APPENDICES:

A Health Carrier Disclosures - "Your Right to an Independent External Review
B Health Carrier Notice - "Notice of Your Right to an Independent External Review"
C Health Carrier's Notice of Initial Determination

Appendix A

The summary description below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5916. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, 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, or
Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and 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 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

See the department's website at http://www.doi.idaho.gov, or
Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the

release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for**

review of our denial after the independent review organization issues its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) -- see below under "Binding Nature of the External Review Decision" for more information.

We have denied your request to provide or pay for a health care service or supply. 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, or
- Our determination your health care service or supply was investigational.

No later than four months from the date of this denial, you may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's website at http://www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require for review to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our decision will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department **within four months** after the date we issued this notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.

2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.

3. If your request is eligible for review, the department will assign an independent review organization to your

review within seven days of receipt of our notice. The department will also notify you in writing.

4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: *[NOTE TO HEALTH CARRIERS: The carrier must include one of the applicable paragraphs below for the covered person's health benefit plan.]*

*[*Your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the independent review organization will be final and binding on the health insurer, but you may have additional review rights provided under federal ERISA laws.*]*

*[*The external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review of your claim, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of your claim after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.*]*

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix C

HEALTH CARRIER'S NOTICE OF INITIAL DETERMINATION

[Date]

[Covered Person/Authorized Representative]

[Address]

RE: Initial Determination of Your Request for an External Review

We completed our preliminary review of your request for an external review sent to us by the Idaho Department of Insurance. As part of our review, we considered:

1. Eligibility of the covered person under the health benefit plan at the time the health care service was requested, or, for a post-service review, the health care service was performed;

2. If the health care service is a covered service under the health benefit plan, except for our determination the health care service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or the service or supply is investigational;

3. If the covered person has exhausted our internal grievance process, or if we failed to provide a timely determination for a grievance under that process; or if we waived the exhaustion requirement under that process; or if we failed to strictly follow our duties in affording a timely, full and fair opportunity for you to take advantage of that grievance process; or if the request qualifies as an urgent care request and you've simultaneously applied for an expedited internal review; and

4. All information and forms required to process an external review, including your signed authorization to disclose protected health information.

[*If the request is complete and eligible for review:*
We determined your request is complete and eligible for external review. We sent a copy of this notice to the Idaho Department of Insurance. The Department of Insurance will assign an independent review organization to perform the review and will notify you of the name of that organization.]

[*OR if the request is not complete:*
We have determined your request is not complete. In order to complete your request, you must provide the following: *(Provide details of what information or materials are needed to make the request complete.)]*

[*OR if the request is not eligible for external review:*
We have determined your request is not eligible for external review. Your request is ineligible for the following reasons: *(Provide details of the reasons for denial.)*
If you disagree with our initial determination that your request is ineligible, you may file a written appeal with the Director of the Idaho Department of Insurance within 30 days of the date of this notice. Your appeal must include adequate detail and documentation to show proof of your eligibility. The Director may determine a request is eligible based on the terms and conditions of the covered person's health benefit plan and the applicable provision of Idaho Code, Title 41, Chapter 59.]

[Include the following for all notices:]

For further information, please contact the Idaho Department of Insurance, (208) 334-4250, or toll-free, 1-800-721-3272. The department's fax number is (208) 334-4398. The department's website is http://www.doi.idaho.gov.

Sincerely,

[Health Carrier]

C: Idaho Department of Insurance/External Review