your review upon receipt of Our notice. The Department will also notify You in writing.
  - Within five working days of the date You receive the Department's notice of assignment to an IRO, You may submit any additional information in writing to the IRO that You want the IRO to consider in its review.
  - Within one working day after receiving the request, the IRO will select a clinical reviewer(s) to conduct the review. The clinic reviewer(s) will provide the IRO a written opinion within 20 calendar days after being selected. The IRO will make its decision based upon the clinical reviewer(s) and must provide written notice of its decision to You, to Us and to the Department within 20 calendar days after receipt of the opinion.

### **Expedited External Review Request**

You may file a written request for an Urgent Care Claim with the Department for an expedited external review of a Pre-Service or concurrent service denial. You may file for a panel-level expedited Appeal with Us and for an expedited external review request with the Department at the same time.

The Department will send Your expedited external review request to Us. We will determine, no later than the second full working day, whether Your request is eligible for review. We will notify You and the Department no later than one working day after Our decision if Your request is eligible or what additional information is needed. If We deny Your eligibility for review, We will provide You and the Department the reason(s) for the ineligibility. You may Appeal that determination to the Department.

If Your request is eligible for review, the Department will assign an IRO to Your review upon receipt of Our notice. The Department will also notify You. The IRO must provide notice of its decision to You, to Us and to the Department within 72 hours after the date of receipt of the expedited external review request.

## **INFORMATION**

If You have any questions about the Appeal process outlined here, You may contact Our Customer Service department at 1 (888) 367-2119 or You can write to Our Customer Service department at the following address: Regence BlueCross BlueShield of Utah, P.O. Box 30272, Salt Lake City, UT 84130-0272.

## **DEFINITIONS SPECIFIC TO THE APPEAL PROCESS**

Adverse Benefit Determination means, based upon Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service, the:

- denial, reduction or termination of a benefit;
- failure to provide or make payment, in whole or in part, for a benefit; or
- rescission of coverage.

An Adverse Benefit Determination also includes:

- the denial, reduction, termination, or failure to provide or make payment, or rescission that is based on a determination of Your eligibility to participate in the plan;
- failure to provide or make payment, in whole or in part, for a benefit resulting from the application of a utilization review;
- the failure to provide coverage for an otherwise Covered Service because it is determined to be:
  - Investigational; or
  - not Medically Necessary; or
- other matters as specifically required by state law or regulation.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Representative, to change a previous decision made by Us concerning an Adverse Benefit Determination.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary external Expedited Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

Post-Service means any claim for benefits under the Contract that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Contract which We must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating provider only.

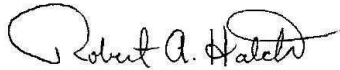
Urgent Care Claim means a request for Pre-Service or concurrent care or treatment with respect to which the time periods for making a non-Urgent Care Claim request determination:

- could seriously jeopardize Your life or health or ability to regain maximum function (in determining whether such a request is to be treated as an Urgent Care Claim, We shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine); or

- in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment (any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Claim shall be treated as such).

Except as specifically provided herein, the provisions of the Contract shall remain in full force and effect without change.

IN WITNESS WHEREOF, We, by Our duly authorized officer, have executed this Endorsement.

A handwritten signature in black ink, appearing to read "Robert A. Hatch". The signature is written in a cursive style with a large initial "R" and "H".

Robert A. Hatch  
President  
Regence BlueCross BlueShield of Utah