Child Health Plus

Subscriber Contract

HIGHMARK WESTERN NEW YORK

Child Health Plus Plan

Western New York

bcbswny.com/stateplans

1013884NYMENHWN 07/21

ATTENTION: Language assistance services, free of charge, are available to you. Call 866-231-0847 (TTY 711).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-231-0847 (TTY 711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866-231-0847 (TTY 711).	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم(TTY 711) (رقم هاتف الصم والبكم 866-231-0847	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 866-231-0847 (TTY 711) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866-231-0847 (телетайп: TTY 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 866-231-0847 (TTY 711).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 866-231-0847 (TTY 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 866-231-0847 (TTY 711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY 711) 866-231-0847.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 866-231-0847 (TTY 711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 866-231-0847 (TTY 711).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন ১- 866-231-0847 (TTY 711).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 866-231-0847 (TTY 711).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 866-231-0847 (TTY 711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 866-231-0847 (TTY 711).	Urdu
BAA !KOHWIINIDZIN: Saad bee 1ka'e'eyeed bee 1ka'an7da'awo', t'11 j77k'eh [a' n1 h0l=-go 1t'4. Kohj8' 866-231-0847 (TTY 711) hod7ilnih.	Navajo

NOTICE OF NON-DISCRIMINATION

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) complies with Federal civil rights laws. **Highmark BCBSWNY** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Highmark BCBSWNY provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Highmark BCBSWNY** at 866-231-0847. For TTY/TDD services, call 711.

If you believe that **Highmark BCBSWNY** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Highmark BCBSWNY** by:

Mail:	Member Complaints and Appeals Department P.O. Box 62509 Virginia Beach, VA 23466-2509
Phone:	844-401-2292 (for TTY/TDD services, call 711)
Fax:	844-759-5954
In person:	Highmark Blue Cross Blue Shield of Western New York 257 West Genesee St., #110 Buffalo, NY 14202

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail:	U.S. Department of Health and Human Services 200 Independence Ave. SW, Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	800-368-1019 (TTY/TDD 800-537-7697)

This is your Child Health Plus rider for Service Area Expansion issued by Highmark Blue Cross Blue Shield of Western New York

This rider amends the paragraphs of your current contract or group plan (policy) issued by Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) pertaining to Service Area Expansion.

1. **Service Area Expansion.** Effective January 1, 2018, Highmark BCBSWNY will be expanding their service area to include Genesee and Niagara counties.

2. **Other provisions.** All of the other provisions contained in your contract or group plan apply to this rider, except as specifically changed by this rider.

Highmark Blue Cross Blue Shield of Western New York
257 West Genesee St.
Buffalo, NY 14202

Dr. Michael Edbauer
President
Highmark Blue Cross Blue Shield of Western New York

bcbswny.com/stateplans

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Western New York
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Child Health Plus Subscriber Contract

Retention
P.O. Box 38
Buffalo, NY 14240-0038

Member Services: 866-231-0847 (TTY 711)
bcbswny.com/stateplans

SUBSCRIBER CONTRACT

This is your Child Health Plus contract with Highmark Blue Cross Blue Shield of Western New York. It entitles you to the benefits set forth in the contract. Coverage begins on the effective date stated on your identification card. This contract will continue unless it is terminated for any of the reasons described in the contract.

NOTICE OF 10-DAY RIGHT TO EXAMINE CONTRACT

You have the right to return this contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within 10 days of the date you receive this contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

IMPORTANT NOTICE

Except as stated in this contract, all services must be provided, arranged, or authorized by your primary care physician (PCP). You must contact your PCP in advance in order to receive benefits, except for emergency care described in Section Five, certain obstetric and gynecological care described in Section Four, vision care described in Section Eight, and dental care described in Section Nine of this contract.

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SECTION ONE — INTRODUCTION

1. **Child Health Plus program.** This contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. We will enroll you in the Child Health Plus program if you meet the eligibility requirements established by New York State, and you will be entitled to the healthcare services described in this contract. You and/or the responsible adult, as listed on the application, must report to us any change in status such as residency, income, or other insurance that may make you ineligible for participation in Child Health Plus within 60 days of the change.

2. **Healthcare through a health maintenance organization (HMO).** This contract provides coverage through an HMO. In an HMO, all care must be medically necessary and provided, arranged or authorized in advance by your primary care physician (PCP). Except for emergency care, for certain obstetric and gynecological services, and for vision and dental services, there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a participating provider, except in an emergency or when your PCP refers you to a nonparticipating provider.

   It is your responsibility to select a PCP from the list of PCPs when you enroll for this plan. You may change your PCP by calling our Member Services department at 866-231-0847 (TTY 711). The PCP you have chosen is referred to as your PCP throughout this contract.

3. **Words we use.** Throughout this contract, Highmark BCBSWNY will be referred to as *we*, *us* or *our*. The words *you*, *your* or *yours* refer to you, the child to whom this contract is issued and who is named on the identification card.

4. **Definitions.** The following definitions apply to this contract:
   A. **Contract** means this document. It forms the legal agreement between you and us. Keep this contract with your important papers so that it is available for your reference.

   B. **Emergency condition** means a medical or behavioral condition, the onset of which is sudden, with symptoms of sufficient severity, including severe pain, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:
      - Placing the health of the person afflicted with such condition in serious jeopardy, or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
      - Serious impairment of such person's bodily functions
      - Serious dysfunction of any bodily organ or part of such person
      - Serious disfigurement of such person

   C. **Emergency services** mean those physician and outpatient hospital services necessary

for treatment of an emergency condition.

D. **Hospital** means a facility defined in Article 28 of the Public Health law which:
   - Is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons.
   - Has organized departments of medicine and major surgery.
   - Has a requirement that every patient must be under the care of a physician or dentist.
   - Provides 24-hour nursing service by or under the supervision of a registered professional nurse (RN).
   - If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USCA 1395xk).
   - Is duly licensed by the agency responsible for licensing such hospitals.
   - Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics or a place for convalescent, custodial, education or rehabilitory care.

E. **Medically necessary** means those health services determined by the member's PCP or his or her designee to be essential to the health of the member in accordance with professional standards accepted in such physician's medical community. In the event of a disagreement as to the medical necessity of a particular healthcare service, the medical director shall make the final determination of whether it is medically necessary, subject to the Highmark BCBSWNY complaint procedures and compliance with the Child Health Plus contract.

F. **Participating hospital** means a hospital that has an agreement with us to provide covered services to our members.

G. **Participating pharmacy** means a pharmacy that has an agreement with us to provide covered services to our members.

H. **Participating physician** means a physician who has an agreement with us to provide covered services to our members.

I. **Participating provider** means any participating physician, hospital, home healthcare agency, laboratory, pharmacy or other entity that has an agreement with us to provide covered services to our members. We will not pay for health services from a nonparticipating provider except in an emergency or when your PCP sends you to that nonparticipating provider (with our approval).

J. **Primary care physician** (PCP) means the participating physician you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered healthcare services.

K. **Service area** means the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming. You must live in the service area to be covered under this contract.

SECTION TWO — WHO IS COVERED

1. **Who is covered under this contract.** You are covered under this contract if you meet all of the following requirements:
   - You are younger than age 19.
   - You do not have other healthcare coverage.
   - You are not eligible for Medicaid.
   - You are a permanent New York State resident and resident of 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 Child Health Plus eligibility requirements. You must periodically resubmit an application to us, so that we can determine whether you still meet the eligibility requirements. This process is called recertification. If more than one child in your family is currently covered by us, the recertification date for all the children in your family covered by us is the month assigned to the child who had the closest recertification date on or after October 1, 2000. You must recertify once each year unless another child in your family applies for coverage with us after you are covered. If another child in your family applies for coverage with us, then you must recertify all children when that child applies for coverage. Thereafter, all the children in your family covered by us will recertify once each year on the same date.

3. **Change in circumstances.** You must notify us of any changes to your income, residency or healthcare coverage that might make you ineligible for this contract. You must give us this notice within 60 days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.

Please call Member Services at 866-231-0847 (TTY 711) if you have any questions or need help with any of your benefits, care or services.

SECTION THREE — HOSPITAL BENEFITS

1. **Care in a hospital.** You are covered for medically necessary care as an inpatient in a hospital if all the following conditions are met:
   - Except if you are admitted to the hospital in an emergency or your PCP has arranged for your admission to a nonparticipating hospital, the hospital must be a participating hospital
   - Except in an emergency, your admission is authorized in advance by your PCP
   - You must be a registered bed patient for the proper treatment 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 diet and nutritional therapy
   - General, special and critical care nursing services but not private-duty nursing services
   - Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care
   - Oxygen and other inhalation therapeutic services and supplies
   - Drugs and medications that are not experimental
   - Sera, biologicals, vaccines, intravenous preparations, dressings, casts and materials for diagnostic studies
   - Blood products, except when participation in a volunteer blood replacement program is available
   - Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations
   - Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation
   - Facilities, services, and supplies and equipment related to radiation and nuclear therapy
   - Facilities, services, supplies and equipment related to emergency medical care
   - Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services
   - Chemotherapy
   - Radiation therapy
   - Any additional medical, surgical or related services, supplies and equipment customarily furnished by the hospital, except to the extent that they are excluded by this contract

3. **Maternity care.** Other than for prenatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a cesarean section. We will pay for inpatient hospital care for at least 96 hours after a cesarean section. Maternity care coverage includes parent education, assistance and training in breast- or bottle-feeding and performance of necessary maternal and newborn clinical assessments.

You have the option to be discharged earlier than 48 hours (96 hours for cesarean section). If you choose an early discharge, we will pay for one home care visit if you ask us to within 48 hours of delivery (96 hours for a delivery by cesarean section). The home care visit will be delivered within 24 hours of your discharge from the hospital or your request for home care. The home care visit will be in addition to the home care visits covered under Section Seven of this contract.

4. **Limitations and exclusions**
   - We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not medically necessary.
   - Benefits are paid in full for a semiprivate room. If you are at a private room at a hospital, the difference between the cost of a private room and a semiprivate room must be paid by you, unless the private room is medically necessary and ordered by your physician.
   - We will not pay for nonmedical items such as television rental or telephone charges.

SECTION FOUR — MEDICAL SERVICES

1. **Your PCP must provide, arrange or authorize all medical services.**
   Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:
   - Your PCP's office
   - Another provider's office or a facility if your PCP determines care from that provider or facility is appropriate for the treatment of your condition
   - The outpatient department of a hospital
   - As an inpatient in a hospital, you are entitled to medical, surgical and anesthesia services

2. **Covered medical services.** We will pay for the following medical services:
   A. **General medical and specialist care, including consultations.**

   B. **Preventive health services and physical examinations.** We will pay for preventive health services including:
      - Well-child visits in accordance with the visitation schedule established by the American Academy of Pediatrics.
      - Nutrition education and counseling.
      - Hearing testing.
      - Medical social services.
      - Eye screening.
      - Routine immunizations in accordance with the Advisory Committee on Immunization Practices recommended immunization schedule.
      - Tuberculin testing.

- Dental and developmental screening.
- Clinical laboratory and radiological testing.
- Lead screening.

C. **Diagnosis and treatment of illness, injury or other conditions.** We will pay for the diagnosis and treatment of illness or injury, including:
   - Outpatient surgery performed in a provider's office or at an ambulatory surgery center, including anesthesia services.
   - Laboratory tests, X-rays and other diagnostic procedures.
   - Renal dialysis.
   - Radiation therapy.
   - Chemotherapy.
   - Injections and medications administered in a physician's office.
   - Second surgical opinion from a board-certified specialist.
   - Second medical opinion provided by an appropriate specialist, including one affiliated with a specialty center, where there has been a positive or negative diagnosis of cancer, or recommendation of a course of treatment of cancer.
   - Medically necessary audiometric testing.
   - Women's health and cancer services in contract, which include treatment of physical complications of mastectomy, including lymphedema in a manner determined in consultation with your attending provider.

D. **Physical and occupational therapy.** We will pay for short-term physical and occupational therapy services. The therapy must be skilled therapy and be a part of a physician's plan of treatment. The services must be provided by an approved therapist and be rehabilitative in nature. Short-term therapy shall not exceed 40 outpatient visits per calendar year.

E. **Radiation therapy, chemotherapy and hemodialysis.** We will pay for radiation therapy and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

F. **Obstetrical and gynecological services.** We will pay for obstetrical and gynecological services, including prenatal, labor and delivery and postpartum services with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from a qualified participating provider of obstetric and gynecologic services. You may also receive the following services from a qualified participating provider of obstetric and gynecologic services without your PCP's authorization:
   - Up to two annual examinations for primary and preventive obstetric and gynecologic care
   - Care required as a result of the annual examinations or as a result of an acute gynecological condition

G. **Cervical cancer screening.** If you are a female 18 years old or older, we will pay for an annual cervical cancer screening, an annual pelvic examination, Pap smear and evaluation of the Pap smear. If you are a female younger than 18 years old and are sexually active, we will pay for an annual pelvic examination, Pap smear and evaluation of the Pap smear. We will also pay for screening for sexually transmitted diseases.

Please call Member Services at 866-231-0847 (TTY 711) if you have any questions or need help with any of your benefits, care or services.

SECTION FIVE — EMERGENCY CARE

1. **Hospital emergency room visits.** We will pay for emergency services provided in a hospital emergency room. You may go directly to any emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval.

   If you go to the emergency room, you or someone on your behalf should notify us within 24 hours of your visit or as soon as it is reasonably possible.

   If the emergency room services rendered were not in treatment of an emergency condition as defined in Section One, the visit to the emergency room will not be covered.

2. **Emergency hospital admissions.** If you are admitted to the hospital, you or someone on your behalf must notify us within 24 hours of your admission, or as soon as it is reasonably possible. If you are admitted to a nonparticipating hospital, we may require that you be moved to a participating hospital as soon as your condition permits.

3. **Prehospital emergency medical services.** We will pay for prehospital emergency medical services, including prompt evaluation and treatment for an emergency condition and/or nonairborne transportation of you to a hospital. Coverage for such transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
   - Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy.
   - Serious impairment to such person's bodily functions.
   - Serious dysfunction of any bodily organ or part of such person.
   - Serious disfigurement of such person.

SECTION SIX — MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

1. **Inpatient mental health and substance use disorder services.** We will pay for inpatient mental health services and inpatient substance use disorder services when they are done in a facility that is one of the following:
   - Operated by the Office of Mental Health under Sec. 7.17 of the Mental Hygiene Law
   - Issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law
   - A general hospital as defined in Article 28 of the Public Health Law

2. **Outpatient visits for treatment of mental health conditions and for treatment of substance use disorder.** We will pay for outpatient visits to diagnose and treat mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if these visits are related to your mental health or substance use disorder treatment.

SECTION SEVEN — OTHER COVERED SERVICES

1. **Diabetic equipment and supplies.** We will pay for the following equipment and supplies for the treatment of diabetes. These must be medically necessary and prescribed or recommended by your PCP or other participating provider legally authorized to prescribe under Title 8 of the New York State Education Law:
   - Blood glucose monitors
   - Blood glucose monitors for the visually impaired
   - Data management systems
   - Test strips for monitors and visual reading
   - Urine test strips
   - Injection aids
   - Cartridges for the visually impaired
   - Insulin
   - Syringes
   - Insulin pumps and appurtenances thereto
   - Insulin infusion devices
   - Oral agents
   - Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes

2. **Diabetes self-management education.** We will pay for diabetes self-management education provided by your PCP or another participating provider.

Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition that makes changes in self-management necessary or when we determine that re-education is medically necessary. We will also pay for home visits if medically necessary.

3. **Durable medical equipment, prosthetic appliances and orthotic devices.**
   A. **Durable medical equipment.** We will pay for devices and equipment ordered by a participating provider, including equipment servicing, for the treatment of a specific medical condition. Covered durable medical equipment includes:
      - Canes.
      - Crutches.
      - Hospital beds and accessories.
      - Oxygen and oxygen supplies.
      - Pressure pads.
      - Volume ventilators.
      - Therapeutic ventilators.
      - Nebulizers and other equipment for respiratory care.
      - Traction equipment.
      - Walkers, wheelchairs and accessories.
      - Commode chairs and toilet rails.
      - Apnea monitors.
      - Patient lifts.
      - Nutrition infusion pumps.
      - Ambulatory infusion pumps.
      - Enteral formula and nutritional supplements are provided through DME as a medical benefit rather than a pharmacy benefit and must be obtained through a DME vendor and will require prior authorization. Enteral formula and nutritional supplements are covered for:
        - Children who have metabolic or absorption disorders.
        - Individuals who have rare, inborn metabolic disorders.
        - Tube-fed individuals who cannot chew or swallow.

   B. **Prosthetic appliances.** We will pay for appliances and devices ordered by a qualified practitioner that replace any missing part of the body, except that there is no coverage for cranial prostheses (e.g., wigs). Further, dental prostheses are excluded from coverage under this section, except those made necessary due to an accidental injury to sound, natural teeth and provided within 12 months of the accident and/or needed in the treatment of a congenital abnormality or as part of reconstructive surgery.

   C. **Orthotic devices.** We will pay for devices that are used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. There is no coverage for orthotic devices that are prescribed solely for use during sports.

4. **Prescription and nonprescription drugs.**

A. **Scope of coverage.** We will pay for FDA-approved drugs that require a prescription. We will pay for over the counter (OTC) drugs that are authorized by a professional licensed to write prescriptions and that appear in the Medicaid drug formulary. We will also pay for medically necessary enteral formulas for the treatment of specific diseases and for modified solid food products used in the treatment of certain inherited diseases of amino acid and organic acid metabolism.

B. **Copay amounts.** As part of the CHP plan, members have a $0 copay for prescription benefits.

C. **Pharmacy network.** We will only pay for prescription drugs and over the counter (OTC) drugs for use outside of a hospital. Except in an emergency, the prescription must be issued by a participating provider and filled at a participating pharmacy.

Our members have access to most national pharmacy chains and many independent retail pharmacies. Our pharmacy network consists of over 2,000 pharmacies in Allegany, Cattaraugus, Chautauqua, Erie, Orleans, Genesee, Niagara and Wyoming counties. It includes CVS Pharmacy, Rite Aid Pharmacy, Tops Pharmacy, Wegmans Pharmacy, and national chains and independent retailers throughout the state.

All members must use a Highmark BCBSWNY network pharmacy when filling prescriptions in order for benefits to be covered. To locate a network pharmacy, go to https://findcare.mybcbswny.com/search-providers

D. **Monthly Limits.** Most prescriptions are limited to a maximum 30-day supply per fill. Members on select asthma controller medications, such as Flovent and Breo Ellipta, are eligible to receive a 90-day supply at a retail pharmacy for a $0 copay. Call Member Services with questions.

E. **Exclusions and limitations.** Under this section, we will not pay for the following:

- Administration or injection of any drugs
- Replacement of lost or stolen prescriptions
- Prescribed drugs used for cosmetic purposes only, unless medically necessary
- Experimental or investigational drugs, unless recommended by an external appeal agent
- Nutritional supplements without medical necessity
- Non-FDA-approved drugs except prescription drugs approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer it has been prescribed for by one of these publications:
  - AMA Drug Evaluations
  - The NCCN Compendium
  - American Hospital Formulary Service

  - U.S. Pharmacopeia Drug Information
  - A review article or editorial comment in a major peer-reviewed professional journal
- Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms and diaphragms
- Prescribed drugs and biological agents and the administration of these drugs and biological agents that are furnished for the purpose of causing or assisting in the death, suicide, euthanasia or mercy killing of a person
- Prescribed drugs used for the purpose of treating erectile dysfunction

5. **Home healthcare.** We will pay for up to 40 visits per calendar year for home healthcare provided by a certified home health agency that is a participating provider. We will pay for home healthcare only if you would have to be admitted to a hospital if home care was not provided.

   Home care includes one or more of the following services:
   - Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse
   - Part-time or intermittent home health aide services that consist primarily of caring for the patient
   - Physical, occupational or speech therapy if provided by the home health agency; and medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered if the covered person had been in a hospital

6. **Pre-admission testing.** We will pay for pre-admission testing when performed at the hospital where surgery is scheduled to take place if:
   - Reservations for a hospital bed and for an operating room at that hospital have been made prior to performance of tests.
   - Your physician has ordered the tests.
   - Surgery actually takes place within seven days of such pre-admission tests.

   If surgery is canceled because of the pre-admission test findings, we will still cover the cost of these tests.

7. **Speech and hearing.** We will pay for speech and hearing services, including hearing aids, hearing aid batteries and repairs. These services include one hearing examination per year to determine the need for corrective action. Speech therapy required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy, will be covered when performed by an audiologist, language pathologist, a speech therapist and/or an otolaryngologist.

8. **Hospice services**. We will provide coverage of hospice services provided by a hospice organization certified under Article 40 of the New York State Public Health Law for

members certified by a physician to be terminally ill with a life expectancy of six (6) months or less. All services must be provided according to a written plan of care. Hospice services include five visits for family members for bereavement counseling.

9. **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 healthcare 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.

10. **Ostomy equipment and supplies**. We will pay for ostomy equipment and supplies prescribed by a licensed healthcare provider legally authorized to prescribe under Title Eight of the Education Law.

11. **Autism spectrum disorder.** We will provide coverage for the following services when such services are prescribed or ordered by a 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).

    A. **Screening and diagnosis.** We will provide coverage for assessments, evaluations and tests to determine whether someone has autism spectrum disorder.

    B. **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.

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

D. **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 contract year.

E. **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.

F. **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 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.

G. **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.

H. 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.

12. **Transportation.** We will pay for ambulance services for pre-hospital services, including prompt evaluation and treatment of an emergency condition.

Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Coverage for emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could expect the absence of such transportation to result in one of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or body part of such person
- Serious disfigurement of such person

We will not pay for airborne transportation or ambulance service for nonmedical or nonbehavioral conditions.

Please call Member Services at 866-231-0847 (TTY 711) if you have any questions or need help with any of your benefits, care or services.

SECTION EIGHT — VISION CARE

1. **Emergency, preventive and routine vision care.** We will pay for emergency, preventive and routine vision care. You do not need your PCP's authorization for covered vision care if you seek such care from a qualified participating provider of vision care services.

2. **Vision examinations.** We will pay for vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective

lenses. We will pay for one vision examination in any 12-month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to:

- Case history.
- External examination of the eye or internal examination of the eye.
- Ophthalmoscopic exam.
- Determination of refractive status.
- Binocular distance.
- Tonometry tests for glaucoma.
- Gross visual fields and color vision testing.
- Summary findings and recommendation for corrective lenses.

3. **Prescribed lenses.** We will pay for quality standard prescription lenses once in any 12-month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

4. **Frames.** We will pay for standard frames adequate to hold lenses once in any 12-month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.

5. **Contact lenses.** We will pay for contact lenses only when deemed medically necessary.

SECTION NINE — DENTAL CARE

1. **Dental care.** We will pay for the dental care services set forth in this contract when you seek care from a qualified participating provider of dental services.

2. **Emergency dental care.** We will pay for emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

3. **Preventive dental care.** We will pay for preventive dental care, which includes procedures that help to prevent oral disease from occurring, including:
   - Prophylaxis (scaling and polishing the teeth at six-month intervals).
   - Topical fluoride application at six-month intervals where the local water supply is not fluoridated.
   - Sealants on unrestored permanent molar teeth.

4. **Routine dental care.** We will pay for routine dental care, including:
   - Dental examinations, visits and consultations covered once within a six-month consecutive period (when primary teeth erupt).
   - Full-mouth X-rays at 36-month intervals if necessary, bitewing X-rays at 6- to 12-month intervals, or panoramic X-rays at 36-month intervals if necessary, and other X-rays as required (once primary teeth erupt).

- All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care.
- In-office conscious sedation.
- Amalgam, composite restorations and stainless steel crowns.
- Other restorative materials appropriate for children.

5. **Endodontics.** We will pay for endodontic services, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

6. **Periodontics.** We will pay for periodontal services, except for services in anticipation of, or leading to, orthodontia.

7. **Prosthodontics.** We will pay for prosthodontic services as follows:
   - Removable complete or partial dentures, including six months of follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases, and treatment of cleft palate.
   - Fixed bridges are not covered unless they are required:
     - For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
     - For cleft-palate stabilization
     - Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation
   - Unilateral or bilateral space maintainers are covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

8. **Orthodontics.** 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 abnormalities); ankylosis of the temporomandibular joint; and other significant skeletal dysplasia.

   Orthodontia services are 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 replacement of retainers)

Highmark BCBSWNY uses a company called LIBERTY Dental to manage your dental benefit. You must use a LIBERTY Dental dentist for your dental care. If you have questions related to your

dental care, or need to find a dental provider, please call the LIBERTY Dental Plan at 833-276-0846 (TTY 711).

SECTION TEN — ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When you need to see a specialist or go to a facility for testing.** It may be necessary for you to see a Highmark BCBSWNY specialist or go to a facility for testing, such as blood tests or X-rays. Your PCP will refer you, as necessary, to these specialty services. All referrals to a specialist must be authorized and arranged by your PCP in advance. If your PCP refers you to another provider, we will pay for your care.

   Your PCP will give you a written referral form. You **must** bring this referral form with you to your appointment with the specialist. The length of time that the referral is in effect depends on your medical needs, and will be determined by both your PCP and by the specialist. For some services, such as prenatal and gynecological care, you do not need a referral to see a network provider. If you have questions about when you need a referral, you can ask your PCP.

   If you have a medical need that cannot be met by a Highmark BCBSWNY participating provider, talk to your PCP. You or your PCP on your behalf will need to ask for approval to be referred to a specialist outside Highmark BCBSWNY. Asking for coverage approval of a treatment or service, including a request for a referral or non-covered service, is called a **service authorization request**. Refer to the **Service Authorization Requests section** for details.

   Any decision to deny coverage of a **service authorization request** or to approve if for an amount that is less than requested is called an **action**. If you are not satisfied with our decision about your care, there are steps you can take. Refer to the **Service authorization appeals (action appeals) section** for details.

2. **When you need approval from Highmark BCBSWNY for services.** There are some treatments and services that you need approval for coverage before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. If you or someone on your behalf does not receive a prior authorization for a service that requires one, you may have to pay for the cost of the services you received. The following treatments and services must be approved before you receive them:
   - Most ambulatory surgery
   - Chemotherapy
   - Dialysis
   - Durable medical equipment
   - Genetic testing

- Growth hormone evaluation and therapy
- Hearing aids
- Home care
- Hyperbaric oxygen therapy
- Inpatient admission
- Lithotripsy
- Nonemergency ambulance
- Obstetrical services (except family planning services)
- Oxygen equipment — respiratory therapy
- Prosthetics and orthotics
- Physical therapy, occupational therapy and speech therapy
- Transplant evaluation

You will also need prior authorization if you are receiving one of these services now, and need to continue or receive more of the care. This is called **concurrent review**.

Asking for coverage approval of a treatment or service, including a request for a referral or non-covered service, is called a **service authorization request**. To receive approval for these treatments or services, you or your doctor can call the Highmark BCBSWNY Medical Management department at 866-231-0847 (TTY 711). If necessary, your doctor can call for an approval after hours and weekends by calling this number. If you have any questions, you can call the Member Services department at 866-231-0847 (TTY 711).

3. **When a specialist can be your PCP.** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, you may ask that a specialist who is a participating provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.

4. **Standing referral to a network specialist.** If you need ongoing specialty care, you may receive a standing referral to a specialist who is a participating provider. This means that you will not need to obtain 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 standing referral would be appropriate in your situation.

5. **Standing referral to a specialty care center.** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, you may request a standing referral to a specialty care center that is a participating provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.

6. **When your provider leaves the network.** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former participating provider, in certain instances, for up to 90 days after the provider's contract ends. If you are pregnant and in your second trimester, you may be able

to continue care with the former provider through delivery and postpartum care directly related to the delivery.

7. However, in order for you to continue care for up to 90 days or through a pregnancy with a former participating provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.

8. **When new members are in a course of treatment.** If you are in a course of treatment with a nonparticipating provider when you enroll with us, you may be able to receive care from the nonparticipating provider for up to 60 days from the date you become covered under this contract. The course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a nonparticipating provider if you are in the second trimester of a pregnancy when you become covered under this contract.

9. You may continue care through delivery and any postpartum services directly related to the delivery.

10. However, in order for you to continue care for up to 60 days or through pregnancy, the nonparticipating provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

SECTION ELEVEN — LIMITATIONS AND EXCLUSIONS

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

1. **Care that is not medically necessary.** You are not entitled to benefits for any service, supply, test or treatment that is not medically necessary or appropriate for the diagnosis or treatment of your illness, injury or condition (See Sections Fifteen and Sixteen).

2. **Accepted medical practice.** You are not entitled to services that are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.

3. **Care that is not provided, authorized or arranged by your PCP.** Except as otherwise set forth in this contract, you are entitled to benefits for services only when provided, authorized or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.

4. **Inpatient services in a nursing home, rehabilitation facility or any other facility not expressly covered by this contract.**

5. **Physician services while an inpatient of a nursing home, rehabilitation facility or any other facility not expressly covered by this contract.**

6. **Experimental or investigational services, unless recommended by an external appeal agent. (See Section Sixteen.)**

7. **Cosmetic surgery.** We will not pay for cosmetic surgery unless medically necessary, except when reconstructive surgery falls under one of the following conditions:
   - When following surgery resulting from trauma, there is infection or other disease of the part of the body involved
   - When required to correct a functional defect resulting from congenital disease or anomaly

8. **In vitro fertilization, artificial insemination or other assisted means of conception.**

9. **Private-duty nursing.**

10. **Orthodontia.**

11. **Autologous blood donation.**

12. **Physical manipulation services.** We will not pay for any services in connection with the detection and correction (by manual or mechanical means) of:
   - Structural imbalance.
   - Distortion.
   - Subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

13. **Routine foot care.**

14. **Other health insurance, health benefits and governmental programs.** We will reduce our payments under this contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross Blue Shield Plans or HMOs or similar programs. Health benefits plans include any self-insured or noninsured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children's program and the Early Intervention program.

15. **No-fault automobile insurance.** We will not pay for any service that is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.

16. **Other exclusions.** We will not pay for:
   - Sex transformation procedures, unless medically necessary

- Custodial care

17. **Workers' compensation.** We will not provide coverage for any service or care for an injury, condition or disease if benefits are provided to you under a workers' compensation law or similar legislation.

SECTION TWELVE — PREMIUMS FOR THIS CONTRACT

1. **Amount of premiums.** The amount of premium for this contract is determined by us and approved by the Superintendent of Insurance of the state of New York.

2. **Your contribution toward the premium.** Under New York State law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any.

3. **Grace period.** All premiums for this contract are due one (1) month in advance; however, we will allow a grace period for the payment of all premiums, except the first month. This means that, except for the first month's premium for each child, if we receive payment within the grace period, we will continue coverage under this contract for the entire period covered by the payment. If we do not receive payment within the grace period, the coverage under this contract will terminate as of the last day of the month of the grace period.

4. **Agreement to pay for services if premium is not paid.** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.

5. **Change in premiums.** If there is to be an increase or decrease in the premium or your contribution toward the premium for this contract, we will give you at least 30 days written notice of the change.

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 866-231-0847 (TTY 711) or by calling the Child Health Plus Hotline at 800-698-4543. At that time, we will provide you with the form and documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within 10 working days of the 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 40 days from the receipt of the completed review and request and supporting documentation.

SECTION THIRTEEN — TERMINATION OF COVERAGE

1. **For nonpayment of premium.** If you are required to pay a premium for this contract, this contract will terminate at the end of the grace period if we do not receive your payment.

2. **When you move outside the service area.** This contract shall terminate when you cease to reside permanently in the service area.

3. **When you no longer meet eligibility requirements.** This contract shall terminate when one of the following occurs:
   - On the last day of the month in which you reach age 19
   - The date on which you are enrolled in the Medicaid program
   - The date on which you become covered under other healthcare coverage
   - The date you become an inmate of a public institution or a patient in an institution for mental disease

4. **Termination of the Child Health Plus program.** This contract shall automatically terminate on the date when the New York state law, which establishes the Child Health Plus program, is terminated or when the state terminates this contract or when funding from New York State for this Child Health Plus program is no longer available to us.

5. **Our option to terminate this contract.** We may terminate this contract at any time for one or more of the following reasons:
   - Fraud in applying for enrollment under this contract or in receiving any services.
   - Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him or her. A copy of such other reasons shall be forwarded to you. We shall give you no fewer than 30 days prior written notice of such termination.
   - Discontinuance of the class of contracts to which this contract belongs upon not fewer than five (5) months prior written notice of such termination.
   - If you do not provide the documentation we request for recertification.
   - If you do not provide the documentation we request within 60 days of your enrollment or recertification date.
   - If you appear Medicaid-eligible at recertification and do not complete the Medicaid application process within the 60-day temporary enrollment period.

6. **Your option to terminate this contract.** You may terminate this contract at any time by giving us at least one month's prior notice. We will refund any portion of the premium for this contract that has been prepaid by you.

7. **On your death.** This contract will automatically terminate on the date of your death.

8. **Benefits after termination.** If you are totally disabled on the date this contract terminates and you have received medical services for the illness, injury or condition that caused the

total disability while covered under this contract, we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:

- A date on which you are no longer totally disabled
- A date 12 months from the date this contract terminates

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

SECTION FOURTEEN — RIGHT TO A NEW CONTRACT AFTER TERMINATION

1. **When you reach age 19.** If this contract terminates because you reach age 19, then you may purchase a new contract as a direct payment subscriber. We will, upon request, send you a list of health plans that offer direct-pay subscriber contracts and assist you in finding alternative coverage.

2. **If Child Health Plus ends.** If this contract terminates because the Child Health Plus program ends, you may purchase a new contract as a direct payment subscriber.

3. **How to apply.** You must apply to us within 31 days of termination of this contract and pay the first premium for the new contract.

SECTION FIFTEEN — COMPLAINT PROCEDURE AND SERVICE AUTHORIZATION APPEALS

- **Complaints.** We hope our health plan serves you well. If you have a problem, talk with your PCP or contact Member Services at 866-231-0847 (TTY 711). Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below. You can ask someone you trust (such as a family member, friend or legal representative) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

  You also have the right to contact the New York State Department of Health about your complaint at 800-206-8125 or write to:

  New York State Department of Health Division of Managed Care
  Bureau of Managed Care Certification and Surveillance, Room 1911
  Corning Tower ESP

Albany, NY 12237

You may call the New York State Insurance department at 800-342-3736 if your complaint involves a billing problem.

How to file a complaint with Highmark BCBSWNY:
To file by phone, call Member Services at 866-231-0847 (TTY 711), Monday through Friday from 8:30 a.m. to 6 p.m. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call Member Services at 866-231-0847 (TTY 711) and request a complaint form. It should be mailed to:

Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

You can also fax the complaint to 844-759-5954.

What happens next
If we cannot solve the problem right away for complaints received by phone, or if we receive your complaint in writing, we will send you a letter within 15 working days. The letter will tell you:

- Name of contact or department assigned your complaint.
- How to contact this person or department.
- If we need more information.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision within 30 days of receiving all information we need if your complaint is about a denied request for a referral or a decision we made about your benefits. For all other complaints, we will let you know our decision within 45 days. We will write you to tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint. We will try to reach you by phone to tell you our decision. We will mail a letter to follow up our communication within three working days.
- You will be told how to appeal the decision if you are not satisfied, and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we do not have enough information, we will send you a letter to let you know.

You may also file a complaint anytime by calling the New York State Department of Health at 800-206-8125 or by writing to the New York State Department of Health, Bureau of Certification and Surveillance, Corning Tower, Albany, NY 12237.

- **Appeals of complaint decisions.** If you are not satisfied with what we decide, you have at least 60 working days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. The appeal must be in writing. If you call us to appeal your complaint, we will send you a form that is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. We need to have this written summary before we can look at your appeal.

  After we receive your complaint appeal, we will send you a letter within 15 working days. The letter will tell you:
  - Who is working on your appeal.
  - How to contact that person.
  - If we need more information.

  Your complaint appeal will be decided by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified healthcare professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about your complaint.

  If we have all the information we need, you will know our decision in 30 working days. If a delay would risk your health, you will receive our decision in two (2) working days of when we have all the information we need to decide the appeal.

  You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint with the New York State Department of Health at 800-206-8125.

3. **Checking our decisions: service authorization requests.** The health plan has a Medical Management team to be sure you receive the services we agree to cover when you ask for a service authorization. Doctors and nurses are on the review board. Their job is to be sure the treatment you asked for is covered (medically needed and allowed under your plan). They do this by checking your treatment plan against medically acceptable standards.

   Any decision to deny coverage of a service authorization request or to approve it for an amount that is less than requested is called an **action**. These decisions will be made by a qualified healthcare professional. If we decide that the requested service coverage is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a healthcare professional who typically provides the care you requested. You can request the

name of the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

When we receive your service authorization request, we will review it under a **standard** or **fast** process. You or your doctor can ask for a fast review if it is believed that a delay will cause serious harm to your health. If your request for a fast review is denied, we will tell you, and your case will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals you will have if you do not agree with our decision.

Here are the time frames for **prior authorization requests**:

- **Standard review:** We will make a decision about your request within three (3) working days of when we have all the information we need. If we do not have all of the information we need to review your request, we will let you know no later than 14 days after we receive your request for review.
- **Fast review:** We will make a decision and you will hear from us within three (3) working days after we receive all of the information we need to review your request. We will tell you by the third working day if we need more information in order to make a decision on your review request.

Here are the time frames for **concurrent review requests**:

- **Standard review:** We will make a decision within one (1) working day of when we have all the information we need. If we do not have all of the information we need to review your concurrent review request, we will let you know no later than 14 days after we receive your concurrent review requests.
- **Fast review:** We will make a decision within one (1) working day of when we have all the information we need to make a decision. We will tell you by the third working day if we need more information in order to make a decision.

If we need more information to make either a standard or a fast decision about your service request, we will:

- Write and tell you what information is needed. If your request is in a fast review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Highmark BCBSWNY to help decide your case. This can be done by calling 866-231-0847 (TTY 711) or writing to us at:

Grievance and Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

You or someone you trust can file a complaint with Highmark BCBSWNY if you do not agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 800-206-8125.

We will notify you by the date our time for review has expired. If for some reason you do not hear from us by that date, it is the same as if we denied your service authorization coverage request. If you are not satisfied with this answer, you have the right to file an action appeal with us.

4. **Service authorization appeals (action appeals).**
There are some treatments and services that you need approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval for coverage of a treatment or service is called a **service authorization request**. This process is described earlier in this contract. Any decision to deny coverage of a service authorization request or to approve it for an amount that is less than requested is called an **action**.

If you are not satisfied with our decision about your care, there are steps you can take.

- Your provider can ask for reconsideration. If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the Highmark BCBSWNY medical director. The medical director will talk to your doctor within one (1) working day.
- You can file a service authorization action appeal. If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 working days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at 866-231-0847 (TTY 711) if you need help filing an appeal.

We will not treat you any differently or act badly toward you because you filed an appeal.

The appeal can be made by phone or in writing. If you make an appeal by phone, it must be followed up in writing.

Your service authorization action appeal will be reviewed under the fast process:

- If you or your doctor asks to have, your appeal reviewed under the fast process. Your doctor will have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you, and your appeal will be reviewed under the standard process.
- If your request was denied when you asked to continue care that you are now receiving or need to extend a service that has been provided.
- If you appeal a denial for home health services after being discharged from an inpatient hospital admission, your appeal must be treated as an expedited appeal. Inpatient hospital admission means services you got in a general hospital that provides inpatient care. This may include inpatient services in a rehabilitation facility.

Fast appeals can be made by phone and do not have to be followed up in writing.

What happens after we receive your appeal:
In the case of a standard appeal, we will send you a letter to let you know we are working on your appeal. This letter will be sent within 15 days of when Highmark BCBSWNY receives your appeal.

Service authorization action appeals of clinical matters will be decided by qualified healthcare professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer. Nonclinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

Before and during the appeal, you or your representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. You can also provide information to be used in making the decision. You can provide the information in person or in writing.

You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained to you or your personal representative. For further appeals, you or someone you trust can file a complaint with the New York State Department of Health at 800-206-8125.

Here are the time frames for **service authorization appeals**:

- **Standard appeals:** If we have all the information we need, we will tell you our decision in 30 calendar days from your appeal. A written notice of our decision will be sent within two (2) calendar days from when we make the decision.
- **Fast appeals:** If we have all the information we need, fast appeal decisions will be made in two (2) calendar days from your appeal but no later than 72 hours after of the date of the receipt. We will tell you immediately after you give us your appeal if we need more information. We will tell you our decision by phone and will send a written notice within 24 hours of the determination.

If we need more information to make a standard or fast decision about your service coverage authorization action appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the Highmark BCBSWNY to help decide your case. This can be done by calling 866-231-0847 (TTY 711) or writing to us at:

Grievance and Appeals Department
P.O. Box 62429

You or someone you trust can file a complaint with Highmark BCBSWNY if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 800-206-8125.

If we do not make a decision about your appeal, the original decision will automatically be reversed, which means your service authorization request will be approved.

Aid to continue while appealing a decision about your care
In some cases, you may be able to continue the services while you wait for your appeal case to be decided. You may be able to continue the services that are scheduled to end or be reduced if you appeal:

- Within 10 days from being told that your coverage request is denied or care is changing.
- By the date, the change in services is scheduled to occur.

If your appeal results in another coverage denial, you may have to pay for the cost of any continued benefits that you received.

5. **Other decisions about your care.**
   Sometimes we will do a concurrent review on the care you are receiving to see if you still need coverage to continue care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

   Here are the time frames for **notice of other actions**:
   - In most cases, if we make a decision to reduce, suspend or terminate coverage of a service we have already approved and you are now receiving, we must tell you at least 10 days before we change the service.
   - If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment coverage for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Child Health Plus even if we later deny payment to the provider.

SECTION SIXTEEN — EXTERNAL APPEAL

External appeals

1. **Your right to an external appeal**
   Under certain circumstances, you have a right to an external appeal of a denial the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, 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 we deny coverage on the basis that the service does not meet our requirements for medical necessity, 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 our internal appeal process and we must have upheld the denial **or** together we must agree in writing to waive any internal appeal

3. **Your right to appeal a determination that a service is experimental or investigational**
   If we deny coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:
   - The service must otherwise be a covered service under this Subscriber Contract; and
   - You must have received a final adverse determination through our internal appeal process and we must have upheld the denial **or** together we must agree in writing to waive any internal appeal.

   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 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

   Your attending physician must certify that your 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 us **or** one for which there exists a clinical trial or rare disease treatment (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 or acceptable); or
   - A clinical trial for which you are eligible (only certain clinical trials can be considered); or
   - For 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 condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

4. **The external appeal process**

If, through our 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, is an experimental or investigational treatment, or is an out-of-network treatment, you have four (4) months from receipt of such notice to file a written request for an external appeal. If together we agree in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If we fail to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through our internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 800-400-8882. Submit the completed application to the Department of Financial Services 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 an 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 we based its denial, the external appeal agent will share this information with us in order for it to exercise its right to reconsider its decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below); we do 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 us. 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, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours 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 our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we 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, we will only cover the costs of services

required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare 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 us. The external appeal agent's decision is admissible in any court proceeding.

5. **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 Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

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, or the failure of the plan to adhere to claim processing requirements. The plan has no authority to grant an extension of this deadline.

Covered services and exclusions

In general, we do not cover experimental or investigational treatments; however, we shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with Section Sixteen of this subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare 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.

SECTION SEVENTEEN — UTILIZATION REVIEW

1. **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 services is performed (retrospective). If you have any questions about the Utilization Review process, please call 866-231-0847 (TTY 711), the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Healthcare 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 healthcare service under review; or 3) with respect to substance use disorder treatment, effective on the date of issuance or renewal of the Contract; on or after April 1, 2015, licensed Physicians or licensed, certified, registered or credentialed Healthcare 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 866-231-0847 (TTY 711); the number on your ID card or visit our website at bcbswny.com/stateplans.

2. **Preauthorization Reviews.**
   A. 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 or receipt of the request.

      If we need additional information, we will request it within three (3) business days from the date of the request. 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 but no longer than 60 days from the date of the request.

   B. **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 and in writing, within 72 hours 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 and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

3. **Concurrent Reviews.**
   A. 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 one (1) business day of the end of the 45-day time period but no longer than 60 calendar days from the date of the request.

B. **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) 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) 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) 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.

C. **Home Healthcare 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), 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.

D. **Inpatient Substance Use Disorder Treatment Reviews.** Effective on the date of issuance or renewal of this Contract 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.

4. **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, failure to make a Utilization Review determination within the applicable timeframes set forth above will be deemed an adverse determination subject to an internal Appeal.

5. **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.

6. **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 within one (1) business day.

7. **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 of the appeal (written or orally). This acknowledgment will inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Healthcare 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.

   A. **Out-of-Network Service Denial.** Effective on the date of issuance or renewal of this Contract; on or after April 1, 2015, 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.

B. **Out-of-Network Referral Denial**. Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, you also have the right to Appeal the denial of a request for 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 healthcare needs who is able to provide the requested healthcare 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 healthcare needs for the healthcare service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet your particular healthcare needs who is able to provide the requested healthcare service.

8. **Standard Appeal.**

A. **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.

B. **Retrospective Appeal.** If your Appeal relates to a retrospective claim, 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.

C. **Expedited Appeal.** An appeal of a review of continued or extended healthcare services, additional services rendered in the course of continued treatment, home healthcare 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.

D. **Substance Use Appeal.** Effective on the date of issuance or renewal of this Contract; on or after April 1, 2015, 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.

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

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017

If you need Assistance filing an Appeal, you can call toll free at 888-614-5400. You send an email to cha@cssny.org or visit the website at communityhealthadvocates.org for more information.

SECTION EIGHTEEN — GENERAL PROVISIONS

1. **No assignment.** You cannot assign the benefits of this contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this contract.

2. **Legal action.** You must bring any legal action against us under this contract within 12 months from the date we refused to pay for a service under this contract.

3. **Amendment of contract.** We may change this contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least 30 days written notice of any change.

4. **Medical records.** We agree to preserve the confidentiality of your medical records. In order to administer this contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this contract, you give us permission to obtain and use such records.

5. **Who receives payment under this contract.** We will pay participating providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.

6. **Notice.** Any notice under this contract may be given by U.S. mail, postage prepaid, addressed as follows:

   If to us:
   Retention
   P.O. Box 38
   Buffalo, NY 14240-0038

   If to you:
   To the latest address provided by you on enrollment or official change-of-address form.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown in the footer of this notice.

Please read this notice carefully. This tells you:

- **Who can see your protected health information (PHI).**
- **When we have to ask for your OK before we share your PHI.**
- **When we can share your PHI without your OK.**
- **What rights you have to see and change your PHI.**

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing, or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files.
  - Destroy paper with health information so others cannot get it.
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in.
  - Use special programs to watch our systems.
- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - Teach people who work for us to follow the rules.

When it is OK for us to use and share your PHI

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it is OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals, and others give the care you need, call Member Services at 866-231-0847 (TTY 711) or Crisis Line at 866-231-0847 (TTY 711)
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we will pay for healthcare or services before you get them (called prior authorization or preapproval)

– To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you do not want this, please visit mybcbswny.com/wny-members/privacy.html for more information.

- **For healthcare business reasons**

– To help with audits, fraud and abuse prevention programs, planning, and everyday work
– To find ways to make our programs better

- **For public health reasons**

– To help public health officials keep people from getting sick or hurt

- **With others who help with or pay for your care**

– With your family or a person you choose who helps with or pays for your healthcare, if you tell us it is OK
– With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We cannot take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we are asked
- To answer legal documents
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

- You can ask us to tell you all the times over the past six years we shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What we have to do

- The law says we must keep your PHI private except as we said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we will do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call
844-203-3796 (TTY 711) toll free to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services toll free at 866-231-0847 (TTY 711) Monday through Friday, 8:30 a.m. to 6 p.m. Eastern time.

What to do if you have a complaint

We are here to help. If you feel your PHI has not been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

You may write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278
Phone: 800-368-1019
TDD: 800-537-7697
Fax: 212-264-3039

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on the web at mybcbswny.com/wny-members/privacy.html.

Race, ethnicity, and language
We get race, ethnicity, and language information about you from state agencies for Medicaid and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:
- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information
We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health.
  - Habits.
  - Hobbies.
- We may get PI about you from other people or groups such as:
  - Doctors.
  - Hospitals.
  - Other insurance companies.
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services toll free at 866-231-0847 (TTY 711) Monday through Friday, 8:30 a.m. to 6 p.m. Eastern time.

bcbswny.com/stateplans

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HIGHMARK WESTERN NEW YORK

Child Health Plus Plan

Child Health Plus
New York State's Health Plan for Kids

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