INDEPENDENT HEALTH'S

2024 Member Contract & Handbook

CHILD HEALTH PLUS

Independent Health®

Updated October 2023

Nondiscrimination statement and language assistance services

If you, or someone you're helping, have questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-833-891-9372.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-891-9372.

如果您，或是您正在協助的對象，有關於[插入 Independent Health 項目的名稱 Independent Health 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-833-891-9372。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-833-891-9372.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-833-891-9372.

만약귀하또는귀하가돕고있는어떤사람이 Independent Health 에관해서질문이있다면귀하는그러한도움과정보를 귀하의언어로비용부담없이얻을수있는권리가있습니다. 그렇게통역사와얘기하기 위해서는 1-833-891-9372 로전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-833-891-9372.

אויב איר. אודר עמצער איר העלפסט. האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך
אומזיסט. צו רעדן מיט דער אי'בערזעצר, קלונג 1-833-891-9372

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health
অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, ফোন করুন 1-833-891-9372

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-833-891-9372.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-891-9372

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-833-891-9372.

اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے Independent Health کے بارے میں، تو اپ دونوں کو اپنی زبان
میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-833-891-9372 فون کریں۔

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-891-9372.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-833-891-9372.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-833-891-9372.

Independent Health

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

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

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-833-891-9372, TTY users call 711, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20211
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**

Independent Health

How to use this contract/handbook

Welcome to Independent Health's Child Health Plus Program (CHPlus). We are glad you chose Child Health Plus from Independent Health for your child. Through Child Health Plus, Independent Health will help you get the medical care your child needs, including services such as routine checkups that will keep your child well.

The first part of this document is the subscriber contract, which is a guide to health services provided to your child through Child Health Plus. No matter what health plan you choose in your area, these benefits will be the same. The second section of the document is a member handbook. It tells you the steps to take to make the plan work for your child, as well as your child's rights and responsibilities as a member of this health plan.

You will see "PCP" noted throughout this handbook. **PCP is short for Primary Care Provider**. A PCP for a child or teen may include a family practice doctor or a pediatrician. When you have a question, check this handbook or call our Member Services Department at 1-833-891-9372, and our representatives will be happy to help you.

KEEP US INFORMED

Please call Member Services at 1-833-891-9372 **whenever these changes happen in your child's life**:

- A change of name, address or telephone number
- A change in circumstances that will affect his/her eligibility for CHPlus
- Your child is pregnant
- Your child becomes covered under another health insurance


Independent
Health

Child Health Plus
Member Contract

CHILD HEALTH PLUS
SUBSCRIBER CONTRACT

This is your Child Health Plus Contract with Independent Health Association, Inc. 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 ten (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, for certain obstetric and gynecological care described in Section Four, vision care described in Section Eight, and except for 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 health care services described in this Contract. You and/or the responsible adult, as listed on the application, must report to us any change in residency or health care coverage that may make you ineligible for participation in Child Health Plus, within thirty (30] days of the change.

2. **Health Care Through an 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 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 non-participating provider.

It is your responsibility to select a PCP from the list of PCPs when you enroll for this coverage. You may change your PCP by contacting our Member Services Department, identify which provider you would like to list as your PCP, and the change will be effective the day you call.. The PCP you have chosen is referred to as “your PCP” throughout this Contract.

3. **Words We Use** Throughout this Contract, Independent Health Association, Inc. 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, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) 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, or (B) serious impairment of such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

C. **Emergency Services** means 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 (R.N.);

- 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 1395x[k]);

- is duly licensed by the agency responsible for licensing such hospitals; and

- 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, alcoholics, or a place for convalescent, custodial, education or rehabilitory care.

E. **Medically Necessary** means any covered health care services that are required to preserve and maintain your health and to diagnose, treat or prevent disease or injury, alleviate symptoms of an illness or disorder, are consistent with accepted standards of medical practice rendered at an appropriate level of intensity, can reasonably be expected to promote effective outcomes, are provided efficiently and economically, facilitate quality of care and are not solely for your convenience, your family's convenience, the physician's convenience or other health care provider's convenience. The Chief Medical Officer or his/her designee shall have the authority to determine whether any health care service rendered to you is a Medically Necessary covered health care service.

We will not pay for any service, test or treatment which our Medical Director determines is not Medically Necessary for the diagnosis or treatment of your illness, injury or condition. Even if a service is listed as a covered benefit, we will only pay for the service if our Medical Director determines that it is Medically Necessary and appropriate for your particular case.

Examples of care that is not Medically Necessary are: when you are admitted to a Hospital for care which could have been provided in a physician's office or provided without admission to a Hospital as a bed patient; when services are performed in a freestanding ambulatory surgery center which could have been performed in a physician's office; when you are in a Hospital for longer than is necessary to treat your condition; when Hospitalized, you receive an ancillary service not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; when you receive an inappropriate or non-essential service to diagnose your condition; when the services you receive are more costly than is

necessary for the proper treatment of your condition.

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 health care 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 non-participating provider except in an emergency or when your PCP sends you to that non-participating 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 health care services.

K. **Service Area** means the following counties: Erie and Niagara Counties You must reside 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 health care coverage.
- You are not eligible for Medicaid.
- You are a New York State resident and a 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. Annually, you must 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, then the recertification date for all the children in your family covered by us will be the same 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 all other children will be recertified when that child's coverage is effective. 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 residency or health care coverage that might make you ineligible for this contract. You must give us this notice within thirty (30) 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.

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:

A. Except if you are admitted to the Hospital in an Emergency or your PCP has arranged for your admission to a non-Participating Hospital, the Hospital must be a Participating Hospital.

B. Except in an emergency, your admission is authorized in advance by your PCP.

C. 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:

A. Daily bed and board, including special diet and nutritional therapy;

B. General, special and critical care nursing service, but not private duty nursing service;

C. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;

D. Oxygen and other inhalation therapeutic services and supplies;

E. Drugs and medications that are not experimental;

F. Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;

G. Blood products, except when participation in a volunteer blood replacement program is available;

H. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations;

I. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;

J. Facilities, services and supplies and equipment related to radiation and nuclear therapy;

K. Facilities, services, supplies and equipment related to emergency medical care;

L. Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services;

M. Chemotherapy;

N. Radiation therapy; and

O. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.

3. **Maternity Care** Other than for perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a Caesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Caesarean 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 Caesarean 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 Caesarean Section). The home care visit will be delivered within 24 hours of the later 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

A. 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.

B. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, the difference between the cost of a private room and a semi-private room must be paid by you unless the private room is medically necessary and ordered by your physician.

C. We will not pay for non-medical 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 that 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 follow 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; and
- 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 care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer, and
- Medically necessary audiometric testing.

D. **Physical and Occupational Therapy** We will pay for Short Term physical and occupational therapy services. The therapy must be skilled therapy. Short Term means services that can be expected to result in significant improvement of your condition during a period of up to two (2) consecutive months, beginning with the first treatment. This benefit is administered on a per diagnosis basis and the services must be determined to be Medically Necessary by us. This benefit includes occupational therapy, neuromuscular therapy and other rehabilitative therapy. Payment for long-term therapy is the member's responsibility.

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** including prenatal, labor and delivery and postpartum services are covered 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; and

- 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 who is eighteen years old, 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 under the age of eighteen years 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. .

H. **Blood Clotting Factor**. We will pay for blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an outpatient basis. We will pay for blood

clotting factor products and services when infusion occurs in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a child that is physically and developmentally capable of self-administering such products.

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 forty-eight (48) 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 twenty-four (24) hours of your admission, or as soon as it is reasonably possible. If you are admitted to a non-Participating 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 non-air-borne 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 (i) 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; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

SECTION SIX – MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE 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 such services are provided in a facility that is:

- Operated by the Office of Mental Health under section 7.17 of the Mental Hygiene Law;
- Issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law; or
- 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 the outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if such 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 which are 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 visually impaired;
- Data management systems;
- Test strips for monitors and visual reading;
- Urine test strips;
- Injection aids;

- Cartridges for visually impaired;
- Insulin;
- Syringes;
- Insulin pumps and appurtenances thereto;
- Insulin infusion devices;
- Oral agents; and
- 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 which makes changes in self-management necessary or where re-education is medically necessary as determined by us. 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; and
- Ambulatory infusion pumps.

B. **Prosthetic Appliances** We will pay for appliances and devices ordered by a qualified practitioner which replace any missing part of the body, except that there is no coverage for cranial prostheses (i.e. wigs). Further, dental prostheses are excluded from coverage under this section, except those: (1) made necessary due to an accidental injury to sound, natural teeth and provided within twelve months of the accident and/or (2) needed in the treatment of a congenital abnormality or as part of reconstructive surgery.

C. **Orthotic Devices** We will pay for devices which are used to support a weak or deformed body member 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 Non-prescription Drugs

A. **Scope of Coverage** We will pay for those FDA approved drugs which require a prescription and which are listed in our formulary. Our formulary is a list of appropriate and cost-effective prescription medications. Your doctor will select a prescription medication from our formulary. We will pay for those non-prescription drugs for which a licensed professional has written a prescription and which 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. Coverage for modified solid food products shall not exceed $2,500 per member, per calendar year. You can obtain a copy of our formulary by visiting independenthealth.com or request a printed copy from Member Services at 1-800-501-3439.

B. **Participating Pharmacy** We will only pay for prescription drugs and non-prescription 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.

C. **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 taken electively.
- Non-FDA approved drugs except that we will pay for a prescription drug that is 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 for which it has been prescribed by one of the following established reference compendia:

:

- the American Hospital Formulary Service-Drug Information (AHFS-DI);
- National Comprehensive Cancer Networks Drugs and Biologics Compendium;
- Thomson Micromedex DrugDex;
- Elsevier Gold Standard's Clinical Pharmacology;

- or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare

& Medicaid Services (CMS);

- or recommended by 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 biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.

Prescribed drugs used for the purpose of treating erectile dysfunction.

5. **Home Health Care** We will pay for up to forty (40) visits per calendar year for home health care provided by a licensed or certified home health agency that is a Participating Provider. We will pay for home health care 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 which 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. **Preadmission Testing** We will pay for preadmission testing when performed at the Hospital where surgery is schedule 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; and

- surgery actually takes place within seven days of such preadmission tests.

If surgery is canceled because of the preadmission 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 otolaryngologist.

8. **Hospice Services** We will pay for a member's coordinate program of home and inpatient services which provide curative and non-curative medical and support services for you if a physician certifies that you are terminally ill and have a life expectancy of six months or less.

Hospice organizations must be certified under Article 40 of the NYS Public Health Law.

Your Family members are eligible for up to five visits for bereavement counseling.

9. **Autism Spectrum Disorder** We will provide coverage for the following services when such services are prescribed or ordered by a participating network licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this section , "autism spectrum disorder" means any pervasive

developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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

2. Assistive Communication Devices We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of 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.

10. 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 Calendar Year.

11. 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.

12. Therapeutic care We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable,

functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.

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

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

14. Ostomy Supplies and Equipment We will pay for ostomy equipment and supplies prescribed by a licensed health care provider legally authorized to prescribe under title eight of the Education Law.

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 twelve (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
- Opthalmoscopic 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 twelve (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 twelve (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 which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals);

- Topical fluoride application at six (6) 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 (6) month consecutive period (when primary teeth erupt);

- X-ray, full mouth x-rays at thirty-six (36) month intervals if necessary, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (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; and

- 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. **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 anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

   Orthodontia coverage is not covered if the child does not meet the criteria described above.

   Procedures include but are not limited to:

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

7. **Periodontics** We will pay for periodontal services, including for those services in anticipation of, or leading to, orthodontia.

8. **Prosthodontics** We will pay for prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months 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 compliment of natural, functional and/or restored teeth;
  - For cleft-palate stabilization; or
  - 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 will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

SECTION TEN - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **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.

2. **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.

3. **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.

4. **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 ninety (90) days after you are notified by us of the provider's leaving. 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.

However, in order for you to continue care for up to ninety (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.

5. **When New Members Are In a Course of Treatment** If you are in a course of treatment with a non-Participating Provider when you enroll with us, you may be able to receive care from the non-Participating Provider for up to sixty (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 non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract.

You may continue care through delivery and any post-partum services directly related to the delivery.

However, in order for you to continue care for up to sixty (60) days or through pregnancy, the non-Participating 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 which 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 which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.

3. **Care Which 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 that we will pay for reconstructive surgery:

- When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or
- 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.

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; or
- Distortion; or
- 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 and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured 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 which 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:

A. Sex transformation procedures, unless medically necessary; or

B. 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.

18. **Transportation** except as defined in Section Five of this Contract

19. **Prescription Drugs** used for purposes of erectile dysfunction. This includes drugs, procedures and supplies for the treatment of erectile dysfunction.

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 Financial Services 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 month in advance. However, we will allow a grace period for the payment of all premiums, except the first month's. 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 thirty days (30) 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 1-833-891-9372 or by calling the Child Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the form and documentation necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within ten (10) business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than forty (40) days from receipt of the review request and supporting documentation.

SECTION THIRTEEN - TERMINATION OF COVERAGE

1. **For Non-Payment of Premium** If you are required to pay a premium for this Contract, this Contract will terminate at the end of the 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 in the Service Area.

3. **When You No Longer Meet Eligibility Requirements** This Contract shall terminate as follows:

A. On the last day of the month in which you reach the age of 19; or

B. The date on which you are enrolled in the Medicaid program; or

C. The date on which you become covered under other health care coverage or gain access to a state health benefits plan.

D. 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 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:

A. Fraud in applying for enrollment under this Contract or in receiving any services.

B. Such other reasons on file with the Superintendent of Financial Services at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give the you no less than thirty (30) days prior written notice of such termination.

C. Discontinuance of the class of Contracts to which this Contract belongs

upon not less than five (5) months prior written notice of such termination.

D. You do not provide the documentation we request within sixty (60) days of your enrollment or recertification date.

E. You do not provide the application we request for recertification.

F. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process with the sixty (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 which 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; or

- A date twelve 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.

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 thirty (31) days of termination of this Contract and pay the first premium for the new contract.

4. **The New Contract** The new contract which we will make available to you will be the direct payment contracts we offer to persons not covered by Child Health Plus.

SECTION FIFTEEN - GRIEVANCE PROCEDURE AND UTILIZATION REVIEW APPEALS

A. Grievances.
Our Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.
You can contact Us by phone at (716) 250-7183 or 1-833-891-9372 or in writing to file a Grievance. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and

telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

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

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A Claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

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

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609

Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov]

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

A. Utilization Review.
We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call (716) 631-3425 or 1-800-711-6202. 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 Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

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

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), 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), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) 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 period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You 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 in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

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

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

using the same specific standards, criteria or procedures as used during the Preauthorization review.

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

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

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

H. Appeal.
1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your

Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

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.

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

I. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION SIXTEEN – EXTERNAL APPEAL

1. Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service

is not medically necessary or 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 the Plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

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

3. Your Rights to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and

- You must have received a final adverse determination through Independent Health Association's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

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

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

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

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be

considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered).

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

4. The External Appeal Process

If, through Independent Health Association's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have 60 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through Independent Health Association's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State at 1-800-400-8882. Submit the completed application to the State Department of Insurance at the address indicated on the application. If you satisfy the

criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

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

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

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

If the External Appeal Agent overturns the Plan's decision that a service

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

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

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 Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage

or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

SECTION SEVENTEEN- 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 twelve (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 Financial Services of the State of New York. We will give you at least thirty (30) days written notice of any change.

4. **Medical Records** We agree to preserve the confidentiality of the 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 United States mail, postage prepaid, addressed as follows:

If to us:

Independent Health Association, Inc.
511 Farber Lakes Drive
Buffalo, New York 14221
Attention: President

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

Attachment

Model Child Health Plus Subscriber Contract Language

January 1, 2023

This rider amends your subscriber contract by adding the following benefits:

Assertive Community Treatment Services. We will pay for Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT. Services must be referred by a physician or other licensed provider of the healing arts, within their scope of practice under State law, for maximum reduction of physical or intellectual disability and restoration of a beneficiary to his best possible functional level.

Medical Supplies. We will pay for Medical Supplies which have been ordered by a provider in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable and for a specific purpose and generally have no salvageable value.

Orthodontic Services for a Severe Physically Handicapping Malocclusion. We will pay for orthodontic services for a severe physically handicapping malocclusion. Prior approval for orthodontia coverage is required. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday.

Air Ambulance Services. We will pay for air ambulance services for catastrophic, life-threatening illnesses or conditions when; rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; ground transport is not appropriate for the patient; or life-support equipment and advanced medical care is necessary

during transport.

Transportation Between Facilities. We will pay for air and ground transportation between facilities when such services are considered emergency transports. This includes transport from an Emergency Room to a Psychiatric Center; transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center; transportation from an Emergency Room to an Emergency Room and transportation from an Emergency Room to Another Facility. Prior authorization is not required.

Children and Family Treatment and Support Services. We will pay for Children and Family Treatment and Support Services (CFTSS). Services may be delivered in the community where the child/youth lives, attends school and/or engages in services. Services include: Services provided by Other Licensed Professionals (OLP), Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation Services, Family Peer Support Services, Youth Peer Support.

Core Limited Health-Related Services. We will pay for Core Limited Health-Related Services at a Voluntary Foster Care Agency (VFCA) /29-I Health Facility. Health and behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. Services include the following five Core Limited Health-Related Services: Skill building services; Nursing Services; Treatment Planning and Discharge Planning; Clinical Consultation/Supervision Services and VFCA Child Health Plus Liaison/Administrator.

Child Health Plus
Member Handbook

Here's where to find the information you want

Welcome to Independent Health's Managed Care Program – Child Health Plus

How Managed Care Works

Independent Health, Our Providers, and Your Child

No doubt you have seen or heard about the changes in health care. Many people now get their health benefits through managed care. Under CHPlus, applicants must join a managed care health plan in order to be able to receive health care benefits.

Independent Health has a contract with the State Department of Health to meet the health care needs of children and teens eligible for the Child Health Plus program. In turn, we choose a group of health care providers to help us meet their needs. These doctors and specialists, hospitals, labs and other health care facilities make up our provider network. You'll find this list in our provider directory. If you do not have a provider directory, call Member Services at 1-833-891-9372 to get a copy.

When your child joins Independent Health, one of our plan providers will take care of him/her. Most of the time that person will be the Primary Care Provider (PCP). If your child needs to have a medical test, see a specialist, or go into the hospital, the PCP will arrange it. Your child's PCP is available to you every day, day and night. If you need to talk to him or her after hours or weekends, leave a message with the PCP's answering service and let him or her know how you can be reached. The PCP will get back to you as soon as possible. Even though the PCP is your child's main source for health care, in some cases, you can "self-refer" to certain doctors for some services. See page 8 for details, and page **2 regarding how to use Independent Health's 24**-Hour Medical Help Line.

Help From Member Services

There is someone to help you in our Member Services Department:
Monday through Friday 8 a.m. – 8 p.m. Call 1-833-891-9372.
If you need help at other times, call us at 1-800-418-9231.
TTY users may call (716) 631-3180.

You can call to get help anytime you have a question. You may call us to choose or change your child's Primary Care Provider, to ask about health care benefits and services, to get help with getting in touch with a doctor, share your concerns or complaints, replace a lost ID card or ask about any change that might affect your child's benefits. Member Services can also explain policies, accept complaints and appeals, and help resolve bills. If you call after business hours, you may leave a message and someone will call you back the next business day.

We offer free sessions to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you. In addition, you can write us at Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221.

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If You Do Not Speak English, We Can Help

We want you to know how to use your child's health care plan, no matter what language you speak. Just call us at 1-833-891-9372 and we will find a way to talk to you in your own language. We will also help you find a PCP who can serve you in your language.

For Children and Teens with Disabilities

If your child uses a wheelchair, if your child is visually impaired, or has trouble hearing or understanding, call us if you need extra help. We can tell you if a doctor's office is wheelchair accessible or has special communications devices.

Also, we have services like:

- TTY machine – our TTY phone number is 711
- Information in large print
- Case management
- Help in making appointments
- Names and addresses of providers who specialize in your child's disability

Independent Health's 24-Hour Medical Help Line

Call (716) 250-7183 or 1-833-891-9372. If you don't have a touch tone phone, simply stay on the line and you will be transferred directly to an Independent Health representative.

Has your child ever woken up in the middle of the night not feeling well, but you're not sure what to do? Our staff is standing by, ready to advise you on what to do, including whether to seek emergency care for your child. All of our Help Line nurses have years of experience working with area physicians and hospitals. Although the 24-Hour Medical Help Line should not be used for diagnosis or as a substitute for a doctor, it's comforting to know that professional help is always just a phone call away. A single, convenient phone call makes getting answers to your child's important health questions quick and easy. Whether you have questions regarding your child's Child Health Plus benefits or medical advice offered 'round the clock, Independent Health's 24-Hour Medical Help Line gives you the answers you need, when you need them most.

Reporting Fraud

Health care fraud costs the government millions of dollars annually and increases the cost of health care nationwide. Examples of health care fraud can include the use of an Independent Health member ID card by someone who is not authorized to use it, or a doctor billing for health care services that were not provided. If you become aware of any potentially fraudulent or illegal activity, please contact Independent Health's Confidential Fraud Hotline at 1-800-665-1182.

You can help prevent health care fraud. Protect your child's Independent Health member ID card as you would a credit card. Be careful about giving

the ID number to strangers. Someone could use your child's card to commit fraud. If the ID card is lost or stolen, call Independent Health Member Services right away. Also, if you get a bill for services that you think should be paid for by Independent Health, call Member Services.

Your Child's Independent Health ID Card

After your child is enrolled in Child Health Plus, we'll send your child a welcome letter. Your child's Independent Health ID card should arrive within 14 days after the enrollment date. **Carry your child's ID card at all times and** show it each time he/she goes for care. If your child needs care before the ID card comes, you can use the welcome letter as proof that your child is a member.

Part 1: First Things You Should Know

How to Choose Your Child's Primary Care Provider (PCP)

You may have already picked your child's PCP. This person could be a doctor or a nurse practitioner. If you have not chosen a PCP, you should do so right away. If you do not choose a doctor for your child within 30 days, we will choose one for your child. Each child or teen in the family covered by CHPlus can have a different PCP, or the provider can care for everyone. A pediatrician treats children (usually up to age 18). Family practice doctors treat the whole family. Internal medicine doctors treat adults (ages 18 and older). Member Services can help you choose a PCP who would best fit your child's needs.

With this handbook, you should have a provider directory. This is a list of all the doctors, clinics, hospitals, labs, and others who provide health care services to Child Health Plus members through Independent Health. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP for your child.

You may want to find a doctor who:

- Your child has seen before
- Understands your child's health problems
- Is taking new patients
- Can service your child in your language
- Is easy to get to

We also contract with Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some people want to get their care from the FQHCs because the centers have a long history in their neighborhood. Maybe you want to try them because they are easy to get to. You have a choice. You can choose any one of the providers listed in our provider directory, or you can sign your child up with a PCP at one of the FQHCs listed below. Just call Member Services at 1-833-891-9372 for help.

Federally Qualified Health Centers:

Community Health Center of Buffalo, Inc.
34 Benwood Ave.
Buffalo, New York 14214
(716) 898-4449

Community Health Center of Niagara
501 Tenth Street
Niagara Falls, New York 14301
(716) 986-9199

Northwest Buffalo Community Health Center
155 Lawn Ave. at Military Rd.
Buffalo, New York 14207
(716) 875-2904

Your child has the right to change his or her PCP at any time. Please call Member Services for help. This change will occur as long as the doctor is accepting new patients. Please remember, not all PCPs are able to take new patients. Simply call Independent Health's Member Services at 1-833-891-9372 and we can help make the necessary changes for you. You can also change specialist doctors. Please call Member Services for help.

In almost all cases, your child's doctors will be Independent Health providers. There are two instances when your child can still see another doctor that he/she had before joining Independent Health. In both cases, however, the doctor must agree to work with Independent Health:

1. Your child is more than three months pregnant when she joins and she is getting prenatal care. In that case, she can keep her doctor until after the delivery and through post-partum care.
2. At the time your child joins, your child has a life threatening disease or condition that gets worse with time. In that case, you can ask to keep his/her doctor for up to 60 days.

If your child has a long-lasting illness, like HIV/AIDS, or other long-term health problems, you may be able to **choose a specialist to act as your child's** PCP. Your child's physician, PCP and a medical director from Independent Health, will decide if your child will require specialized medical care for a prolonged period of time and if this arrangement is best for your child. Requests for approval must be made by your child's PCP in writing to:

Independent Health's Office of the Medical Director
511 Farber Lakes Drive
Buffalo, NY 14221

Please note that the HIV/AIDS specialists in our area do act as PCPs. This means you can **easily list one of them as your child's PCP. Please** call Member Services for help.

If your provider leaves Independent Health, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if your child is more than three months pregnant or if he or she is receiving ongoing treatment for a condition. If your child is pregnant, she

may continue to see her doctor for up to 60 days after delivery. If your child is seeing a doctor regularly for an ongoing condition, he or she may continue the present course of treatment for up to 90 days. Your child's doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-833-891-9372.

Please note that continued care by your child's provider will not be allowed if the provider left the network due to imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or governmental agency that impairs the provider's ability to practice.

As part of your child's dental benefit, he or she will have a Primary Care Dentist, or PCD. This PCD must be a participating dentist in the network of the dental company Independent Health contracts with. This dental company is called Liberty Dental. Liberty Dental assigns members to dentists based on your address. You can change your child's PCD assignment at any time by calling Liberty Dental. Your PCD will provide most of your child's dental care and will refer them to a specialist for dental services when they need one.

If you need to find a dentist or **change your child's dentist**, please call Liberty Dental at 1-877-550-4283. Liberty Dental representatives are there to help you. Many speak your language or have a contract with interpreter services. You may also call with any questions or concerns to Independent Health's Member Services at 1-833-891-9372.

You will receive a separate Liberty Dental Dental ID card with the name of your child's assigned dentist. Show your child's Dental ID card to access dental benefits.

How to Obtain Information About Practitioners

To learn more about our network physicians, go to independenthealth.com or request a printed provider directory from Member Services. Both sources indicate whether a doctor is board certified. Member Services can also give you more information on a doctor's qualifications.

How to Get Regular Care

"Regular care" means medical exams, regular checkups, shots or other treatments that keep your child well, and referral to the hospital or specialists when needed. It means you and your child's PCP working together to keep your child well or see that your child gets the care he or she needs. Day or night, the PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your child's PCP knows your child and knows how Child Health Plus works. Please also read the section on page 2 about how to use Independent Health's 24-Hour Medical Help Line.

Your child's PCP will take care of most of your child's health care needs – but you must have an appointment to see your child's PCP. If you are not able to keep an appointment, call to let the PCP know. As soon as you choose a PCP for your child, call to make a first appointment. Your child's PCP will need to know as much about your child's medical history as you can tell him or her. If you can, get ready for your first appointment. Make a list of your child's

medical background, any medical problems your child has now and the questions you want to ask your child's PCP. In most cases, your first visit should be within three months of your child joining Independent Health.

If your child needs medical care before his/her first appointment, call your child's PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the "first" appointment.)

Use the following list as an appointment guide for our limits on how long your child may have to wait after your request for an appointment:

- Your child's first appointment and routine physicals – within 12 weeks
- Urgent care at your child's doctor's office – within 24 hours
- Non-urgent sick visits – within 3 days
- Routine, preventive care – within 4 weeks
- First prenatal visit – within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- First newborn visit – within 2 weeks of hospital discharge
- First family planning visit – within 2 weeks
- Follow-up after a mental health/substance abuse ER or inpatient visit – 5 days
- Non-urgent mental health or substance abuse visit – 2 weeks

Your child's health care must be "medically necessary." The services your child gets must be needed to:

1. Prevent, or diagnose and correct what could cause more suffering, or
2. Deal with a danger to your child's life, or
3. Deal with a problem that could cause illness, or
4. Deal with something that could limit your child's normal activities.

How to Get Urgent or Emergency Care

Your child may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be a child with an earache who wakes up in the middle of the night and won't stop crying.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-833-891-9372. Tell the person who answers what is happening. They will tell you what to do.

If you believe you have an emergency, call 911 or go to the emergency room. You do not need approval from Independent Health or your child's PCP before getting emergency care, and you are not required to use our hospitals or doctors. If you're not sure, call your child's PCP or Independent Health.

Tell the person you speak with what is happening. Your child's PCP or member services representative will:

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room. If you are out of the area when you have an emergency:
- Go to the nearest emergency room.

Non-Emergency Care Outside the Service Area

Non-emergency services delivered outside the Independent Health network are not covered unless they are previously authorized. If you are traveling and have a medical need that is urgent but not an emergency—such as a sore throat or infection—call Independent Health at 1-833-891-9372. They will advise you and approve needed care. Routine preventive care—such as a checkup—is not covered out of the service area.

Care Outside of the United States

If you travel outside of the United States, your child can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If your child needs medical care while in any other country (including Canada and Mexico), you will have to pay for it.

How to Get Specialty Care and Referrals

If your child needs care that your child's PCP cannot give, he or she will refer you to a specialist who can. If your child's PCP refers you to another doctor, we will pay for your child's care. Most of these specialists are Independent Health providers. Talk with your child's PCP to be sure you know how referrals work. If you think a specialist does not meet your child's needs, talk to your child's PCP. Your child's PCP can help you if your child needs to see a different specialist within the approved Child Health Plus provider network. There are some treatments and services that your child's PCP must ask Independent Health to approve *before* your child can get them. Your child's PCP will be able to tell you what they are. If you are having trouble getting a referral you think you need, contact Member Services at 1-833-891-9372.

If your child's PCP recommends that your child receive services from a specialist who is not an Independent Health participating provider, your child's PCP must obtain a prior written approval from Independent Health's Medical Director.

If we do not have a specialist in Independent Health who can give your child the care they need, we will get them the care they need from a specialist outside Independent Health. You will need prior authorization from Independent Health. This is true even if the Independent Health network does not have the right specialist to meet your child's particular health care needs. To ask for an out-of-plan referral, call Independent Health at 1-833-891-9372. Your child's PCP will be contacted and asked to supply a treatment plan explaining why they need an out-of-plan referral. We will

assess the treatment plan and consult with your child's PCP and the out-of-plan provider and make a decision. When a decision is made, you will receive a letter from an Independent Health medical director telling you whether your request has been approved or denied. If it is denied, specific information needed to file an appeal will be explained in the denial letter. If your child's PCP or Independent Health refers you to a provider outside our network, you are not responsible for any of the costs.

If you need to see a specialist for ongoing care, your child's PCP may be able to refer you for a specified number of visits or length of time (a standing referral). If you have a standing referral, your child will not need a new referral for each time they need care.

If your child has a long-term disease or a disabling illness that gets worse over time, your child's PCP may be able to arrange for:

- Your child's specialist to act as your child's PCP
- A referral to a specialty care center that deals with the treatment of your child's problem
- Hospice services if your child is terminally ill

Please see page 25 of the subscriber contract for further information.

Get These Services Without a Referral

Covered Health Care Services That Do Not Require a Referral:
Your child will not need to obtain a referral from his or her PCP before seeing the following participating doctors:

- Dermatologist (skin doctor)
- Allergist (allergy doctor)
- Ophthalmologist (eye doctor)
- Optometrist
- Dental Care
- Vision Care
- Office visits, including periodic health examinations when the services are rendered by your child's Primary Care Provider or designated participating OB/GYN practitioner.
- Emergency room health services.
- Urgent care facility services
- Reproductive health care when the services are rendered by your designated participating OB/GYN practitioner.
- Emergency, Preventive, and Routine Vision Care when the services are rendered by a network provider.
- Emergency, Preventative and Routine Dental Care.

- Outpatient Acute Mental Health Care Services rendered by a psychologist or social worker that are coordinated by Carelon Behavioral Health. Services rendered by a psychiatrist still require a referral from your Primary Care Provider.

- Outpatient Chemical Abuse and Dependency Treatment Services that are coordinated by Carelon Behavioral Health.

Of course, you can always call your child's primary care physician with questions, and are encouraged to provide updates on any care your child receives at the doctors listed above.

This list highlights key examples of services for which you do not need a referral. Please review your membership contract for the complete list.

We Want to Keep Your Child Healthy

Besides the regular checkups and the shots your child needs, here are some other ways to keep them in good health:

- Asthma counseling and self-management training.
- Diabetes counseling and self-management training.
- Weight control,
- Stop-smoking classes,
- Cholesterol control,
- Prenatal care and nutrition,
- Breast feeding and baby care,

Call Member Services at 1-833-891-9372 to find out more.

Premiums (your monthly cost)

The monthly cost of CHPlus for your child is set at the time your child applies for CHPlus and is calculated according to your household income and size of your family. Your child's coverage may be at no cost (fully subsidized by the State of New York), partially subsidized (you pay a certain part and the State pays the rest), or you may pay the full monthly cost. The full monthly cost ("premium") may be different among health plans that offer CHPlus.

At time of your child's application, one month premium was collected. CHPlus requires that your child's coverage is paid in full 60 days in advance. Therefore, Independent Health must bill your child immediately for two months. Once your child's coverage is paid two months in advance, your child will be billed for one month thereafter.

You may mail a check or money order each month to Independent Health. If you misplace your child's bill, you can mail the monthly amount due to:

Independent Health
Dept. 858
P.O. Box 8000
Buffalo, NY 14267-0002

Billing (charges from providers)

Your child is NOT responsible for any out-of-pocket expenses for copayments, deductibles, or any other charges related to covered services. Almost all medically necessary health care services will be covered by your **child's Independent Health ID card.** "Medically necessary" health care services means those services required to preserve and maintain your child's health as determined by acceptable standards of medical practice. Please see the subscriber contract for an explanation of all services that are covered by Child Health Plus.

However, you may have to pay the bill for services provided to your child that are NOT covered by CHPlus. Services not covered include those provided by a doctor or other provider outside the Independent Health network, services your child receives without required pre-approval by Independent Health, or services not covered by CHPlus (for example, cosmetic procedures or orthodontia). Excluded services (services not covered by CHPlus) are also noted in section 11 of the subscriber contract.

What if My Child Gets a Bill?

Your child shouldn't get any bills, but if he or she does get one, don't ignore it. Call Independent Health right away at (716) 250-7183 or 1-833-891-9372. Member Services will help you. You may also call Member Services if you have any questions about how Independent Health pays your child's health care providers.

Recertification

To continue your child's CHPlus coverage, you must verify your household income, residency and non-Medicaid eligibility each year. This is called recertification. Independent Health will send you a form three months before your child's renewal date. It is important that you complete and return this form along with any other required documents before the due date. Failure to do so on time will cause your child to lose health insurance coverage.

Part 2: Additional Information About Your Child's Benefits and Plan Procedures

A complete explanation of health care services covered by CHPlus is found in the Subscriber Contract. Your child must get all services that are **covered by Independent Health's CHPlus from the providers who** are in our plan. These providers are listed in the Provider Directory. All services must be medically necessary and provided or referred by your child's PCP or pediatrician.

The following is additional information that may assist you. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

Permission Required From Your Child

Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information, including payment information, for:

- Pregnancy tests and options counseling
- Abortion services
- Contraceptive care and counseling, including emergency contraception (EC)
- Medical, dental, health and hospital services relating to prenatal care
- Labor and delivery services
- All medical care for your child and their child, once the child is born
- Testing and treatment for sexually transmitted infections (STIs)
- Testing and treatment for HIV
- Alcohol and substance abuse counseling and treatment
- Mental health services

Independent Health works with Beacon Strategies to provide you with Mental Health and/or chemical dependence services that include alcohol and/or substance abuse. Beacon Strategies will work with Independent Health to make sure you get the Services you need. Your Provider can also call Carelon Behavioral Health any time for help, if immediate care is needed. Call Carelon Behavioral Health at 1-855-481-7038 if you have any questions about mental health and/or chemical dependence services.

Covered Benefits

Regular Medical Care

- Office visits with your child's PCP.
- Eye/hearing exams.

Preventive Care

- Well-child care.
- Well-baby care.
- Regular check-ups.
- Shots for children through childhood.
- Smoking cessation counseling. Enrollees are eligible for 6 sessions in a calendar year.

Specialty Care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists. Audiologists
- Midwives
- Cardiac rehabilitation
- Podiatrists (if your child is diabetic)

Hospital Care

- Inpatient care.
- Outpatient care.
- Lab, x-ray, other tests.

Emergency Care

Your child is always covered for emergencies. An emergency means a medical or behavioral condition:

- That comes on all of a sudden, and
- Has pain or other symptoms.

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- A heart attack or severe chest pain,
- Bleeding that won't stop or a bad burn,
- Broken bones,
- Trouble breathing, convulsions, or loss of consciousness,
- When you feel your child might hurt themself or others,
- If your child is pregnant and has signs like pain, bleeding, fever, or vomiting.

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

Maternity Care

- Pregnancy care.
- Doctors/mid-wife and hospital services.
- Newborn nursery care.

If your daughter becomes pregnant while covered by CHPlus, she may be eligible for Medicaid.

Your child's baby may also be eligible for Medicaid. In order to be sure the newborn will have access to all the services covered by Medicaid, your child will need to apply for Medicaid when she becomes pregnant. You can get started helping your daughter arrange for coverage for her baby before it is born, regardless of the choice of coverage made for your child.

Prenatal Case Management

Our goal is to have all pregnant Independent Health women enrolled in Prenatal Case Management. As soon as you learn your child is pregnant, please call our prenatal case management team at (716) 635-3523.

Independent Health's Prenatal Case Management Program will support your child's doctor's plan of care while your child awaits the arrival of her new baby. A registered nurse will schedule an appointment to visit her in the

privacy of your home. This visit and all following visits will help her understand all the changes that are occurring to her body and make sure she understands pregnancy and newborn care. These visits will help your daughter and her baby do well. Educating expectant and new mothers is very important to us. We work very closely with your child's doctor so that we can ensure that she has every opportunity to deliver a very healthy baby. After your daughter's delivery, a nurse will visit her again to answer her questions about her new baby.

Other Case Management Services

Our Case Management Department can also help if your child has complicated medical needs such as diabetes, asthma, or high-risk pregnancy. Our team of nurses is available to help you manage these illnesses. We can also help you find certain community support programs. Educating our members and supporting your needs is important to us.

Dental Care

Independent Health believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Liberty Dental, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, X-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your child's PCP to see a dentist.

EMERGENCY DENTAL COVERAGE

If your child has a dental emergency, call the dentist who is listed on your child's Dental ID card. If you are not able to reach your child's dentist, call Liberty Dental, at 1-877-550-4283 to find the emergency treatment site closest to you.

DENTAL PRESCRIPTIONS

If your child's dentist prescribes medicine, this prescription can be filled at any pharmacy accepting CHPlus with Independent Health.

Orthodontia

This benefit includes procedures which help to restore oral structures to support 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; sever asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if you do not meet the criteria described above. Prior approval is required for orthodontia services. Please review your subscriber contract for additional details on covered procedures.

Emergency, Preventive and Routine Vision Care

We will pay for emergency, preventive and routine vision care. This includes vision examinations performed by a participating physician or participating practitioner optometrist 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 twelve (12) month

period, unless required more frequently with the appropriate documentation. We will pay for:

- Quality standard prescription lenses provided by a Participating Physician, Participating Practitioner optometrist, or Participating Practitioner optician once in any 12-month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

- 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.

- Contact lenses - only when deemed medically necessary.

Coverage for standard prescribed lenses, frames and contact lenses is limited to the amounts listed in your contract. We will not pay more than these amounts for lenses, frames and/or contact lenses. If you would like to purchase a more expensive line of lenses, frames and/or contact lenses, you are responsible for any amounts due above and beyond these amounts.

Prescription Drugs

- Coverage for prescription drugs is subject to the conditions listed in your contract. Please review the contract for details of your prescription coverage. As a highlight, Independent Health only covers medically necessary prescription drugs. Prescriptions must be written by a participating provider, they must be filled at a participating pharmacy. Coverage is subject to the Independent Health Prescription Drug Formulary that is in effect on the date the prescription is filled. Non-prescription drugs that appear on the Medicaid drug formulary are covered.

- The following types of prescription drugs may require prior approval: injectibles, recombinant DNA products, immune-modulating agents, monoclonal antibodies, enteral formulas/modified solid food products, weight loss agents, cosmetic agents used for non-cosmetic medical diagnoses, compounded prescriptions and COX-2 inhibitors. It is your responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in you being responsible for the total cost of the drug. You also may contact the Member Services Department at 1-833-891-9372 or may consult the Independent Health's Web site at independenthealth.com to determine at what level, if any, an individual Prescription Drug is Covered or if prior approval is required.

Home Health Care

(must be medically needed and arranged by Independent Health)
Up to 40 visits per calendar year by a certified Participating Home Health Care agency Provider when Medically Necessary, ordered by your participating provider and approved in writing by Independent Health's Medical Director as an alternative to hospitalization or treatment in a skilled nursing facility. A care plan must be established in writing and approved by

your child's participating provider and Independent Health's Medical Director. The medical necessity of Home Health Care Services is determined on a case-by-case basis.

Professional Ambulance Services

Pre-Hospital Emergency medical services, including prompt evaluation and treatment of an Emergency condition and/or non-airborne transportation to a Hospital.

Inpatient Mental Health Care and Alcohol and Substance Abuse Services

We will pay for all Medically Necessary facility, diagnostic and physicians' charges for mental health services, inpatient detoxification and inpatient rehabilitation for alcohol and substance abuse services when such services are provided in a facility that is 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, or a general Hospital as defined in Article 28 of the Public Health Law.

Outpatient Mental Health Care and Alcohol and Substance Abuse Services

Independent Health works with Carelon Behavioral Health to provide Mental Health and Chemical Dependence services that include Alcohol and/or Substance Abuse services. Carelon Behavioral Health will work with Independent Health to make sure you get the services you need. Your or your provider can call Carelon Behavioral Health anytime for help at 1-855-481-7038, TTY 1-866-727-9441.

- Visits may be for family therapy related to mental health care or the alcohol or substance abuse care Outpatient Mental Health Services—You must contact Beacon Health Stategies or your child's Primary Care Physician prior to receiving services from a psychologist or social worker. A referral from your child's Primary Care Physician is still required for services rendered by a psychiatrist. Outpatient Alcohol and Substance Abuse Services—Services must be provided by certified and/or licensed professionals. The services must be ordered by your child's Primary Care Physician and must be coordinated by Beacon Health Stategies.

Please note: Mental and behavioral health benefits and alcohol and substance abuse benefits are performed by Beacon Health Stategies. You can call us 24 hours a day, seven days per week, at 1-855-481-7038. TTY users, call 1-866-727-9441.

Autism Spectrum Disorder

Independent Health 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. 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). Please review your subscriber contract for more details about this coverage.

Exclusions from Coverage

Your contract details the service/items that are excluded from Coverage. Please review the contract language.

If you have any questions, call Member Services at 1-833-891-9372.

Reviewing Your Child's Health Care

The Medical Resource Management (MRM) staff makes sure your child's medical care is orderly, meets all the standards, and achieves the goal of providing quality, cost-effective, and appropriate medical care to members. MRM staff uses a special book called The Hayes Directory that provides technology reports of procedures or medical approaches. The ratings in The Hayes Directory include:

A. Standard of care.
B. Investigational and/or experimental. This rating indicates that there is reasonably good data to support its use in the cited application.
C. Investigational and/or experimental. This rating indicates that the data on the procedure is promising but uncertain regarding safety and efficiency.
D. Investigational and/or experimental and not effective and/or not safe. The reports of the medical community do not support use of the research regarding this procedure/device.

There is a committee set up at Independent Health to talk about new tests, procedures or operations in health care and it's called TAAC – Technology Assessment and Approval Committee. This committee also uses information from the following government agencies to decide if new medical methods are efficient and correct:

NYSDOH	New York State Department of Health
FDA	Food and Drug Administration
CMS	Centers for Medicare and Medicaid Services
CHCT	Center for Health Care Technology
NCI	National Cancer Institute
NIH	National Institute of Health
HHS	Health and Human Services

Prior Approval and Time Frames

There are some treatments and services that your child's doctor needs to get approval for before your child receives them or in order to be able to continue receiving them. This is called prior approval.

Some outpatient and ancillary services require telephone and/or written preapproval by your child's provider and a referral from your child's primary care physician. The following is a list of those services:

- Out-of-Plan Services
- Short-Term Physical Therapy and Occupational Therapy

- Subacute/Skilled Nursing Home Admissions
- Home Care Services
- Mental Health/Substance Abuse

To get prior approval for these treatments or services, your child's doctor needs to receive a telephone precertification for elective surgical admissions from Independent Health's Utilization Management Department within seven days of a hospital admission. To obtain prior approval, your doctor should call Independent Health at (716) 631-3425 or 1-800-711-6202. Failure by the reviewer or Independent Health to make a determination within the required time will be considered an adverse determination and is subject to internal appeal.

The following surgical procedures require approval by your child's doctor:

- Lumbar laminectomy
- Spinal fusion
- UPPP
- Cosmetic procedures such as rhinoplasty, scar revision, breast reduction, bariatric surgery, etc.
- Photodynamic therapy
- Clinical trials and experimental procedures
- Enhanced external pulsation
- Transplants
- Autologous chrondrocyte transplantation
- Percutaneous vutetroplasty and kyphoplasty
- Extra corporal shock wave therapy for plantar fasciitis
- Gamma knife surgery
- IDET
- Implantable cardioventer – defibrillators
- Intacs corneal ring implants for kerataconnus
- Intradialytic parenteral and intra peritoneal nutrition
- Lung volume reduction surgery
- Transpupillary thermotherapy for related macular degeneration
- Varicose veins
- Wireless capsule endoscopy

The hospital is required to notify Independent Health of all admissions resulting from an emergency room visit within 24 hours of admission. Our nurses obtain the clinical information through an interview process with your child's doctor to determine the medical necessity for the elective/emergent hospital admission.

Specific targeted diagnoses have been identified as referral for our Case Management services. Following is the list of targeted diagnoses:

- AIDS/ HIV
- ALS
- Asthma/Bronchitis
- Burns
- Cancer
- CHF
- CIDP
- COPD
- CVA
- Cystic Fibrosis
- Diabetes
- Gaucher
- Hemophilia
- Lupus Erythematosus
- Multiple Sclerosis
- Myasthenia Gravis
- Parkinson's Disease
- Pneumonia
- Renal Failure
- Rheumatoid Arthritis
- Seizures
- Sickle Cell Anemia
- Transplants

If your child is getting one of these services now and needs to continue or get more of the care, this is called concurrent review.

Resolving Differences – Claims & Appeals Procedures

How to File a Complaint

If you do not like some part of your Independent Health coverage that does not involve a decision we have made, you may file a complaint by calling or writing to us. You can ask a designee (such as a lawyer, family member, or trusted friend) to file the complaint or grievance for you.

You can file a verbal complaint:

- To file a complaint by phone, call the Member Services department at 1-833-891-9372. If we need more information to make a decision, we will tell you.

You can file a written complaint:

- by writing us a letter, or
- by asking us for a complaint form to fill out.

To get a complaint form, call us at 1-833-891-9372. Mail your complaint (form or letter) to:

Independent Health
Attn: Member Services
511 Farber Lakes Drive
Buffalo, NY 14221

Timeframes for Appeals

Within 15 workdays after we get your complaint we will send you a letter to let you know we are working on it. This letter will include the name, address and telephone number of the individual who will answer your complaint. Qualified personnel will review your complaint, or if it's a medical matter, a licensed, certified, or registered health care professional will look into it.

We also will request any other information we need from you or your practitioner/provider to decide your complaint. If we only get part of that information, we will ask for the missing information, in writing, within five workdays of getting the partial information.

We will give you or your designee a written decision on your complaint within 30 workdays after we get your complaint, or within 30 days after we get all needed information, whichever is first. If we do not have all the information we need to decide your case by the 30th workday, we will send you a letter telling you why. We will then make a decision based on the information we have, and inform you of the decision within the next 15 workdays.

If a delay would significantly increase the risk to your health, we will decide your case and tell you our decision by telephone within 48 hours after we get all needed information, or 72 hours after we get your complaint, whichever is first. We will send you written notice of our decision in three workdays.

All written decisions also tell you how to appeal if you wish, and include any forms you need.

Claim (Non-Utilization Review) Determinations

You or your designee may file a claim for benefits, either verbally or in writing, by calling or writing to us. This section does not apply to utilization review determinations.

For utilization review determinations, see the section titled "Utilization Review Decisions."

- Pre-service claims are requests for care, which has not yet been provided to you and needs Independent Health's prior approval. We will decide pre-service claim requests within 15 days after we get the request for coverage of services. If we do not have all the needed information to decide by then, we may take up to 15 more days to decide your case. We will send you a letter by the end of the first 15-day period, telling you why we cannot make a decision. You will be given 45 days from the time we tell you why we cannot make a decision to send us the needed information.

- We will let you know ahead of time of any decision to reduce or end our coverage for ongoing care previously approved by us. We will give you enough time to appeal our decision and get a determination before coverage for the benefit is reduced or ended.
- An urgent (fast) decision can be made in cases where a delay could seriously endanger your life, health, or ability to regain the most function. (We use the "prudent layperson standard" to decide if you meet these criteria). We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent care claims decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days.
- If you ask to extend a course of treatment for urgent care beyond a previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account your medical needs. You will be told of our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.
- If your claim involves care that has already been provided (post-service claims), we will issue our decision to you in writing within 30 calendar days of receiving your grievance. All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file a grievance.

How to File a Grievance

If you do not like a decision Independent Health has made, other than a medical necessity decision, you or your designee may file a grievance by calling or writing to us. This section does not apply to utilization review appeals. See the separate section titled "Utilization Review Appeals."

You have 180 days after we tell you of our decision to file a grievance. To file a grievance by phone, call member services at 1-833-891-9372. If we need more information to make a decision, we will tell you.

You can file a written grievance:

- by writing us a letter, or
- by asking us for a grievance form to fill out.

To get a grievance form, call us at 1-833-891-9372. Mail your grievance (form or letter) to:

Independent Health
Attn: Member Services
511 Farber Lakes Drive
Buffalo, NY 14221

After we get your grievance, we will send you a letter within 15 workdays. We will tell you the name, address, and telephone number of the person who is working on your grievance. We also will request any other information we need from you or your practitioner/provider to make a grievance determination. If we only get part of that information, we will ask for the missing information, in writing, within five workdays of getting the partial information.

If your case is a medical matter, a clinical peer reviewer who did not make the first decision will look at it. If your case is not medical, a qualified person who is at a higher level than the person who made the first decision will look at it.

If your grievance involves pre-service claims (request for care not yet given) we will decide it within 15 calendar days after we get it.

If your grievance involves urgent care claims, and a fast decision is needed, we will decide it as soon as possible, taking your medical needs into account, but no later than 48 hours after we get your grievance. We will tell you of our decision with written or electronic notice to follow within three days.

If your grievance involves post-service claims (care given in the past) we will decide it within 30 calendar days from when we get your grievance.

All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

Appeals

If you are not satisfied with how we decide your complaint or grievance, you have 60 workdays after hearing from us to file an appeal. You can do this yourself or ask a designee to file the appeal for you. The appeal may be in writing or by phone. You can call, write a letter, or use the Independent Health complaint form.

Send your appeal letter or form to:

Independent Health
Attn: Member Services
511 Farber Lakes Drive
Buffalo, NY 14221

Or call member services at 1-833-891-9372 for help.

We will send you a letter within 15 working days. The letter will tell you the name, address, and telephone number of the person who is working on your appeal. It will also tell you if we need more information. Your appeal will be decided by:

- Qualified health care professionals, at least one of whom is a clinical peer reviewer who did not work on your original complaint or grievance, if your appeal involves a medical matter; or
- If your appeal is not about medical matters, people who work at a higher level than those who decided your original complaint or grievance.

When a delay would risk your health, we will let you know our decision within 48 hours after we get the information we need, or within 72 hours after we get your appeal, whichever is first. We will send you written notice of our decision within three working days.

For all other appeals, Independent Health will decide within 15 days of getting an appeal for pre-service claims and within 30 days of getting post-service claims. All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

Utilization Management Decisions

Independent Health has a utilization review (UM) team made up of doctors and nurses. Qualified health care professionals make all UM decisions. If you disagree with a UM decision, our resource coordination department (1-833-891-9372) may be able to help. You, a designee, or your doctor may question any utilization review decision.

Reviews

Prior Approval and Prospective Review

You or your doctor must contact the Independent Health resource coordination department to get prior approval for certain covered treatments.

For pre-service claims, decisions are made in three workdays after we get the needed information, or 15 days after we receive a request for services, whichever comes first. If we do not have all the information we need by the 15th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 15-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you receive our request to provide the information to us. We will let you or your designee, and your doctor know our decision by telephone and in writing.

Concurrent Review

If you have been getting care or treatment that should be continued, or if more services are needed, we will review the request and make our decision within one workday after we get the information we need, or 15 days after your first request, whichever is first. We will let you or your designee and your doctor know our decision by telephone and in writing. We will let you know of any decision to reduce or end our coverage for ongoing care approved by us earlier. We will give you enough time to appeal our decision and get a decision before coverage for the benefit is reduced or ended.

Retrospective Review

If we are checking on care that has been given in the past, we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us.

Urgent Review

An urgent (fast) decision can be made in some prior approval, prospective review, and concurrent review cases. We will make a fast decision when waiting for the above timeframes could seriously endanger your child's life, health, or ability to regain the most function. We use a "prudent layperson standard" to decide if your child meets these criteria. We will also make a fast decision if your child's doctor believes they would suffer severe pain without the requested care or treatment. Urgent decisions are not available for retrospective reviews.

Urgent care utilization review decisions are made as soon as possible, taking your child's medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days. If you ask to extend a course of treatment for urgent care beyond the approved period of time or number of treatments, a decision will be made as soon as possible, taking your medical needs into account. We will tell you our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

Reconsideration of Reviews

If we make a decision without speaking to your doctor, your doctor may ask to speak to Independent Health's medical director. This option does not apply to a retrospective review. The medical director will talk to your doctor and make a decision within one workday.

Notice of Appeal Rights

All notices of decisions from Independent Health are in writing and include detailed reasons for the decision, including the medical rationale and the section of your contract upon which the decision was based.

Your options for asking for an appeal from us, or the State, will be explained. If you request, you may also receive, free of charge, reasonable access to or copies of all documents about your case.

If Independent Health fails to make a utilization review decision within the above timeframes, this can be considered the same thing as a denial, which would then be subject to appeal.

Utilization Review Appeals

You or your designee can appeal a utilization review (UR) decision. Just call member services at 1-833-891-9372 to appeal any Independent Health utilization review decision. In the case of past care reviews, your doctor can also make the appeal. There are two kinds of UR appeals: fast track and standard.

Use the fast track UR appeals process when:

- you need an OK to continue current health care, or
- you need more services added to those your child is getting, or
- your child's doctor thinks our plan should look at the request again right away, or

- a delay could seriously put your child's life, health, or ability to regain the most function in danger (based on the "prudent layperson standard"), or
- your child's doctor believes you would suffer severe pain without the requested care or treatment.

We will decide fast track UR appeals within two workdays after we get the information we need, or within 72 hours after we get your appeal, whichever is first. If we need more information to decide your case, we will immediately tell you and your practitioner/provider by telephone and in writing of what we need. A clinical peer reviewer will be available to talk with you or your designee within one workday after we get notice of the UR appeal. The decision on your appeal will not be made by the same reviewer who decided it the first time.

We will follow up with written notice to you within 24 hours after our decision. The notice will tell you the specific reasons for our decision, including the medical reason, and all options for appeal. If we deny your fast track UR appeal, you can request a standard UR appeal or an external appeal.

In all other cases (non-fast track), if you, your designee, or your doctor do not agree with what we decided, you may appeal using the standard UR appeals process.

- You must file a standard UR appeal (by phone or in writing) within 180 days of getting notice of our decision (which will tell you how to appeal).
- Within five workdays, we will send you a letter telling you the name, address, and telephone number of the person who is working on your appeal.
- The decision on your appeal will not be made by the same reviewer who decided the first time.

If we need any additional information to decide your UR appeal, we will send you or your practitioner/provider a letter within five days after we get your UR appeal.

- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
- If we do not make a fast track or standard decision within the above timeframes, we must allow you to get the service you or your doctor asked for.

In some cases, you can ask to skip the UR appeal step and go directly to an external appeal. If we agree to an external appeal, we will send you a letter within 24 hours. See the following section.

External Appeals

You may ask for an external appeal if one of the three conditions below is met:

1. Independent Health turned down your request for service, saying that it was not medically necessary. The service must otherwise be covered under your contract;
2. Independent Health denied coverage for a health care service because we believe it is experimental or investigational; or
3. Independent Health turned down your request for a service, on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network.

With respect to #2 above, the following must also be true:

- Your child's doctor tells us that they have a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Independent Health, or (c) for which there exists a clinical trial or rare disease treatment.
- A "life-threatening condition or disease" is one that your child's doctor believes has a high probability of death. A "disabling condition or disease" is a health issue that can be expected to result in death, last for a year or more, or keep you from working and/or doing any age-appropriate substantial, gainful activities.
- Your child's doctor has:
  a) recommended a service or pharmaceutical product (as described in New York Public Health Law § 4900(5)(b)(B)) that is more likely to help your child than any covered care. He or she must base the request on two acceptable documents from available medical and scientific evidence. Only certain documents will be considered. Your child's doctor should contact the State Insurance Department to find out more; or
  b) in the case of a rare disease, provided a certification (as described in New York Public Health Law § 4900(7-g)) that the requested health service or procedure is likely to benefit your child in the treatment of their rare disease and that the benefit to you outweighs the risk of the service or procedure; or
  c) recommended a clinical trial for which your child is eligible (only certain clinical trials are covered).
- Your child's doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.
- The care your child's doctor recommends would be covered under your contract if we had not decided it was experimental or investigational.

With respect to #3 above, the following must also be true:

- Your child's doctor has:

  d) certified that the out-of-network health service is materially different than the alternate recommended in-network service; and

  e) recommended a health care service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

- Your child's doctor must be licensed and board-certified or board-eligible in the specialty needed for their condition.

If you wish, you and Independent Health may agree in writing to waive the UR appeal step and go directly to an external appeal.

All external appeals will be conducted by agents who are certified by the Commissioner of the New York State Department of Health. These agents are randomly assigned to conduct external appeals.

You or your designee has 45 days after getting an adverse UR appeal decision from Independent Health to ask for external appeal. Your designee may file for it on your behalf. Or, if it is a situation where the care has already been delivered, your child's doctor may file for the external appeal.

If you and Independent Health agree in writing to waive the UR appeal step, you have 45 days after filing the waiver to submit a written request for an external appeal.

External appeal requests must be in writing on a standard New York State Department of Financial Services (DFS) form. Independent Health will give you a copy of this form with our UR appeal decision or our written waiver of that step. Or, you can ask for a form by calling Independent Health at 1-833-891-9372 or DFS at 1-800-400-8882. It is also available online at www.dfs.ny.gov or www.health.ny.gov.

Having an external appeal means you give up your rights to complete the rest of Independent Health's grievance process (hearing and board of directors review).

You, your designee, and your child's doctor may submit supporting documents to the external appeal agent during the same 45-day period. If these documents contain new information that is different from the facts Independent Health used to make its UR appeal decision, Independent Health may take up to three workdays to consider the new facts and review its decision.

The external appeal agent will decide your appeal within 30 days of getting it. During that time, he or she may request information from you, your designee, your doctor, and Independent Health. If the agent asks for more

information, he or she may take up to five extra workdays to decide your case. The agent will notify you and Independent Health, in writing, of the decision within two workdays after the decision is made.

However, if your child's doctor says that a delay could be an imminent or serious threat to your child's health, the decision will be made within three days of the request. The agent will notify you and Independent Health of the decision right away, either by phone or fax. A written copy of the decision will also be sent right away.

If the external appeal goes in your favor, Independent Health will cover the care in question, subject to the terms of your contract. If the agent agrees that you should be allowed to enter a clinical trial, Independent Health will only cover the costs of your treatment within the trial. Independent Health will not cover investigational drugs or devices that are part of the clinical trial. We also will not cover costs of the clinical trial that would not be covered under your contract, such as for research or non-health-related items.

It is YOUR RESPONSIBILITY to initiate the external appeal process. You can file an external appeal by sending a completed form to DES. If you already received the service in question, your doctor may file an external appeal for you, but you would need to agree to this in writing.

Under New York State law, a completed request for appeal must be filed within 45 days of either the date upon which you get written notification from us that we have upheld a denial of coverage or the date upon which you get a written waiver of the utilization review appeal step. We have no authority to grant an extension of this deadline.

Independent Health's Grievance Committee Hearing

If you do not agree with the decision made through our appeal processes, you or your designee may ask for a hearing before the Independent Health grievance committee. This option is not available if you have an external review. You must ask us for a hearing (verbal or written) within 60 workdays after we tell you of our appeal decision.

The grievance committee is made up of individuals not previously involved in any of our prior decisions in your case.

We will send you a letter within five workdays after we get your request for a hearing. The letter will include the name, address, and telephone number of the person who will answer the hearing request, as well as any additional information needed.

A hearing will be held within 45 days after you make your request. The hearing will be led by the chairperson of the Independent Health grievance committee or his or her designee, and will be recorded by a court stenographer. You can appear before the grievance committee, or to participate by telephone or other appropriate technology. You may also choose a person to represent you at the hearing.

The Independent Health grievance committee will send you or your representative a letter with its decision within five workdays after the hearing.

The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision.

If a delay would considerably increase the risk to your health, we will make sure that the hearing is held and you get the decision within 48 hours after we get all the needed information, or 72 hours after you asked for a hearing, whichever is first, with a letter sent to you within three workdays after the decision.

Board of Directors

If you do not agree with the decision made by the Independent Health grievance committee, you can ask that the Independent Health board of directors review the decision. You must ask in writing within 30 days of when you get the Independent Health grievance committee decision. After we get your letter, the board of directors will review your request at its next regularly scheduled meeting. The Independent Health board of directors will only consider the full record of the Independent Health grievance committee hearing. The board of directors will provide you or your designee a written decision within 30 days of its meeting.

Complaints to New York State

If you are unable to resolve a problem with Independent Health, you may also file a complaint anytime by contacting:

New York State Department of Health
Corning Tower Room 2019
Empire State Plaza Albany, NY 12237
1-800-206-8125
www.health.ny.gov or

New York State Department of Financial Services
One Commerce Plaza
Albany, NY 12257
1-800-342-3736
http://www.dfs.ny.gov

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your child's use of health care services. You can call Member Services at 1-833-891-9372 if you have specific concerns.

Most of our providers are paid in one or more of the following ways:

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect their salary.
- Our PCPs who work from their own offices may get a set fee every month for each patient who has selected them to act as their PCP. The fee stays the same whether the patient needs one visit or many – or even none at all. This is called capitation.

- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) is held back and placed in an incentive fund. At the end of the year, the PCP may receive extra pay if he or she has met certain standards set by Independent Health.
- Providers may also be paid by fee-for-service. This means they get a plan-agreed-upon fee for each service they provide.

The Independent Health Quality Initiative

Quality Doctors

"Credentialing" is the process Independent Health uses to select qualified doctors for our network of participating doctors. Our credentialing team checks the status of a doctor's license, verifies that the doctor has had the appropriate training for his or her specialty and looks for any potential problems with the quality of care a doctor provides his or her patients. This review takes place when a doctor first joins the network, every two years thereafter, and on an ongoing basis through the Quality Management program. In addition, before being accepted into our network, office inspections are performed at all PCP's offices and OB/GYN offices.

If you would like to receive a complete copy of Independent Health's Quality Management Program Description, which includes organizational arrangements and on-going procedures of Independent Health's Quality Assurance program, please call our Member Services Department at (716) 250-7183 or 1-833-891-9372 (TTY at (716) 631-3180). You may also view it online at independenthealth.com.

Filing a Claim

Even though you should not be billed for services covered through Independent Health, if you do receive covered services and pay for them out of your own pocket, you may file a claim with us to be reimbursed. Please send the itemized bill and a receipt to:

Independent Health
Attn: Member Services
511 Farber Lakes Drive
Buffalo, NY 14221

Claims should be sent within 90 days of receiving care.

You Can Help With Independent Health Policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas, tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. One third of our Board of Directors is made of Independent Health members. Their active participation in the creation and approval of our policies is a check and balance to what our members want and don't want. Call our Member Services at 1-833-891-9372 to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services at 1-833-891-9372:

- A list of names, addresses, and titles of Independent Health's Board of Directors, Officers, Controlling Parties, Owners and Partners
- A copy of the most recent annual certified financial statements/balance sheets, summaries of income and expenses
- Information from the Department of Financial Services about consumer complaints about Independent Health
- A copy of the most recent Child Health Plus drug formulary
- Information about how we keep your child's medical records and member information private

If you ask in writing, we will tell you:

- How Independent Health checks on the quality of care to our members.
- Which hospitals our health providers work with.
- The guidelines we use to review conditions or diseases that are covered by Independent Health.
- The qualifications needed and how health care providers can apply to be part of Independent Health.

If you ask, we will tell you:

- Whether our contracts or subcontracts include physician incentive plans that affect the way the doctor refers your child to other medical services and, if so,
- Information on the type of incentive arrangements used, and
- Whether stop-loss protection is provided for doctors and groups of doctors
- Information about how Independent Health is organized and how it works

Termination of Your Contract

Described below are reasons why this Contract may terminate.

Default in Payment of Premiums. If you are required to pay all or a portion of your premium under this Contract, this Contract will automatically terminate as of the date to which your premium has been paid if we do not receive the premium by the end of the grace period. If the premium is not paid by the *end of the grace period*, you will not be entitled to any service under this Contract given to you after the date to which your premium has been paid. If you receive care from an Independent Health physician following the date this Contract terminates, the adult must pay the Independent Health physician at his or her normal charges. However, if you are totally disabled on the date this Contract terminates you will continue to be entitled to service covered under this Contract for the condition, which caused the disability (See Paragraph 8 on page 32 of the subscriber contract).

If You No Longer Qualify. If your child no longer meets the Child Health Plus eligibility requirements your child's coverage will end. Your child will no longer be eligible for Child Health Plus: on the last day of the month in which they reach the age of 19; or the date on which they are enrolled in the Medicaid program; or the date on which they become covered under other health coverage. This Contract will terminate on the first day of the month following any event that results in your child no longer meeting the Child Health Plus eligibility requirements.

We will require you to provide documentation each year to certify that you still meet the Child Health Plus eligibility requirements. Failure to provide the requested documentation may result in termination of this contract.

When the State Child Health Plus Program Terminates. This Contract will terminate on the date when the State law that establishes and provides funding for the Child Health Plus Program is terminated, or on the date our participation in the Child Health Plus Program terminates.

Your Option to Terminate This Contract. You may terminate this Contract at any time by giving us at least 30 days prior written notice. If this Contract is terminated in this manner we will refund any portion of the premiums for the Contract, which have been prepaid.

Our Option to Terminate This Contract. We may terminate this Contract for any of the following reasons:

A. If we discontinue the entire class of contract to which this Contract belongs. In other words, we may terminate this Contract if we also terminate the same contract held by everyone else. We will give you or the adult at least 5 months written notice that this Contract will be terminated in this manner.

B. We may terminate this Contract for any reason, which is approved by the Superintendent of Insurance. If this Contract is terminated in this manner, a copy of the reason will be provided to you upon request. We will give you at least 30 days written notice that this Contract will be terminated in this manner.

C. We may terminate this Contract for fraud committed by you when you applied for this Contract or when you filed any claim under this Contract.

D. If you move outside of the State your child will no longer be eligible to participate in the Child Health Plus program and this Contract will be terminated.

E. If you move outside our Service Area, this Contract will terminate.

Your Child's Rights

While an eligible member of Independent Health's CHPlus, your child (or you, as parent/guardian where applicable) has the right to:

- Be cared for with respect and dignity, without regard for health status, sex, race, color, religion, national origin, age, or sexual orientation.

- Be told where, when and how to get the services he/she needs from Independent Health.
- Be told by his/her PCP what is wrong, what can be done, and what will likely be the result in language you and your child can understand.
- Get a second opinion about care.
- Have his/her treatment or plan for care fully explained to you before you give your okay.
- Refuse treatment on behalf of your child, as allowed by law, and to be told of the medical risks of refusing.
- Allow you to get a copy of your child's medical record (please note: there are some types of certain medical information that may only be accessed by your child), and talk about it with his/her PCP. You can ask that your child's medical record be amended or corrected, if needed.
- Be sure that his/her medical record is private and will not be shared with anyone except as required by law, contract, or with your okay.
- Request information about Independent Health, its services, its doctors and your child's rights and responsibilities. You may also make recommendations regarding our member's rights and responsibilities policy.
- Use the Independent Health complaint system to settle any complaints or complain to the New York State Department of Health any time you feel your child was not treated fairly.
- Appoint someone (relative, friend, lawyer, etc.) to speak for your child if you are unable to speak about your child's care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- Appoint someone (i.e., a relative or friend) to speak for your child if he or she is 18 years old or older or is an unemancipated minor and is unable to speak for him/herself about his or her health care and treatment. (Also see Advance Directives below.)

Your Responsibilities

For your child, as a member of Independent Health's CHPlus, you agree to:

- Work with your child's PCP to guard and improve your child's health.
- Find out how your child's health care plan works.
- Listen to your child's PCP's advice and ask questions when you are in doubt.
- Call or go back to your child's PCP if your child does not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Please call Member Services.

- Keep your child's appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for true emergencies.
- Call your child's PCP when your child needs medical care, even if it is after-hours, or call our 24-Hour Medical Help Line at (716) 250-7183 or 1-833-891-9372.
- Give your child's PCP medical information so the PCP can care for your child.
- Report any issues you believe are fraudulent health care billing practices or misuse of a member ID card to our Fraud and Abuse Hotline number at 1-800-665-1182.

Privacy Notice

What is Your Personal Information?

Personal information is any information about you, received or created by Independent Health, for the purpose of administrating your child's health benefits. This includes any information that can identify your child as an individual, such as his/her name, address and Social Security Number and other information.

HOW INDEPENDENT HEALTH USES AND DISCLOSES YOUR CHILD'S PERSONAL INFORMATION

In order to administer your child's health insurance, Independent Health uses and discloses your child's health information to coordinate treatment with his/her doctors, payment for care, and our health care operations. Under the law, we may perform these functions without your specific authorization or approval. When performing these functions, we only use or disclose the minimum amount of information necessary. These functions include:

- Treatment. We may disclose your child's personal information to his/her health care providers to help them provide medical care. Here are a few examples:

  – If your child is in the hospital, we may give your child's doctor at the hospital access to medical or pharmacy records that we have. We may use your child's personal information to coordinate care.

  – To inform you of other health-related benefits, such as medical treatments, health-related products and services, or a description of our health plan or providers. For example, we might send you information about prescription refill reminders.

  – If your child needs urgent care and you call Independent Health's 24-Hour Medical Help Line, the help line discloses your child's personal information to us so any bills for care received out of our service area will be properly processed.

- Payment. To help pay for your child's covered services, we may use and disclose your child's personal information. For example, we may use and disclose your child's personal information:

  - To pay your child's medical bills that your child's health care providers have submitted to us.
  - To conduct "utilization review" (which means deciding if a particular health care item or service is medically appropriate).
  - To coordinate benefits between our coverage and other insurers who may be fully or partially responsible for payments.

- Health Care Operations. We may use and disclose your child's personal information to others who help us conduct our health care operations. For example, we may disclose your child's personal information for the following purposes:
  - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating Independent Health.
  - Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs.
- Business Associates. We may disclose your child's personal information to companies that we have contracted with if they need it to perform services we have requested. For example, we may disclose your child's personal information to become approved or accredited by an independent quality assurance entity called the National Committee for Quality Assurance (NCQA). We only will disclose your child's personal information to outside entities that agree to protect your personal information just as we would and we only transfer the minimum information necessary to accomplish a task. We obtain a written agreement from every business associate and review their practices to ensure they are protecting your child's personal information just as we would.

USES AND DISCLOSURES REQUIRED BY LAW

We may use or disclose your child's personal information without your authorization when required by law:

- For public health and disaster relief efforts.
- To regulatory bodies, such as the United States Department of Health and Human Services (HHS), the New York State Department of Financial Services (DFS) and the New York State Department of Health (DOH).
- To report public health activities. For example, we may report to entities that track certain diseases such as cancer.
- To a coroner or medical examiner to help identify a deceased person, to determine a cause of death, or as authorized by law. We may also disclose your child's personal information to a funeral director as necessary to carry out their duties.
- To public health agencies in order to avoid harm. For example, we may report your child's personal information to a government authority if we believe there is a serious health or safety threat to your child or others, or in cases of child abuse, neglect or domestic violence.

- For health oversight activities, such as audits, inspections, licensure and disciplinary actions.
- To meet legal requirements. For example, in response to a court ordered subpoena.
- For law enforcement activities. For example, we may disclose personal information to identify or locate a suspect, fugitive, material witness or missing person, to report a crime or to provide information about crime victims.
- For specific government functions, such as military and veteran activities, national security and intelligence activities, and providing protective services to the President.
- **For workers' compensation purposes.**

OTHER USES AND DISCLOSURES
We may also use or disclose your child's personal information without your authorization in the following miscellaneous circumstances:

- For purposes of organ donation, such as for procurement, banking or transplantation of organs, eyes or tissue.
- For research. If we use or disclose your child's personal information for a research project that contributes to knowledge generally, we take steps to keep your child's information private and secure. In some instances we may have a research review board approve the procedures we have put in place to secure your child's personal information. If we do not receive approval from a research review board, we will ask for your authorization before we use or disclose your child's personal information for research.
- If your personal information has been de-identified. "De-identifying" information means removing all parts of your information that could identify your child. HIPAA gives us rules to follow when de-identifying your child's personal information and permits us to disclose de-identified information without your authorization.

SPECIAL CONSIDERATIONS
Either state or federal law contains important limitations on how we can disclose your child's personal health information pertaining to HIV/Aids, mental health, alcohol and substance abuse and sexually transmitted diseases. For those conditions, we follow rigorous standards that provide heightened privacy protections to your child. These additional standards are designed to give you added security and confidence regarding our handling of such information while still allowing your child to obtain needed medical treatment freely and without hesitation.

USES AND DISCLOSURES WE WILL NOT MAKE
Even though permitted by law, we will not use and disclose your child's personal information for the following reasons:

- Sale. We will not sell your personal information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION If we disclose your child's information for a reason that does not fit in one of the general categories listed above, we must obtain your written permission. This written permission is called an "authorization." Here are examples of instances when we must ask for your permission before disclosing your child's personal information:

- If you consult an attorney and your attorney needs your child's personal information in order to represent your child.
- If anyone other than you or a doctor who is treating your child asks us to disclose your child's personal information.
- If we use your child's personal information to market an outside company's product or service and we receive financial payment from the outside company for making the communication. However, we may send you refill reminders and communications about treatment, health-related products or services that are included in your child's plan, case management, and governmental programs (such as Medicaid managed care) without asking for your authorization first.

If you give us written permission and then change your mind about that permission, you may take back or revoke your written permission at any time, except if we have already acted based on your permission. If you have questions or would like to obtain a copy of our authorization form, please call our toll-free Member Services number on your ID card, Monday through Friday from 8 a.m. to 8 p.m., or email us at memberservice@servicing.independenthealth.com.

WHEN YOU ASK US FOR PERSONAL INFORMATION ABOUT OTHERS If you request your family members' personal information, we may need to obtain written permission from that family member. Here are some examples:

- If you are a parent and ask for personal information about your son or daughter who is 18 or over, we will need to get your son or daughter's written permission before disclosing their information to you.
- If you ask us for information about a health care item or service that your minor child can obtain without your parental consent, such as outpatient mental health treatment, we will ask for your child's written permission before disclosing that information to you.

If you have questions, please call our toll-free Member Services number on your child's ID card, Monday through Friday from 8 a.m. to 8 p.m., or email us at memberservice@servicing.independenthealth.com.

YOUR RIGHTS REGARDING YOUR PERSONAL INFORMATION
By law, you have several important rights with respect to your child's personal information. You may exercise any of the rights described below, or ask any questions about these rights by calling our toll-free Member Services number on your ID card, Monday through Friday from 8 a.m. to 8 p.m., or email us at memberservice@servicing.independenthealth.com.

- You have the right to ask us to restrict how we use, or disclose your child's personal information for treatment, payment, or health care operations. You may also ask that we limit the information we give to others who are involved in your child's health care or payment for your child's health care such as a family member or a friend. Your request may be received verbally or in writing. Please note that we will accommodate reasonable restriction requests. If we do agree, we will honor your request unless it is an emergency situation.
- You have the right to ask us to communicate with you by a different method or in a different manner. For example, if you believe that your child would be harmed if we send your child's personal information to your current mailing address (situations involving domestic disputes), you may ask us to send your child's personal information by fax instead of mail or to a P.O. Box instead of your child's home address. We will agree to reasonable requests.
- You have the right to request a copy of your child's personal information in your child's designated record set, including an electronic copy in many cases. You also have the right to inspect your child's personal information in your child's designated record set. A
- "designated record set" is a group of records that is used by or for us to make decisions about your child. We may ask you to request copies of your child's personal information in writing and to specify the
- information you are requesting. We also may charge a reasonable fee for copying and mailing your child's personal information. In certain situations, we may deny your request, or part of your request, but we will tell you why we are denying your request. You have the right to ask for a review of that denial.
- You have the right to ask us to make changes to your child's personal information we maintain about you in your "designated record set" if you believe it is wrong or if information is missing. This is called the right "to amend" your child's personal information. Your request may be verbal or in writing, but you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within the 60 days, we may extend that time by no more than an additional 30 days. If we make the change, we will notify you that it was made. In some cases, we may deny your request to change your personal information. For example, we may deny your request if we did not create the information you want changed. If we deny your request, we will notify you in writing about the reason for the denial. The denial will explain your right to file a written statement of disagreement. These statements will be filed with the record you asked us to change.
- You have the right to ask for an accounting of disclosures we have made for reasons other than treatment, payment and health care operations. You have the right to receive a maximum of six (6) years' worth of disclosures in your child's accounting. Your request for an accounting must be in writing and specify the information requested. We will act on your request within 60 days, unless we need an additional 30 days.

- You have the right to receive an electronic or paper copy of this notice.
- You have the right and will receive notice about any breaches of your child's personal information in accordance with applicable state and federal laws.
- You have the right to file a complaint if you believe your child's privacy rights have been violated or if you disagree with a decision we made about your access to your child's personal information. We will not take any action against you for filing a complaint. You may contact us with your complaint by calling, writing, or emailing Independent Health's Information Risk Office at:

  Information Risk Office
  Independent Health
  511 Farber Lakes Drive
  Buffalo, New York 14221
  (716) 631-3001 or 1-800-247-1466
  memberservice@servicing.independenthealth.com

You could also contact the United States Department of Health and Human Services (HHS).

OUR OBLIGATION

We are required by law to maintain the privacy of your child's personal health information, give you notice of our legal duties and privacy practices, notify you following a breach of your child's personal information, and to follow the terms of the notice currently in effect. We may change the terms of this notice at any time. The revised notice will apply to any personal information we maintain. Once revised, we will give you the new notice by United States mail and will post it on our website.

QUESTIONS

If you have any questions about this notice or about how we use or disclose your child's personal information, please contact Independent Health's Information Risk Office at (716) 631-3001 or 1-800-247-1466. Our office is open Monday through Friday from 9 a.m. to 5 p.m. You can also send us questions by email at memberservice@servicing.independenthealth.com.

HOW INDEPENDENT HEALTH PROTECTS YOUR CHILD'S PERSONAL FINANCIAL INFORMATION

Most information we obtain about your child relates to your child's health. However, your child's personal information could contain information that is financial in nature. We may obtain personal financial information about you from the following sources:

- Information received from you on applications or other forms such as your child's name, address, Social Security Number and telephone number;
- Information about your transactions with us, our affiliates or others, such as your premium payment history, your child's enrollment history, type of health insurance coverage, medical claims history, and coordination of benefits information; and

- Information about your child from other sources, such as a hospital or medical facility your child has visited.

Integrity Helpline

The business of insurance is heavily regulated at the state and federal level. Our regulators expect and demand that Independent Health conduct its business in an ethical and compliant manner. We are committed to observing and complying with all government regulations and rules as well as following corporate policies and procedures. Independent Health is committed to maintaining a culture that promotes the prevention, detection and resolution of potential violations of law or company policy. In order to maintain a culture that promotes compliance, Independent Health has established the Integrity Helpline, a mechanism available to all employees, members, providers and vendors to report actual or suspected incidents of non-compliance. If you become aware of any incidents of actual or suspected noncompliance with policies and/or laws, rules and regulations, you can report the incident by calling our confidential Integrity Helpline at 1-877-229-4916. Calls to the Integrity Helpline may be made anonymously.

Fraud Prevention

Health care fraud can cost the government millions of dollars annually and increase the cost of health care nationwide. Examples of health care fraud include the use of an Independent Health member ID card by someone who is not authorized to use it, or a health care provider billing for health care services that were not provided. If you become aware of any potentially fraudulent or illegal activity, please contact Independent Health's confidential Fraud and Abuse Hotline at 1-800-665-1182.

Advance Directives

If your child has reached age 18, is pregnant, has delivered a baby or is married, your child has the right to make advance directives. An advance directive is planning now for your child's wishes to be carried out if he or she becomes incapacitated. Your child can do this by first letting family, friends and his or her doctor know what kinds of treatment he or she does or does not want. Second, your child can appoint an adult he or she trusts to make health-related decisions for him or her. Third, it is best if your child puts his or her thoughts in writing.

Your child does not have to use a lawyer, but he or she may wish to speak with one about this. Your child can change his or her mind and these documents at any time. We can help you get these documents. They do not change your child's right to quality health care benefits. The only purpose is to let others know what your child wants if he or she can't speak for him/herself.

According to law, health care providers and facilities cannot deny your child care or discriminate against your child based on whether your child signed an advance directive. If your child signed an advance directive and your child believes that a doctor or hospital has not followed the instructions in it, your child may file a complaint with the New York State Department of Health at 1-800-206-8125.

Important Phone Numbers

Your Primary Care Physician (PCP)_____

Your Nearest Emergency Room_____

Your Local Pharmacy_____

Other Health Providers_____

_____

_____

Independent Health Member Services_____ (716) 250-7183 or 1-800-833-9372/TTY 711

Carelon Behavioral Health (Mental Health and Alcohol/Substance Abuse)_____**1-855-481-7038/TTY 1-866-727-9441**

24-Hour Medical Help Line_____ **(716) 250-7183 or 1-833-891-9372**

Confidential Fraud Hotline_____ **1-877-229-4916/TTY (716) 631-3108**

Benefit Administration Department_____**1-800-247-1466, ext. 3651**

New York State Department of Health (Compliments)_____ **1-800-206-8125**

New York State Managed Care Helpline Outside NYC_____**1-888-367-6557**

New York State Growing Up Healthy Hotline_____ **1-800-522-5006**

New York State Department of Financial Services_____ **1-800-400-8882**

Independent Health
Dedicated to Making a Difference

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(716) 250-7183 • 1-833-891-9372 • TTY: 711

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