# MEMBER INFORMATION HANDBOOK

## AND DISCLOSURE STATEMENT

How to Use Your PPO or
High Deductible PPO Benefits

## A Special Message to Members

Thank you for selecting CDPHP Universal Benefits,® Inc. (CDPHP UBI) for your health coverage. We are glad to have you as a member and are committed to providing you with quality services that are easy to use.

This member handbook and disclosure statement will help you understand your coverage. Please take some time to review it. Although this handbook contains a great deal of information about CDPHP UBI, it is only an overview of how to use your benefits. For more details, please refer to your membership certificate and any riders detailing special added benefits.

If you have any questions about your coverage, please call the CDPHP UBI member services department at (518) 641-3140 or 1-877-269-2134. Member services representatives are available Monday through Friday, 8 a.m. to 8 p.m., to assist you. You may also visit a member service representative at CDPHP UBI, 500 Patroon Creek Boulevard, Albany, NY 12206, between 8:30 a.m. and 4:30 p.m. Please call ahead for an appointment so you will not have to wait. In addition, members can write to us at the above address, or visit us on the web at **www.cdphp.com**.

Again, thank you for joining CDPHP UBI. We look forward to serving you.

## In-Network vs. Out-of-Network

Each time you access care under the PPO plan or the High Deductible PPO (HDPPO) plan, you have a choice. You may elect to get in-network care from a CDPHP UBI participating practitioner or provider, or you may choose to receive services from practitioners and providers not in the CDPHP UBI network. Your out-of-pocket expenses may be lower, however, when you seek care within the CDPHP UBI network.

Please refer to the benefit materials provided to you for specific details on your coinsurance, copayment, and deductible levels. These vary according to the plan purchased by your employer group.

## Your Deductible

CDPHP UBI urges you to keep track of your out-of-pocket medical expenditures so you know when you have met your deductible. It is your responsibility to assure that all providers of care (whether in-network or out-of-network) file claims for service to us at P.O. Box 66602, Albany, NY 12206-6602. This will enable us to enter them into our system and apply them toward your deductible.

Please be aware that only eligible and verifiable out-of-pocket expenses are credited. The expenditures must be for services that are covered by your benefit plan, e.g., physician, hospital, and diagnostic fees. The claims must reflect the care provided and amounts charged for services rendered to you and/or your dependents covered by your plan.

It is also advised that you retain all receipts for health expenses, including any copayment or coinsurance amounts. These will enable you to document payments that should be credited to your deductible or maximum. Additionally, if you have a health savings account (HSA), you may need this information to file for reimbursement and/or prepare your income taxes.

As a member of CDPHP UBI, you can log in securely at www.cdphp.com and check to be sure we have received claims filed on your behalf, and credited these to your deductible as appropriate.

If you have a flexible spending account (FSA), health reimbursement arrangement (HRA), or health savings account (HSA) through CDPHP UBI, please refer to www.cdphp.com to learn more. After logging in securely, click on "Health Funding Arrangements" to see the details of your account.

If you have verifiable documentation of eligible expenditures that for any reason remain unreported, please make a copy for your files and send the originals to the Member Services Department at 500 Patroon Creek Boulevard, Albany, NY 12206-1057, along with a note indicating your name and member ID number.

## The CDPHP UBI Network

The PPO and HDPPO do not require that a primary care physician (PCP) direct your care. You have the freedom to seek specialty care without a referral.

Still, you should have a personal physician who provides and coordinates your health care. To have services covered at the in-network level of care, select a physician in the CDPHP UBI network by using Find-A-Doc at www.cdphp.com or the *Directory of Participating Practitioners and Providers.* Both Find-A-Doc and the directory supply information about our physicians' certification and indicate whether a particular practitioner is accepting new patients. You can also call member services for more information on a doctor's qualifications.

Primary care physicians in the CDPHP UBI network must be available 24 hours a day, seven days per week, or supply coverage for those times when they are not available. If you have an urgent medical need after business hours, you may call your physician's office for direction.

Your group may have coverage that extends your in-network options outside the CDPHP UBI service area. If you have this rider, the front of your card will display a logo for the national network. It is important to remember, however, that within our service area, your care must be delivered by a CDPHP UBI practitioner in order to be considered in-network. You can determine which providers are considered in-network within a geographic area by using the Find-A-Doc feature at www.cdphp.com.

## Seeking Prior Authorization

Certain services require that you obtain prior authorization from CDPHP UBI. This means that CDPHP UBI needs to review your treatment plan before we agree to cover the care. We need to determine that the care is medically necessary, appropriate, and a covered benefit. Services that require prior authorization include:

**Whether in-network or out-of-network**

- Bariatric (gastric bypass) surgery, which needs to be performed within a designated network
- Cardiac rehabilitation beyond 36 sessions

- Speech therapy beyond the first visit
- Skilled nursing facility admissions
- Home care benefits
- Durable medical equipment, orthotics, and prosthetics exceeding $500, and repairs or replacement of durable medical equipment
- Organ transplant services
- Covered non-emergency transportation
- Medically necessary non-emergency, non-airborne, inter-facility transportation

**Out-of-network**

- Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
- CAT scans and PET scans
- Nuclear medicine studies

For more information on services that require prior authorization, please see the Prior Authorization Policy in the secure member portal at www.cdphp.com. It is your responsibility to be sure that prior authorization is in place before receiving one of the above-named services. You or your practitioner may call the CDPHP UBI resource coordination department at (518) 641-4100 or 1-800-274-2332 to arrange for prior authorization. Failure to obtain such prior authorization will result in you being responsible for additional payments along with the applicable copayment, deductible, and/or coinsurance. See your membership certificate for additional details.

After review, CDPHP UBI will notify you and your practitioner as to whether the care is eligible for coverage.

## Filing a Claim

If you have met your deductible and paid out-of-pocket for a covered service, you should file a claim with us to be reimbursed. To file a claim, send the itemized doctor's bill and a receipt (if you have paid the bill) to CDPHP UBI, 500 Patroon Creek Boulevard, Albany, NY 12206-1057. Many doctors' offices supply standard claim forms, or you can download a CDPHP claim form from www.cdphp.com. Claims should be sent within 120 days of receiving care. Payment will be sent directly to the provider when the provider is in our network. If the provider does not participate with us, reimbursement will be sent directly to the member.

## Member Services

CDPHP UBI has a dedicated team of member service professionals to help you. They are available Monday through Friday, 8 a.m. to 8 p.m., at (518) 641-3140 or 1-877-269-2134. Member services representatives can explain benefits and policies, accept complaints and appeals, and help resolve bills. Changes to your address or telephone number may be completed online at www.cdphp.com.

To help non-English speaking members, CDPHP UBI's member service staff includes Spanish speaking representatives and CDPHP UBI makes available a telephone translation service for other languages. The telephone system also includes a line for those equipped with a TTY/TDD (teletypewriter/telecommunications device for the deaf) system. If you are a TTY/TDD user and wish to contact CDPHP, please use 1-877-261-1164.

For members who prefer to do business via the Internet, we offer the convenience of using www.cdphp.com at any time of the day or night. This secure interface enables you to register a change of address, order a new ID card, or check the status of claims.

## Communication

We keep in touch with you on a regular basis. After you enroll, you should receive:

- Membership certificate
- Member handbook
- CDPHP UBI ID card
- Member newsletters

Please hold on to these materials and refer to them before seeking care. In addition to these materials, we will often send you other materials that relate to your coverage. Read these materials carefully and keep them for future use.

A special benefit of CDPHP UBI is a free quarterly member newsletter that gives you regular updates on your benefits. It also includes tips to help you stay healthy and includes our schedule of free wellness programs, which are open to all of our members.

At times, CDPHP UBI may need to change your benefits. This could include adding additional coverage or terminating a benefit or service. In each of these cases, members will be notified by mail and/or in the next quarterly member newsletter. If your employer changes benefit plans you will receive a new membership certificate by mail.

CDPHP UBI also will make every attempt to provide you with the most accurate list of participating practitioners and providers as possible. However, since the Plan is growing rapidly, the list of participating practitioners and providers can change often. The printed *Directory of Participating Practitioners and Providers* is updated annually and is available upon request from member services. For the most up-to-date listing at any time, please use the Find-A-Doc feature at our website at www.cdphp.com.

## Utilization Management

The CDPHP UBI utilization review (UM) program has been established to monitor the utilization of services and the allocation of health care provided. This coordination is accomplished by planning, organizing, and directing in-network health care services. For members with complex medical or social needs, one-on-one case management with an experienced nurse or social work case manager is available to help the member coordinate care.

Utilization review is conducted to determine whether health care services recommended and/or provided to a member are medically necessary. Reviews may incorporate several aspects of medical or behavioral services, including case management, pharmacy, clinical coding and auditing, as well as utilization management. Services that can cause or result in under- or excessive resource utilization are identified and reviewed. There is special concern for under-utilization. CDPHP UBI's system provides for the formal assessment of the medical necessity of care, the judicious use of resources, the appropriate delivery of care and the use of ancillary services. The system is designed to promote the use of best clinical practices on a prospective, concurrent, and retrospective basis and utilizes appropriate community resources to augment available services. UM decision making is based only on appropriateness of care and services and the terms and conditions of the member's certificate of coverage. CDPHP UBI does not compensate, nor does it offer incentives as encouragement, for denials made by CDPHP UBI employees or utilization review agents. Practitioners, providers, and employees who make utilization-related decisions are made aware of special concerns regarding the risks of underutilization.

This UM program is evaluated annually and enhanced as required to reflect new policy development, new technology, new legislation, and new initiatives.

### *How to Obtain Information About the UM Process and Authorization of Care*

Utilization management staff are available to assist you with any questions or concerns you may have regarding the UM process and the authorization of care. You may speak with a UM staff member by calling (518) 641-4100 or 1-800-274-2332 during normal business hours, Monday through Friday, 8 a.m. to 6 p.m. Any follow-up calls by the UM staff will be made during normal business hours unless otherwise agreed upon. On-call UM staff can be reached for urgent issues after hours, weekends, and holidays by calling the same phone numbers and advising the answering service of your need to speak with a UM staff member.

## Quality Management

Quality is more than a buzzword at CDPHP UBI; it's the backbone of our health plan. Our quality management program is a comprehensive, proactive program that provides the required processes and structure to define, evaluate, monitor, and assist in assuring that medically appropriate and cost-effective care and service are provided to members of CDPHP UBI. Acute and chronic diseases, preventive health, mental health, and prenatal care, as well as the needs of the under-served are considered. In addition, aspects of service to employers, practitioners, providers, and members are considered.

## Specialists

If you wish to see a specialist and receive this care at the in-network level, seek care from a participating specialist. If the specialty care you need is medically necessary and no participating specialist is available you may be covered for services from a non-participating specialist at the in-network level. This would require written approval by a CDPHP UBI medical director. Either way, you will be responsible for your usual out-of-pocket obligations as listed in your Schedule of Benefits.

Remember, CDPHP UBI extends you the privilege of seeing participating or non-participating specialists without obtaining a referral. In the case of a non-participating specialist (unless services are unavailable from a participating specialist), you would be responsible for any difference between the specialist's actual charge and the amount paid by CDPHP UBI.

## Pharmacy

If your coverage with CDPHP UBI includes a prescription drug rider, your prescriptions must be written by a duly licensed health care practitioner and filled at a network pharmacy. CDPHP UBI participates with Caremark, a national network that includes virtually all major chain stores and most independents.

What you pay for your prescription will depend upon the specific rider purchased by your group, whether the drug is a brand-name or generic, and its formulary status. The formulary is a list of drugs that is developed by the CDPHP pharmacy and therapeutics (P & T) committee, a group of community physicians and pharmacists. The P & T commitee meets at least five times a year to evaluate new drugs and drug classes for their safety, efficacy, and overall therapeutic and cost value.

The most common prescription benefit is the three-tier plan (e.g., $10/$25/$40). Drugs that are in the first tier require the lowest copayment. Tier 2 is the middle copayment, and Tier 3 is the highest copayment. Excluded drugs are generally not covered. A list of excluded drugs can be found in the forms section of www.cdphp.com under "Prescription Forms and Lists."

With a generic-only plan, you have coverage for all generic drugs. If your pharmacy benefit calls for a coinsurance, you will pay a percentage of the total drug cost.

Prescribing practitioners may file a medical exception request for you if a drug prescribed for you is excluded from the formulary, requires prior authorization, or has not yet been reviewed by the CDPHP P&T Committee. A determination regarding the medical exception request will be forwarded to both you and your health care practitioner.

Please be aware that other prescribing limitations (such as quantity limits, prior authorization, dose optimization, and step therapy) may also apply, no matter which prescription drug rider you have with CDPHP UBI. Covered drugs, formulary status, any applicable quantity limitations, prior authorization, step therapy, and dose optimization criteria are all subject to change. For further information about your drug benefits, call Caremark directly at 1-888-292-6330. That line is open 24 hours a day.

Rx Corner at www.cdphp.com is also a good source of in-depth information. It provides details about the convenient mail order service and includes a link to the Caremark website, where you can perform a national search for pharmacy locations and see specific details about our formulary.

Note: With the High Deductible PPO plan, all covered pharmacy costs are subject to your deductible. Until you meet your deductible, you will need to pay for all prescriptions out-of-pocket, but these expenses are applied to your deductible and out-of-pocket maximum. Participating pharmacies will automatically forward claims for your eligible drug expenditures to us so we can track them.

## Dental Benefits

Your employer group may have purchased dental coverage that is administered by Delta Dental of New York. If so, you will receive a separate dental ID card to use when going for routine preventive and restorative dental care. Please refer to that card for the number to call with questions on your dental benefits. To find out if your dentist participates with Delta Dental, go to www.deltadental.com. You are also encouraged to register at that site so you can track your dental claims and benefits.

Please note, treatment of accidental dental injuries will continue to be covered by your medical insurance. Use your CDPHP UBI ID card and visit a CDPHP UBI-participating dental provider for such care. To locate a dentist in the CDPHP UBI network, use Find-A-Doc at www.cdphp.com.

## Technology Assessment

CDPHP UBI systematically evaluates the inclusion of new technologies and the new applications of existing technologies as covered services in a timely manner. Your insurance benefit provides coverage only for therapies that have been shown in the scientific medical literature to be safe and effective. The CDPHP UBI technology assessment process assures that coverage will be available when evidence of safety and effectiveness exists.

CDPHP UBI provides benefits for medical, behavioral health, surgical, or other treatments, devices, procedures, techniques, and pharmacological therapies after consideration of all of the following: 1.) has received approval from the FDA or other appropriate regulatory agency where required, 2.) improves health outcomes at least as well as existing technologies, 3.) is not cosmetic and is required for reasons other than convenience, 4.) provides greater benefit than currently available therapies; 5.) safety and effectiveness has been documented in scientific studies.

A review of scientific literature comparing the new technology to current technology as well as care-specific reviews will be conducted by the CDPHP medical technology assessment team or a CDPHP medical director using up-to-date information, including but not limited to evidence based medical literature, board certified consultants, physician workgroups, professional societies, and government agencies.

Drugs that are new to the medical community are reviewed and discussed by the CDPHP pharmacy and therapeutics committee.

## Hospitalization

Out-of-network hospitalization must be pre-authorized by CDPHP UBI (except in an emergency). Failure to pre-authorize will result in you being responsible for additional payments along with the applicable copayment, deductible, and/or coinsurance. See your membership certificate for additional details.

# Behavioral Health Benefits

CDPHP UBI members are entitled to behavioral health benefits. This includes both mental health and substance abuse/chemical dependency services.

If you need information about your behavioral health care benefits or want to request a service, simply call 1-888-320-9584. This toll-free number also appears on your member ID card.

You will be connected to an experienced behavioral health specialist who will ask you a few questions and advise you regarding the types of services that are appropriate for you. The behavioral health specialist will give you all the information you need to schedule a convenient appointment with a psychiatrist, counselor, or other behavioral health clinician.

The services you receive will be subject to any deductible, copayment or coinsurance, and preauthorization requirements indicated by your membership certificate.

## Emergency Care

As a member of CDPHP UBI, you have the security of knowing that your coverage includes medical emergencies worldwide. In order to avoid confusion, however, it is essential that you understand your coverage for emergency health services.

CDPHP UBI defines a medical emergency as a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; or
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

You should go directly to the emergency room, call 911 or the appropriate emergency response number, or an ambulance if the situation is a medical emergency as defined above.

CDPHP UBI does not cover visits to the emergency room for non-emergency services. If you use the hospital emergency room to seek care for a condition that is not an emergency, you can expect the claim to be denied, and you will be responsible for payment.

## Students Out-of-Area

Out-of-area benefits for covered students work the same as they do for any other member. Here are some points to remember:

- If an emergency occurs, the student should simply dial 911 or go directly to the hospital. Emergency room visits are covered at the in-network level (subject to any deductible, coinsurance, or copayment) as long as the situation is a true medical emergency as defined above.
- Our PPO and High Deductible PPO plans provide out-of-network coverage, but the most cost-effective option is generally to receive care from a network practitioner.
- It is a good idea for the student to seek advice and direction from the CDPHP UBI resource coordination department at 1-800-274-2332 before seeking non-emergency care out-of-network. This may help you avoid an unexpected medical bill.

# Dependent Coverage

To be eligible to enroll as a family dependent, an individual must be the spouse and/or dependent of the subscriber. Dependents include:

- A natural child under the age of 26. There is no requirement that the child be financially dependent upon you, living in your household, enrolled as a full-time student, or unmarried. Coverage lasts until the end of the month in which the child turns 26 years of age.
- A legally adopted child; a stepchild dependent upon you; a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

- A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order, if unmarried. Coverage lasts until the end of the month in which the child turns 26 years of age.
- Any unmarried dependent child, regardless of age, who is incapable of self- sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which he or she would otherwise have been terminated. The child's disability must be certified by a physician. You must file an application requesting that the child remain on your family plan. We have the right to check whether a child is and continues to qualify.Note: Children-in-law (spouses of children) and grandchildren are not covered.

Coverage is sometimes extended to age 29 through a rider. Please check your membership certificate and your riders to verify the details of this coverage.

Any addition or deletion on your original dependent application must be made in writing to CDPHP UBI by using an Application/ Change Form indicating a change of status. This must be received by CDPHP UBI within 30 days from the date of marriage, divorce, birth, adoption, etc., in order for coverage to be extended or terminated for dependents. These changes should be submitted through your employer.

## Member Confidentiality

CDPHP UBI considers the confidentiality of member information extremely important. To maintain member confidentiality, CDPHP UBI has instituted many procedures including the following:

- A notice of privacy practices is provided annually which details the necessary uses and disclosures of member information and rights with regard to member information.
- As required by the U.S. Department of Labor's ERISA claims regulation, upon request members are provided with all documentation free of charge.
- Medical records are the property of the practitioner or provider. Members may access their medical records directly from their practitioners or providers.
- All CDPHP UBI employees sign confidentiality agreements at the time of employment.
- Access to the CDPHP UBI building is limited through the use of an electronic security system.
- All members of CDPHP UBI committees sign a confidentiality agreement that affirms the confidential nature of both member and practitioner or provider information shared within those committees.
- CDPHP UBI will release protected health information only to the member who is the subject of the information, someone authorized to act on the member's behalf, subjct to a valid authorization, or as permitted/ required by law.
- CDPHP UBI limits employees' system access to protected health information in accordance with employees' job function and responsibilities (role-based access).
- Member services personnel verify member name, address, telephone number, and CDPHP UBI identification number prior to releasing any information to callers.
- CDPHP UBI protects information on its electronic website through multiple security levels.
- CDPHP UBI removes all member identifiable information when initiating an external peer review for clinical decisions (not applicable to external appeals).
- CDPHP UBI verifies that a legally sufficient authorization is present prior to sharing protected health information with external entities.
- CDPHP UBI assists in obtaining a signed authorization from a member if necessary, to receive medical records from a non-participating treating practitioner or provider.
- CDPHP UBI evaluates the confidentiality of medical record documentation at primary care practices and other practitioner offices as part of its periodic medical record audits.

## How CDPHP UBI Doctors are Paid

CDPHP UBI participating practitioners are paid in a variety of ways, including discounted fee-for-service. Discounted fee-for-service is a form of payment in which the practitioner receives a specific fee for a specific service. The fee is generally discounted based on a prearranged fee schedule agreed upon by the practitioner and CDPHP UBI. CDPHP UBI uses this payment system so that our members benefit from lower health care costs.

The primary reimbursement method for hospitals is a set negotiated fee for the services rendered. For some very specialized services, such as organ transplants, a global rate may be negotiated which includes all related services—such as organ procurement, physician services, and facility services. Another method used sometimes involves a discounted fee for service, with the hospital's charges discounted by a predetermined percentage.

Under no circumstances will these financial arrangements influence your receipt of quality, medically necessary health care services.

### You May Get an EOB

You will receive an explanation of benefits (EOB) in the mail in the event that you owe a coinsurance, deductible, or other outstanding payment for care that is denied or covered in part. You may also receive an EOB, as required by law, in some circumstances where you have no payment obligation. The EOB is not a bill, but it will inform you of the status of your claim. Your provider should bill you for the amount you owe.

## Members' Rights and Responsibilities

CDPHP UBI believes that members have the following rights and responsibilities with respect to their health coverage:

### Members' Rights

1. You have the right to receive information about CDPHP UBI, its services, practitioners and providers, and members' rights and responsibilities.
2. You have a right to be treated with respect and recognition of your dignity and right to privacy.
3. You have a right to participate with practitioners in making decisions about your health care.
4. You have a right to a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
5. You have a right to obtain from a practitioner complete, current information concerning your diagnosis, treatment, and prognosis, in terms you can reasonably be expected to understand. If appropriate, this information should be made available to another person acting on your behalf.
6. You have the right to receive from a practitioner the information you need to give informed consent prior to the start of any procedure or treatment.
7. You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
8. You have the right to formulate advance directives (such as naming a health care proxy form and living will) about your care.
9. You have a right to voice complaints, grievances, or appeals about CDPHP UBI or the services it provides.
10. You have a right to make recommendations regarding the CDPHP UBI member rights and responsibilities policies.

### Members' Responsibilities

1. You have a responsibility to supply information (to the extent possible) that CDPHP UBI and its practitioners and providers need in order to provide care.
2. You have a responsibility to follow plans and instructions for care that you have agreed on with your practitioners.
3. You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

In addition to these listed rights and responsibilities, members are invited to participate in the development of policies for the Plan. If you have a suggestion, idea, or comment please forward it to our Member Mailbox, CDPHP UBI Member Services Department, 500 Patroon Creek Boulevard, Albany, NY 12206-1057.

## Resolving Differences

We hope our health plan serves you well. If you have a problem, talk with your doctor, or call or write member services. Most problems can be solved right away. Problems that are not solved right away over the phone, and any complaints or grievances that come in the mail, will be handled according to our complaint and grievance procedures described below.

CDPHP UBI will not retaliate against you for bringing concerns to our attention. We will abide by the CDPHP UBI membership certificate in any dispute over your benefits or rights as a CDPHP UBI member.

## How to File a Complaint

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

1. **You can file a verbal complaint:** To file a complaint by phone, call the member services department at (518) 641-3140 or 1-877-269-2134 Monday–Friday from 8 a.m. to 8 p.m. If we need more information to make a decision, we will tell you.
2. **You can file a written complaint**
   - by writing us a letter, or
   - by asking us for a complaint form to fill out. To get a complaint form, call us at **(518) 641-3140 or 1-877-269-2134.**
   - Mail your complaint (form or letter) to: **CDPHP UBI**
     **Quality Enhancement Department**
     **500 Patroon Creek Boulevard**
     **Albany, NY 12206-1057**

### *What Happens Next?*

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

Within 15 work days from when we get your complaint, we will request in writing any other information we need from you or your provider to decide your complaint. If we only get part of that information, we will ask for the missing information, in writing, within five work days of getting the partial information.

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

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

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

## Claim (Non-Utilization Review) Determinations

You or your designee may file a claim for benefits, either verbally or in writing, by calling or writing to us. This section does not apply to utilization review determinations. For utilization review determinations, see the section titled "Utilization Review Decisions."

- Pre-service claims are requests for care which has not yet been provided to you and needs CDPHP UBI's prior approval. We will decide pre-service claim requests within 15 days after we get the request for coverage of services. If we do not have all the needed information to decide by then, we may take up to 15 more days to decide your case. We will send you a letter by the end of the first 15-day period, telling you why we cannot make a decision. You will be given 45 days from the time we tell you why we cannot make a decision to send us the needed information.
- We will let you know ahead of time of any decision to reduce or end our coverage for ongoing care previously approved by us. We will give you enough time to appeal our decision and get a determination before coverage for the benefit is reduced or ended.
- An urgent (fast) decision can be made in cases where a delay could seriously endanger your life, health, or ability to regain the most function. (We use the "prudent layperson standard" to decide if you meet these criteria.) We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent care claims decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days.
- If you ask to extend a course of treatment for urgent care beyond a previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account your medical needs. You will be told of our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.
- If your claim involves care that has already been provided (post-service claims), we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide

your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us.

All adverse benefit determinations will tell you the specific reasons for our decision, including medical reasons for the decision (if any), and how to file a grievance.

## How to File a Grievance

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

You have 180 days after we tell you of our decision to file a grievance.

To file a grievance by phone, call member services at (518) 641-3140 or 1-877-269-2134 Monday–Friday from 8 a.m. to 8 p.m. If we need more information to make a decision, we will tell you.

**You can file a written grievance**

- by writing us a letter, or
- by asking us for a grievance form to fill out. To get a grievance form, call us at **(518) 641-3140 or 1-877-269-2134.**
- Mail your grievance (form or letter) to:
  **CDPHP UBI Appeals Department**
  **500 Patroon Creek Boulevard**
  **Albany, NY 12206-1057**

### *What Happens Next?*

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

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

If we need any other information to decide your grievance, we will ask you or your provider for the information within five days after we get your grievance. If you only send us some of the information we need, we will send you a letter within five work days telling you what other information we still need.

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

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

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

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

## Appeals

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

Send your appeal letter or form to: CDPHP UBI Appeals Department, 500 Patroon Creek Boulevard, Albany, NY 12206-1057 or call member services at (518) 641-3140 or 1-877-269-2134 for help.

We will send you a letter within 15 working days. The letter will tell you the name, address, and telephone number of the person who is working on your appeal. It will also tell you if we need more information. If we only get part of that information, we will ask for the missing information in writing within five workdays of getting the partial information.

Your appeal will be decided by:

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

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

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

## Utilization Management Decisions

CDPHP UBI has a utilization management (UM) team made up of doctors, nurses, and pharmacists. Qualified health care professionals make all UM decisions. If you disagree with a UM decision, our resource coordination department (1-800-274-2332) may be able to help. You, a designee, or your doctor may question any utilization review decision.

### *Prior Approvals and Prospective Review*

**You or your doctor must contact the CDPHP UBI resource coordination department to get prior approval for certain covered treatments.**

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

### *Concurrent Review*

**If you have been getting care or treatment that should be continued,** or if more services are needed, we will review the request and make our decision within one work day after we get the information we need, or 15 days after your first request, whichever is first. We will make our decisions involving home health care services following an inpatient admission within one business day of receiving all necessary information (or within 72 hours if the day after the request falls on a weekend or legal holiday). Appeals of home health care following an inpatient hospital admission will be handled on an expedited basis. We will let you or your designee and your doctor know our decision by telephone and in writing. We will let you know of any decision to reduce or end our coverage for ongoing care approved by us earlier. We will give you enough time to appeal our decision and get a decision before coverage for the benefit is reduced or ended.

### *Urgent Review*

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

With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

With respect to prospective urgent claims, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within 24 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

**Your Right to an Immediate External Appeal.** If we fail to adhere to the utilization review requirements described in this handbook, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external appeal as described in this handbook.

### *Reconsideration of Reviews*

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

CDPHP UBI can legally reverse its decision to cover a preauthorized service based on new information being made available after the original decision was made. This could occur, for example, if we find out that information was withheld or falsified during the time of our utilization review. If a different decision would have been made at the time of our review if we had had the information, we reserve the right to change our decision. The new determination will be made using the same standards and procedures we used during the first utilization review.

### *Retrospective Review*

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

### *Notice of Appeal Rights*

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

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

If CDPHP UBI fails to make a utilization review decision within the above time frames, this can be considered the same thing as a denial, which would then be subject to appeal.

## Utilization Review Appeals

You or your designee can appeal a utilization review (UR) decision. Just call member services at (518) 641-3140 or 1-877-269-2134 to appeal any CDPHP UBI utilization review decision. In the case of past care reviews, your doctor can also make the appeal. There are two kinds of UR appeals: fast track and standard.

Use the **fast track** UR appeals process when:

- you need an OK to continue current health care, or
- you need more services added to those you are getting, or
- your doctor thinks our plan should look at the request again right away, or
- a delay could seriously put your life, health, or ability to regain the most function in danger (based on the "prudent layperson standard"), or, your doctor believes you would suffer severe pain without the requested care or treatment.

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

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

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

- You must file a standard UR appeal (by phone or in writing) within 180 days of getting notice of our decision (which will tell you how to appeal).

- Within 15 work days, we will send you a letter telling you the name, address, and telephone number of the person who is working on your appeal.
- The decision on your appeal will not be made by the same reviewer who decided the first time.
- If we need any additional information to decide your UR appeal, we will send you or your provider a letter within five days after we get your UR appeal. If we only get part of that information, we will ask for the missing information in writing within five workdays of getting the partial information.
- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing within two business days of making our decision. This notice, which is called a final adverse determination, will tell you the reasons for our decision, including the clinical rationale. We will also tell you how you can further appeal with us or New York State and what the timeframes are for filing further appeals. If you or your designee elects to pursue an external appeal with the state, you will give up your right to complete the rest of CDPHP's grievance process (hearing and Board of Directors review).
- If we do not make a fast track or standard decision within the above time frames, we must allow you to get the service you or your doctor asked for.

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

## External Appeals

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

1. The requested health care service does not meet CDPHP requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or
2. the service is experimental and/or investigational (includes clinical trials and rare disease treatments); or
3. a request for an out-of-network service was denied on the basis that an alternate in-network service was available and your provider certifies that the requested service is materially different from, and likely to be more beneficial than, the in-network service, and the adverse risk of the requested service would likely not be substantially increased over the in-network service.

To be eligible to file an external appeal:

- You must have received a final adverse determination as a result of the plan's first level UR standard or expedited appeal process; or
- CDPHP and you have jointly agreed to waive the internal process; or
- You have filed both an expedited appeal request with CDPHP and an expedited external appeal at the same time; or
- CDPHP did not comply with the internal appeal requirements for your appeal.

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

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

- "Rare disease" means a condition or disease that is or has been the subject of a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or affects fewer than 200,000 United States residents per year; and for which there does not exist a standard health service or procedure covered by CDPHP that is more clinically beneficial than the requested health service or treatment.
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.
- The care your doctor recommends would be covered under your contract if we had not decided it was experimental or investigational.

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

Your doctor has:

1. Certified that the out-of-network health service is materially different than the alternate recommended in-network service, and
2. Recommended a health care service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested service would likely not be substantially increased over the alternate recommended in-network health service.
    - Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.

If you wish, and your case fulfills the above criteria, you and CDPHP may agree in writing to waive the UR appeal step and go directly to an external appeal.

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

You or your designee have four months after getting an adverse UR appeal decision from CDPHP to ask for external appeal. Your designee may file for it on your behalf. You or your designee must sign the request for an external appeal and consent to the release of medical and treatment records in order for you to be eligible for an external appeal. Or, if it is a situation where the care has already been delivered, your doctor may file for the external appeal.

External appeal requests must be in writing on a standard New York State Department of Financial Services (NYS DFS) form. CDPHP will give you a copy of this form with our UR appeal decision or our written waiver of that step. Or, you can ask for a form by calling CDPHP at 1-800-777-2273 or NYS DFS at 1-800-400-8882. It is also available online at www.dfs.ny.gov.

You, your designee, or your doctor will be required to submit relevant medical information concerning your appeal. If these documents contain new information that is different from the facts CDPHP used to make its UR appeal decision, CDPHP may take up to three work days to consider the new facts and review its decision.

## Standard Appeal

The external appeal agent will decide your appeal within 30 days of getting it. During that time, he or she may request information from you, your designee, your doctor, and CDPHP. If the agent asks for more information, he or she may take up to five extra work days to decide your case. The agent will notify you and CDPHP, in writing, of the decision within two work days after the decision is made.

## Expedited Appeal

You may request an expedited external appeal:

- If your attending physician states that a delay in providing the health care service would pose an imminent or serious threat to your health; or
- The denial concerns an admission, availability of care, continued stay, or health care service for which you received emergency services and remain hospitalized.

The expedited external appeal shall be completed within no more than 72 hours of the request and the external appeal agent shall make every reasonable attempt to immediately notify you and CDPHP of its determination by telephone or facsimile, followed immediately by written notification of such determination.

The decision of the external appeal agent is binding on you and the plan.

Per Public Health Law Section 4917, if the external appeal goes in your favor, CDPHP will cover the care in question, subject to the terms of your contract. If the agent agrees that you should be allowed to enter a clinical trial, CDPHP will only cover the costs of your treatment within the trial. CDPHP will not cover investigational drugs or devices that are part of the clinical trial. We also will not cover costs of the clinical trial that would not be covered under your contract, such as for research or non-health-related items.

**It is the MEMBER'S RESPONSIBILITY to initiate the external appeal process.** You can file an external appeal by sending a completed form to NYS DFS. If you already received the service in question or are currently receiving treatment, your doctor may file an external appeal for you, but you would need to agree to this in writing.

If the external appeal agent overturns an appeal for concurrent services that was filed by your doctor on your behalf, your doctor is prohibited from seeking payment from you, other than the copayment, coinsurance, or deductible (if any) that you would be subject to if the care were approved.

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

### CDPHP UBI Grievance Committee Hearing

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

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

We will send you a letter within 15 work days after we get your request for a hearing. The letter will include the name, address, and telephone number of the person who will answer the hearing request, as well as any additional information needed.

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

The CDPHP UBI grievance committee will send you or your representative a letter with its decision within five work days after the hearing. The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision. If we have not received enough information to make a determination, we will send you a written statement to that effect.

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

### Board of Directors

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

### Complaints to New York State

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

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

## Continuity of Care

Since community practitioners and providers contract to provide health care services to CDPHP UBI members, the continued participation of any practitioner or provider cannot be guaranteed.

## Coordination of Benefits

Coordination of benefits (COB) is a process whereby two or more insurance plans determine which plan is responsible for payment of health care services provided when a member is eligible for benefits under more than one insurance plan. Greater detail on how COB affects your coverage can be found in your membership certificate.

## Termination/Conversion of Coverage

CDPHP UBI will not pay for any health services after the termination of your coverage, except in the case of an extension or continuation of coverage or upon conversion to direct pay coverage. Please refer to your member certificate or contact member services for information about your conversion privileges.

If you need a certificate of creditable coverage from CDPHP UBI, you may request one by contacting member services. You have up to 24 months after your coverage has ended to request this documentation.

## Additional Information Available Upon Request

The following information about CDPHP UBI is available upon request by calling the member services department at (518) 641-3140 or 1-877-269-2134 or writing to them at CDPHP UBI, 500 Patroon Creek Boulevard, Albany, NY 12206-1057:

1. A list of names, business addresses, and official positions of the membership of the board of directors and officers of CDPHP UBI.
2. A copy of CDPHP UBI's most recent annual certified financial statement including a balance sheet and summary of receipt and disbursements prepared by a certified public accountant.
3. A copy of the most recent individual subscriber contracts.
4. Information relating to consumer complaints compiled pursuant to Section 210 of the New York State Insurance Law.
5. Procedures for protecting the confidentiality of medical records and other member information.
6. A written description of the organizational arrangements and ongoing procedures of the CDPHP UBI quality assurance program as well as a report on CDPHP UBI's progress in meeting its goals.
7. A description of CDPHP UBI procedures for making decisions about the experimental or investigational nature of individual drugs, medical devices, or treatments in clinical trials.
8. Individual health practitioner affiliations with participating hospitals.
9. Specific clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which CDPHP UBI might consider in its utilization review. CDPHP UBI may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to CDPHP UBI, the member or prospective member shall only use the information for the purposes of assisting the member or prospective member in evaluating the covered services provided by CDPHP UBI.
10. Written application procedures and minimum qualification requirements for health care providers and practitioners to be considered for participation in the CDPHP UBI network.
11. Other information as required by the Superintendent of the New York State Department of Financial Services, provided that such requirements are promulgated in accordance with the State Administrative Procedure Act.

In addition, members or prospective members have the right to inspect the following:

Drug formularies used by CDPHP UBI. CDPHP UBI shall also disclose whether individual drugs are included or excluded from coverage to a member or prospective member who requests this information.

If you have any questions about the information contained in this handbook, please contact our member services department at (518) 641-3140 or 1-877-269-2134.