E. If you do not provide the documentation we request within 60 days of your enrollment or recertification date.
F. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process within the 60 day temporary enrollment period.

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

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

8. **Benefits after termination.** If you are totally disabled on the date this contract terminates and you have received medical services for the illness, injury or condition 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
   - A date 12 months from the date this contract terminates

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

SECTION FOURTEEN — RIGHT TO A NEW CONTRACT AFTER TERMINATION

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

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

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

SECTION FIFTEEN — GRIEVANCE (COMPLAINT) PROCEDURE

Grievances (Complaints). 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.

1. **Filing a Grievance.** You can contact us by phone at 800-300-8181 (TTY 711); the number on your ID card or, in writing to file a grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that you sign a written acknowledgement of Your oral Grievance, prepared by Us.

Mail your written Grievance to:

Complaint Specialist
Quality Management Department
Anthem Blue Cross and Blue Shield HP
PENN 1, 35th Floor
New York, NY 10119

You can also fax the grievance to us at 866-495-8716.

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.

2. **Grievance Determination.** Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified, or registered healthcare professional will look into it. We will decide the grievance and notify you within the following timeframes:

Expedited/Urgent Grievances:	By phone, within 48 hours of receipt of all necessary information In writing, within 3 business days after we notify you by phone
Referrals/Covered Benefit Determination:	In writing, within 30 calendar days of receipt of all necessary information
All Other Grievances: (that are not in relation to a claim or request for a service)	In writing, within 45 calendar days of receipt of all necessary information

3. **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 800-206-8125 or write them at:
New York State Department of Health
Corning Tower
Anthem State Plaza
Albany, NY 12237
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 3rd Ave. 10th Floor
New York, NY 10017
Or call toll free: 888-614-5400, or email cha@cssny.org
communityhealthadvocates.org

D. **Grievance Appeals**. If you are not satisfied with the resolution of Your Grievance, You or Your designee my file an Appeal by phone or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

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

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

Expedited/Urgent Grievances:	Within 48 hours of receipt of all necessary information
All Other Grievances:	Within 30 calendar days of receipt of all necessary information

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

Call the New York State Department of Health at 800-206-8125 or write them at:
New York State Department of Health
Corning Tower
Anthem State Plaza
Albany, NY 12237
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 3rd Ave. 10th Floor
New York, NY 10017
Or call toll free: 888-614-5400, or email cha@cssny.org
communityhealthadvocates.org

SECTION SIXTEEN — EXTERNAL APPEAL

External Appeals

1. Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial 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 the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

3. Your right to appeal a determination that a service is experimental or investigational

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

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

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 the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four 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 four months from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State at 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-healthcare services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and 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

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

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

Covered Services and Exclusions
In general, we don't cover experimental or investigational treatments; however, we shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with Section of this Subscriber Contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for nonexperimental or non-investigational treatments provided in such clinical trial.

SECTION SEVENTEEN — UTILIZATION REVIEW

1. **Utilization Review.**

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the services is performed (retrospective). If You have any questions about the Utilization Review process, please call 800-300-8181 (TTY: 711); the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Healthcare Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the healthcare service under review; or 3) with respect to substance use disorder treatment, effective on the date of issuance or renewal of the Contract; on or after April 1, 2015, licensed Physicians or licensed, certified, registered or credentialed Healthcare Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 800-300-8181 (TTY: 711); the number on Your ID card or visit Our website at anthembluecross.com/ny/medicaid.

2. **Preauthorization Reviews.**

A. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or