SECTION XVIII – GRIEVANCE PROCEDURES

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

B. Filing a grievance
You can contact us by phone at 1-800-300-8181 (TTY 711) (the number on your ID card) or in writing to file a grievance. You must use our grievance form for written grievances. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

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

We keep all requests and discussions confidential 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 30 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 your grievance.
All other grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of your grievance but no more than 45 calendar days of receipt of all necessary information.

D. Grievance appeals
If you are not satisfied with what we decide, you have at least 60 working days after hearing from us to file a complaint or grievance appeal. You can do this yourself or ask someone you trust to file the complaint or grievance appeal for you. The complaint or grievance appeal must be in writing. If you call us to file a complaint or grievance appeal, we will send you a form that is a summary of your verbal appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. We need to have this written summary before we can look at your complaint or grievance appeal. If we do not receive a written signed summary of your complaint or grievance appeal, we will not be able to move forward with the investigation of your complaint or grievance appeal.

After we get your complaint or grievance appeal, we will send you a letter within 15 working days. The letter will tell you:

- Who is working on your complaint or grievance appeal
- How to contact that person
- If we need more information

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

If we have all the information we need, you will know our decision in 30 working days. If a delay would risk your health, you will get our decision in two working days of when we have all the information we need to decide your complaint or grievance appeal.

You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint with the New York State Department of Health at 1-800-206-8125.

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

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
1 Commerce Plaza
Albany, NY 12257
Website: www.dfs.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 Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400,
Email: cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XIX – UTILIZATION REVIEW

A. Utilization review
We review health services to determine whether the services are or were medically necessary or experimental or investigational (medically necessary). This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call 1-800-300-8181 (TTY 711). 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 mental health or 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 mental health or 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. For substance use disorder treatment, we will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for your review upon request. For more information, call 1-800-300-8181 (TTY 711) or visit our website at www.empireblue.com/nyessentialplan.

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 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 earlier of the receipt of part of the requested information or 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 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. Written notification will be provided within the earlier of three business days of our receipt of the information or three calendar days after the verbal notification.

3. Court-ordered treatment. Effective on the date of issuance or renewal of this contract on or after April 1, 2016, with respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, 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 notification will be provided within three business days of our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

C. Concurrent reviews

1. Nonurgent 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 business day of receipt of all necessary information. If we need additional information, we will request it within one 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 the earlier of 15 calendar days of the receipt of part of the requested information or 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 business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and we have all the information necessary to make a determination, we will make a determination and provide written notice to you (or your designee) and your provider within the earlier of 72 hours or one 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 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. Home health care reviews

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of the necessary

information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

4. Inpatient substance use disorder treatment reviews
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.

5. Inpatient substance use disorder treatment at participating OASAS-certified facilities
Coverage for inpatient substance use disorder treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified facility notifies us of both the admission and the initial treatment plan within two business days of the admission. After the first 28 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your inpatient admission.

6. Outpatient substance use disorder treatment at participating OASAS-certified facilities
Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 4 weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified facility notifies us of both the start of treatment and the initial treatment plan within two business days. After the first 4 weeks of continuous treatment, not to exceed 28 visits, we may review the entire outpatient treatment to determine whether it is medically necessary and we will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your outpatient treatment.

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 you 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.
- 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. Step therapy override determinations
You, your designee or your health care professional may request a step therapy protocol override determination for coverage of a prescription drug selected by your health care professional. When conducting utilization review for a step therapy protocol override determination, we will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

1. Supporting rationale and documentation. A step therapy protocol override determination request should include supporting rationale and documentation from a health care professional, demonstrating that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to you.
- The required prescription drug is expected to be ineffective based on your known clinical history, condition and prescription drug regimen.
- You have tried the required prescription drug while covered by us or under your previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- You are stable on a prescription drug selected by your health care professional for your medical condition, provided this does not prevent us from requiring you to try an AB-rated generic equivalent.
- The required prescription drug is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. Standard review. We will make a step therapy protocol override determination and provide notification to you (or your designee), and where appropriate, your health care professional, within 72 hours of receipt of the supporting rationale and documentation.

3. Expedited review. If you have a medical condition that places your health in serious jeopardy without the prescription drug prescribed by your health care professional, we will make a step

therapy protocol override determination within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, we will request the information within 72 hours for preauthorization and retrospective reviews, the lesser of 72 hours or one business day for concurrent reviews, and 24 hours for expedited reviews. You or your health care professional will have 45 calendar days to submit the information for preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For preauthorization reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours or one business day of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 24 hours of our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If we do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If we determine that the step therapy protocol should be overridden, we will authorize immediate coverage for the prescription drug prescribed by your treating health care professional. An adverse step therapy override determination is eligible for an appeal.

G. 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.

H. 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 include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a physician or (2) a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue.

1. **Out-of-network service denial.** You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating provider, but only when the service is not available from a participating provider. For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:
   - A written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-network referral; authorization denial.** You also have the right to appeal the denial of a request for a referral; an authorization to a nonparticipating provider when we determine that we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a utilization review appeal of an out-of-network referral; authorization denial, you or your designee must submit a written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition:
   - That the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
   - Recommending a nonparticipating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

I. First level; standard 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 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 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, mental health and/or substance use disorder services that may be subject to a court order, 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 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 business days of receipt of the information necessary to conduct the appeal. Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the appeal request.

   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 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.

J. Full and fair review of an appeal

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

K. Appeal assistance

If you need Assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017

Or call toll free: 1-888-614-5400
E-mail: cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX – EXTERNAL APPEAL

A. Your right to an external appeal
In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service is not medically necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal, you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered service under this contract; and
- In general, you must have received a final adverse determination through our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
    - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal.
    - You file an external appeal at the same time as you apply for an expedited internal appeal.
    - We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

B. Your right to appeal a determination that a service is not medically necessary
If we have denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you meet the requirements for an external appeal in paragraph "A" above.

C. Your right to appeal a determination that a service is experimental or investigational
If we have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external appeal in paragraph "A" above and your attending physician must certify that your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate
2. There does not exist a more beneficial standard service or procedure covered by us or
3. There exists a clinical trial or rare disease treatment (as defined by law)

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

1. A service, procedure or treatment that two 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 for current information as to what documents will be considered or acceptable)

2. A clinical trial for which you are eligible (only certain clinical trials can be considered)
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

D. Your right to appeal a determination that a service is out-of-network
If we have denied coverage of an out-of-network treatment because it is not materially different from the health service available in-network, you may appeal to an external appeal agent if you meet the two requirements for an external appeal in paragraph "A" above, and you have requested preauthorization for the out-of-network treatment.

In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

The physician must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

E. Your right to appeal an out-of-network preauthorization denial to a nonparticipating provider
If we have denied coverage of a request for an authorization to a nonparticipating provider because we determine we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service, you may appeal to an external appeal agent if you meet the two requirements for an external appeal in paragraph "A" above.

In addition, your attending physician must: certify that the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs; and recommend a nonparticipating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

For purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

F. Your right to appeal a formulary exception denial
If we have denied your request for coverage of a nonformulary prescription drug through our formulary exception process, you, your designee or the prescribing health care professional may appeal the formulary exception denial to an external appeal agent. See the **Prescription drug coverage** section of this contract for more information on the formulary exception process.

G. The external appeal process
You as the member have four months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. Your provider has 60 days from the receipt of the final adverse determination or from receipt of the waiver of the internal appeal to file an external appeal.

If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or us. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two 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; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within 72 hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If your internal formulary exception request received a standard review through our formulary exception process, the external appeal agent must make a decision on your external appeal and notify you or your designee and the prescribing health care professional by telephone within 72 hours of receipt of your completed application. The external appeal agent will notify you or your designee and the prescribing health care professional in writing within two business days of making a determination. If the external appeal agent overturns our denial, we will cover the prescription drug while you are taking the prescription drug, including any refills.

If your internal formulary exception request received an expedited review through our formulary exception process, the external appeal agent must make a decision on your external appeal and notify you or your designee and the prescribing health care professional by telephone within 24 hours of receipt of your completed application. The external appeal agent will notify you or your designee and the prescribing health care professional in writing within two business days of making a determination. If the external appeal agent overturns our denial, we will cover the prescription drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the nonformulary prescription drug.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of this contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing the research, or costs that would not be covered under this contract for noninvestigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

H. Your responsibilities

It is your responsibility to start the external appeal process. You may start 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 application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.