UTAH EVOLVE
OFF-RENEWAL NON-RATE INCREASE REFORM LETTER FOR MEMBERS WITH EFFECTIVE DATES OF 3/1/10 – 9/1/10

Date

NAME
ADDRESS
CITY STATE ZIP

Dear Name:

We are writing to inform you about important changes that will affect your current Regence contract. Effective March 1, 2011, your Evolve plan will be updated to include new coverage and benefit provisions, which are part of the new federal Patient Protection and Affordable Care Act. You can learn more at the Health Care Reform link at www.Regence.com:

- **Annual dollar limits on Essential Benefits:** Requires that insurers remove annual dollar limits on benefits considered essential. Between now and 2014, however, insurers can place an annual dollar limit on payments for all essential benefits combined.

  - Clarification on the finer points of the new law is expected in late 2011. Until then, Regence has decided to treat almost all benefits as essential, except most dental and vision services and adoption benefits.
  - Regence has set the annual dollar limit on essential benefits for all covered expenses, at $2 million. Limits that are not expressed as dollar amounts are allowed. Where feasible, we have changed some limits from dollars to days or visits, or increased the Prescription Medications deductible on some plans, to help stabilize any rate impact from removing the dollar limits.
  - We understand that you may have additional questions regarding this provision. Therefore, we have provided more information about this issue on Regence.com at www.regence.com/annual-limit or call us at the number below.

- **Lifetime dollar limits:** Eliminates the overall lifetime dollar limit on benefits deemed "essential" by the Department of Health and Human Services (HHS).

  - Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan as long as the subscriber is still enrolled. Individuals have 30 days from this renewal to request enrollment.

- **Dependent coverage to age 26:** Extends eligibility of “adult children” up to age 26 regardless of marital or student status or financial dependency. Individuals may apply to enroll children who are

under age 26, but over age 19, and whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children previously ended due to marriage. Children over age 19 but under age 26 are subject to underwriting, and may be accepted or rejected.

- **Pre-existing conditions:** Pre-existing condition waiting periods will not be applied to coverage of enrollees under age 19.

- **Preventive services:** Includes coverage of some preventive services and medications at 100%, no deductible, no copay. This does not apply to services received from non-participating providers. Please contact us for a list of services and supplies covered under this benefit, or visit www.myRegence.com at the end of this month for the list.

Our goal is to anticipate the financial needs of our members as accurately as possible and to collect just enough premiums to cover costs and maintain adequate financial reserves as required by law. Premium increases are due in large part to rising medical and prescription costs. High rates of use, technology, and changes to federal and state regulations also have an impact on premiums. You may experience a rate increase at your next renewal July 1, 2011 or after. We will notify you of those rates in advance.

We have also updated your BlueCard benefits based on the Blue Cross Blue Shield Association requirements.

Enclosed are updated endorsements reflecting the changes. Health insurers continue to receive additional guidance from HHS regarding the new law. Therefore, benefit updates related to the new law may be subject to change. Contact your agent, visit www.regence.com, or call us at 888-367-2119 should you have any questions about this notice.

Thank you for being a Regence member. We appreciate the opportunity to provide you with the highest quality health care coverage.

Sincerely,

Tom Shearer
Membership Accounting

PATIENT PROTECTION AND AFFORDABLE CARE ACT ENDORSEMENT TO YOUR INDIVIDUAL POLICY

Due to the Patient Protection and Affordable Care Act (PPACA), this Endorsement makes certain changes to Your Regence Evolve HSA℠ Policy effective **September 23, 2010**, or the date on which Your Policy becomes effective or renews with Us, whichever is later.

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

To accomplish the above, the following changes are made to Your Policy:

ANNUAL ENROLLMENT PERIOD

An annual enrollment period is being added to the plan, during which a member under 19 years may enroll in the plan without regard to health status.

In the **Who is Eligible, How to Apply and When Coverage Begins** Section, after the **Newly Eligible Dependents** subsection, the following **"Annual Enrollment Period"** subsection shall be added:

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the designated 30 day period of time each Calendar Year and is the only time, other than the period of initial eligibility for a newly eligible dependent, during which Your eligible child who is under 19 years of age, may enroll without being denied coverage based upon health status. You must submit an enrollment form on behalf of the child(ren) You want enrolled. Coverage for Your enrolling eligible child(ren) will begin on the Effective Date, which, if enrolled within the specified 30 days, will be the first day of the month following the request for enrollment.

ENROLLED CHILD(REN) ELIGIBILITY

Coverage for children has been extended up to age 26, regardless of student or marital status, or financial dependence. The following changes will reflect how this revision applies to Your Policy.

All references throughout the Policy to the term **"dependent"** as used in conjunction with **"dependent child(ren)"** shall be removed. Such references shall now be **"child(ren)."**

Additionally, the **Who is Eligible, How to Apply and When Coverage Begins** Section, **Dependents** subsection shall be replaced in its entirety with the following:

Your Enrolled Dependents are eligible for coverage when You have listed them on the application or on subsequent change forms and when We have enrolled them in coverage under this Policy. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner, provided that all of the following conditions are met:
    - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
    - both You and Your domestic partner are age 18 or older;
    - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
    - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before submitting an application for Your domestic partner;
    - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;

  - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
  - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

  - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
  - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
  - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and who is a Disabled Dependent due to a Physical Impairment or a Mental Impairment that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's impairment, within 31 days of the later of the child's 26th birthday or Your Effective Date, the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:

  - he or she is an enrolled child immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on accident and health insurance since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site at **www.myRegence.com**, or by calling Our Customer Service department at 1 (877) 508-7360.

The **When Coverage Ends** Section, **Loss of Dependent Status** subsection shall be replaced in its entirety with the following:

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the calendar month in which the child exceeds the dependent age limit so long as premium has been received for the calendar month.
- For an enrolled child who is no longer eligible due to disruption of placemen before legal adoption and who is removed from placement, eligibility ends on the last day of the calendar month in which the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the calendar month in which the child is no longer a dependent so long as premium has been received for the calendar month.

FRAUD AND MISREPRESENTATION

In order to clarify misrepresentation must be of a material fact, the following will reflect how this revision applies to Your Policy.

The **When Coverage Ends** Section, the lead-in paragraphs shall be replaced in their entirety with the following:

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. If You lose an Enrolled Dependent, You must notify Us within 30 days.

No person will have a right to receive benefits under this Policy after the date it is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Policy for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Policy was in effect.

If this Policy is cancelled for a reason other than an intentional misrepresentation of material fact or fraud, We shall refund the unearned amount of the collected premium. If We cancel this Policy because of an intentional misrepresentation of material fact or fraud, We shall refund all premiums collected minus claims that have been paid.

The **Other Causes of Termination** Section, **Fraudulent Use of Benefits**, and **Fraud or Misrepresentation in Application** subsections shall be replaced in their entirety with the following:

If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under this Policy will terminate for that Insured.

We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud, We will have the right to declare all coverage under this Policy null and void in accordance with Utah Code 31A-22-721 (or any successor thereto); or We, at Our option, have the right to retroactively exclude or deny coverage for any claim, condition, or Enrollee related in any way to such untrue, inaccurate, or incomplete information.

LIFETIME MAXIMUM BENEFITS

Covered Services will no longer accumulate to an overall Lifetime Maximum Benefit, if applicable. The following changes will reflect how this revision applies to Your Policy.

The **Understanding Your Benefits** Section, **Maximum Benefits** subsection shall be replaced in its entirety with the following:

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, We will provide benefits until the specified Maximum Benefit (which may be a number of days, visits or services, a dollar amount or specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit that is expressed in this Policy as a number of days, visits or services. Refer to the Medical Benefits **[**and Dental Option **{**1 / 2**}]** Section**[**s**]** of this Policy to determine if a Covered Service has a specific Maximum Benefit.

The **Understanding Your Benefits** Section, **How Calendar Year Benefits Renew** subsection shall be replaced in its entirety with the following:

Many provisions of this Policy (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of this Policy have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections of this Policy.

The **Medical Benefits** Section, **Lifetime Maximum Benefits** subsection shall be removed in its entirety.

Additionally, the **Policy and Claims Administration** Section, **Submission of Claims and Reimbursement** subsection shall be replaced in its entirety with the following:

We have the sole right to decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

You will be responsible for the total billed charges for benefits in excess of any Maximum Benefits, and for charges for any other service or supply not covered under this Policy, regardless of the Provider rendering such service or supply.

PREEXISTING EXCLUSIONS FOR CHILDREN

An applying Insured under 19 years of age will not have a waiting period for Preexisting Conditions imposed. The following changes will reflect how this revision applies to Your Policy.

The **General Exclusions** Section, **Preexisting Condition** subsection shall be replaced in its entirety with the following:

> By Preexisting Condition, We mean a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before We received Your application for coverage under this Policy. Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis related to such information. In addition, exclusion periods for Preexisting Conditions are not imposed on an Insured who is enrolled prior to reaching 19 years of age.

PREVENTIVE CARE SERVICES

Preventive care services as specified will be covered at no cost sharing to You. The following changes will reflect how this revision applies to Your Policy.

The **Medical Benefits** Section, **Calendar Year Deductibles** subsection, benefits that do not apply to the Deductible paragraph, shall be replaced in its entirety with the following:

> You do not need to meet any Deductible before receiving benefits for preventive care, including immunizations.

The **Medical Benefits** Section, **Preventive Care** subsection shall be removed and coverage shall be replaced with the **"Preventive Care"** benefit listed below:

PREVENTIVE CARE

Category: 1	**Category: 2**	**Category: 3**
Provider: [Preferred] (VC) [Participating] (TR)	**Provider: Participating**	**Provider: Nonparticipating**
Payment: We pay 100% of the Allowed Amount, not subject to the Deductible.	**Payment:** We pay 100% of the Allowed Amount, not subject to the Deductible.	**Payment:** We pay 75% of the Allowed Amount and You pay balance of billed charges, not subject to the Deductible. Your 25% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover the following preventive care services and supplies provided by a professional Provider or facility. Coverage is provided only for those preventive care services designated by: the United States Preventive Service Task Force (USPSTF) for services with an A or B rating in the current recommendations; by the Health Resources and Services Administration (HRSA); or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) as otherwise specified below:

- We cover routine visits for preventive care, including, but not limited to, well-baby care, screenings for women and routine physical exams.
- We cover routine radiology and laboratory services, including, but not limited to, routine mammography and prostate screening.
- We cover routine procedures, including, but not limited to, routine colonoscopies.
- We cover immunizations for adults and children according to, and as recommended by, the CDC.

Benefits will be covered under this preventive care benefit, not any other provision of this Policy, if services or supplies are in accordance with age limits and frequency guidelines according to, and as

recommended by, the USPSTF, CDC or HRSA. For a list of services and supplies covered under this benefit, please visit **www.myRegence.com** or contact Customer Service at 1 (877) 508-7360. NOTE: Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury.

The **Medical Benefits** Section, **Prescription Medications: Covered Prescription Medications** subsection shall be replaced in its entirety with the following:

We cover benefits for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride and iron) according to, and as recommended by, the United States Preventive Service Task Force, when obtained with a Prescription Order;
- immunizations for adults and children according to, and as recommended by, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications, or for immunizations, as specified above. For a list of such medications, please visit **www.myRegence.com** or contact Customer Service at 1 (877) 508-7360. NOTE: The applicable Deductible and/or Coinsurance as listed in this Prescription Medications benefit will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy

The **Medical Benefits** Section, **Prescription Medications: Limitations** subsection, lead-in paragraph, shall be replaced in its entirety with the following:

The following limitations apply to this Prescription Medications benefit, except for certain preventive medications as specified in the Covered Prescription Medications section of this provision:

The **Medical Benefits** Section, **Prescription Medications: Exclusions** subsection, the exclusion "Immunization Agents, Biological Sera, Blood or Blood Plasma" shall be revised as follows:

<u>Biological Sera, Blood or Blood Plasma</u>

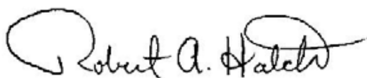
The **General Exclusions** Section, **Specific Exclusions** subsection, lead-in paragraph, shall be replaced in its entirety with the following:

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for a preventive service as specified under the Preventive Care benefit in the Medical Benefits Section.

All other terms and conditions of the Policy remain unchanged.

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

And visit Our Web site at: **www.myRegence.com**



[Robert A. Hatch**]**
President
Regence BlueCross BlueShield of Utah

ENDORSEMENT TO YOUR INDIVIDUAL POLICY

This Endorsement makes certain changes to Your Regence Evolve Core℠; Plus℠; HSA℠; or HSA 100℠ Policy as of **September 23, 2010**, or the date on which Your Policy becomes effective or renews with Us, whichever is later.

Regence BlueCross BlueShield of Utah agrees to provide Insureds the following benefits in accordance with and subject to the provisions, terms, conditions, limitations and exclusions set forth in this Endorsement and the Policy to which this Endorsement applies. If there is any inconsistency between this Endorsement and the Policy, the terms of this Endorsement will prevail.

To accomplish the above, the following changes are made to Your Policy:

ANNUAL MAXIMUM BENEFIT LIMIT

A $2,000,000 annual Maximum Benefit limit has been added for all benefits, except for adoption benefits and dental or vision care, if included in Your Policy.

MAXIMUM BENEFIT LIMIT REMOVAL

All **dollar** Maximum Benefit limits have been removed, except for adoption benefits and dental or vision care, if included in Your Policy, or as otherwise revised to a visit/day Maximum Benefit, as specified below.

Exception for the Evolve Core and Plus Policies only: The dollar Maximum Benefit limit for Upfront Benefits for Outpatient Laboratory and Radiology Services shall be retained.

MAXIMUM BENEFIT LIMIT REVISION

The existing dollar Maximum Benefit limit has been revised to a visit/day limit, per Insured per Calendar Year, for the following specified benefits:

- Rehabilitation Services:
  - five inpatient days
  - 30 outpatient visits

PRESCRIPTION MEDICATIONS DEDUCTIBLE INCREASE

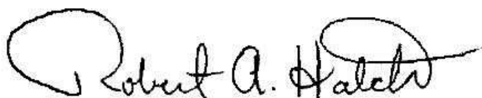
This revision only affects the Evolve Core Policy.

The Prescription Medications Deductible has been increased, as follows:

- $3,750

All other terms and conditions of the Policy remain unchanged.

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



Robert A. Hatch
President
Regence BlueCross BlueShield of Utah

ENDORSEMENT TO YOUR INDIVIDUAL POLICY

This Endorsement makes certain changes to Your Regence Evolve HSA℠ Policy effective **January 1, 2011**, or the date on which Your Policy becomes effective or renews with Us, whichever is later.

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

To accomplish the above, the following changes are made to Your Policy:

BLUECARD® PROGRAM

Blue Cross Blue Shield Association has revised the BlueCard program. The following changes will reflect how this revision applies to Your Policy.

The **Contract and 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 Our Service 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

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

- 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.

APPEAL PROCESS

Revising the Appeal process to be consistent with new requirements under Patient Protection and Affordable Care Act (Reform). The following changes will reflect how this revision applies to Your Policy.

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 Policy 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

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 (877) 508-7360.

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

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

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

If You have any questions about the Appeal Process outlined here, You may contact Our Customer Service department at 1 (877) 508-7360 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

Appeal means a written or verbal request from an Insured or, if authorized by the Insured, the Insured'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 Insured and Us;
- rescission of Your health care Policy 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 Policy that is not considered Pre-Service.

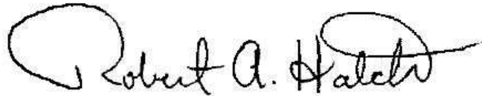
Pre-Service means any claim for benefits under this Policy which We must approve in advance, in whole or in part, in order for a benefit to be paid.

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 Insured 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.

All other terms and conditions of the Policy remain unchanged.

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



Robert A. Hatch
President
Regence BlueCross BlueShield of Utah