

DRAFT letter



Date

Dear (Member)

It has come to our attention that information about Regence's claims review process may inadvertently have been omitted from your recent explanation of benefits (EOB) statements.

Regence BlueShield is committed to transparency in our communications with members and we want you to know all your rights under your plan.

As spelled out in the policy on the reverse side of this letter, you have the right to request a review of any denied claims, up to and including external review by outside parties. The claims review process offers additional opportunities for the responsible parties to furnish Regence with relevant medical information on your behalf.

We urge you to review the explanation of the claims review policy on the reverse side of this letter, because there is a time limit on appealing claim denials.

If you have questions, please call the number on the back of your Regence member card. Also, you may go to myRegence.com and email us a question, or click "Live Chat" (in the upper right corner of myRegence.com screen) for a real-time response between 6 a.m. and 6 p.m. weekdays.

We apologize for any inconvenience and look forward to working with you on any claims issues you may have.

Thank you.

Penny Garrett
Director
Customer Service

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REGENCE CLAIMS REVIEW PROCEDURE

Specific reason(s)

The reason(s) for our determination, including reference to plan provisions and explanation of any additional information that is needed, are detailed on the Explanation of Benefits accompanying this notice.

Internal rules, guidelines, protocols and similar criterion are relied upon by Regence BlueShield in making its determinations. A free copy of those relevant to our determination is available upon request.

If the reason provided for our determination involves conclusions about the medical necessity or experimental/investigational nature of care or a similar medical judgment, a free explanation of our scientific or clinical judgment, applying the terms of the plan to your medical circumstances, is available upon request.

Review Procedures

If you disagree with our decision on your claim, you have the right to request a review either verbally or in writing. This is the first level of the member appeal process. A complete description of the member appeal process for your health plan is available at your request.

Regular Process

First Level – You must request review within 180 days of this notice. When we receive your first level request for review, we will send you an acknowledgement letter, including a complete description of the entire member appeal process applicable to your plan. First level review will be done by a Correspondence Department representative and a decision will be reached within 30 days.

Subsequent Levels – If you disagree with the decision made in the first level review, you have the right to additional review under the member appeal process for your plan. Our letter to you regarding your appeal will include steps you can take to request further appeals, or you can obtain this information any time by contacting our Member Services Department.

Subsequent Action

Upon exhaustion of the full member appeal process for your plan, you may have a right to pursue voluntary appeal procedures and, for most members covered by a private employer sponsored group coverage (not public employer group or individual coverage), may bring action under Section 502(a) of ERISA.