New York **Child Health Plus**

Subscriber Contract

February 2018

Member Services

1-800-493-4647, TTY 711

CSNY17MC4036647_000

Model Subscriber Contract.

This is your Child Health Plus contract with UnitedHealthcare of New York, Inc. otherwise known as UnitedHealthcare Community Plan. It gives you the right to the benefits discussed in the contract. Coverage starts on the effective date shown on your identification card. This contract will remain in effect unless it is terminated for one of the reasons described in the contract.

Notice of Right to 10 Days to Study the Contract.

You have the right to return this contract. Study it carefully. You can send it back and ask us to cancel it. The application must be made in writing within 10 days following the date on which you received this contract. We will reimburse the premiums you have paid. If you return this contract, we will not give you any benefits.

Important Notice.

All services covered under this contract must be rendered, coordinated or authorized by your primary care physician. You must contact your primary care physician in advance to receive benefits, except for the emergency medical care described in Section Five and except for certain obstetric and gynecological care described in Section Four of this contract.

Table of Contents

Section 1: Introduction 4

Section 2: Who is Covered 6

Section 3: Hospital Benefits 7

Section 4: Medical Services 8

Section 5: Emergency Medical Care 13

Section 6: Other Covered Services 14

Section 7: Additional Information 20

Section 8: Restrictions and Exclusions 21

Section 9: Contract Premiums 23

Section 10: Termination of Coverage 24

Section 11: Right to a New Contract after Termination 26

Section 12: Utilization Review and Grievance Procedures 26

Section 13: External Appeal 34

Section 14: General Provisions 37

Section 1: Introduction

1. Child Health Plus Program. This contract is issued in conformity with a special program of the Department of Health of New York State (New York State Department of Health) (DOH) designed to provide subsidized health insurance coverage for uninsured children in the State of New York. We will enroll you in the Child Health Plus program if you meet the eligibility requirements established by New York State and you will have a right to the medical care services described in this contract.

You and/or the responsible adult, as it appears on the application, must inform us within a period of 60 days after the change about changes in your status, such as residence, income or other insurance that can make you ineligible to participate in Child Health Plus.

2. Medical Care Through an HMO. This contract provides coverage through an HMO. In an HMO, all medical care must be necessary from the medical point of view and your primary care physician (PCP) must provide, coordinate or authorize it in advance. Except for emergency care and certain obstetric and gynecological services, there is no coverage for medical care you receive without the approval of your PCP. In addition, the coverage is offered only for medical care provided by a participating provider, except in an emergency or when your PCP refers you to a non-participating provider.

It is your responsibility to select a PCP from the list of PCPs when you enroll in Child Health Plus. You can change PCPs by contacting Member Services at **1-800-493-4647, TTY 711**. The PCP you have chosen will be referred to as “your PCP” throughout this contract.

3. Words We Use. In this contract, we will refer to UnitedHealthcare Community Plan as “we,” “us” and “our.” The words “you,” “your” or “yours” and “member” or “members” refer to you and the child for whom this contract is issued and whose name appears on the identification card.

4. Definitions. The following definitions apply to this contract:

Contract means this document. It is a legal agreement between you and us. Keep this contract with your important papers so you will have it available to refer to.

Emergency Condition means a medical or behavioral condition that manifests with symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in (A) placing the health of the person affected by this condition in severe danger, or in the case of a behavioral condition, placing the health of that person or others in severe danger; or (B) serious change in the bodily functions of that person; or (C) serious dysfunction of any organ or part of that person; or (D) serious disfiguration of that person.

Emergency Services means the hospital services by doctors and for outpatients necessary for the treatment of an emergency condition.

Hospital means a general short-term acute hospital that:

1. Is concerned primarily with providing, through or under the continuous supervision of physicians, to admitted patients, diagnostic services and therapeutic services for the diagnosis, treatment and medical care of injured or sick persons;
2. Has sizeable organized medicine and surgery departments;
3. Has a requirement that all patients must be under the care of a doctor or dentist;
4. Provides nursing service 24 hours a day through or under the supervision of a professional degreed nurse (RN);
5. If it is located in New York State, it has a hospitalization review plan in effect that applies to all patients, that meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97 (42USCA 1395xk);
6. It has the proper authorizations from the agency responsible for authorizing those hospitals; and
7. It is not, except by chance, a rest home, a place primarily for the treatment of tuberculosis, an old-age home, a place for drug addicts, alcoholics or a convalescent care, custodial, educational or rehabilitation location.

Necessary for the Medical Point of View means medical care or medical services or materials that UnitedHealthcare Community Plan determines are appropriate from the medical point of view, and:

1. Necessary to meet the basic health needs of the covered member;
2. Are provided in a worthwhile manner and in a setting appropriate for medical care;
3. Uniform with regard to type, frequency and duration of treatment with scientifically-based guidelines of national medical organizations accepted by the Plan;
4. Are in accordance with the diagnosis of the condition;
5. Required for reasons other than the comfort or convenience of the covered member or his/her doctor; and
6. Are of demonstrated medical value.

Participating Hospital means a hospital that has an agreement with us for providing covered services to our members.

Participating Pharmacy means a pharmacy that has an agreement with us for providing covered services to our members.

Participating Physician means a doctor that has an agreement with us for providing covered services to our members.

Participating Provider means any doctor, hospital, home medical care agency, laboratory, pharmacy or other participating entity that has an agreement with us for providing covered services to our members. We will not pay for health services from a non-participating provider except in an emergency or when your PCP sends you to a non-participating provider with our approval.

Primary Care Physician (PCP) means the participating doctor that you selected when you enrolled or to whom you switched afterwards, according to our rules, and who provides or coordinates all your covered medical care services.

Service Area means the following counties: Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester, Wyoming and Yates. You must reside in the service area to be covered under this contract. Except for Emergencies you are not covered for services received outside of the service area.

Section 2: Who Is Covered?

1. Who Is Covered Under This Contract. You are covered under this contract if you meet all the following requirements:

- You are under 19 years of age;
- You do not have other medical care coverage that covers the majority of the services covered under this Contract (“equivalent coverage”);
- You are not eligible for Medicaid; and
- You are a permanent resident of New York State and reside in our service area.
- Your parent or guardian is not a public employee with access to family health insurance coverage by a state health benefits plan and the state or public agency pays all or part of the cost of family coverage
- You are not an inmate of a public institution or a patient of an institution for mental diseases.

2. Recertification. We will review your application for coverage to determine if you meet the eligibility requirements for Child Health Plus. Each year you will present an application so we can determine whether you continue to meet the eligibility requirements. This process is called “recertification.”

3. Change in Circumstances. You must inform us of changes in your income, residence or medical care coverage that may make you ineligible for this contract. You must give us notice within a period of sixty (60) days following this change. If you do not inform us of a change in circumstances, refund of any premium you may have paid can be requested.

Section 3: Hospital Benefits

1. Medical Care in a Hospital. You have coverage for medical care necessary from a medical point of view as a hospital inpatient if you meet all the following conditions:

- You are admitted to a hospital in an emergency or your PCP has coordinated your admission into a non-participating hospital with our approval;
- Your admission was authorized in advance by your PCP, except in an emergency; and
- You must be a registered bed patient for appropriate proof of an illness, injury or condition that cannot be treated on an outpatient basis.

2. Covered Inpatient Services. Covered inpatient services under this contract include the following:

- Daily bed and board, including special diets and nutritional therapy.
- General, special and critical nursing service, but not private nursing service;
- Centers, services, materials and equipment related to surgeries, recovery institutions, anesthesia and facilities for intensive or specialized medical care.
- Oxygen and other therapeutic services and materials for inhalation;
- Drugs and medications that are not experimental;
- Sera, biological products, vaccines, intravenous preparations, dressings, casts and materials for diagnostic studies;
- Blood products, except when participation in a voluntary blood replacement program is available;
- Facilities, services, materials and equipment related to diagnostic studies and the monitoring of physiological functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiological and electroencephalographic studies and examinations;
- Facilities, services and materials related to physical medicine and occupational therapy and rehabilitation;
- Facilities, services, materials and equipment related to emergency medical care;
- Facilities, services, materials and equipment related to mental health, substance and alcohol abuse services;
- Facilities, services and materials related to radiotherapy and nuclear therapy;
- Chemotherapy;
- Radiotherapy; and
- All medical, surgical or related additional services, materials and equipment usually provided by the hospital, except to the extent excluded in this contact.

3. Maternity Care. Aside from perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any birth that is not a Caesarean section. We will pay for inpatient hospital medical care for at least 96 hours after a Caesarean section. Maternity care coverage includes parent education, help and training in nursing or bottle feeding and the clinical evaluations necessary for the mother and newborn.

You have the option of being released before 48 hours (96 for a Caesarean section). If you choose early release, we will pay for a home medical care visit if requested within 48 hours after a birth (96 hours for a birth via Caesarean section).

The home medical care visit will be provided within a period of 24 hours following your release from the hospital or request for home medical care, whichever occurs later. The home medical care visit will be in addition to the home medical care visits covered under Section Six of this contract.

4. Restrictions and Exclusions. We will not provide benefits for any day that you are out of the hospital, including for a portion of the day. We will not provide benefits for any day when inpatient medical care was not necessary from a medical point of view and was not approved by UnitedHealthcare Community Plan.

- Benefits will be paid in full for a semi-private room. If you are in a private hospital room, you will have to pay the difference between the cost of a private room and a semi-private room unless the private room is necessary from a medical point of view and indicated by your doctor.
- We will not pay for non-medical items such as television rent or telephone charges.

Section 4: Medical Services

1. Your PCP Must Provide, Coordinate or Authorize All Medical Services. Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services below only if your PCP provides, coordinates or authorizes the services. You have the right to medical services provided in one of the following locations:

- Your PCP's office,
- The office or facility of another provider if your PCP finds that the medical care from this provider of the facility is appropriate for the treatment of your condition; and
- The outpatient department of a hospital.
- As an inpatient in a hospital, you have a right to medical, surgical and anesthesia services.

2. Covered Medical Services. We will pay for the following medical services:

- General medical care and specialists, including consultants
- Preventive health services and physical examinations. We will pay for preventive health services, including:
  - Well child visits in conformity with the schedule of visits established by the American Academy of Pediatrics;
  - Education in nutrition and advice;
  - Hearing tests;
  - Family planning, including birth control devices and medications;
  - Social medical services;
  - Vision detection examinations;
  - Routine immunization in accordance with the schedule of immunization recommended by the Advisory Committee on Immunization Practices;
  - Tuberculin test;
  - Dental detection tests;
  - Development detection tests;
  - Clinical and radiology lab tests; and
  - Lead detection tests.

3. Blood Clotting Factor. We will pay for blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an outpatient basis. We will pay for blood clotting factor products and services when infusion occurs in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a child that is physically and developmentally capable of self-administering such products.

4. Diagnosis and Treatment of Illnesses, Injuries and Other Conditions.
We will pay for the diagnosis and treatment of diseases or injuries, including:

- Surgery for outpatients performed in a provider's office or in an outpatient surgery center, including anesthesia services;
- Dental care in connection with an accidental injury to natural healthy teeth within a period of twelve months following the accident;
- Laboratory and radiographic tests and other diagnostic procedures;
- Kidney dialysis;
- Radiotherapy;
- Chemotherapy;
- Injections and medications administered in a doctor's office;

- Second surgical opinion from a specialist certified by the medical board;
- Second medical opinion from an appropriate specialist, in case of a positive or negative diagnosis of cancer, recurrence of cancer, or a recommendation for a cycle of cancer treatment; and
- Audiometric tests necessary from a medical point of view.

5. Physiotherapy and Occupational Therapy. We will pay for short-term physical and occupational therapy services. The therapy must be specialized therapy. Short-term means that it is expected that the services will result in a significant improvement within a period of two months.

6. Hearing Services. We will pay for a hearing exam every calendar year to determine the need for corrective action. Hearing aids, including batteries and repairs, are covered.

7. Speech Services. We will pay for speech therapy services required for a condition that can be treated, resulting in a significant clinical improvement within a period of two months, starting from the first day of treatment. These services must be performed by a participating audiologist, language pathologist, speech therapist and/or otorhinolaryngologist.

8. Autism Spectrum Disorder. We will provide coverage for the following services when such services are prescribed or ordered by a participating network licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this section, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

1. **Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
2. **Assistive Communication Devices.** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech generating devices. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will determine whether the device should be purchased or rented. We will not cover items, such as, but not limited to laptops, desktops, or tablet computers. We will, however, cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not

covered; however, we will cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance.

Prior approval of assistive communication devices is required. Refer to the prior approval procedures in your Contract.

3. **Behavioral Health Treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

   Our coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

4. **Psychiatric and Psychological Care.** We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

5. **Therapeutic Care.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.

6. **Pharmacy Care.** We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Contract.

   We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

9. Radiotherapy, Chemotherapy and Hemodialysis. We will pay for radiotherapy and chemotherapy, including injection and medications administered at the time of treatment. We will pay for hemodialysis services at home or in a facility which we consider appropriate.

10. Outpatient Visits for Treatment of Mental Health Conditions and for the Treatment of Disorders Due to Substance Abuse. We will pay for outpatient visits for the diagnosis and treatment of mental health conditions and disorders due to substance abuse. In addition, we will pay for outpatient visits for your family members if these visits are related to your mental health treatment or treatment of disorders due to substance abuse.

11. Inpatient Mental Health Services and Services for Disorders Due to Substance Abuse. We will pay for inpatient mental health services and inpatient services for disorders due to substance abuse when these services are provided in a facility that is:

- Operated by the Office of Mental Health under Section 7.17 of the Mental Hygiene Act;
- It has received an operating certificate in conformity with Article 23 or Article 31 of the Mental Hygiene Act; or
- A general hospital as defined in Article 28 of the Public Health Law.

12. Obstetric and Gynecological Services. We will pay for prenatal, labor and delivery, and postpartum services with respect to pregnancy. You do not need the authorization of your PCP or from UnitedHealthcare Community Plan for medical care related to the pregnancy if you seek medical care from an eligible participating provider for obstetric and gynecological services. In addition, you can receive the following services from an eligible participating provider of obstetric and gynecological services without the authorization of your PCP:

- Up to two annual exams for primary and preventive obstetric and gynecological medical care; and
- Medical care required as a result of annual exams or a result of an acute gynecological condition.

13. Cervical Cancer Detection Tests. If you are a woman of eighteen years of age, we will pay for an annual cervical cancer detection test. We will pay for an annual pelvic exam, Papanicolaou test and evaluation of the Papanicolaou test.

Section 5: Emergency Medical Care

1. Hospital Emergency Room Visits. We will pay for emergency services provided in a hospital emergency room. You can go directly to an emergency room for medical care. You do not have to call your PCP first. If you go to an emergency room, we recommend that someone inform us in your name within a period of 48 hours after your visit or as soon as reasonably possible. If the services provided in the emergency room were not for the treatment of an emergency condition as defined in Section One, the visit to the emergency room will not be covered.

2. Admissions From Emergency to a Hospital. If you are admitted to the hospital as a result of an emergency room visit, you or someone in your name should inform us within a period of 24 hours after your admission, or as soon as reasonably possible. If you are admitted to a non-participating hospital, we can request that you be transferred to a participating hospital as soon as your condition permits.

3. Emergency Transport. Pre-hospital emergency medical services, including an ambulance to the hospital (does not include air transport) and evaluation and treatment of an emergency condition are covered benefits as of March 1, 2002.

These services must meet the definition of prudent laypersons. This is defined as a medical condition or behavior, the onset of which is sudden, that manifests with symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in:

(i.) Placing the health of the affected person with such condition in serious danger;

(ii.) Serious damage to that person's bodily functions;

(iii.) Serious dysfunction of any bodily organ or part of that person;

(iv.) Serious disfiguration of that person.

Section 6: Other Covered Services

1. Emergency, Preventive and Routine Vision Care. We will pay for emergency, preventive and routine vision care. You do not need the authorization of your PCP for covered vision care if you seek that care from an eligible participating provider of vision care services.

Vision Care. We will pay for vision examinations performed by a doctor or optometrist to determine the need for corrective lenses and, if necessary, to issue a prescription. We will pay for a vision exam in each twelve (12) month period, unless it is required more frequently with the appropriate documentation. The vision exam may include but is not limited to:

- Case history;
- External examination of the eye and external or internal examination of the eye;
- Ophthalmoscopic examination;
- Determination of refraction condition;
- Binocular equilibrium;
- Tonometry tests for glaucoma;
- General visual field and color vision tests; and
- Summary of findings and recommendations for corrective lenses.

Lenses, Frames and Contact Lenses. We will pay for:

- The lenses prescribed provided by a participating doctor, optometrist or optician once in each twelve (12) month period, unless required more frequently with appropriate documentation. The lenses prescribed can be made of glass or plastic;
- Standard frames for holding the lenses once in a twelve (12) month period, unless required more frequently with the appropriate documentation; and
- Contact lenses when necessary from a medical point of view.

2. Emergency, Preventive and Routine Dental Care.
Emergency Dental Care. We will pay for emergency treatment to alleviate pain and suffering caused by dental disease or trauma.

Preventive Dental Care. We will pay for procedures that help prevent the occurrence of oral disease, including but not limited to:

- Prophylaxis: Sealing and cleaning of teeth at 6 month intervals.
- Topical application of fluoride at 6 month intervals when the local water supply is not fluoridated;
- Sealants on unrepaired permanent molars.

Routine Dental Care. We will pay for the following services:

- Covered dental exams, visits and consultations once within a consecutive 6 month period (when the primary teeth are coming out);
- X-rays, full mouth X-rays at 36 month intervals, if necessary, bitewing X-rays at intervals of 6 to 12 months, or panoramic X-rays at 36 month intervals if necessary; and other X-rays as required (once the primary teeth have come out);
- All procedures necessary for simple extractions and other routine dental surgery that does not require hospitalization, including:
  - Pre-operative care;
  - Post-operative care;
  - Conscious sedation in the office;
  - Amalgam, compound reconstructions and stainless steel crowns; and
  - Other reconstruction materials appropriate for children.

Endodontia. We will pay for all procedures necessary for the treatment of the pulp chamber and the root canals affected, in those cases that do not require hospitalization.

Peridontia. We will pay for periodontic services,

Orthodontia. Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if the child does not meet the criteria described above.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE)
- Placement of component parts (e.g. brackets, bands)
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)
- Removable appliance therapy
- Orthodontic retention (removal of appliances, construction and placement of retainers)

Prosthodontics. We will pay for full or partial dentures, including follow-up care for 6 months. The additional services include the introduction of identification strips, repairs and liners. Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain the space for permanent teeth that are developing normally. Fixed bridges are not covered unless:

- They are required for the replacement of an upper anterior incisor or cuspid (central/lateral) in a patient who otherwise has a complete set of natural, functional and/or reconstructed teeth;
- Required for stabilization of the cleft palate; or
- Due to the presence of any neurological or physiological condition that would impede the insertion of a removable prosthesis; demonstrated by medical documentation.

3. Diabetes Materials and Equipment. We will pay for the following equipment and materials for the treatment of diabetes that are necessary from the medical point of view and prescribed or recommended by your PCP or other participating provider legally authorized to prescribe under Title 8 of the New York State Education Act:

- Blood glucose monitors;
- Blood glucose monitors for persons with vision problems;
- Data management systems;
- Test strips for monitors and visual reading;
- Urine test strips;
- Injection aids;
- Cartridges for persons with vision problems;
- Insulin;
- Syringes;
- Insulin pumps and their accessories;
- Insulin infusion devices;
- Oral agents; and
- Additional equipment and materials designated by the Health Commission as appropriate for the treatment of diabetes.

4. Education for Self-Management of Diabetes. We will pay for education for the self-management of diabetes provided by your PCP or another participating provider. The education will be provided upon diagnosis of the diabetes, when a major change in your condition occurs, the onset of a condition that makes changes in self-management necessary or when re-education is necessary from the medical point of view as we ourselves determine. In addition, we will pay for home visits if necessary from a medical point of view.

5. Durable Medical Equipment. We will pay for devices and equipment indicated by a professional for the treatment of a specific condition that:

- Can withstand repeated use over a long period of time;
- Is used principally and habitually for medical purposes;
- Is generally not useful in the absence of disease and injury; and
- Is not normally custom-made, designed or created for the use of one person in particular.

Durable medical equipment includes the following:

- Hospital beds and accessories;
- Oxygen and materials for oxygen;
- Pressure pads;
- Volume ventilators, therapeutic ventilators and other equipment for respiratory care;
- Nebulizers;
- Traction equipment;
- Walkers;
- Accessories for walkers;
- Wheelchairs and accessories;
- Canes and crutches;
- Chairs with urinal;
- Bars for the toilet;
- Apnea monitors;
- Patient elevators;
- Feeding pumps;
- Infusion pumps for outpatients; and
- Other varied durable medical equipment.

The coverage for durable medical equipment includes maintenance of the equipment (i.e., labor and parts).

6. Prosthetic Devices. We will pay for the equipment and devices indicated by a qualified professional that replace any part of the body that is missing.

7. Orthotic Devices. We will pay for the devices indicated by a qualified professional that are used to support a part of the body that is weak or deformed or to restrict or eliminate movement of a diseased or injured part of the body.

8. Prescribed Medications.

Scope of Coverage. We will pay for medications approved by the FDA that require a prescription and that are in our formulary. Our formulary is UnitedHealthcare Community Plan – 1998 National Formulary. In addition, we will pay for the following if it is determined that it is necessary from the medical point of view and it is prescribed by a doctor and/or the plan authorizes it:

- Nutritional supplements (formulas) for the treatment of PKU (phenylketonuria), branched-chain ketonuria, galactosemia and homocystinuria;
- Enteric formulas for use at home for the treatment of specific illnesses:
- Modified solid food products with low protein contents or containing modified proteins for the treatment of certain hereditary diseases of the amino acid and organic acid metabolism.
- Coverage will not exceed $2,500 per calendar year;
- Non-prescription medications authorized by a professional authorized to write prescriptions and that are in the Medicaid medications formulary; and
- Family planning and birth control devices, basal thermometers, female and male condoms and diaphragms.

Participating Pharmacy. We will only pay for medications prescribed for use outside the hospital. Except in an emergency, the prescription must be written by a participating provider and must be dispensed by a participating pharmacy.

Exclusions and Restrictions. Under this section, we will not pay for the following:

- Administration or injection of medications;
- Replacement of lost or stolen prescriptions;
- Medications prescribed for cosmetic reasons, unless they are necessary from a medical point of view.
- Experimental medications or medications in research, unless they are recommended by an outside appeals agent;
- Medications not approved by the FDA except for a prescribed medication that is approved by the FDA for the treatment of cancer when the medication is prescribed for a different type of cancer than the type for which it was approved by the FDA. Nonetheless, the medication must be recognized for the treatment of the type of cancer for which it was prescribed by one of these publications:
  - AMA Drug Evaluations
  - American Hospital Formulary Service
  - U.S. Pharmacopoeia Drug Information
  - A review article or editorial comment in a major peer-reviewed professional journal
- Nutritional supplements taken optionally; and

- Devices and materials of all types, except family planning or birth control devices, basal thermometers, female and male condoms and diaphragms.
- Prescribed medications and biological products and the administration of these medications and biological products provided with the intention of causing or helping to cause death, suicide, euthanasia or the compassionate killing of a person.
- Medications prescribed for purposes of treating erectile dysfunction.

9. Home Medical Care. We will pay for up to 40 visits per calendar year for home medical care provided by a certified home medical care agency that is a participating provider. We will pay for home medical care only if you would have to be admitted to a hospital if the home medical care were not provided. The home medical care includes one or more of the following services:

- Part-time or intermittent home nursing care by a registered professional nurse or under the supervision of the same;
- Part-time or intermittent home medical care services by an assistant that consist primarily of patient care;
- Physical, occupational or speech therapy if provided by a home medical care agency; and
- Medical materials, drugs and medications prescribed by a physician and laboratory services from a home medical care agency or in the name thereof to the extent that these items would have been covered if the member had been in the hospital.

10. Tests Prior to Admission. We will pay for the tests prior to admission when they are performed in the hospital at which the surgery is scheduled, if:

- Reservations have been made for a hospital bed and an operating room in this hospital before performing the tests prior to admission;
- Your doctor has indicated these tests; and
- The surgery is performed within seven days following these tests prior to admission.

If the surgery is cancelled due to the findings on the tests prior to admission, we will continue to cover the costs of these tests.

11. Palliative Care Services (Hospice). We will pay for a coordinated palliative care program for providing non-curative medical and support services (whether at home or in a hospital setting as an inpatient) for children (up to 19 years of age) that a doctor has certified as a terminal disease with a life expectancy of six months or less.

The palliative care services cover palliative and support care provided to a child that meets the special needs arising from the physical, psychological, spiritual, social and economic stress experienced during the final stages of a disease and during death and grieving. In addition, family members are eligible for up to five visits for consulting on the grieving.

The palliative care services programs must be certified under Article 40 of the New York State Public Health Law. All services must be provided by qualified employees and volunteers in the palliative care program or by staff qualified through contractual arrangements to the extent permitted by Federal and state requirements.

In Compliance with Section 2302 of the Affordable Care Act, if you are eligible for and choose to receive palliative care services, you may do so without foregoing curative or other service that are covered benefits under your Child Health Plus subscriber contract for treatment of the terminal disease.

Section 7: Additional Information on How This Plan Works

1. When a Specialist Can Be Your PCP. If you have a condition or illness that is life-threatening or a degenerative or incapacitating condition or illness, you can ask for a participating specialist to be your PCP. We will consult with the specialist and your PCP and decide if it would be appropriate for the specialist to serve in that capacity.

2. Permanent Referral to a Specialist in the Network. If you need continuous specialized care, you can receive a “permanent referral” to a specialist who is a participating provider. This means that you will not need to get a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether a “permanent referral” would be appropriate in your situation.

3. Permanent Referral to a Specialized Care Center. If you have a condition or illness that is life-threatening or a degenerative or incapacitating condition or illness, you can ask for a permanent referral to a specialized care center that is a participating provider. We will consult with your PCP, your specialist and the specialized care center to decide if such a referral is appropriate.

4. When Your Provider Withdraws From the Network. If you are undergoing a cycle of treatment and your provider withdraws from our network, you may, under certain circumstances, continue receiving medical care from the old participating provider up to 90 days after you receive our notice that the provider is withdrawing. If you are pregnant and in your second trimester, you may continue your care with the old participating provider until the delivery and postpartum care directly related to the delivery. However, for you to continue care up to 90 days or until the end of the pregnancy with an old participating provider, the provider must agree to accept our payment and adhere to our procedures and policies, including those for guaranteeing the quality of medical care.

5. When New Members Are in a Treatment Cycle. If you are in a treatment cycle with a non-participating provider when you enroll in our plan, you may receive care from the non-participating provider up to 60 days from the date on which you started to be covered under this contract. The treatment cycle must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In addition, you can continue receiving medical care from a non-participating provider if you are in your second trimester of pregnancy when you start coverage under this contract. You can continue your medical care up to the delivery and the postpartum services directly related to your delivery.

However, for you to continue receiving medical care up to 60 days or during the entire pregnancy, the non-participating provider must agree to accept our payment and to adhere to our policies and procedures, including those for guaranteeing the quality of the medical care.

Section 8: Restrictions and Exclusions

In addition to the restrictions and exclusions already described, we will not pay for the following:

1. Medical Care That is Not Necessary From a Medical Point of View. You do not have a right to benefits for any service, supply, test or treatment that is not necessary from a medical point of view or appropriate for the diagnosis or treatment of your illness, injury or condition (see Section Twelve).

2. Accepted Medical Practice. You do not have a right to services that are not in accordance with accepted medical or psychiatric practices and the standards in effect at the time of treatment.

3. Medical Care Not Provided, Authorized or Coordinated by Your PCP. Except as described in this contract, you have a right to benefits for services only when they are provided, authorized or coordinated by your PCP. If you choose to obtain medical care that is not provided, authorized or coordinated by your PCP, we will not be responsible for any cost you may incur.

4. Services for Inpatients in a Geriatric or Convalescence Facility, Rehabilitation Center or Any Other Facility Not Explicitly Covered by This Contract.

5. Doctors' Services for Inpatients in a Geriatric or Convalescence Facility, Rehabilitation Center or Any Other Facility Not Explicitly Covered by This Contract.

6. Experimental Services or Services in Research, unless necessary from a medical point of view.

7. Experimental Medications and Medications That Can Be Purchased Without a Prescription Except as Explicitly Described in This Contract.

8. Cosmetic Surgery, unless necessary from a medical point of view. We will not pay for cosmetic surgery, except that we will pay for reconstructive surgery: When it follows surgery resulting from trauma, infection or other diseases of part of the part of the body involved; or when it is required to correct a functional defect resulting from a congenital disease or abnormality.

9. Dental Care Except as Described in Section Six.

10. Personal Items or Items for Comfort.

11. *In Vitro* Fertilization, Artificial Insemination or Other Assisted Means of Conception.

12. Private Nursing.

13. Durable Medical Equipment and Materials, Except as Described in Section Six.

14. Prosthetic Devices. We will not pay for skull prostheses (i.e., wigs) and dental prostheses except those necessary due to accidental injury to healthy natural teeth that are provided within a period of twelve months following the accident, and except for dental prostheses necessary for the treatment of a congenital abnormality or as part of reconstructive surgery.

15. Autologous Blood Donations.

16. Speech and Hearing Services Not Explicitly Described in the Contract.

17. Physical Manipulation Services. We will not pay for any service in connection with the detection and correction (by manual or mechanical means) of:

- Structural disequilibrium of the vertebral column; or
- Distortion of the vertebral column; or
- Subluxation of the vertebral column in the human body for purposes of eliminating nerve interference and the effects thereof. These exclusions apply when the nerve interference is a result of or related to distortion, incorrect alignment or subluxation of or in the vertebral column.

18. Routine Foot Care.

19. Routine Transport to Doctors' Appointments.

20. Other Medical Insurance, Health Benefits and Governmental Programs. We will reduce our payments under this contract by the amount that you are eligible to receive for the same service under another health insurance policy, health benefits plan or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield plans or HMO or similar programs. Health benefit plans include any self-insurance or without insurance plan such as, for example, those offered or coordinated through employers, boards of directors, unions, employers' organizations or employee benefit

organizations. Governmental programs include Medicare, Medicaid or any other federal, state or local program, except for the Physically Handicapped Children's Program and the Early Intervention Program.

21. No-Fault Automobile Insurance. We will not pay for any service that may be covered by mandatory no-fault automobile benefits. We will not make payments, even if you do not claim the benefits to which you have a right under no-fault automobile insurance.

22. Other Exclusions. We will not pay for:

- Sex change operations, unless they are necessary from a medical point of view; or
- Custodial care.

23. Workers' Compensation. We will not provide coverage for any service or medical care for an injury, condition or disease if benefits are provided under a Workers' Compensation Act or similar legislation.

24. Transportation in Cases Not Involving an Emergency.

25. Services Received Outside of the Service Area. Other than Emergency and Urgent care, this plan does not cover any services received outside of the service area. See **Section 1** under **Service Area** for a list of New York State counties that the plan covers.

Section 9: Premiums for This Contract

1. Amount of Premiums. We determine the amount of the premium for this contract and it is approved by the New York State Superintendent of Insurance.

2. Your Contribution for the Premium. Under New York state law, you may have to contribute for the premium on this contract. The amount you have to contribute, if any, is based on the gross annual income of your family or household.

If the gross annual income of your family or household is up to 230% of the federal poverty level, New York state will pay all or part of the premiums for this contract. If the gross annual income of your family or household is greater than 230% of the federal poverty level, you will have to pay the full premium for this contract.

3. Grace Period. All premiums for this contract are due one month in advance. However, we will permit a 30-day grace period for the payment of all premiums, except for the first month. This means that, except for the premium for the month for each child, if we receive payment within a 30-day period following the due date for the payment, we will continue the coverage under this contract for the entire period covered by the payment. If we do not receive payment within the 30-day grace period, the coverage under this contract will terminate starting as of the last day of the month in which the payment was due.

4. Agreement to Pay for Services if You do Not Pay the Premium. You do not have a right to any service for periods for which we have not received the premium. If services are received during this period, you agree to pay for the services received.

5. Change in Premiums. If there is going to be an increase or decrease in the premium or your contribution to the premium for this contract, we will notify you of the change in writing at least 30 days before.

6. Changes in Your Income or Household Size. You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at **1-800-493-4647, TTY 711** or by calling the Child Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the form and documentation necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within ten (10) business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than forty (40) days from receipt of the review request and supporting documentation.

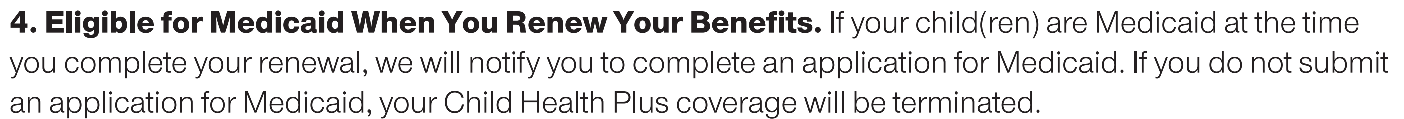
Section 10: Termination of Coverage

1. For Non-Payment of Premium. If you are required to pay a premium for this contract, this contract will terminate at the end of the 30-day grace period if we do not receive your payment. For example, if your premium is due on July 1 and it has not been paid by July 31, the end of the 30-day grace period, no payment will be made under this contract for any service that has been provided since July 31.

2. When You Move Outside the Service Area. This contract will terminate when you cease residing permanently in the service area.

3. When You No Longer Meet the Eligibility Requirements. This contract will terminate as follows:

- On the last day of the month in which you complete 19 years; or
- The date on which you enroll in the Medicaid program; or
- The date on which your coverage starts under another health benefits program (including an insured or self-insured program through an employer group, union or other association), considered equivalent to coverage under this contract.
- The date you become an inmate of a public institution or a patient in an institution for mental disease.



4. Eligible for Medicaid When You Renew Your Benefits. If your child(ren) are Medicaid at the time you complete your renewal, we will notify you to complete an application for Medicaid. If you do not submit an application for Medicaid, your Child Health Plus coverage will be terminated.

5. Termination of the Child Health Plus Program. This contract will terminate automatically if: the State terminates the contract; or the State financing for this program is no longer available to us; or the New York state law establishing the Child Health Plus program is abrogated.

6. Our Option to Terminate This Contract. We can terminate this contract at any time for one or more of the following reason(s):

- Fraud on the enrollment application under this contract or upon receiving services;
- Other reasons filed by the Superintendent of Insurance at the time of such termination and approved by him. You will be sent a copy of these reasons. We will notify you in writing in case of such termination 30 days in advance;
- Suspension of the class of contracts to which this contract belongs with written advance notice of five (5) months in case of such termination; or
- If you do not provide documentation that we request for recertification.

7. Your Option to Terminate This Contract. You can terminate this contract at any time by giving us advance notice of at least 30 days. We will reimburse any portion of the premium prepaid by you within a period of 90 days.

8. Upon Your Death. This contract will be terminated automatically on the date of your death.

9. Benefits After Termination. If you are totally disabled as of the date on which this contract is terminated and you have received medical services for the illness, injury or condition causing the total disability while you are covered under this contract, we will continue paying for services, care and treatment of the illness, injury or condition in relation to the total disability during an uninterrupted period of total disability until:

- The date on which you, at our sole discretion, are not totally disabled; or
- The date 12 months after the date on which this contract terminates, whichever comes first.

We will not pay for more medical care than what you would have received if your coverage under this contract had not been terminated.

Section 11: Right to a New Contract After Termination

1. When You Complete 19 Years of Age. If this contract terminates because you have completed 19 years, then you can purchase a new contract as a direct payment affiliate or you may be eligible for Medicaid. call Member Services at **1-800-493-4647, TTY 711** for more information.

2. If Child Health Plus Is Terminated. If this contract is terminated because the Child Health Plus program is terminated, you can purchase a new contract as a direct payment affiliate.

3. How to Apply for Enrollment. You must ask us to enroll you within a period of 31 days following the termination of this contract. Your complete enrollment application is required together with your first payment of the premium for the new contract.

4. The New Contact. The new contract we will make available to you will be the direct payment contracts that we offer to people who are not covered by Child Health Plus.

Section 12: Utilization Review and Grievance Procedures

Utilization Review

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, or need help, please call Member Services toll free at **1-800-493-4647, TTY 711**, from 8:00 a.m. – 6:00 p.m., Monday through Friday. Language help is available.

All determinations that services are not Medically Necessary will be made by:

1. licensed Physicians; or
2. licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or

3. with respect to substance use disorder treatment, on or after April 1, 2015, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment.

We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, call Member Services at **1-800-493-4647, TTY 711**, the number on Your ID card, or visit our website at **UHCCommunityPlan.com**.

B. Preauthorization Reviews.

1. If we have all the information necessary to make a determination regarding a Preauthorization review, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If we need additional information, we will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) and your Provider by telephone within 48 hours of the earlier of our receipt of the information or the end of the 48 hour time period. Written notification will be provided within the earlier of three (3) business days of our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour time period.
3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and Your Provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.
4. **Inpatient Substance Use Disorder Treatment Reviews.** Effective on or after April 1, 2015, if, a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within
   24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

D. Retrospective Reviews.
If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and Your Provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and Your Provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.
If we did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.
You, your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. We will acknowledge your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:

- A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral or an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, we will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, we will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be

determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. If you are not satisfied with the resolution of your expedited Appeal, You may file a standard internal Appeal or an external appeal

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

Substance Use Appeal. If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your Provider file an expedited internal Appeal of our adverse determination, we will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

I. Appeal Assistance.

If you need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010

Or call toll free: 1-888-614-5400, or e-mail **cha@cssny.org**
www.communityhealthadvocates.org

Grievances

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

B. Filing a Grievance.

You can contact us by phone at **1-800-493-4647, TTY 711**, the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral Grievance, prepared by us. You or Your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the Grievance.

When we receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your Grievance and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential but we may need to contact your health care provider to investigate your grievance. We will take no discriminatory action because of your issue. We have a process for both standard and expedited Grievances, depending on the nature of your inquiry.

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify you within the following timeframes:

<u>Expedited/Urgent Grievances</u>:
By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance.

<u>Pre-Service Grievances</u>:
(A request for a service or a treatment that has not yet been provided.)
In writing, within 30 calendar days of receipt of your Grievance.

<u>Post-Service Grievances</u>:
(A claim for a service or a treatment that has already been provided.)
In writing, within 30 calendar days of receipt of all necessary information, but no later than 60 days of receipt of your Grievance.

<u>All Other Grievances</u>:
(That are not in relation to a claim or request for service.)
In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of your Grievance.

D. Grievance Appeals.
If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by phone at **1-800-493-4647, TTY 711**, the number on your ID card, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When we receive your Appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify you in writing within the following timeframes:

Expedited/Urgent Grievances:
The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your Appeal.

Pre-Service Grievances:
(A request for a service or a treatment that has not yet been provided.)
15 calendar days of receipt of your Appeal.

Post-Service Grievances:
(A claim for a service or a treatment that has already been provided.)
30 calendar days of receipt of your Appeal.

All Other Grievances:
(That are not in relation to a claim or request for a service.)
30 business days of receipt of all necessary information to make a determination

E. Assistance.
If you remain dissatisfied with Our Grievance determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:

New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

www.health.ny.gov

If you need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010

Or call toll free: **1-888-614-5400**, or e-mail **cha@cssny.org**
www.communityhealthadvocates.org

Section 13: External Appeal

1. Your Right to an External Appeal.
Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis:

- that the service is not medically necessary, or
- that the service is experimental or investigational treatment, or
- that the out-of-network service requested was no different from a service that is available in our network or the services is treatment for a rare disease.

You or your representative may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

2. Your Right to Appeal a Determination That a Service is Not Medically Necessary.
If the Plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

- The service, procedure or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

3. Your Rights to Appeal a Determination That a Service is Experimental or Investigational.
If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and
- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

4. Your Rights to Appeal a Determination of an Out-of-Network Provider and/or Treatment of a Rare Disease.

If you have been denied coverage on the basis that the out-of-network service you requested was not different from a service you could receive through our network providers or was for the treatment of a rare disease, your must ask your doctor to send us:

1. a written statement that the service you asked for is different from the service we have in our network; and
2. two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

5. In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician, has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

6. The External Appeal Process.
If, through the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 4 months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 4 months from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the External Appeal Agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or the Plan. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of your completed application. The External Appeal Agent must try to notify you and the Plan by telephone or facsimile immediately after reaching a decision.

If the External Appeal Agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the other terms and conditions of this Subscriber Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

7. Your Responsibilities.
It Is Your Responsibility to Initiate the External Appeal Process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

Section 14: General Provisions

1. No Assignment. You cannot assign the benefits of this contract. Any assignment or attempt to do so invalidates it. Assignment means the transfer to another person or organization of your rights to the benefits this contract provides.

2. Legal Action. If you need to take legal action against us under this contract, you must do so within a period of 24 months after the date on which we refused to pay for a service under this contract.

3. Amendment to the Contract. We can change this contract if the change is approved by the New York State Superintendent of Insurance. We will notify you in writing of any change at least 30 days before.

4. Medical Records. We agree to maintain the confidentiality of your medical records. We may need to obtain your medical records from hospitals, doctor or other providers who have treated you. When your coverage starts under this contract, you give us permission to obtain and use these records in order to administer this contract.

5. Who Receives Payment Under This Contract. We will pay the participating providers who provide services directly. If you receive covered services from any other provider, we reserve the right to pay you or the provider.

6. Notification. Any notification under this contract may be sent by United States mail, post prepaid, to the following address: If it is for us:

UnitedHealthcare Community Plan
ATTN: Member Services
P.O. Box 1037
New York, NY 10268-1037

If it is for you: To the most recent address you have given us on the enrollment forms or the official change of address forms.

We’re here for you.

Remember, we’re always ready to answer any questions you may have. Just call Member Services at **1-800-493-4647, TTY 711**, from 8:00 a.m. – 6:00 p.m. Monday through Friday. Language help is available. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan of New York
77 Water Street, 14th Floor
New York, NY 10005

myuhc.com/CommunityPlan

1-800-493-4647, TTY 711

DFS approved 3.2.15