



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association (RBL)

P.O. Box 30270  
Salt Lake City, UT 84130-0270

Dear Regence Member,

At Regence we understand that you have several options when selecting an insurance carrier, and we appreciate your membership. As you know, there have been a number of changes in state and federal health care regulations recently, and Regence is working to make all transitions as smooth as possible.

We would like to notify you of a change that will impact your new or recently renewed policy beginning September 23, 2010. Due to the new health care reform law, Regence has removed all annual dollar limits on specific covered services that are considered "essential health benefits."

### **What are "Essential Benefits?"**

The health reform statute is very broad in defining essential benefits, and specific clarification on this component of the legislation is not anticipated from the U.S. Department of Health and Human Services (HHS) until late in 2011; therefore, Regence has decided to treat all benefits offered by Regence as "essential," except dental services and vision. Additionally, adoption benefits in Utah will not be classified as an essential benefit.

### **Annual Dollar Limits Removed on Essential Benefits**

Regence removed annual dollar limits on specific essential benefits. To help stabilize any rate impact created by the removal of dollar limits, there is a \$2 million combined annual maximum benefit for all essential benefits and, on plans where it is feasible, we have changed some dollar limits to days or visits or increased the prescription medications deductible on some plans.

Information about your new contract is included with this notice, and reflects the change in benefits. A small number of Regence claims have been impacted by this change. Regence is working to reprocess them at this time.

### **Questions?**

We understand you may have questions regarding this provision, and we invite you to visit the Frequently Asked Questions document on this issue on Regence.com at [www.regence.com/annual-limit](http://www.regence.com/annual-limit). However, please do not hesitate to contact your agent/producer or Regence Customer Service Representative at 888-367-2119 for more information.

Also enclosed is a amendment reflecting changes to BlueCard and Appeals language.

Thank you for being a Regence member. We are here to serve you, and will continue to keep you updated on this issue.

Sincerely,

Joanne S. Gholston  
Vice President, Customer Service

**AMENDMENT  
TO THE  
HEALTH CARE AGREEMENT FOR INDIVIDUALS AND FAMILIES**

Regence BlueCross BlueShield of Utah ("Regence BCBSU") and its non-insurer subsidiary, Regence ValueCare, agree to provide Enrollees the following benefits in accordance with and subject to the provisions, terms, conditions, limitations and exclusions set forth in this Amendment and the Health Care Agreement (the "Agreement") to which this Amendment is attached. If there is any inconsistency between this Amendment and the Agreement, the terms of this Amendment will prevail.

***The following modifications are effective: September 23, 2010, or the Enrollee's Effective Date, whichever is later.***

**ANNUAL MAXIMUM BENEFIT LIMIT**

A \$2,000,000 annual Maximum Benefit limit has been added for all benefits, except for adoption benefits, as follows:

Annual Maximum Benefit	
For each Enrollee	<b>\$2,000,000</b>

**MAXIMUM BENEFIT LIMIT REMOVAL**

All **dollar** Maximum Benefit limits have been removed, except for adoption benefits and the Additional Accidental Injury/Life-Threatening Illness benefit or as otherwise revised to a visit Maximum Benefit, as specified below.

**MAXIMUM BENEFIT LIMIT REVISION**

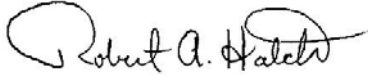
The existing dollar Maximum Benefit limit has been revised to a visit limit, per Enrollee per Calendar Year, for Outpatient and Office or Clinic Rehabilitation Services (including Chiropractic Care) and Mental Health Services, as follows:

Outpatient and Office or Clinic Rehabilitation Services (including Chiropractic Care)		
	Preferred Provider	Non-Preferred Provider
Physical, Speech, and Occupational Therapies, and Chiropractic Care	After Deductible, We pay 80% of EME and You pay 20% of EME. 20% of EME will be applied toward Out-of-Pocket Maximum.	After Deductible, We pay 60% of EME and You pay balance of billed charges. 40% of EME will be applied toward Out-of-Pocket Maximum.
Limited to 30 visits per Enrollee per Calendar Year		

## Mental Health Services

	Preferred Provider	Non-Preferred Provider
Mental Health Condition Services (including use/abuse of alcohol/drugs)	After Deductible, We pay 50% of EME and You pay 50% of EME. Coinsurance cannot be applied toward Out-of-Pocket Maximum.	After Deductible, We pay 50% of EME and You pay balance of billed charges. Coinsurance cannot be applied toward Out-of-Pocket Maximum.
Inpatient Mental Health Services are limited to 4 days per Enrollee per Calendar Year.		
Outpatient Mental Health Services are limited to 39 visits per Enrollee per Calendar Year		

IN WITNESS WHEREOF, Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare, by its duly authorized officer, has issued this Amendment.



Robert A. Hatch  
President  
Regence BlueCross BlueShield of Utah

**AMENDMENT  
TO THE  
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***The following modifications are effective: January 1, 2011, or the Enrollee's Effective Date, whichever is later.***

The **Claims Administration** Section, **BlueCard Program** subsection, shall be replaced in its entirety with the following:

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of the geographic area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Our Service Area, You will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating Providers. Our payment practices in both instances are described below.

BLUECARD PROGRAM

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access Covered Services outside Our Service Area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If any state laws mandate other liability calculation methods, including a surcharge, We would then calculate Your liability for any Covered Services according to applicable law.

#### NEGOTIATED NATIONAL ACCOUNT ARRANGEMENTS

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As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Us by the Host Blue.

#### NONPARTICIPATING PROVIDERS OUTSIDE OUR SERVICE AREA

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- **Member Liability Calculation.** When Covered Services are provided outside of Our Service Area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.
- **Exceptions.** In certain situations, We may use other payment bases, such as billed covered charges, the payment We would make if the health care services had been obtained within Our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

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 this Agreement and wishes to have it reviewed, You may Appeal. There is a single level of Appeal You may pursue within Regence. In some circumstances there is an additional voluntary Appeal level You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

#### FILING APPEALS

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If You believe a policy, action or decision of Ours is incorrect, please contact Our Customer Service department. If We cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal -- that is, ask for Us to review Your case again.

A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Utah P.O. Box 5726, Portland, OR 97228 or facsimile 1 (888) 309-8720. Verbal requests can be made by calling Us at 1 (888) 231-8424.

Appeals, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our original adverse decision that You are Appealing. External Appeals must be pursued within four months of Your receipt of Our determination. If You don't Appeal within these time periods, 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.

We will send You free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with Your Appeal and any new rationale on which a final adverse benefit determination would be made. We will provide You this information as soon as possible and in advance of the date on which We will make Our final decision.

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 treating Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

Appeals are reviewed by an employee or employees who were not involved in, or subordinate to anyone 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. You or Your Representative may submit written materials supporting Your Appeal, 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 Post-Service Investigational issue, a written notice of the decision will be sent within 20 working 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.

## VOLUNTARY EXTERNAL APPEAL - IRO

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A voluntary Appeal to an Independent Review Organization (IRO) is available only after You have exhausted the applicable non-voluntary level of Appeal, unless state or federal law does not require exhaustion of internal Appeals under the circumstances of Your Appeal and Your Appeal addresses one of the following:

- Medical Necessity;
- determination that the treatment is Investigational.

The voluntary external Appeals decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation. A written notice of the IRO's decision will be sent to You. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding, except to the extent other remedies are available under state or federal law.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us.

## EXPEDITED APPEALS

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An Expedited Appeal is available if one of the following applies:

- the application of regular Appeal time frames on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function, or
- according to a Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

### Expedited Appeal

The Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. 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. A verbal notice of the decision will be given to You within 72 hours after receipt of the Appeal. A written notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than three working days after the verbal notice.

### Voluntary Expedited Appeal - IRO

If You disagree with the decision made in the panel-level Expedited Appeal and You or Your Representative reasonably believe that preauthorization or concurrent care (Pre-Service) remains clinically urgent, You may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for Voluntary External Appeal - IRO review. You may request a voluntary expedited external review at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision. A written notice of the decision will be provided to You and Your Representative as soon as possible after the decision. Choosing the voluntary expedited Appeal as the final level to determine an Appeal will be binding, except to the extent other remedies are available under state or federal law.

The voluntary Expedited Appeal by an IRO is optional and You should know that other forums may be used as the final level of Expedited Appeal to resolve a dispute You have with Us.

## INFORMATION

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If You have any questions about the Appeal Process outlined here, You may contact Our Customer Service department at 1 (888) 231-8424 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

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Appeal means a written or verbal request from an Enrollee or, if authorized by the Enrollee, the Enrollee's Representative, to change a previous decision made by Us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;

- matters pertaining to the contractual relationship between an Enrollee and Us;
- rescission of Your health care Agreement with Us; and
- other matters as specifically required by state law or regulation.

Expedited Appeal means an Appeal where the application of regular Appeal timeframes:

- could, on a Pre-Service or concurrent care claim, jeopardize Your life, health or ability to regain maximum function,
- would, according to a Provider with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary external Appeals and voluntary 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.

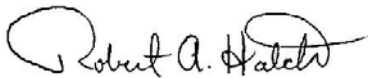
Medical Director means for purposes of the Appeal process only, a Physician employed by, or consulted by, Us. The Medical Director will reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside Practitioner with specialty in the medical condition/procedure involved in the review.

Post-Service means any claim for benefits under this Agreement that is not considered Pre-Service.

Pre-Service means any claim for benefits under this Agreement 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 an Enrollee 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.

IN WITNESS WHEREOF, Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare, by its duly authorized officer, has issued this Amendment.



Robert A. Hatch  
 President  
 Regence BlueCross BlueShield of Utah  
 Form # BV10292-003-CONV

Prepared: 10/10