HealthNow New York Inc.

Looking Out For You

Health Maintenance Organization (HMO)
Point of Service (POS)
Preferred Provider Organization (PPO)
Exclusive Provider Organization (EPO)

Resolving Differences

Most problems can be resolved with a call to Customer Service. Unresolved problems can be addressed using the Grievance/Appeals and Use Management Appeals procedures.

- **Grievance and Appeal Procedure:** Unresolved complaints or requests to change contractual determinations that are not in regard to medical necessity determinations or experimental/ investigational determinations can be reviewed through the grievance and appeal procedure.
- **Medical Management Appeals Process:** We review adverse medical necessity determinations or experimental/investigational determinations through the Use Management appeals process.

The Grievance Procedure

Our grievance and appeal procedure ensures a timely review of:

- any unresolved complaints,
- your concerns regarding our policies and procedures, or
- any decision we have made regarding a service that you believe is covered or should be provided to you as part of your coverage.

Filing a Grievance

You may file a grievance concerning a determination we make regarding benefits. Examples of issues which may be reviewed under our grievance procedure include, but are not limited to:

- denial of a referral to a specialist,
- denial of coverage for a referred service,
- denial because a benefit is not covered according to the terms of your contract(s),

- denial of a benefit because it was provided by an ineligible provider or at an ineligible place of service, or
- determination that you were not a member of the health plan at the time services were rendered.

We will not take any discriminatory action against you because you have filed a grievance or an appeal.

The grievance process for chiropractic services are handled by the organization managing the benefits for these services.

Designating a Representative for the Grievance and Appeal Procedure

You may designate someone to represent you in the grievance and appeal procedure. If you designate a representative, we will communicate with you and your representative, unless directed otherwise. To appoint a representative, you must complete, sign, and return the Appointment of Authorized Representative Form. This is the HIPAA 2A form that you can download from the forms section of the web site or you may call Customer Service to request the form.

In cases involving urgent care, a health care professional with knowledge of your medical condition may act as your authorized representative without completing the Appointment of Authorized Representative Form.

Filing a Grievance

Any time we deny a referral or determine that a benefit is not covered under your contract(s), you will receive notification of our grievance procedures. If you disagree with our decision, you may file a written or oral grievance up to 180 days after you receive our original determination. Your grievance request should state (1) the name and identification number of the member for whom the benefit or referral was denied and (2) the facts and circumstances relating to the case. You may submit any oral or written comments, documents, records, or other information relevant to the grievance.

Telephone: Call Customer Service to initiate the grievance. When our offices are closed, you may notify us about your grievance by leaving a detailed message with our answering service. We will acknowledge the receipt of your oral grievance by phone within one business day of receipt of the message. We can communicate with non-English speaking members through our translator service.

Written: You may also send a written grievance to the Grievance Unit in the Customer Service department.

After You File a Grievance Under an HMO/POS Product

We will send you a notice of receipt of your grievance within 15 calendar days. This letter will include the name, address and phone number of the department that is handling your grievance. We may need additional information before we can review your grievance. If so, we will contact you. A Customer Service Representative who was not involved in the initial determination and who is not a subordinate of the initial reviewer will thoroughly research

the case by contacting all appropriate departments and providers. The Customer Service Representative will review all relevant documents, records and other information including any written comments, documents, records and other information you or your representative have submitted.

If the issues are of a clinical nature, they will be reviewed by a health care provider who was not involved in our initial determination and who has the appropriate training and experience in the field of medicine. Clinical matters would be those that require appropriate medical knowledge and experience to make an informed decision.

Notification of the Grievance Decision

In **urgent cases**, when a delay would significantly increase the risk to your health, a decision will be made and communicated to you by telephone within 48 hours after receipt of the grievance. You will also be contacted in writing within two business days of the notice by phone.

In cases involving requests for referrals or disputes involving contract benefits and all other non-urgent cases, a decision will be made and communicated to you as follows:

- Pre-service claims: In writing within 15 calendar days after receipt of the grievance.
- Post-service claims: In writing within 30 calendar days after receipt of the grievance.

Our response will include: the detailed reasons for our determination; the provisions of the contract, policy or plan on which the decision was based; a description of any additional information necessary for you to complete your claim and why the information is necessary; the clinical rationale in cases requiring a clinical determination; the process to file an appeal; and an appeal form.

PPO/EPO Members have a one level grievance procedure with the following timeframes for notification of the grievance decision:

Urgent cases:	72 hours
Pre-service:	30 calendar days
Post-service:	60 calendar days

The Appeal Process for HMO/POS — Next Steps When You Don't Agree With the Decision

If you are not happy with our decision about your grievance, you may file an appeal. Your request for an appeal should include any additional information (including written comments, documents, records or other additional information) you feel is necessary.

You have 60 business days from the time you receive the grievance determination to submit an appeal to us. You may submit your request for an urgent appeal verbally or in writing. For a non-urgent appeal, you may submit your written request in the form of a letter or you may use our appeal form. You will receive a copy of our appeal form with the grievance decision.

We will send you a notice of receipt of your appeal request within 15 calendar days. This notice will include the name, address and phone number of the individual who will respond to your appeal.

Who Reviews Appeals

Non-clinical matters will be reviewed by a panel from our Provider Relations, Customer Service, Health Care Quality Improvement and Use Management areas who were not previously involved in your grievance. If your appeal involves a clinical matter, it will be reviewed by a panel of personnel qualified to review clinical matters. This includes licensed, certified, or registered health care professionals.

At least one of the health care professionals reviewing your appeal will be a Clinical Peer Reviewer. A Clinical Peer Reviewer is a licensed physician or a licensed, certified, or registered health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Appeal Decision Timeframe

Pre-service (before service is provided)

- In urgent cases, a decision will be made and notice provided by phone within 24 hours after receipt of the appeal, followed by written notice within two business days of the telephone notice.
- For non-urgent pre-service claims, a written decision will be sent within 15 calendar days from receipt of the appeal.

Post-service (after service is provided)

- A written decision will be provided within 30 calendar days from receipt of the appeal.
- Our notification with regard to your appeal will include the detailed reasons for our determination, the provisions of the contract, policy, or plan on which the decision was based, and the clinical rationale in cases where the determination has a clinical basis.

Utilization Review

Utilization Review is a process used to determine if the services in question are or were medically necessary, experimental or investigational. Utilization review occurs when judgments are made regarding medical necessity and the provision of services or treatments.

All decisions are made by qualified clinical personnel. Denial notices will include the reason for their decision and if there are further appeal rights.

For questions about the Use Management review process, including Use Management decision making, please call us at the telephone number on the back of your identification card.

The utilization review and appeal process for chiropractic services, mental health and chemical dependency services is handled by the organization managing the benefits for these services.

Designating a Representative for You for Your Appeal

You may designate someone as your representative for your appeal. If you designate a representative, we will communicate with you and your representative, unless directed otherwise. To appoint a representative, you must complete, sign, and return the Appointment of Authorized Representative Form. This is the HIPAA 2A form that you can download from the forms section of the web site or you may call Customer Service to request the form.

If the case involves urgent care, a health care professional with knowledge of your medical condition may act as your authorized representative and does not need to complete the Appointment of Authorized Representative Form.

Initiating Utilization Review

You may request a utilization review by telephone or in writing by contacting the Customer Service department. The request should include the name and ID number of the member for whom the review is requested, along with the facts relating to the case. Our telephones are staffed Monday through Friday during normal business hours. If you call after business hours, you may leave a message on our confidential voice mail. We will contact you by telephone within one business day after receipt of your message.

Pre-service Claims

Pre-service claims are for procedures or treatments that require prior authorization. We will make a determination regarding your pre-service claim and provide notice by telephone and/or in writing to you or your representative and/or your health care provider within three business days after receiving all necessary information.

If all necessary information to render a decision has not been provided, we may give you an opportunity to submit the missing information. If so, we will notify you in writing within 15 calendar days after receipt of your claim of the specific missing information. We will allow you up to 45 calendar days from the date of our notice to provide the missing information.

If we receive all information requested, we will make a decision and provide notice by telephone and in writing within three business days of receipt of the information. If only partial information is received, we will make a decision and provide notice by telephone and in writing within 15 calendar days from receipt of the partial information. If we do not receive any information by the end of the 45-day period, we will make a decision and provide notice by telephone and in writing within 15 calendar days from the end of the 45-day period.

If you or your authorized representative fail to follow our procedures for properly filing a pre-service claim, we will notify you or your authorized representative (verbally or in writing within five calendar days after receipt of your claim) about the proper procedures for filing a pre-service claim. If the pre-service claim involves urgent care, we will notify you within 24 hours after receipt of your claim. We will only provide this notice if the following requirements are satisfied:

- The initial communication by you or your authorized representative is received by the Use Management area;
- The communication includes the name of the claimant;

- The specific medical condition or symptom is indicated; and
- A specific treatment, service or product is requested.

Concurrent Care Claims

Concurrent care claims involve continued or extended health care services or additional services for a member undergoing a course of continued treatment prescribed by a health care provider for a specific period of time or number of treatments.

For non-urgent concurrent care claims, we will make a decision and provide notice to you or your designee by telephone and in writing within one business day of receipt of all necessary information.

For urgent care claims, we will make a decision and provide notice to you or your designee within 24 hours of receipt of the claim. We are only required to provide notice to you or your designee within 24 hours if you made the request for an extension at least 24 hours before the scheduled expiration of the services.

If the request for an extension of care beyond the period of time or number of treatments approved was not provided at least 24 hours before the scheduled expiration of the services, we will make a decision and provide notice to you or your designee within one business day or after receipt of the necessary information or prior to the expiration of services.

If we are reducing or terminating course of treatment that was previously approved, we will provide notice and the right to an appeal prior to the reduction or termination. You will have 24 hours to submit your appeal. A decision will be made and notice will be provided within 72 hours or two business days after receipt of your appeal or at the end of the period to submit the appeal, whichever occurs first.

Notification of an approval of continued or extended concurrent care services will include the following:

- The number of extended services provided,
- The new total of approved services,
- The date the services are authorized to begin, and
- The date the next utilization review is scheduled to take place.

Urgent Care Claims

An urgent care claim is for medical care or treatment for which failure to make an expeditious decision could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment requested.

We will make a decision and provide notice by telephone and in writing to you or your representative within 72 hours or three business days after receipt of all necessary information, whichever is less.

If you fail to provide all necessary information, we will notify you about the missing information within 24 hours after receipt of your claim. You will have 48 hours to give us the missing information. We will notify you of our decision within 48 hours after receiving the missing information or by the end of the 48-hour period afforded you to provide the additional information if no information is provided.

Post-service Claims

A utilization review determination involving services which have already been provided will be made within 30 calendar days after receiving all necessary information.

If all necessary information is not provided, we may provide you with an opportunity to submit the missing information. If we allow the extension, we will notify you in writing within 30 calendar days after receipt of your claim of the specific missing information. We will allow you up to 45 calendar days from the date of our notice to provide the missing information.

If we receive any of the information requested, we will render a decision within 15 calendar days after receipt of the information. If no information is received, we will render a decision within 15 calendar days after the end of the 45 calendar day period.

If we fail to make a utilization review decision within the time frame above, it will be deemed an adverse determination subject to the internal appeals process.

Right to Reconsideration

In situations where there has been a denial of services as not medically necessary and we have not discussed the matter with the provider who recommended the services, procedure or treatment under review, the provider has the right to request a reconsideration of the denial. The reconsideration review shall occur within one business day of receipt of the request, except when the reconsideration request is for services already provided.

Use Management (UM) Appeals Process

You may receive a letter explaining that we have reached an adverse determination, meaning that we have decided that an admission, extension of a stay or other health care service is not medically necessary.

You have the right to appeal this decision, or appoint a representative to do this for you. Appeals are offered at one level internally. The only exception is if you receive an adverse determination on an expedited appeal, you may appeal the adverse determination as a standard appeal or an external appeal.

Your notice of an adverse determination will include the reasons for the determination including the clinical rational, if any, as well as instructions and timeframes on how to:

- Initiate a standard appeal;
- Initiate an expedited appeal;
- Request an external appeal; and

- Request a written statement of clinical rationale, including the clinical review criteria used.

If we fail to provide an internal appeal determination within the specified timeframe, the initial adverse determination will be reversed.

Requesting a Standard Appeal (Level I)

Once you receive our adverse decision, you or someone you designate may request an appeal using our standard appeals process. You have 180 calendar days from the date of receipt of our initial adverse determination to request an appeal. The notice we send you will explain why we made the adverse decision and include the telephone number you can call to request an appeal.

Once we receive the appeal request, we'll obtain a copy of the medical record. We will let you know that we received the appeal request by sending you, or your representative, an acknowledgement letter within 15 calendar days of the date we receive the request.

Our Medical Director, or a physician consultant (who is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review), will review your records. The reviewer will not have been involved in the original decision, and will not report to the person who made the initial determination.

Notified of the Appeal Decision

We will provide a written decision to you, your representative, and health care provider where appropriate, within two business days of the decision. Notification will not be later than 30 calendar days after receipt of your appeal for pre-service claims or 60 calendar days for post-service claims.

If we do not change our original decision, we will give you the medical reason for the decision. When you receive our final adverse determination, you may request an external review.

The notice of final adverse determination regarding your appeal will include:

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol or similar criterion was used in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used will be provided.
3. The provisions of your policy, contract or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. Our contact person and his/her telephone number.
6. Your coverage type.

7. The name and full address of our utilization review agent.
8. The utilization review agent's contact person and his/her telephone number.
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment or the developer/manufacturer of the health care service.
10. A statement that you may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that you are entitled to receive, on request and free of charge:
    a. Reasonable access to and copies of all documents, records and other information relevant to the claim.
    b. A copy of each internal rule, guideline, protocol or similar criterion that was used to make the determination on appeal.
    c. The name of any medical or vocational experts whose advice was obtained in connection with the determination without regard to whether the advice was relied upon in making the determination.
12. The information supplied by the Commissioner of the Insurance Department describing the external appeal process.
13. A statement that you may have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

What an Expedited Appeal is and When You Can Request One

Expedited or immediate appeals are available to you if you want to appeal an adverse determination that involves:

- continued or extended health care services;
- procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her health care provider; or
- a situation where your health care provider believes an immediate appeal is needed.

This does not apply in situations involving a retrospective adverse determination.

We encourage physicians and specialty providers to share information by telephone and/or fax. You, or the person acting for you, can contact both the nurse and physician to talk about the appeal. You can do this within one business day of the date we receive the notice of expedited appeal.

We will make a decision and call you about the expedited appeal within two business days after receipt of all necessary information or within 72 hours, whichever is less. We'll also send you written notice within 24 hours of the decision.

The notification will include the information referenced above for a final adverse determination.
When you receive our final adverse determination on the Level I expedited appeal, you may request a standard appeal or an external review.

Your grievance/appeal and utilization appeal rights

On written request and free of charge, you have the right to:

- copies of all documents, records, and other information relevant to your claim, as well as the name of each medical or vocational expert whose advice was used in connection with your claim.
- an explanation of any scientific or clinical judgment for the determination to deny your claim that applies the terms of your contract, policy or plan to your medical circumstances.
- a copy of each rule, guideline, protocol or similar criteria that was used to make the determination to deny your claim.

You may have the right to bring a civil action under the Employment Retirement Income Security Act of 1974 (ERISA) §502 (a) if you file an appeal and your request for coverage or benefits is denied following review. You have this right if your coverage is provided under a group health plan that is subject to ERISA.

The External Appeals Process

- If you receive a final adverse determination, you have the right to an external appeal of certain coverage determinations made by us. Final adverse determinations are issued at the end of the Level I appeal. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by New York State, and may not have any affiliation with any health insurer, health maintenance organization (HMO), medical facility, member or health care provider associated with the appeal.
- **Expedited external appeals**: You may have the right to an expedited external appeal if your doctor can attest that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the time frames for standard external appeals. The External Appeals Agent will make a decision within three days for expedited appeals.
- Every reasonable effort will be made to notify you and the plan of the decision by telephone or fax immediately. This will be followed by a written notice.
- **Standard external appeals**: The External Appeals Agent will make a decision within 30 calendar days after receiving your completed application for appeal. Five more business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by the plan, the plan will have three additional business days to reconsider or affirm its decision. You and the plan will be notified within two business days of the external review agent's decision.
- In general, you may not request an external appeal unless we have issued a final adverse determination of your request for coverage. Final adverse determinations are issued at the end of the first level internal utilization review appeal process. You may ask us to agree to an external appeal even though you have not completed the internal appeal process and have not obtained a final adverse determination but we have no obligation to agree to your request. If we do agree, we will send you a letter stating that we have agreed to an external appeal even though you have not completed the internal appeal process.

Services Eligible for an External Appeal

To be eligible for external appeal, the first level final adverse determination must be based on a determination that the requested service is not medically necessary and the service would otherwise be covered under the member's contract, or that the requested service is experimental or investigational. You do not have the right to an appeal of any other determinations, even if those other determinations affect your coverage.

Denial Involving Medical Necessity

You may ask for an external appeal if a requested service has been denied because it has been determined to be medically unnecessary. If the requested service is to be provided by a hospital, public health center, diagnostic and treatment center, or other health care facility, the facility must meet either of these criteria:

- the facility must be licensed in the state of New York; or
- must participate with a BlueCross BlueShield Plan in another state or have a reciprocal agreement with the local plan.

If the facility does not meet either of these criteria, you may request an external appeal only if we have referred you to the facility, or have preauthorized services provided by the facility.

Experimental or Investigational Treatment Denials

Your attending physician must certify that you have a life-threatening or disabling condition or disease when you request an external appeal for experimental or investigational treatment. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity. Additionally, your attending physician must certify that:

- standard health services or procedures have been ineffective or would be medically inappropriate in treating your life-threatening condition or disease; or
- a more beneficial standard health treatment covered by the plan does not exist and;
- the recommended health service or procedure (including off-label usage of a pharmaceutical product) is likely to be more beneficial to you than any covered standard health service or procedure based on at least two documents from the available medical literature.

Your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease to recommend experimental or investigational treatment.

Clinical Trials

To request an external appeal regarding clinical trials, your attending physician must certify that you have a life-threatening or disabling condition or disease as described under experimental or investigational treatment. Additionally, he or she must certify that a clinical trial for your condition exists and that you are eligible to participate in it.

The clinical trial you are requesting coverage for must be peer-reviewed, then reviewed and approved by a qualified Institutional Review Board and approved by one of the following:

- the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration, or the Department of Veterans Affairs;
- an organization that has been identified by the NIH as a qualified nongovernmental research organization; or
- an Institutional Review Board of a facility that has a multiple project assurances approved by the Office of Protection from Research Risks of the NIH.

The particular service being appealed must be otherwise covered under the member's contract.

After an External Appeal is Requested

After you, or your representative, or your attending physician applies for an external appeal, an independent External Appeal Agent will review your appeal and make a final determination based on the circumstances of your case.

The External Appeal Agent's decision is final and binding on both parties—your health insurance carrier (us) and the patient (you). In the event that the External Appeal Agent rules in our favor, we will not cover the requested service. If the External Appeal Agent decides in your favor, we will cover the service as follows:

- For services denied as not medically necessary, we will treat the services as medically necessary and provide coverage subject to all other conditions of your coverage plan.
- For services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the costs you incur for the services, subject to all other conditions of your coverage plan.
- For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of your coverage plan. Our coverage doesn't include the cost of the drugs or devices when those items are part of the clinical trial.

Request an External Appeal

You may obtain an external appeal application from the State Insurance Department or by contacting us. We will send an external appeal application to you when we have made a final adverse determination that is subject to external appeal. The application will provide clear instructions for completion.

To request an external appeal application from the New York State Insurance Department, please contact them at:

Web site:	www.ins.state.ny.us
Telephone:	1-800-400-8882
Mail:	New York State Insurance Department One Commerce Plaza Albany, NY 12257

You must file your application for an external appeal with them within 45 calendar days after receiving a final adverse determination of our Level 1 appeal process or within 45 calendar days after receiving a letter from us waiving the internal utilization review appeal process. We do not have the authority to grant extensions of this deadline.

Additional internal plan appeals may be available to you. Regardless of whether you participate in additional internal plan appeals, an application for external appeal must be filed with the New York State Department of Insurance within 45 calendar days from your receipt of the notice of final adverse determination from a Level 1 internal plan appeal to be eligible to be reviewed by an external appeal agent.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 calendar days from your receipt of the final adverse determination from the Level 1 internal plan appeal. You (and your doctors) must sign an appropriate authorization to release all pertinent medical information concerning your medical condition and request for services.

If you have any questions, please call Customer Service.

Quality of Care Access Review

If you are concerned about the quality of your care or timely access to a provider, you have the right to ask us to look into this. We closely track all complaints. If we receive similar complaints from our customers about a provider during a certain time period, we address those issues with the provider. This is our informal process.

We also have a formal process. At your request, we will investigate your concern by requesting records or other documentation. Our Medical Director reviews this information. If necessary, our Medical Director will meet with the provider to discuss the concern. To express this type of concern, call Customer Service.

We will send you a letter explaining the complaint process and give you a number to call if you wish to file a formal complaint. It also explains the appeal process if you disagree with the way our staff handles your concerns.

Unresolved Disputes

We always recommend that you follow our grievance or utilization review process to remedy any issues concerning your coverage. If you are not satisfied with any health plan decision, you have the right to contact the New York State Insurance Department or New York State Department of Health (DOH). The addresses and telephone numbers for these agencies are:

New York State Department of Health
Office of Managed Care
Empire State Plaza
Corning Tower Building
Albany, NY 12237

DOH Hotline 1-800-206-8125

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257

1-800-342-3736

Member Rights

As a member, you have rights and responsibilities that will help you make the most of your health benefits. These rights range from being treated with respect and dignity, to confidentiality of your medical records and having the chance to voice complaints or appeals about the health plan or your care. You can review the list in its entirety on our web site or contact Customer Service for a paper copy.

Planning in Advance

The New York Health Care Proxy Law allows you to appoint someone you trust (e.g., a family member or close friend) to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes.

Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own.

You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. The Health Care Proxy form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

Information about the Health Care Proxy and forms are available from your health care provider. You can also find information on the New York State Department of Health web site at www.health.state.ny.us.

Additional Information Available on Request

Many of our customers have questions about our company, our procedures and the health care coverage options we offer. The following is a list of information that's available to you upon request:

- The names, business addresses and official positions of the officers and board of directors of the health plan;
- A copy of our most recent annual certified financial statement, including a balance sheet and summary of receipts and disbursements;
- Copies of our individual direct payment contracts;
- Information related to consumer complaints as reflected in the Annual Consumer Guide published by the New York State Insurance Department;
- Procedures for protecting the confidentiality of your medical records and membership information;
- A description of our Quality Assurance Program;
- A description of how determinations are made about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

- The specific written clinical review criteria relating to a particular condition or disease (this request must be in writing);
- A copy of our written application procedures and minimum qualification requirements for providers to be considered for participation with our plan;
- Information about specific individual provider affiliations with participating hospitals;
- Information on how we determine the usual and customary or reasonable charge. This includes the percentile upon which the schedule is based. This also includes the specific amount of reimbursement for a particular elective surgery or treatment; and
- For members with prescription drug coverage, information about whether a specific prescription drug is covered under your contract(s). You also have the right to review our prescription drug formulary. A prescription drug formulary is a list of quality, cost-effective medications that, if prescribed by your physician, will be covered under your prescription drug rider.

Physician Reimbursement

One of the ways we can serve you is to support the doctors who care for you. We support doctors in several ways, including sharing information about health-care treatments, helping them to coordinate quality care and reimbursing them fairly for the care they provide. We use several widely accepted methods of paying your doctor for the care he or she provides. Here's how we do it:

Resource-Based Relative Value Scale – We use a method called resource-based relative value scale to price medical procedures based on the relative cost of providing a service. This scale considers the time a doctor spends on a procedure, how much it costs to run a medical practice and the cost of medical malpractice insurance. The scale also adjusts reimbursement based on how costs vary among different geographic locations. The federal government uses this method to pay doctors across the nation.

Capitation – We pay providers a fixed dollar amount in advance, regardless of the number of services they provide to a member. We establish this payment on a per-month basis.

BlueCard® Program – The BlueCross BlueShield Association, a national organization of independent BlueCross BlueShield plans, developed this program to help pay your claims when you receive care from an out-of-area provider who participates with his or her local BlueCross and/or BlueShield plan. The BlueCard Program processes your claims using the payment agreement the doctor has with his or her local plan. The local plan pays the doctor directly, subject to the copay or deductible and coinsurance provisions of your contract.

Agreed-Upon Amount – A negotiated rate agreed to by a medical facility and a health plan.

Diagnosis-Related Grouping – A method of reimbursing hospitals for providing inpatient hospital care. It takes into account both the diagnosis and the length of time a patient usually stays in the hospital for that particular diagnosis.

Protected Health Information

We work hard to protect confidential information. We adhere to corporate security/privacy policies and procedures for oral, written and electronic data. All employees undergo privacy awareness training and are required to use appropriate physical, administrative and technical security mechanisms.

On enrollment, you received the Notice of Privacy Practices, which describes how medical information about you may be used and disclosed. The Notice of Privacy Practices addresses the right to approve release of information, the use of such authorizations, access to medical records and information for employers. You may also view the Notice of Privacy Practices on our web site.