



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

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 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: Regence BlueCross BlueShield of Utah, P.O. Box 1271 MS C7A, Portland, OR 97207. 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 decision 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 and information describing the entire appeal process and your rights.

If your treating provider determines that your health could be jeopardized by waiting for a decision under the regular appeal process, he or she 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.

Panel-Level (Second-Level) Appeals

Second-level appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the first-level decision. You or your

representative, on your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference or other technology and/or to provide written materials. 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.

Voluntary External Appeal - IRO

A voluntary appeal to an Independent Review Organization (IRO) is available only after you have exhausted all of the applicable non-voluntary levels of appeal, or if we have failed to provide you with a first-level or panel-level appeal decision within the timeframes given and the issue on appeal addresses one of the following:

- Medical Necessity;
- determination that the treatment is investigational; or
- treatment of a preexisting condition and the benefit denial is based in whole or in part on a medical review determination by the plan.

We coordinate voluntary external appeals, but the decision is made by an Independent Review Organization (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 within 30 days of receipt of your request. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

Expedited Appeals

An expedited appeal is available if one of the following applies:

- the application of regular appeal timeframes on a pre-service or concurrent care claim could jeopardize your life, health or ability to regain maximum function, or
- according to 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.

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 who 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 participate via telephone and/or provide written materials. A verbal and written 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.

Voluntary Expedited Appeal - IRO

If you disagree with the decision made in the panel-level appeal and you or your representative reasonably believes that preauthorization remains clinically urgent (pre-service), 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 non-urgent IRO review.

We coordinate voluntary expedited appeals, but the decision is made by an IRO at no cost to you. In order to have the appeal decided by an IRO, you must sign a waiver granting the IRO access to medical records. We will provide the IRO with the appeal documentation. Verbal notice of the IRO's decision will be provided to you and your representative as soon as possible after the decision, but no later than within 72 hours of your request. Choosing the voluntary expedited appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section.

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, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

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 1271 MS C7A, Portland, OR 97207.

Definitions Specific to the Appeal Process

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:

- 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 a member and us; and
- other matters as specifically required by state law or regulation.

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