

1998

# Gerald McCoy representative of the estate of Frieda McCoy, deceased v. Blue Cross and Blue Shield of Utah, a Utah Corporation : Brief of Appellant

Utah Court of Appeals

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Andrew H. Stone; James E. Magleby; Jones, Waldo, Holbrook & McDonough; Attorneys for Appellant.

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IN THE SUPREME COURT OF THE STATE OF UTAH

GERALD McCOY, individually and  
as personal representative of  
the estate of FRIEDA McCOY,  
deceased,

Plaintiff,

VS.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendant.

Case No. 981246

Trial Court No.: 970901461PI

Priority No.: 15

ADDENDUM TO BRIEF OF APPELLANT BLUE CROSS AND BLUE SHIELD OF UTAH

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Blue Cross and Blue Shield  
of Utah

**FILED**

**Utah Court of Appeals**

601 22 1998

**Julia D'Alesandro**  
**Clerk of the Court**

IN THE SUPREME COURT OF THE STATE OF UTAH

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GERALD McCOY, individually and	:	
as personal representative of	:	
the estate of FRIEDA McCOY,	:	
deceased,	:	
	:	
Plaintiff,	:	Case No. 981246
	:	
vs.	:	Trial Court No.: 970901461PI
	:	
BLUE CROSS AND BLUE SHIELD OF	:	Priority No.: 15
UTAH, a Utah Corporation,	:	
	:	
Defendant.	:	

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ADDENDUM TO BRIEF OF APPELLANT BLUE CROSS AND BLUE SHIELD OF UTAH

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## Exhibit A

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FILED  
DISTRICT COURT  
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THIRD JUDICIAL DISTRICT  
SALT LAKE COUNTY  
BY J. Ashley  
CLERK

IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah corporation,

Defendant.

**COMPLAINT AND  
JURY DEMAND**

Civil No.

970901461 P1

Judge.

JUDGE PAT BRIAN

Plaintiff complains of defendant and avers as follows:

### JURISDICTION

1. Plaintiff, GERALD McCOY ("Mr. McCoy"), is a resident of the State of Utah, as was his spouse, FRIEDA McCOY ("Mrs. McCoy"), prior to her death.
2. Defendant, BLUE CROSS AND BLUE SHIELD OF UTAH ("Blue Cross"), is a Utah corporation doing business as a health insurance company in Utah.

### FACTS

3. Mr. McCoy purchased a "Qualifier One" policy of health insurance through Blue Cross (the "Blue Cross policy" or the "Policy"), which promised to pay health insurance claims for both Mr. and Mrs. McCoy. The policy's effective date was October 3, 1985. The contract number was 520465247.
4. At the time of his purchase of the Policy, Blue Cross issued to Mr. McCoy a Qualifier One brochure describing the policy.
5. The Qualifier One brochure contains no exclusion of coverage for any treatment for breast cancer, including bone marrow transplant. The brochure states that "chemotherapy" is a covered benefit.
6. Mr. McCoy performed all acts necessary to maintain the Blue Cross policy in full force and effect at least through April 1994.
7. In January 1992, Mrs. McCoy was found to have breast cancer in the left breast.

8. From January 1992 through December 1993, Mrs. McCoy underwent two breast surgeries, radiation therapy to the left chest, and three courses of standard dose chemotherapy for initial treatment and local recurrences of breast cancer in the left chest.

9. On or about December 27, 1993, Mrs. McCoy's oncologist, Dr. Greg Litton, recommended high dose chemotherapy with peripheral stem cell rescue (HDCT/PSCR) for the recurrent breast cancer. This recommendation received the support of multiple other cancer specialists and of Mrs. McCoy's primary care physician, all of whom were familiar with Mrs. McCoy's case.

10. All specialist physicians agreed that no other treatment was available for Mrs. McCoy, that her best chance of prolonging her life lay in HDCT/PSCR, and that without such therapy she would die in a short time.

11. At this time, Mrs. McCoy was 48 years old.

12. Mr. and Mrs. McCoy consulted with the University of Utah Bone Marrow Unit. Dr. Patrick Beatty of that unit concurred with the referring specialists and with their recommendation for HDCT/PSCR. On January 20, 1994, Dr. Beatty began arrangements to proceed with the therapy for Mrs. McCoy.

13. On or about March 1, 1994, the McCoy's, through Dr. Beatty, requested from Blue Cross prior approval of payment ("preauthorization") for HDCT/PSCR.

14. On March 17, 1994, Blue Cross denied preauthorization "for medical necessity" and stated, "The patient has no obvious disease and has had no chemotherapy," which was not true.

15. In April 1994, Mrs. McCoy received HDCT/PSCR at the University of Utah, funded by Mr. McCoy's former employer, Pacifcorp.

16. The McCoy's appealed the Blue Cross denial to the Benefit Appeals Committee on May 25, 1994 (Appeal Case No. BCBS 2041), and obtained a confirmation of receipt.

17. Blue Cross policy states that appeals will be decided within thirty days.

18. On June 30, 1994, Mr. McCoy contacted Blue Cross and was told that there was no record of the receipt of the appeal. He was assured that someone would call him back the next day to confirm whether Blue Cross had received the appeal.

19. When Blue Cross did not call Mr. McCoy back, he sent a letter dated July 5, 1994, asking for an immediate response in writing.

20. On July 14, 1994, Blue Cross confirmed that it had received the appeal and related information.

21. On September 29, 1994, Blue Cross issued its denial of the appeal, stating, "Your contract specifically excludes bone marrow transplant services in the treatment of breast cancer." Blue Cross further stated that if Mr. McCoy was dissatisfied with its explanation he could submit a written appeal to Blue Cross's general counsel.

22. On October 3, 1994, Mr. McCoy informed Blue Cross that he had reviewed his Blue Cross policy and documentation and found no exclusion in the Policy for bone marrow transplant in the treatment of breast cancer. Mr. McCoy asked Blue Cross to reverse its decision and approve the treatment.

23. On October 19, 1994, Frank Pignanelli, General Counsel for Blue Cross, requested an additional ten working days to respond to Mr. McCoy's appeal.

24. On January 13, 1995, Mr. Pignanelli denied Mr. McCoy's requests for reversal on the grounds that, under "the Endorsement that was attached to your health care agreement, . . . medical treatment for which you seek coverage is specifically excluded."

25. A copy of the endorsement in question, entitled "Blue Cross and Blue Shield of Utah Transplant, Non-Assignability, and Payment Differential Endorsement" and annotated "Effective: 1 January 1991" (hereinafter "the Endorsement"), was enclosed with Mr. Pignanelli's letter.

26. The Endorsement purports to exclude from coverage all medical care related to bone marrow transplants for treatment of breast cancer. It does not mention HDCT/PSCR in the treatment of breast cancer.

27. The McCoy's had never been notified that the Endorsement was part of their Blue Cross policy prior to the receipt of Mr. Pignanelli's letter.

28. As a result of Blue Cross's acts and omissions, Mrs. McCoy's treatment was delayed, her disease progressed, and her chances of survival were decreased.

29. On March 2, 1995, Mrs. McCoy died from complications of metastatic breast cancer.

30. Blue Cross's acts and omissions caused or contributed to Mrs. McCoy's death.

31. On July 31, 1995, Blue Cross sent to Mr. McCoy a letter entitled "Dear Customer." The letter stated that Blue Cross would henceforth provide insurance coverage for "Myeloablative Chemotherapy With Autologous Hematopoietic Stem Cell and/or Colony Stimulating Factor Support

(MC-AHSC/CSF) Services.” This procedure is identical to and an alternative name for HDCT/PSCR.

32. The letter of July 31, 1995, recognized that doctors and courts had disagreed as to whether a stem cell rescue procedure is a “bone marrow transplant” and confirmed that the procedure described in the letter “is a covered benefit” under the Blue Cross policy.

33. As a result of the defendant’s acts and omissions, the McCoys suffered general, special and consequential damages, including, without limitation, damages for medical expenses incurred; loss of earnings and earning capacity; loss of household services and financial support; mental and emotional anguish and suffering; enhanced disability and impairment; reduced chance of survival; loss of Mrs. McCoy’s society, comfort and care; and attorney fees.

#### FIRST CAUSE OF ACTION

34. Plaintiff incorporates all preceding averments as if fully set forth herein.

35. HDCT/PSCR is not excluded from coverage under the Blue Cross policy issued to the McCoys.

36. Blue Cross breached the express terms of its contract with the McCoys by denying coverage for HDCT/PSCR.

37. As a result of Blue Cross’s breach of contract, the McCoys were damaged in amounts to be proved at trial.

#### SECOND CAUSE OF ACTION

38. Plaintiff incorporates all preceding averments as if fully set forth herein.

39. The defendant owed the McCoys a duty of good faith and fair dealing.

40. The defendant breached its duty of good faith and fair dealing duty by, without limitation, doing the following:

- a) Failing to reasonably investigate the medical necessity of HDCT/PSCR for Mrs. McCoy before denying coverage for HDCT/PSCR;
- b) Failing to timely investigate the McCoys' requests for coverage;
- c) Failing to act on the McCoys' requests for preauthorization and coverage in a timely and reasonable manner;
- d) Denying preauthorization and coverage for HDCT/PSCR;
- e) Giving reasons for its denial that it knew or should have known were not true;
- f) Failing to act on the McCoys' appeal of Blue Cross's denial of benefits in a timely and reasonable manner;
- g) Failing to notify the McCoys of the Endorsement; and
- h) Denying the McCoys' appeal based on a provision that was not referred to in the initial denial of the claim.

41. As a result of the defendant's breaches of its duty of good faith and fair dealing, the McCoys were damaged in amounts to be proved at trial.

### THIRD CAUSE OF ACTION

42. Plaintiff incorporates all preceding averments as if fully set forth herein.

43. The defendant owed the McCoys a duty to exercise reasonable care in investigating, handling and responding to their request for preauthorization and for coverage and in handling and responding to their appeals of Blue Cross's denial of coverage.



44. The defendant breached its duty to exercise reasonable care.

45. As a direct and proximate result of the defendant's breach of its duty to exercise reasonable care, the McCoys were damaged in amounts to be proved at trial.

#### FOURTH CAUSE OF ACTION

46. Plaintiff incorporates all preceding averments as if fully set forth herein.

47. The defendant acted intentionally or recklessly toward the McCoys.

48. The defendant's acts and omissions toward the McCoys constitute extreme and outrageous conduct and offend against the generally accepted standards of decency and morality.

49. The defendant knew or reasonably should have known that the plaintiff, enduring Mrs. McCoy's severe and prolonged illness and facing her certain death without treatment, would suffer emotional distress as a result of the defendant's acts and omissions.

50. As a direct and proximate result of the defendant's acts and omissions, the plaintiff did suffer severe emotional distress.

#### FIFTH CAUSE OF ACTION

51. Plaintiff incorporates all preceding averments as if fully set forth herein.

52. The defendant should have realized that its conduct involved an unreasonable risk of causing the plaintiff emotional distress and that, if emotional distress were caused, it might result in illness or bodily harm to the plaintiff.

53. As a direct and proximate result of the defendant's acts and omissions, the plaintiff has suffered emotional distress resulting in illness or bodily harm.

### SIXTH CAUSE OF ACTION

54. Plaintiff incorporates all preceding averments as if fully set forth herein.

55. The defendant had a pecuniary interest in Mrs. McCoys' proposed treatment and the McCoys' request for preauthorization and coverage and was in a superior position to know the material facts.

56. The defendant made false or misleading representations of material facts to the McCoys, including, without limitation, representations that HDCT/PSCR was not medically necessary for Mrs. McCoy, that Mrs. McCoy had "no obvious disease" and had had no chemotherapy and that the Policy specifically excluded coverage for the requested procedure.

57. The defendant had a duty to disclose to the McCoys the terms of the policy and failed to do so.

58. The defendant made the misrepresentations and omissions knowing that they were false or misleading or with reckless disregard for their truth or falsity or carelessly and negligently, without regard to their truth or falsity.

59. Defendants knew and intended that the McCoys and their physicians would rely upon the misrepresentations and omissions

60. The McCoys reasonably relied on the defendant's misrepresentations and omissions to their detriment.

61. As a result of the defendant's misrepresentations and omissions, the McCoys suffered damages, including financial damages, in amounts to be proved at trial.

### SEVENTH CAUSE OF ACTION

62. Plaintiff incorporates all preceding averments as if fully set forth herein.

63. Blue Cross was in a superior position to the McCoys with respect to knowledge about the state of the medical art in the treatment of breast cancer.

64. Blue Cross was in a superior position to the McCoys with respect to knowledge about how courts, doctors and insurers regarded HDCT/PSCR.

65. Blue Cross knew that courts had frequently required health insurers to provide coverage for HDCT/PSCR after an initial denial.

66. Blue Cross knew that without HDCT/PSCR Mrs. McCoy's chances of survival were greatly diminished and that any delay in the treatment would allow the disease to progress, reducing the effectiveness of HDCT/PSCR.

67. Because of its superior knowledge, Blue Cross stood in a special relationship of trust to the McCoys. Blue Cross had a duty to deal with the McCoys in the utmost good faith and to make a full and fair disclosure of all the facts.

68. Without limitation, Blue Cross breached its duty by treating the McCoys as antagonists, by placing its own economic interests above the life of its insured without a clear, good-faith basis for doing so, and by fraudulently misrepresenting, concealing or failing to reveal essential facts, including, but not limited to facts about the medical necessity for treatment of Mrs. McCoy, facts about the coverage for HDCT/PSCR available under the Policy and facts about the reasons for its denials of coverage.

69. The McCoys justifiably relied upon Blue Cross's representations and omissions.

70. Mrs. McCoy was thereby prevented from receiving appropriate treatment in a timely fashion.

71. As a result of Blue Cross's breach of its duty, the McCoy's were damaged in amounts to be proved at trial.

#### EIGHTH CAUSE OF ACTION

72. Plaintiff incorporates all preceding averments as if fully set forth herein.

73. The defendant's acts or omissions were the result of willful and malicious or intentionally fraudulent conduct or conduct that manifested a knowing and reckless indifference toward and a disregard of the McCoy's rights, entitling the plaintiff to punitive damages.

#### PRAYER FOR RELIEF

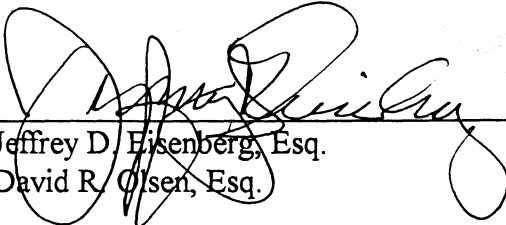
WHEREFORE, plaintiff prays for judgment against the defendant for general, special, consequential and punitive damages in amounts to be determined at trial; for costs, interest and attorney fees to the extent allowed by law; and for such other relief as the court deems proper.

#### DEMAND FOR A JURY

The plaintiff demands a trial by jury of all issues triable of right by a jury.

DATED this 28 day of February, 1997.

WILCOX DEWSNUP & KING



---

Jeffrey D. Eisenberg, Esq.  
David R. Olsen, Esq.

Plaintiff's Address:

835 18th Avenue  
Salt Lake City, UT 84103

f:\data\jdahl\data\mccoy\complaint

## Exhibit B

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Thomas J. Hartford, III (USB #4591)  
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P.O. Box 30270  
Salt Lake City, Utah 84130-0270  
Telephone: (801) 487-6441

FILED

COURT

97 MAY 27 PM 4:51

CLERK OF DISTRICT COURT

J. Avery

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendant.

AFFIDAVIT OF EDWINA H. GREEN

Civil No. 970901461PI

Judge: Pat B. Brian

STATE OF UTAH

)

) ss.

County of Salt Lake

)

Edwina H. Green, and being first duly sworn, states to the best of her  
knowledge and belief:

1. I have been employed in the legal department of Blue Cross and  
Blue Shield of Utah since August, 1981. My responsibilities as a paralegal since then  
have included drafting of Blue Cross and Blue Shield of Utah health contracts and  
preparing amendments to these contracts.

2. In the fall of 1985, a decision was made by the management of Blue Cross and Blue Shield of Utah to modify existing and future health contracts to exclude benefits for services related to temporomandibular joint dysfunction (TMJ) and radial keratotomy. The Utah State Insurance Department at about the same time mandated that all policies include a new Coordination of Benefits provision. Additionally, a decision was made to amend contracts to include a binding arbitration provision.

3. These amendments were to be effective January 1, 1986 and required notice to subscribers by November 30, 1985. I was assigned the task of coordinating the mailing to affected subscribers, notifying them of the modifications to their health policies, which included a cover letter explaining those modifications.

4. At my direction, the programming department prepared a tape of all subscribers who were to receive the mailing described above. The tape containing the subscriber list was forwarded to Image Printing of Salt Lake City during the week of November 11, 1985. Image Printing printed the subscriber letter and inserted each subscriber's name and address on Blue Cross and Blue Shield of Utah letterhead. The completed letter, with the endorsement prepared by Blue Cross and Blue Shield of Utah, was then forwarded to Progressive Direct Mail Advertising of Salt Lake City for mailing.

5. To the best of my knowledge, as based upon my review of records, all subscribers who were at that time insured under the individual product Qualifier I - Type 57H, were sent the mailing by December 1, 1985, which included the amendment to the contract providing for binding arbitration. A true and correct copy of the amendment and cover letter are attached as Exhibit "A".



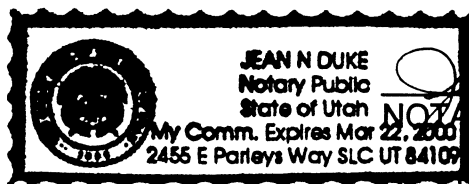
6. I have reviewed the documents and records in regards to coverage provided to the Plaintiffs and said documents and records indicate that Plaintiff McCoy was originally covered through Blue Cross and Blue Shield of Utah in a group agreement provided through his employer, Triad, effective October 1, 1985 (Type 1GE). Plaintiff McCoy has been covered through an individual health insurance policy with Blue Cross and Blue Shield of Utah Qualifier I - Type 57H since October 16, 1985 and as of July 16, 1995 is covered by an individual health insurance policy Qualifier I - Type 57J.

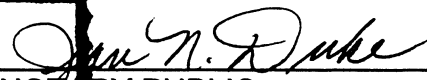
7. That as an individual policyholder of individual product Qualifier I - Type 57H in November of 1985 and as an individual policyholder since that time, the Plaintiffs would have received documents attached as Exhibit "A" and would have received all reprints and additions of the health care agreement Qualifier I - Type 57H sent by Blue Cross and Blue Shield of Utah at various times.

DATED this 27th day of May, 1997.

  
Edwina H. Green

SUBSCRIBED AND SWORN to before me this 27th day of May, 1997.



  
NOTARY PUBLIC  
Residing at Salt Lake City, Utah  
My commission expires March 22, 2000

**EXHIBIT 'A'**



2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270

Customer Service (801) 486-3314  
Administrative Offices (801) 487-6441  
Sales Information (801) 486-2583

November 25, 1985

Dear Subscriber:

As your insurance carrier, Blue Cross and Blue Shield is responsible for providing you with the most cost-efficient coverage available in Utah. As part of our continuing effort to keep your insurance costs down, the enclosed Endorsement will be added to your contract effective January 1, 1986.

Please note that one exclusion specifically deals with radial keratotomy, a procedure used to surgically correct vision. This procedure, which is both expensive and elective in nature, is utilized by a relatively few subscribers, thereby increasing costs for everyone. This exclusion is not a new policy for Blue Cross and Blue Shield. We have not covered the cost of eyeglasses in the past and we are now specifically excluding radial keratotomy.

We would also like to announce that effective January 1, 1986 we will adopt an arbitration procedure for the resolution of any disputes you may have with Blue Cross and Blue Shield of Utah. This will save you the trouble of having to go through the courts to settle a dispute with us, and should further save money on behalf of our subscribers.

Finally, all insurance companies in Utah have been mandated by the Insurance Department to implement changes in our coordination of benefits practices. Please see the enclosed Endorsement for further details.

As a valued customer of Blue Cross and Blue Shield of Utah, we want to keep you fully informed of the benefits of your contract and our cost-containment efforts. Please contact our Customer Service Department at 486-3314 or 1-800-662-6515 (toll free) if you have any questions.

Enc.

## BASIC HEALTH CARE AGREEMENT

s Endorsement is issued to you, a Subscriber of Blue Cross and Blue Shield of Utah (the "an"), to amend your Health Care Agreement to the following extent:

The Limitations and Exclusions section shall be amended to exclude the following:

1. Services, supplies, or accommodations provided in connection with vision or hearing examinations, except when required as part of an examination to diagnose an illness or injury other than refractive errors of vision. No benefits shall be provided for (i) surgical correction of refractive errors of vision, including radial keratotomy and keratomileusis; (ii) eyeglasses or contact lenses, except for the initial prosthetic lens following cataract surgery; or (iii) hearing aids or similar devices.
2. Services, supplies, or accommodations in connection with temporomandibular joint dysfunction, upper or lower jaw augmentation or reduction procedures (orthognathic surgery); or appliances or restorations necessary to increase vertical dimensions or restore occlusion.\*

Binding arbitration is adopted for final resolution of any dispute. The General Terms and Conditions section of your Health Care Agreement shall incorporate the following arbitration provision:

### ARBITRATION

In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of this Agreement arising between the Employer, Subscriber, eligible Family Member, or the heir-at-law or personal representative of such person, and the Plan, whether involving a claim in tort, contract or otherwise, the same shall be submitted to arbitration under the appropriate rules of the American Arbitration Association

In all arbitration matters submitted to the American Arbitration Association, the party initiating the demand for arbitration shall advance all administrative fees connected therewith; subject, however, to final apportionment by the arbitrator in his or her award.

The parties agree that the arbitrator's award shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award.

The General Terms and Conditions section of your Health Care Agreement with respect to "Nonduplication of Benefits" shall be replaced with provisions to the following effect:

### NONDUPLICATION OF BENEFITS

Where a Member, in addition to coverage under this Agreement, is covered by one or more other health care programs which have at least one benefit in common with this Agreement and which provide benefits for or by reason of care or treatment of illness or injury (hereafter "programs"), the benefits of all the programs, including this one, will be coordinated to prevent duplication of benefits. Programs with which coordination will be performed include: (i) Group, blanket, or franchise insurance or prepayment coverage; (ii) Labor-management trust plan, union welfare plan, or employer or employee organization benefit plan coverage; (iii) Trade, professional, or cooperative association plan coverage; (iv) Federal, state, or other governmental employer or employee plan coverage (including Worker's Compensation, Medicare, No-Fault Auto Insurance, or services rendered by the Veteran's Administration; but not including any state plan under Medicaid or any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program); (v) Health Maintenance Organization coverage; (vi) Plan coverage, where the plan is solely or largely supported by taxes, grants, or other governmental or charitable assistance; (vii) Other plan coverage, where any employer or other organization contributes toward premium costs or makes payroll deductions for, or otherwise collects premiums.

ur Health Care Agreement may already exclude benefits for temporomandibular joint dysfunction.

The first step in coordination is the identification of that program which should pay its benefits first (the "primary" program). The primary program is identified through the use of a list of rules. The first rule which is applicable identifies the primary program. The rules are:

1. A program not containing these rules is primary to a program containing them.
2. A program covering the claimant as anything other than a dependent is primary to a program of dependent coverage.
3. Where two or more programs cover the claimant as the dependent of different parents, who are not separated or divorced,
  - a. the program of the parent whose birthday (regardless of year of birth) falls earlier in the calendar year is primary to the other parent's program;
  - b. if the parents have the same birthday, the coverage of the parent who has had his or her program the longer will be primary to the program the other parent has had for a shorter time.

(Rule 3 of this program will be superceded by the rule of another program, where such other program uses a rule based upon the genders of the parents.)

4. Where two or more programs cover the claimant as the dependent of divorced or separated parents,
  - a. the program of the parent with custody of the claimant shall be primary to any other dependent coverage;
  - b. the program of the claimant's stepparent who is married to the claimant's custodial parent shall be primary to the program of the non-custodial parent.


EXCEPT, if there is a court decree establishing financial responsibility for the claimant's health care expenses in one parent and that parent's program is aware of the terms of such decree, the responsible parent's program shall be primary to any other dependent coverage;

5. A program covering the claimant as an employee, neither laid-off nor retired, shall be primary to coverage of the claimant as a laid-off or retired employee. (Rule 5 is ignored if the other program does not also contain it.)
6. Finally, the program which has covered the claimant for the longer period is primary to that which has covered him or her for the shorter period.

Once the order of benefits has been determined pursuant to rules 1 through 6 above, the amount of payment owed by each program is calculated. If this Agreement is primary, it will pay the benefits of the Agreement as if there were no other programs involved. If another program is primary to this Agreement (and, thus, this Agreement is "secondary"), the benefits of this Agreement are reduced from those available when this Agreement is primary. To calculate the benefits of this Agreement when it is a secondary program, the benefits available if this Agreement were primary are calculated, and from that sum are subtracted the benefits payable by plans primary to this Agreement. It should be noted that where this Agreement is secondary, its benefits, plus those of plans primary to it, may total less than one hundred percent of the necessary, reasonable, and customary expense for items of expense which are covered, in whole or part, by any or all of the health care programs.

IN WITNESS WHEREOF, Blue Cross and Blue Shield of Utah, by its duly authorized officer, has executed this Endorsement.

BLUE CROSS AND BLUE SHIELD OF UTAH

  
\_\_\_\_\_  
Jed H. Pitcher, President

Effective: January 1, 1986

## EXHIBIT 'B'

# Health Care Agreement

QUALIFIER I



Blue Cross  
Blue Shield  
of Utah

Type 57H

## OF UTAH

### Endorsement to Health Care Agreement

57-57H

57-57J

Endorsement is issued to modify the Health Care Agreement between the Subscriber and Blue Cross and Blue Shield of Utah to the extent specifically provided.

Health Care Agreement shall be amended to provide all benefits for care and treatment of pregnancy; provided, however, that benefits shall be provided for care and treatment of pregnancy which begins on January 1, 1988 until the earlier of (i) the date of termination of such pregnancy, or (ii) December 30, 1988. Benefits shall remain in effect in the event of severe Complications of Pregnancy.

II.D.4. **General Exclusions** shall be amended to include the following exclusion:

Services, supplies or accommodations provided for care or treatment of pregnancy.

Health Care Agreement shall be renumbered as necessary to accommodate the foregoing amendments.

**WITNESSETH** WHEREOF, Blue Cross and Blue Shield of Utah, by its duly authorized officer, has executed this endorsement.

BLUE CROSS AND BLUE SHIELD OF UTAH



J. H. Pitcher, President

January 1, 1988

BLUE CROSS  
AND  
BLUE SHIELD OF UTAH  
Post Office Box 30270  
Salt Lake City, Utah 84130

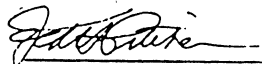
### HEALTH CARE AGREEMENT FOR NON-GROUP MAJOR MEDICAL PROTECTION

In consideration for payment of quarterly Dues, Blue Cross and Blue Shield of Utah, a Utah nonprofit corporation, agrees to provide to the Subscriber and enrolled Family Dependents of the Subscriber, health care benefits in accordance with and subject to the provisions, terms, conditions, limitations, and exclusions set forth in this Agreement.

Blue Cross and Blue Shield of Utah, by its duly authorized officer, has executed this Agreement.

Upon receipt of this Agreement, the Subscriber shall have 10 days to cancel this Agreement and shall be entitled to a refund of all dues paid.

BLUE CROSS AND  
BLUE SHIELD OF UTAH,  
a Utah nonprofit  
corporation,



Jed H. Pitcher,  
President

The benefits under this contract will be reduced when more than one health benefits contract is in effect, including No-Fault Auto Insurance, whether the No-Fault is in effect or not (see Part II.D.4 and III.F.). This contract also requires waiting periods before benefits are provided for certain health conditions and maternity care (see Part II. D.).



**STEP THREE - Plan's General Counsel or  
Medical Director**

Upon written request, including any pertinent additional information or comments, a Claims Appeal Committee decision with which you disagree may be reviewed by the Plan's General Counsel or the Medical Director. An investigation will be completed within ten (10) working days and you will receive written notification of the decision.

**STEP FOUR - Utah State Insurance  
Department**

Should you remain dissatisfied after completing the preceding three steps, you may submit a report to the Consumer Service Division of the Utah State Insurance Department for consideration. Your report will be handled in accordance with the Insurance Department's policy and procedures.

**STEP FIVE - Binding Arbitration**

Binding arbitration is the final step for the resolution of any dispute. When you enroll as a Member of the Plan, you agree that any dispute will be resolved by binding arbitration, and agree to give up the right to a jury or court trial for the settlement of such disputes. All administrative fees connected with initiating a demand for arbitration shall be split equally and advanced by you and the Plan; subject, however, to final apportionment by the arbitrator in his or her award. The Customer Service or Legal Affairs Departments can assist you with procedures for initiating and participating in arbitration.

**QUESTIONS OR INFORMATION**

If you (a Member) should have any questions regarding this Agreement or if you need information or assistance regarding this Agreement, please contact your local Customer Service Department of the Plan.

**PART II. MAJOR MEDICAL BENEFITS**

When a Member incurs Eligible Medical Expenses for care and treatment of illness, injury, pregnancy, or misuse and/or abuse of alcohol or drugs, the Plan will provide Major Medical Benefits as follows:

**A. DEDUCTIBLE AMOUNT AND MAXIMUM BENEFITS**

1. Deductible Amount. Major Medical Benefits hereunder shall be subject to a Deductible Amount of One Thousand Dollars (\$1,000.00) for each calendar year for each Member; provided, however, that in any calendar year such Deductible will not be required for more than two (2) Members of the same Family Unit.

Eligible Medical Expenses incurred by a Member for covered services in the last three (3) calendar months of any calendar year and applied against the Deductible Amount for such year shall be carried forward and applied against the Deductible Amount for such Member for the next following calendar year.

2. Maximum Benefits. Major Medical Benefits under this Agreement are limited to a lifetime maximum of One Million Dollars (\$1,000,000) for each Member. When a Member has received Major Medical Benefits under this Agreement totalling One Million Dollars (\$1,000,000), this Agreement and all coverage hereunder shall automatically terminate with respect to such Member.

**B. REIMBURSEMENT AND ELIGIBLE MEDICAL EXPENSES**

1. Reimbursements. As to any calendar year in which a Member incurs Eligible Medical Expenses (as defined below in Part II. B.3) in excess of the Deductible Amount, the Plan will reimburse the Member (i) for eighty percent (80%) of the amount by which the Member's Eligible Medical Expenses for such calendar year exceed

ported by taxes, grants, or other governmental or charitable assistance; (vii) Other plan coverage, where any employer or other organization contributes toward premium costs or makes payroll deductions for, or otherwise collects, premiums.

"Individual health care program" as used herein means any plan, contract, or policy (other than a group health care program) which provides benefits for or by reason of care or treatment of an illness or injury and which is sold directly to an individual. The term "individual health care program" shall include any group conversion policy or contract issued directly to a group member or such member's family dependents upon termination of group eligibility, provided that such conversion policy or contract is not a group sponsored retirement or disability program.

"Overinsurance provision" as used herein means this Part III. F. and any other provision which may reduce the liability of a health care program by reason of the existence of benefits under other valid coverage.

Expansion of Benefits. In no case shall this Part III.F. operate to increase the total benefits that may be provided under this Agreement in the absence of this Part

Prohibition of Overpayment. In the event the Plan provides benefits to behalf of a Member in excess of the amount which would have been payable by reason of the Member's coverage under another health care

plan, the plan shall be entitled to recover the amount of such excess from the Member or the related Subscriber. When a health care program provides benefits in the form of services, the reasonable cash value of such services shall be deemed to be the benefit paid for purposes of this Part III.F.

6. Information. The Member shall promptly furnish or cause to be furnished to the Plan any information necessary or appropriate for administration of the provisions of this Part III.F. by the Plan. Receipt of such information by the Plan shall be a condition precedent to the obligation of the Plan to provide benefits under this Agreement.
7. Payments. In administering and accomplishing the provisions of this Part III.F., the Plan shall have the absolute right (i) to make and recover any payments to or from a Subscriber, a Member, a Provider of Covered Services, Supplies, or Accommodations, and/or any health care program, and (ii) to release any information which the Plan deems appropriate in connection therewith.
8. This Part III.F. shall not apply to independent dental programs, except with respect to duplication of benefits for the same services or supplies.

#### G. GENERAL PROVISIONS

1. Arbitration. In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of this Agreement arising between the Employer, Subscriber, eligible Family Member, or the heir-at-law or personal representative of such person, the Plan, whether involving a claim in tort, contract or otherwise, the same shall be submitted to

arbitration under the appropriate rules of the American Arbitration Association.

All arbitration fees connected with initiating the demand for arbitration shall be split between and advanced by the parties by the arbitrator in his or her award.

The parties agree that the arbitrator's award shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award.

2. Interpretation. This Agreement shall be governed by and construed in accordance with the laws of the State of Utah. Where the law or judicial interpretation of the law changes over time, the administration of benefits for otherwise identical claims may differ, unless such change is expressly made retroactive. Where not directly in conflict with the laws of the State of Utah, this Agreement will be interpreted in accordance with those Plan rules and regulations in effect at the time of interpretation. Whenever the context requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Agreement are for reference only and shall not affect the manner in which any provision hereof is construed.

3. Entire Agreement. This Agreement sets forth the entire understanding between the parties relative to the subject matter hereof, and supersedes and cancels all and any health service agreements heretofore issued to the Subscriber by the Plan. No modifications of or additions to this Agreement shall be binding upon the Plan unless set forth in an endorsement or rider duly issued by

the Plan and signed by its duly authorized officers.

4. Notices. Any notice to the Subscriber provided for in this Agreement shall be deemed to have been given to and received by the Subscriber when deposited in the United States Mail with first class postage prepaid and addressed to the Subscriber at the address shown in the records of the Plan. Any notice to the Plan provided for in this Agreement may be given by mail addressed to Blue Cross and Blue Shield of Utah, P.O. Box 30270, Salt Lake City, Utah 84130; provided, however, that any notice to the Plan shall not be deemed to have been given to and received by the Plan until physically received by the Plan.
5. No Assignment. No person other than an enrolled eligible Member shall be entitled to receive any benefits under this Agreement. Such right to receive benefits may not be transferred or assigned.
6. Independent Contractors. All Providers, Hospitals, Skilled Nursing Facilities, Special Care Facilities, and other persons and organizations furnishing services, supplies, and accommodations to a Member do so as independent contractors. The Plan shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a Member while receiving such services, supplies, or accommodations.
7. Choice of Facility or Provider. Nothing contained in this Agreement shall be deemed to restrict a Member in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility, Special Care Facility, or Provider for care or treatment of an injury or illness.

**EXHIBIT 'C'**

# Health Care Agreement



Blue Cross  
Blue Shield  
of Utah

7/89

**QUALIFIER 1**

Type 57H

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**BLUE CROSS  
AND  
BLUE SHIELD OF UTAH  
Post Office Box 30270  
Salt Lake City, Utah 84130**

**HEALTH CARE AGREEMENT  
FOR  
NON-GROUP MAJOR  
MEDICAL PROTECTION**

In consideration for payment of quarterly Dues, Blue Cross and Blue Shield of Utah, a Utah nonprofit corporation, agrees to provide to the Subscriber and enrolled Family Dependents of the Subscriber, health care benefits in accordance with and subject to the provisions, terms, conditions, limitations, and exclusions set forth in this Agreement.

Blue Cross and Blue Shield of Utah, by its duly authorized officer, has executed this Agreement.

Upon receipt of this Agreement, the Subscriber shall have 10 days to cancel this Agreement and shall be entitled to a refund of all dues paid.

BLUE CROSS AND  
BLUE SHIELD OF UTAH,  
a Utah nonprofit  
corporation,



Jed H. Pitcher,  
President

The benefits under this contract will be reduced when more than one health benefits contract is in effect, including No-Fault Auto Insurance, whether the No-Fault is in effect or not (see Part II.D.3 and III.F.). This contract also requires waiting periods before benefits are provided for certain health conditions (see Part II. D.).

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not assignable by the Subscriber in whole or in part to a Nonparticipating Provider or to any other person or entity.

#### **D. MEMBER GRIEVANCE PROCEDURE**

The following is a description of the steps available to you, the Member, to resolve any complaints or grievances regarding the administration of your health care coverage. Blue Cross and Blue Shield of Utah employees have been trained to work with you to resolve any problems with your coverage which are brought to their attention. You may call the Plan for more information at 486-6198 (Salt Lake City) or, toll free from anywhere else in Utah, at 1-800-662-9585.

##### **STEP ONE — Customer Service Department**

The Customer Service Department is your first recourse for claim processing, eligibility and benefit information. Customer Service may be contacted by telephone or letter. Where a problem cannot be resolved by telephone and you document it in a written grievance, an investigation will be initiated when the grievance is received by the Plan and will result in a written decision, a copy of which will be sent to you.

##### **STEP TWO — Claims Appeal Committee**

If you do not agree with the decision made by the Customer Service Department, you may make a written request that the problem be reviewed by the Claims Appeal Committee of the Plan by sending your written appeal, with any additional information or comments, to:

Claims Appeal Committee  
Blue Cross and Blue Shield of Utah  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270

This appeal should be made within sixty (60) days after you receive notification of the Customer Service Department's decision. The Claims Appeal Committee will reach a decision within sixty (60) days of your written request for review and you will be advised of the decision in writing.

##### **STEP THREE — Plan's General Counsel**

Upon written request, including any pertinent additional information or comments, a Claims Appeal Committee decision with which you disagree may be reviewed by

the Plan's General Counsel. An investigation will be completed within ten (10) working days and you will receive written notification of the decision.

#### **STEP FOUR — Binding Arbitration**

Binding arbitration is the final step for the resolution of any dispute. When you enroll as a Member of the Plan, you agree that any dispute will be resolved by binding arbitration, and agree to give up the right to a jury or court trial for the settlement of such disputes. All administrative fees connected with initiating a demand for arbitration shall be split equally and advanced by you and the Plan; subject, however, to final apportionment by the arbitrator in his or her award. The Customer Service or Legal Affairs Departments can assist you with procedures for initiating and participating in arbitration.

#### **E. QUESTIONS OR INFORMATION**

If you (a Member) should have any questions regarding this Agreement or if you need information or assistance regarding this Agreement, please contact your local Customer Service Department of the Plan.

#### **PART II. MAJOR MEDICAL BENEFITS**

When a Member incurs Eligible Medical Expenses for care and treatment of illness, injury, or misuse and/or abuse of alcohol or drugs, the Plan will provide Major Medical Benefits as follows:

##### **A. DEDUCTIBLE AMOUNT AND MAXIMUM BENEFITS**

- 1. Deductible Amount.** Major Medical Benefits hereunder shall be subject to a Deductible Amount of One Thousand Dollars (\$1,000.00) for each calendar year for each Member; provided, however, that in any calendar year such Deductible will not be required for more than two (2) Members of the same Family Unit.

Eligible Medical Expenses incurred by a Member for covered services in the last three (3) calendar months of any calendar year and applied against the Deductible Amount for such year shall be carried forward and applied against the Deductible Amount for such Member for the next following calendar year.

### 3. Definitions

- a. **"Allowable expenses"** means reasonable charges for health care services, supplies, and accommodations which are covered, in whole or in part, under this Agreement or under any other health care program having at least one common benefit with this Agreement.
- b. **"Health care program"** as used herein means any plan, contract, or policy which provides benefits for or by reason of care or treatment of an illness or injury by or through any of the following: (i) Group, blanket, or franchise insurance or prepayment coverage; (ii) Labor-management trust plan, union welfare plan, or employer or employee organization benefit plan coverage; (iii) Trade, professional, or cooperative association plan coverage; (iv) Federal, state, or other governmental employer or employee (statutory or non-statutory) plan coverage; (v) Health maintenance organization coverage; (vi) Plan coverage; where the plan is solely or largely supported by taxes, grants, or other governmental or charitable assistance; (vii) Other plan coverage, where any employer or other organization contributes toward premium costs or makes payroll deductions for, or otherwise collects, premiums.
- c. **"Individual health care program"** as used herein means any plan, contract, or policy (other than a group health care program) which provides benefits for or by reason of care or treatment of an illness or injury and which is sold directly to an individual. The term "individual health care program" shall include any group conversion policy or contract issued directly to a group member or such member's family dependents upon termination of group eligibility, provided that such conversion policy or contract is not a group sponsored retirement or disability program.
- d. **"Overinsurance provision"** as used herein means this Part III. F. and any other provision which may reduce the liability of a health care program by reason of the existence of benefits under other valid coverage.

4. **No Expansion of Benefits.** In no event shall this Part III.F. operate to increase the total benefits that would be provided under this Agreement in the absence of this Part III.F.
5. **Recovery of Overpayment.** In the event the Plan provides benefits to or on behalf of a Member in excess of the amount which would have been payable by reason of the Member's coverage under another health care program, (whether group or individual), the Plan shall be entitled to recover the amount of such excess from the Member or the related Subscriber. When a health care program provides benefits in the form of services, the reasonable cash value of such services shall be deemed to be the benefit paid for purposes of this Part III.F.
6. **Information.** The Member shall promptly furnish or cause to be furnished to the Plan any information necessary or appropriate for administration of the provisions of this Part III.F. by the Plan. Receipt of such information by the Plan shall be a condition precedent to the obligation of the Plan to provide benefits under this Agreement.
7. **Payments.** In administering and accomplishing the provisions of this Part III.F., the Plan shall have the absolute right (i) to make and recover any payments to or from a Subscriber, a Member, a Provider of Covered Services, Supplies, or Accommodations, and/or any health care program, and (ii) to release any information which the Plan deems appropriate in connection therewith.
8. **This Part III.F. shall not apply to independent dental programs, except with respect to duplication of benefits for the same services or supplies.**

### G. GENERAL PROVISIONS

1. **Arbitration.** In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of this Agreement arising between the Employer, Subscriber, eligible Family Member, or the heir-at-law or personal representative of such person, and the Plan, whether involving a claim in tort, contract or otherwise, the same shall be submitted to arbitration under the appropriate rules of the American Arbitration Association.



All arbitration fees connected with initiating the demand for arbitration shall be split between and advanced by the parties to the arbitration; subject, however, to final apportionment by the arbitrator in his or her award.

The parties agree that the arbitrator's award shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award.

2. **Interpretation.** This Agreement shall be governed by and construed in accordance with the laws of the State of Utah. Where the law or judicial interpretation of the law changes over time, the administration of benefits for otherwise identical claims may differ, unless such change is expressly made retroactive. Where not directly in conflict with the laws of the State of Utah, this Agreement will be interpreted in accordance with those Plan rules and regulations in effect at the time of interpretation. Whenever the context requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Agreement are for reference only and shall not affect the manner in which any provision hereof is construed.
3. **Entire Agreement.** This Agreement sets forth the entire understanding between the parties relative to the subject matter hereof, and supersedes and cancels all and any health service agreements heretofore issued to the Subscriber by the Plan. No modifications of or additions to this Agreement shall be binding upon the Plan unless set forth in an endorsement or rider duly issued by the Plan and signed by its duly authorized officers.
4. **Notices.** Any notice to the Subscriber provided for in this Agreement shall be deemed to have been given to and received by the Subscriber when deposited in the United States Mail with first class postage prepaid and addressed to the Subscriber at the address shown in the records of the Plan. Any notice to the Plan provided for in this Agreement may be given by mail addressed to Blue Cross and Blue Shield of Utah, P.O. Box 30270, Salt Lake City, Utah 84130; provided, however, that any notice to the Plan shall not be deemed to have been given to and received by the Plan until physically received by the Plan.

5. **No Assignment.** No person other than an enrolled eligible Member shall be entitled to receive any benefits under this Agreement. Such right to receive benefits may not be transferred or assigned.
6. **Independent Contractors.** All Providers, Hospitals, Skilled Nursing Facilities, Special Care Facilities, and other persons and organizations furnishing services, supplies, and accommodations to a Member do so as independent contractors. The Plan shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a Member while receiving such services, supplies, or accommodations.
7. **Choice of Facility or Provider.** Nothing contained in this Agreement shall be deemed to restrict a Member in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility, Special Care Facility, or Provider for care or treatment of an injury or illness.
8. **Reimbursement Payments.** Any reimbursement payment to be made to a Member for benefits under this Agreement may be made by the Plan to such Member, or to the Subscriber of which such Member is a Family Dependent, or to both jointly.
9. **Overpayments.** If for any reason the Plan pays any amounts to or on behalf of the Subscriber or a Family Dependent (or person believed to be a Family Dependent) of the Subscriber (i) for services, supplies, or accommodations not covered under this Agreement, or (ii) with respect to a Family Dependent (or person believed to be a Family Dependent) not covered under this Agreement, or (iii) which exceed amounts to be paid as benefits under this Agreement, the Subscriber agrees to reimburse the Plan on demand for all and any such amounts.
10. **Medical Records.** The Plan shall have the right from time to time to require, without cost or expense to the Plan and as a condition precedent to liability for any benefits to be provided under this Agreement, that the Plan be furnished with medical reports (including certificates of medical necessity), medical records, and hospital records relating to care and treatment of any Member, which are maintained or possessed by any Provider, Hospital, Skilled Nursing Facility, Special Care Facility, or other person or organization providing services, supplies, or ac-

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All arbitration fees connected with initiating the demand for arbitration shall be split between and advanced by the parties to the arbitration; subject, however, to final apportionment by the arbitrator in his or her award.

The parties agree that the arbitrator's award shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award.

2. **Interpretation.** This Agreement shall be governed by and construed in accordance with the laws of the State of Utah. Where the law or judicial interpretation of the law changes over time, the administration of benefits for otherwise identical claims may differ, unless such change is expressly made retroactive. Where not directly in conflict with the laws of the State of Utah, this Agreement will be interpreted in accordance with those Plan rules and regulations in effect at the time of interpretation. Whenever the context requires, the singular shall include the plural, the plural shall include the singular, the whole shall include any part thereof, and any gender shall include both genders. The captions which precede parts of this Agreement are for reference only and shall not affect the manner in which any provision hereof is construed.
3. **Entire Agreement.** This Agreement sets forth the entire understanding between the parties relative to the subject matter hereof, and supersedes and cancels all and any health service agreements heretofore issued to the Subscriber by the Plan. No modifications of or additions to this Agreement shall be binding upon the Plan unless set forth in an endorsement or rider duly issued by the Plan and signed by its duly authorized officers.
4. **Notices.** Any notice to the Subscriber provided for in this Agreement shall be deemed to have been given to and received by the Subscriber when deposited in the United States Mail with first class postage prepaid and addressed to the Subscriber at the address shown in the records of the Plan. Any notice to the Plan provided for in this Agreement may be given by mail addressed to Blue Cross and Blue Shield of Utah, P.O. Box 30270, Salt Lake City, Utah 84130; provided, however, that any notice to the Plan shall not be deemed to have been given to and received by the Plan until physically received by the Plan.

5. **No Assignment.** No person other than an enrolled eligible Member shall be entitled to receive any benefits under this Agreement. Such right to receive benefits may not be transferred or assigned.

6. **Independent Contractors.** All Providers, Hospitals, Skilled Nursing Facilities, Special Care Facilities, and other persons and organizations furnishing services, supplies, and accommodations to a Member do so as independent contractors. The Plan shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by a Member while receiving such services, supplies, or accommodations.

7. **Choice of Facility or Provider.** Nothing contained in this Agreement shall be deemed to restrict a Member in exercising full freedom of choice in the selection of a Hospital, Skilled Nursing Facility, Special Care Facility, or Provider for care or treatment of an injury or illness.

8. **Reimbursement Payments.** Any reimbursement payment to be made to a Member for benefits under this Agreement may be made by the Plan to such Member, or to the Subscriber of which such Member is a Family Dependent, or to both jointly.

9. **Overpayments.** If for any reason the Plan pays any amounts to or on behalf of the Subscriber or a Family Dependent (or person believed to be a Family Dependent) of the Subscriber (i) for services, supplies, or accommodations not covered under this Agreement, or (ii) with respect to a Family Dependent (or person believed to be a Family Dependent) not covered under this Agreement, or (iii) which exceed amounts to be paid as benefits under this Agreement, the Subscriber agrees to reimburse the Plan on demand for all and any such amounts.

10. **Medical Records.** The Plan shall have the right from time to time to require, without cost or expense to the Plan and as a condition precedent to liability for any benefits to be provided under this Agreement, that the Plan be furnished with medical reports (including certificates of medical necessity), medical records, and hospital records relating to care and treatment of any Member, which are maintained or possessed by any Provider, Hospital, Skilled Nursing Facility, Special Care Facility, or other person or organization providing services, supplies, or ac-

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## Exhibit C

JEFFREY D. EISENBERG, ESQ. (#4029)  
DAVID R. OLSEN, ESQ. (#2458)  
WILCOX DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111  
Telephone: (801) 533-0400

CLARK NEWHALL, ESQ. (#7091)  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101  
Telephone: (801) 530-0350

Attorneys for Plaintiff

FILED  
97 JUL -8 AM 11:34  
THIRD JUDICIAL DISTRICT  
SALT LAKE COUNTY  
BY Mashley  
DEPUTY CLERK

IN THE THIRD JUDICIAL DISTRICT COURT  
SALT LAKE COUNTY, STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah corporation,

Defendant.

**AFFIDAVIT OF  
GERALD McCOY**

Civil No. 970901461PI  
Judge Pat B. Brian

STATE OF UTAH            )  
                                  :  
COUNTY OF SALT LAKE )

Gerald McCoy, being duly sworn, upon his oath deposes and states as follows:

1. I am the plaintiff in this action and have personal knowledge of the matters stated herein.

2. In October 1985, effective October 16, 1985, I changed my health insurance coverage from a group health insurance policy provided by Blue Cross and Blue Shield of Utah ("Blue Cross") through my former employer to an individual health insurance policy provided by Blue Cross known as the Qualifier I plan for non-group major medical protection.

3. A true and correct copy of the policy I received at the time I changed to the Qualifier I plan is attached as exhibit 1. The policy does not contain an arbitration provision, and nowhere in the policy does it say that an insured cannot bring an action in a court of law to enforce his rights under the policy.

4. In connection with this change in health insurance, I received a brochure explaining the Qualifier I plan. A true and correct copy of this brochure is attached as exhibit 2. The brochure does not mention arbitration, nor does it say that the insured does not have the right to bring a legal action to enforce his rights.

5. I was the senior contract manager on the Trans-Alaska pipeline and have reviewed and managed other contracts professionally. As a businessman involved in the formation and administration of contracts, I am aware of the importance of documenting changes in contracts and of the importance of record keeping.

6. My wife, Frieda McCoy, was a librarian and was also very aware of the importance of record keeping.

7. My wife and I kept all documents and correspondence we received from Blue Cross relating to the Qualifier I plan.

8. I have reviewed my records and have not found a copy of the November 25, 1985, letter and endorsement attached to the Affidavit of Edwina H. Green dated May 27, 1997, as exhibit A, nor have I found copies of the Health Care Agreements portions of which are attached to Ms. Green's affidavit as exhibits B and C.

9. I do not recall ever having received copies of any of the attachments to Ms. Green's affidavit at any time before January 1995, nor do I recall ever having received any other copy of the policy between November 1985 and January 1995. Because of my work with contracts, I believe I would remember if I had received a copy of the endorsement attached as exhibit A to Ms. Green's affidavit.

10. To the best of my knowledge, I never received notice of the arbitration requirement that Blue Cross alleges was added to the policy effective January 1, 1986, until some time in January 1995.

11. On or about March 1, 1994, my wife and I requested, through my wife's treating physician, Dr. Patrick G. Beatty, preauthorization from Blue Cross for payment of the treatment my wife's physicians recommended for her breast cancer. On or about March 17, 1994, we received a letter from Blue Cross notifying us that our request for preauthorization had been denied "for medical necessity." According to the letter, "The patient has no obvious disease and has had no chemotherapy." Both of these assertions were false. Blue Cross had been provided with documents showing that the reasons given for denial of preauthorization were invalid.

12. A true and correct copy of the March 17, 1994, letter I received from Blue Cross is attached as exhibit 3. Nowhere in the letter does it mention arbitration, nor does the letter say that we could not bring a legal action to challenge Blue Cross's denial of benefits. The letter merely said, "If further clarification is required, please contact the Medical Services Department . . . ."

13. On May 25, 1994, I faxed to Blue Cross a package of material appealing Blue Cross's denial letter and requesting approval of high-dose chemotherapy with peripheral stem cell rescue procedure for my wife and obtained a confirmation of receipt. By June 30, 1994, I had not heard from Blue Cross, so I contacted Blue Cross's Medical Claims Section and was told that there was no record of the materials I had sent. When I still had not heard anything by July 5, 1994, I sent Blue Cross a letter requesting an immediate response in writing to my appeal. A true and correct copy of that letter is attached as exhibit 4.

14. On or about July 14, 1994, I received a letter from Blue Cross acknowledging that Blue Cross had received the information I had submitted to them and stating that Blue Cross's Appeals Committee would make a decision following review of the medical information by an independent medical advisor. A true and correct copy of this letter is attached as exhibit 5.

15. On or about September 29, 1994, I received a letter from Blue Cross stating that Blue Cross's Benefit Appeals Committee had considered our appeal and determined that the services we had requested were appropriately denied. A true and correct copy of this letter is attached as exhibit 6. The letter stated that if I was dissatisfied with Blue Cross's explanation or have additional information Blue Cross had not considered I could submit a written appeal to Blue Cross's general counsel.

16. By a letter dated October 3, 1994, I appealed the Benefits Appeals Committee's decision to Blue Cross's general counsel. A true and correct copy of this letter is attached as exhibit 7.

17. On or about October 19, 1994, I received a letter from Frank R. Pignanelli, General Counsel for Blue Cross, requesting an additional ten working days to respond to my appeal. A true and correct copy of Mr. Pignanelli's letter is attached as exhibit 8.

18. On or about November 3, 1994, Mr. Pignanelli wrote me another letter in which he requested information concerning other insurance. A true and correct copy of this letter is attached as exhibit 9.

19. On December 14, 1994, I wrote to Mr. Pignanelli stating that I did not see how other insurance was relevant to Blue Cross's timely acceptance of the responsibility to pay a claim. A true and correct copy of my letter is attached as exhibit 10.

20. Sometime in January 1995, I received a letter from Mr. Pignanelli dated January 13, 1995, stating that he had concluded that the decision of the Benefit Appeals Committee to deny coverage for my wife's treatment was correct. A true and correct copy of Mr. Pignanelli's letter is attached as exhibit 11. Enclosed with Mr. Pignanelli's letter was a copy of an endorsement purporting to exclude coverage for my wife's treatment. This was the first time that I had seen a copy of that endorsement. Mr. Pignanelli's letter concluded: "If you remain dissatisfied with this decision, you have the right to seek binding arbitration of the dispute pursuant to the Rules of the American Arbitration Association. The Customer Service Department can assist you with information about how to initiate and participate in arbitration." I understood from Mr. Pignanelli's



letter that binding arbitration was an option that I was entitled to but did not understand that it was my only option.

21. Between March 1, 1994, and January 13, 1995, I had numerous conversations with representatives of Blue Cross regarding coverage for medical treatment for my wife. In none of those conversations and in none of the letters I received from Blue Cross during this period was there any mention of arbitration.

22. In 1994 and at other times I have received Explanation of Claims Processed forms from Blue Cross. A true and correct copy of one of these forms is attached as exhibit 12. In small print at the bottom of the front of the form it says: "If you disagree with our decision on your claim, you may ask us to reconsider. You also have the right to arbitration. See the reverse side of this page for additional information." On the reverse side of the form, in small print, it says that a person may appeal a denial of benefits to the "Claims Appeal Committee." It then says: "If you are dissatisfied with the decision following review, you may have the right to have the matter arbitrated in accordance with the rules of the American Arbitration Association."

23. I do not recall reading this language on the Explanation of Claims Processed forms, but if I had I would not have understood from this language that binding arbitration was my only option, nor would I have understood that I was precluded from exercising my right to bring a court action against Blue Cross.

24. Had I known that the contract required binding arbitration of any dispute or controversy concerning the construction, interpretation, performance or breach of the contract before my wife was diagnosed with and treated for cancer, I would have sought another health insurance

policy that did not require binding arbitration, or I would have dropped my health insurance coverage with Blue Cross, since I had other insurance in place.

25. From my previous dealings with Blue Cross, I did not know that any response by me was needed to reject Blue Cross's proposed arbitration provision.

26. By not responding to a change in the policy that I never knew about, I did not intend to accept Blue Cross's proposed modification of my policy.

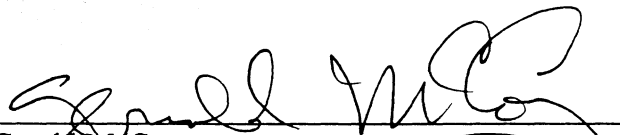
27. I have never agreed to binding arbitration of any dispute with Blue Cross or of any claim I may have against Blue Cross.

28. On March 2, 1995, my wife died from complications from breast cancer.


29. My premiums never went down between the time I first enrolled in the Qualifier I plan and the date of my wife's death. In particular, my premiums never decreased as a result of any change Blue Cross purportedly made in the policy effective January 1, 1986.

30. On February 28, 1997, I filed this action, through my attorneys, alleging claims for breach of contract, breach of Blue Cross's duty of good faith and fair dealing, negligence, intentional and negligent infliction of emotional distress, fraudulent and negligent misrepresentation, breach of Blue Cross's duty arising out of its relationship to my wife and me, and punitive damages.

DATED this 27 day of June, 1997.

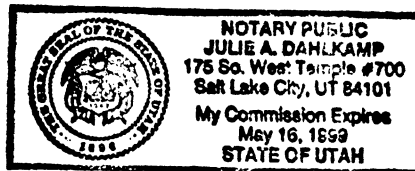
  
\_\_\_\_\_  
Gerald McCoy

SUBSCRIBED AND SWORN to before me this 27<sup>th</sup> day of June, 1997.

  
\_\_\_\_\_  
Notary Public

My Commission Expires:

5-16-99

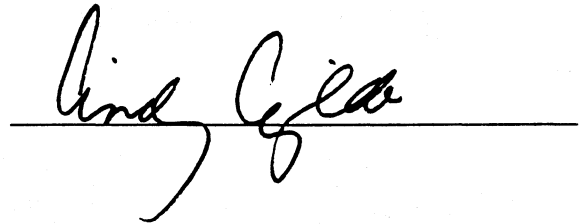


### CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of July, 1997, I caused to be served a true and correct copy of the foregoing by U.S. mail, first-class postage prepaid, addressed to--

Frank R. Pignanelli  
Thomas J. Hartford III  
2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270

Attorneys for Blue Cross and Blue Shield of Utah



f:\data\jdahl\data\mccoy\affidav.gmc

## Exhibit D

Andrew H. Stone (USB #4921)  
D. James Morgan (USB #6005)  
JONES, WALDO, HOLBROOK & McDONOUGH  
1500 First Interstate Plaza  
170 South Main Street  
Post Office Box 45444  
Salt Lake City, Utah 84145-0444  
Telephone: (801) 521-3200

Thomas J. Hartford, III (USB #4591)  
2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270  
Telephone: (801) 481-6441

Attorneys for Blue Cross and Blue Shield of Utah

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendant.

**AFFIDAVIT OF KEITH STODDARD**

Civil No. 970901461PI

Judge Pat B. Brian

STATE OF UTAH )  
: ss.  
COUNTY OF SALT LAKE )

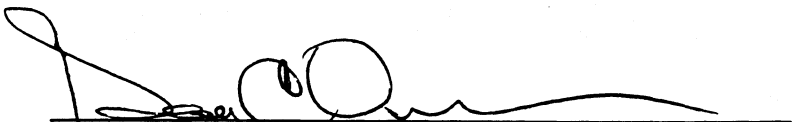
FILED  
97 SEP 15 PM 3:52  
THIRD JUDICIAL DISTRICT  
SALT LAKE COUNTY  
BY Deputy Clerk  
DEPUTY CLERK

I, Gary C. Warner, being first duly sworn upon oath, do hereby state as follows:

1. I am a resident of Salt Lake County, State of Utah.
2. I am over the age of 18, and have personal knowledge of the information set forth in this Affidavit.
3. I am, and at all relevant times was, a partner and operator of Image Printing ("Image"), located in Salt Lake City, Utah.
4. Image has been involved in the laser printing service and business since approximately 1984, and my partner and I each have approximately twenty-five years experience in the computer and data processing field.
5. Image's average volume is approximately 2.5 million pages of printed output per month.
6. In the fall of 1985, I was contacted by Bob Johnston of Blue Cross and Blue Shield of Utah ("BCBSU") to provide him with a quote to do a printing and mailing on behalf of BCBSU. Image was eventually assigned the job of printing and arranging for the mailing of over 30,000 amendments and cover letters to BCBSU subscribers.
7. In connection with that printing and mailing project, BCBSU provided Image with a magnetic tape of the names and addresses of those subscribers who were to receive this mailing, along with BCBSU letterhead for the cover letter.
8. I am familiar with the procedures that Image would have followed at that time when it undertook such a printing and mailing project. They would have been as follows:

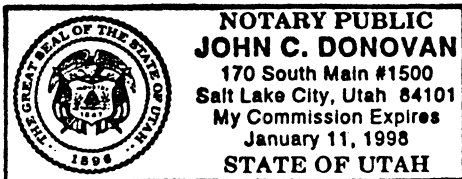
- a. Image would receive from its customer (in this case, BSBSU) a magnetic tape or other appropriate magnetic media that would contain the necessary data from the customer, e.g., correspondence and the names and addresses of all the people to whom the mailing was to go;
- b. Image's employee's would then have all the names and addresses contained on the magnetic tape, as well as text of the letter, printed onto the customer's letterhead;
- c. Image would then deliver the letters, now with the appropriate names addresses affixed, along with appropriate enclosures, to a mailing service, in this instance, Progressive Direct Mail Advertising, who would then be instructed to collate, fold, and insert the letters and any enclosures into the envelopes, and then deliver the materials to the post office for the actual mailing of the letters.

9. Because the printing project occurred almost twelve years ago, Image has no records regarding this particular mailing of BCBSU amendments besides that already provided to BCBSU (i.e., the Image invoice to BCBSU that specifies the number of pieces mailed, as well as other information).

  
Gary C. Warner



SUBSCRIBED AND SWORN TO before me this 11<sup>th</sup> day of September, 1997.



John C. Donovan  
NOTARY PUBLIC  
Residing at: Salt Lake City, UT

My Commission Expires:

1/11/98

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 15<sup>th</sup> day of September, 1997, I caused to be hand delivered a true and correct copy of the foregoing **AFFIDAVIT OF GARY C.**

**WARNER** to the following:

Jeffrey D. Eisenberg  
David R. Olsen  
WILCOX, DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111

Clark Newhall  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101

D. James

## Exhibit E

Andrew H. Stone (USB #4921)  
D. James Morgan (USB #6005)  
JONES, WALDO, HOLBROOK & McDONOUGH  
1500 First Interstate Plaza  
170 South Main Street  
Post Office Box 45444  
Salt Lake City, Utah 84145-0444  
Telephone: (801) 521-3200

FILED  
COURT  
97 SEP 15 PM 3:52  
THIRD JUDICIAL DISTRICT  
BY J. A. [Signature]  
DEPUTY CLERK

Thomas J. Hartford, III (USB #4591)  
2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270  
Telephone: (801) 481-6441

Attorneys for Blue Cross and Blue Shield of Utah

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendant.

:  
:  
: **SUPPLEMENTAL AFFIDAVIT OF**  
: **EDWINA H. GREEN**

:  
:  
: Civil No. 970901461PI

:  
:  
: Judge Pat B. Brian  
:  
:  
:

STATE OF UTAH )  
: ss.  
COUNTY OF SALT LAKE )

I, Edwina H. Green, being first duly sworn upon oath, do hereby state as follows:

1. I am a resident of Salt Lake County, State of Utah.

2. I am over the age of 18, and have personal knowledge of the information set forth in this Affidavit.

3. As stated in my original affidavit, I have been employed in the legal department of Blue Cross and Blue Shield of Utah ("BCBSU") since August of 1981. My responsibilities as a paralegal since that time have included drafting BCBSU health contracts and preparing amendments to those contracts. In addition, I have at times also been responsible for overseeing the mailing of contracts and amendments to contracts.

4. Accordingly, and as mentioned in my original affidavit, I was assigned the task of coordinating the mailing in November of 1985 of amendments to certain contracts (specifically, all individual plan subscribers and subscribers of certain group plans), including an amendment to the contract of Plaintiff. In fact, all persons who were BCBSU subscribers under the 57H non-group, individual contract were to receive the amendment. Plaintiff had a 57H non-group, individual contract. A cover letter, which explained the amendments, was sent with this mailing. This mailing was to go to over 30,000 BCBSU subscribers.

5. At my direction, BCBSU's programming department prepared a magnetic tape of all BCBSU subscribers who would be affected by the above-described amendment and who would therefore be sent the mailing.

6. According to BCBSU's current records, on or about October 1, 1985, Mr. McCoy's name was input into BCBSU's system as a subscriber to a 1GE plan, which is a group plan.

7. Approximately one week later, Mr. McCoy's insurance was converted to the above-mentioned 57H non-group individual contract.

8. On or about November 11, 1985, a magnetic tape was made that would have included Mr. McCoy, since he was then carried on the BCBSU system as a subscriber under 57H non-group, individual contract, and all such subscribers were included on the magnetic tape.

9. In addition, also included on the magnetic tape were all subscribers under the 1GE group plan of which Mr. McCoy had been a subscriber for approximately two weeks. Thus, even if Mr. McCoy's membership had not yet been transferred to the 57H non-group individual contract subscribers, he would still have been included in the mailing by virtue of his having been a member of the 1GE group plan because that particular group plan was included in the mailing.

10. On or about November 14, 1985, the magnetic tape was sent to Image Printing ("Image") for printing of the subscribers' names and addresses on the cover letter to the amendment endorsement.

11. In addition, at the time the foregoing magnetic tape was sent to Image for preparation of the mailing materials, Mr. McCoy's name and address had not been removed from the list of names and addresses on the magnetic tape.

12. After Image printed the mailing materials, it forwarded those materials to Progressive Direct Mail Advertising ("Progressive") for the insertion of the materials into envelopes and the actual mailing of the materials.

13. After sending the mailing materials to Image, I received confirmation from Image that Progressive had completed the bulk mailing of 30,356 pieces of mail on November 25, 1985.

14. I also received confirmation from Image, in the form of an invoice dated December 6, 1985, that Progressive had mailed 30,356 pieces of mail to BCBSU subscribers. (A true and correct copy of that invoice is attached to this affidavit as Ex. A.)

15. BCBSU also received independent confirmation that the mailing was sent to the intended BCBSU subscribers because BCBSU received numerous inquiries from subscribers about the changes effected by the mailing.

16. On or about November 22, 1985, BCBSU filed with Utah's insurance commission the arbitration amendment endorsement to the individual insurance contract that pertained to Mr. McCoy (the 57H).

17. Subsequently, on or about August 10, 1989, BCBSU filed the actual complete contract containing the arbitration provision with the insurance commission.

18. On or about April 16, 1997, Mr. McCoy ceased making payments of his premiums and his policy was therefore cancelled.

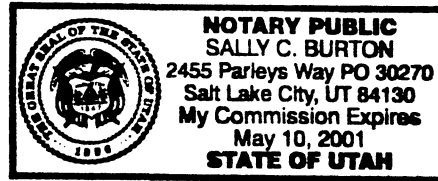
Edwina H. Green  
Edwina H. Green

SUBSCRIBED AND SWORN TO before me this 12 day of September, 1997.

Sally C. Burton  
NOTARY PUBLIC  
Residing at: BC/BS CV  
Sh County, Utah

My Commission Expires:

May 10, 2001





CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 15<sup>th</sup> day of September, 1997, I caused to be hand delivered a true and correct copy of the foregoing **SUPPLEMENTAL AFFIDAVIT OF EDWINA H. GREEN** to the following:

Jeffrey D. Eisenberg  
David R. Olsen  
WILCOX, DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111

Clark Newhall  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101

D. James My

## INVOICE

## IMAGE PRINTING SYSTEMS

1055 South 700 West Salt Lake City, Utah 84104 (801)973-7651

Invoice No. 1126  
Date 12-06-85

Customer

BLUE CROSS-BLUE SHIELD  
2455 PARLEY'S WAY  
P.O. BOX 30270  
SALT LAKE CITY, UTAH 84125

021201

QUANTITY	DESCRIPTION	RATE	AMOUNT
30426	LETTERS TO SUBSCRIBERS PRINTED	.026	791.08
30356	LETTERS WITH (1) ADDITIONAL ENCLOSURE FOLDED, INSERTED, METERED & MAILED @ 20.00 PER 1000 LETTERS		607.12
	SUB TOTAL		1398.20
	POSTAGE RESERVE \$ 5700.00		
	POSTAGE USED 5526.44		
	CREDIT - 173.56		
	POSTAGE CREDIT		- 173.56
	INVOICE TOTAL		1224.64

## Exhibit F

Andrew H. Stone (USB #4921)  
D. James Morgan (USB #6005)  
JONES, WALDO, HOLBROOK & McDONOUGH  
1500 First Interstate Plaza  
170 South Main Street  
Post Office Box 45444  
Salt Lake City, Utah 84145-0444  
Telephone: (801) 521-3200

Thomas J. Hartford, III (USB #4591)  
2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270  
Telephone: (801) 481-6441

Attorneys for Blue Cross and Blue Shield of Utah

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendant.

**AFFIDAVIT OF GARY NELSEN**

Civil No. 970901461PI

Judge Pat B. Brian

STATE OF UTAH )  
: ss.  
COUNTY OF SALT LAKE )

FILED  
DISTRICT COURT  
97 SEP 15 PM 3:52  
THIRD JUDICIAL DISTRICT  
SALT LAKE COUNTY  
BY Jerry  
DEPUTY CLERK

I, Gary Nelsen, being first duly sworn upon oath, do hereby state as follows:

1. I am a resident of Salt Lake County, State of Utah.

2. I am over the age of 18, and have personal knowledge of the information set forth in this Affidavit.

3. At all times relevant to the matters discussed in this affidavit I was the sole proprietor of Progressive Direct Mail Advertising ("Progressive").

4. Progressive has performed mailing services on behalf of businesses for approximately twenty-one years.

5. Progressive has handled business mailings involving substantial pieces of mail (e.g., over 20,000) approximately one half dozen times per week and was conducting that many such mailings in November of 1985 as well.

6. In that role, and in or about November of 1985, I coordinated a mailing for Progressive and on behalf of Blue Cross and Blue Shield of Utah ("BCBSU").

7. At that time, Progressive's procedures with respect to such a mailing were as follows:

a. Progressive would receive laser printed letters and enclosures from Image Printing (or some other printer);

b. Progressive would then pre-fold the letters to fit into window envelopes and also pre-fold all enclosures for the letters;

- c. Progressive's employee's would then put the folded letters and enclosures into the insertion machine, which would then collate and insert the correct number of pieces into each envelope;
- d. the insertion machine is designed to make certain that the appropriate number of pages are added to each envelope. If too few pieces are put into a particular envelope or if too many pieces are put in, the machine stops and alerts the operator to the inconsistency;
- e. Progressive would then seal the envelopes;
- f. Progressive's employees would then either meter the envelopes at the appropriate United States Postal Service ("USPS") rate or using permit imprint have the mailing verified by weight sampling through the USPS;
- g. Progressive's employees would then sort the envelopes according to USPS regulations in order to obtain a discount on the postage rate;
- h. Progressive's employees would then prepare the appropriate USPS form for the mailing;
- i. Progressive's employees would then deliver that form to the USPS;
- j. The USPS would then verify the mailing weight of each piece of mail by weighing a sample batch of the mailing, returning the mailing to Progressive for reworking if the weight is not accurate; and finally,

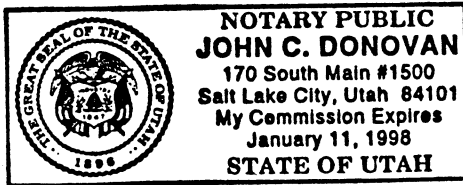
k. The USPS would then take control of the mailing.

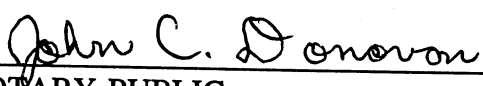
8. Progressive would receive confirmation from the USPS on the number of pieces of mail in the mailing.

9. Because it occurred almost twelve years ago, Progressive has no records remaining that pertain to the BCBSU mailing of November of 1985.

  
\_\_\_\_\_  
Gary Nelsen

SUBSCRIBED AND SWORN TO before me this 11<sup>th</sup> day of September, 1997.



  
\_\_\_\_\_  
NOTARY PUBLIC  
Residing at: Salt Lake City, UT

My Commission Expires:

1/11/98

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 5<sup>th</sup> day of September, 1997, I caused to be hand delivered a true and correct copy of the foregoing **AFFIDAVIT OF GARY NELSEN** to the following:

Jeffrey D. Eisenberg  
David R. Olsen  
WILCOX, DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111

Clark Newhall  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101

D. James [Signature]

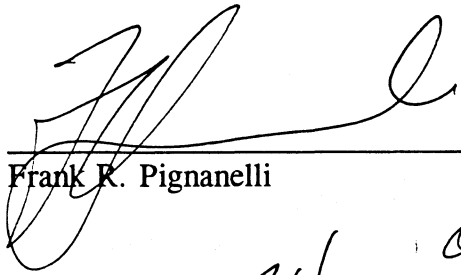


## Exhibit G

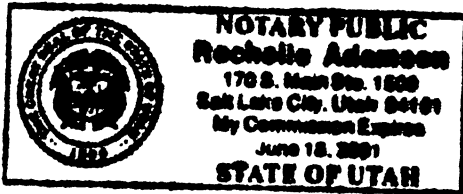
BY \_\_\_\_\_  
DEPUTY CLERK


I, Frank R. Pignanelli, being first duly sworn upon oath, do hereby state as follows:

1. I am a resident of Salt Lake County, State of Utah.
2. I am over the age of 18, and have personal knowledge of the information set forth in this Affidavit.
3. At all times relevant to the matters set forth in this Affidavit, I was employed in the legal department of Blue Cross and Blue Shield of Utah ("BCBSU") as General Counsel.
4. In connection with my job as BCBSU General Counsel, I was responsible for, among other things, communicating with subscribers about their claims for benefits with BCBSU.
5. In connection with that responsibility, I corresponded with Plaintiff, Gerald McCoy, regarding the status of his claim for benefits under his insurance contract with BCBSU.
6. More specifically, on or about January 13, 1995, I sent a letter to Mr. McCoy addressing his claim for benefits. A true and correct copy of that letter is attached to this Affidavit as Exhibit A.
7. Based upon my review of my McCoy file, I conclude that I enclosed a copy of the Type 57J health care agreement and the appropriate endorsements with that letter.
8. That Agreement contained the mandatory arbitration provision on pages 5 and 31.

  
Frank R. Pignanelli

SUBSCRIBED AND SWORN TO before me this 24 day of October, 1997.



  
NOTARY PUBLIC  
Residing at: Jones Waldo 170 S. Main

My Commission Expires:

June 18, 2001

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 24<sup>th</sup> day of October, 1997, I caused to be hand delivered a true and correct copy of the foregoing **AFFIDAVIT OF FRANK R.**

**PIGNANELLI** to the following:

Jeffrey D. Eisenberg  
David R. Olsen  
WILCOX, DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111

Clark Newhall  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101



---

## Exhibit H

FILED  
DISTRICT COURT

98 JAN 12 PM 4:33

THIRD JUDICIAL DISTRICT  
SALT LAKE COUNTY  
BY J. O'Shea  
DEPUTY CLERK

JEFFREY D. EISENBERG, ESQ. (#4029)  
DAVID R. OLSEN, ESQ. (#2458)  
WILCOX DEWSNUP & KING  
2020 Beneficial Life Tower  
36 South State Street  
Salt Lake City, Utah 84111  
Telephone: (801) 533-0400

CLARK NEWHALL, ESQ. (#7091)  
136 South Main Street, Suite 415  
Salt Lake City, Utah 84101  
Telephone: (801) 530-0350

Attorneys for Plaintiff

---

IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

---

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiff,

vs.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah corporation,

Defendant.

---

**SUPPLEMENTAL  
AFFIDAVIT OF  
GERALD McCOY**

Civil No. 970901461PI  
Judge Pat B. Brian

---

STATE OF UTAH            )  
                                  :  
COUNTY OF SALT LAKE    )

Gerald McCoy, being duly sworn, upon his oath deposes and states as follows:

1. I am the plaintiff in this action and have personal knowledge of the matters stated herein.

2. Sometime in January 1995 I received a letter dated January 13, 1995, from Frank R. Pignanelli, Assistant Vice President and General Counsel of Blue Cross Blue Shield of Utah ("Blue Cross"), a true and correct copy of which was attached to my affidavit dated June 27, 1997, as exhibit 11. Mr. Pignanelli's letter upheld the decision of Blue Cross's Benefit Appeals Committee. The letter concluded: "If you remain dissatisfied with this decision, you have the right to seek binding arbitration of the dispute pursuant to the Rules of the American Arbitration Association. The Customer Service Department can assist you with information about how to initiate and participate in arbitration."

3. I understood from Mr. Pignanelli's letter that I could request arbitration of Blue Cross's decision but was not required to resolve my dispute with Blue Cross through binding arbitration. I understood from Mr. Pignanelli's letter that I had the choice of resolving the dispute through arbitration or through the normal litigation process.

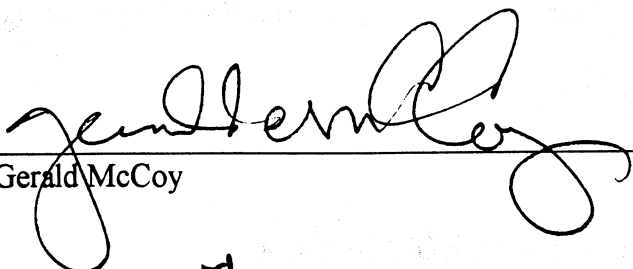
4. I did not receive a copy of the arbitration provision that Blue Cross relies on in January 1995 or at any other time before I brought this action.

5. By not canceling my health insurance after January 1995, I did not intend to accept Blue Cross's offer to modify my policy to require binding arbitration of any dispute with Blue Cross.

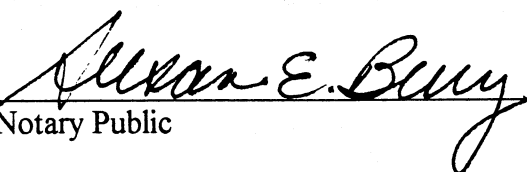
6. I never agreed to modify my policy with Blue Cross to include an arbitration provision.



DATED this 23<sup>rd</sup> day of December, 1997.

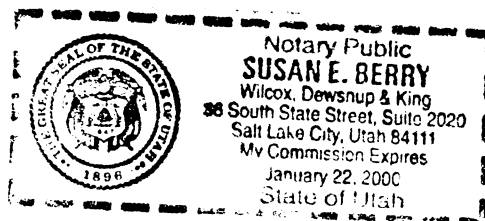
  
Gerald McCoy

SUBSCRIBED AND SWORN to before me this 23<sup>rd</sup> day of December, 1997.

  
Notary Public

My Commission Expires:

1-22-2000



### CERTIFICATE OF SERVICE

I hereby certify that on this 12th day of January, 1998, I caused to be served a true and correct copy of the foregoing by hand delivery to--

Andrew H. Stone  
James E. Magleby  
JONES, WALDO, HOLBROOK & McDONOUGH  
1500 First Interstate Plaza  
170 South Main Street  
Post Office Box 45444  
Salt Lake City, Utah 84145-0444

and by U.S. mail, first-class postage prepaid, addressed to--

Frank R. Pignanelli  
Thomas J. Hartford III  
2455 Parley's Way  
P.O. Box 30270  
Salt Lake City, Utah 84130-0270

Paul M. Simmons

## Exhibit I

---

---

**IN THE THIRD JUDICIAL DISTRICT COURT  
SALT LAKE COUNTY, STATE OF UTAH**

GERALD McCOY, individually and as  
personal representative of the estate of  
FRIEDA McCOY, deceased,

Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF  
UTAH, a Utah Corporation,

Defendants.

**FINDINGS OF FACT  
CONCLUSIONS OF LAW AND  
ORDER**

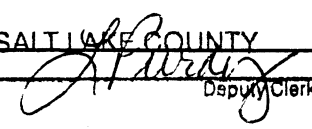
CASE NO. 970901461PI

DATE: 26 FEB. 1998

JUDGE: PAT B. BRIAN

FILED DISTRICT COURT  
Third Judicial District

MAR 5 1998

SALT LAKE COUNTY  
By  Deputy Clerk

This matter came before the Court February 6, 1998 on a hearing for Defendant's Motion to Compel Arbitration and to Stay Proceedings Against Blue Cross and Blue Shield of Utah. Having heard argument and reviewed memoranda in support of and in opposition to the Motion, the Court hereby makes the following Findings of Fact, Conclusions of Law, and Order:

**FINDINGS OF FACT**

1. When Mr. McCoy enrolled in the Qualifier I plan, his policy did not contain an arbitration provision nor did the policy provide for binding arbitration as a means to resolve disputes.

2. In the fall of 1985, Blue Cross decided to amend the Qualifier I plan to

include a provision for binding arbitration as a means to resolve disputes. This amendment would take effect January 1, 1986. Blue Cross had to notify subscribers of the amendment by November 30, 1985.

3. Edwina H. Green, a Blue Cross employee, directed Blue Cross' programming department to prepare a tape of all the subscribers who were to receive mailings of the arbitration amendment.

4. Sometime during the week of November 11, 1985 Blue Cross sent the tape containing the subscribers' names to Image Printing of Salt Lake City, Utah. Ms. Green's affidavit indicates that Image Printing "printed the subscriber letter and inserted each subscriber's name and address on Blue Cross and Blue Shield of Utah letterhead. The completed letter, with the endorsement prepared by Blue Cross and Blue Shield of Utah was then forwarded to Progressive Direct Mail Advertising of Salt Lake City for mailing." Affidavit of Edwina H. Green at 2.

5. Page 42, paragraph 3 of Mr. McCoy's Qualifier 1 plan states that:

Any notice to the Subscriber provided for in this Agreement shall be deemed to have been received by the Subscriber when deposited in the United States Mail with first class postage prepaid and addressed to the Subscriber at the address shown in the records of the Plan.

6. Blue Cross relies solely on the affidavit of Ms. Green as evidence that they mailed an arbitration amendment to Mr. McCoy.

7. Mr. McCoy claims he never received the arbitration amendment.

## CONCLUSIONS OF LAW

1. “If an issue is raised concerning the existence of an arbitration agreement or the scope of the matters covered by the agreement, the court shall determine those issues and order or deny arbitration accordingly.” Utah Code §78-31a-4(1) (1997).

2. Blue Cross bears the burden to prove it actually mailed notice of the arbitration amendment to Mr. McCoy. *See, Diamond T. Utah, Inc., v. Canal Insurance Co.*, 361 P.2d 665, 667 (Utah 1961).

2. In McGreevy v. Oregon Mutual Insurance Co., 876 P.2d 463 (Wash. Ct. App. 1994), *aff’d on other grounds*, 904 P.2d 731 (Wash. 1995), the Washington court considered the public policy that requires insurance companies to prove they actually mailed notice. The court noted that the insurance company “made a business decision not to maintain the records of specific mailings of significant changes in policy coverage. It could have had each insured sign a copy of the amendment and return it to an insurance agent verifying that they received and understood the changes; . . .” *McGreevy*, 876 P.2d at 470.

3. Blue Cross made a business decision not to maintain records of specific mailings. Although Blue Cross argued that the cost certified and or registered mail prohibited them from so mailing, this Court believes there are other, less costly means whereby Blue Cross could secure evidence of mailing. Blue Cross could have required a returned, signed copy of the amendment, or even preserved the mailing tape that was sent to the mailing company.

4. Ms. Green’s affidavit does not rise to the level of proof of mailing. Ms. Green’s affidavit cannot say whether or not Mr. McCoy’s name and address were actually on the

tape, an important fact in determining whether or not Mr. McCoy's arbitration amendment was ever mailed.

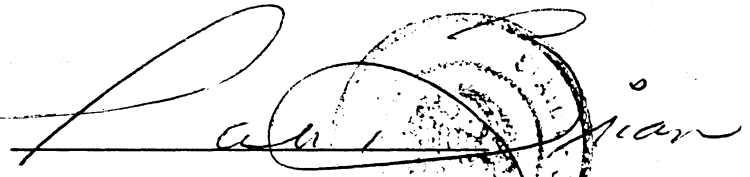
5. Blue Cross has failed to establish that Mr. McCoy's notice of the arbitration amendment was ever mailed to him. Consequently, Blue Cross cannot apply the arbitration amendment to him.

**ORDER**

ACCORDINGLY, Defendant's Motion to Compel Arbitration and to Stay Proceedings Against Blue Cross and Blue Shield of Utah is hereby DENIED.

DATED this 3 day of March, 1998

BY THE COURT:

  
PAT B. BRIAN  
DISTRICT COURT JUDGE

**CERTIFICATE OF SERVICE**

I hereby certify that on this 5 day of March, 1998, I caused to be mailed, first class postage prepaid, a true copy of the foregoing FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER to:

JEFFREY D. EISENBERG  
DAVID R. OLSEN  
ATTORNEYS AT LAW  
2020 BENEFICIAL LIFE TOWER  
36 SOUTH STATE STREET  
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CLARK NEWHALL  
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ANDREW H. STONE  
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FRANK R. PIGNANELLI  
THOMAS J. HARTFORD III  
2455 PARLEY'S WAY  
P O BOX 30270  
SALT LAKE CITY UT 84130-0270

DATED this 5 day of March, 1998

  
CLERK



CERTIFICATE OF SERVICE

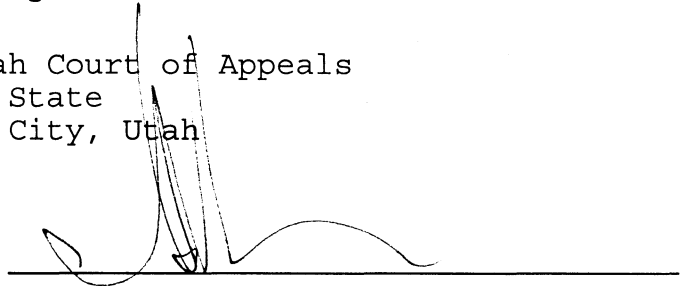
I hereby certify that on the 22<sup>ND</sup> day of October, 1998,  
I caused to be hand-delivered, two true and correct copies of the  
foregoing **ADDENDUM TO BRIEF OF APPELLANT BLUE CROSS AND BLUE  
SHIELD OF UTAH**, to the following:

Jeffrey D. Eisenberg  
David R. Olsen  
2020 Beneficial Life Tower  
36 South State  
Salt Lake City, UT 84111

Clark Newhall  
136 South Main, Suite 415  
Salt Lake City, UT 84101

and the original plus seven true and correct copies of the  
foregoing **ADDENDUM TO BRIEF OF APPELLANT BLUE CROSS AND BLUE  
SHIELD OF UTAH**, to the following:

Clerk, Utah Court of Appeals  
450 South State  
Salt Lake City, Utah

A handwritten signature in black ink, appearing to be "Clark Newhall", is written over a horizontal line. The signature is stylized with a large, looped initial 'C' and a long, sweeping tail.