Child Health Plus Member Handbook

November 2018

NOTICE OF NON-DISCRIMINATION

Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits, Inc., and Capital District Physicians' Healthcare Network, Inc. (collectively known as CDPHP®) complies with Federal civil rights laws. **CDPHP** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (as defined in 45 CFR § 92.101(a)(2)).

CDPHP provides the following:

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

If you need these services, call **CDPHP** at 1-800-388-2994. For TTY/TDD services, call 711.

If you believe that **CDPHP** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with the **CDPHP Civil Rights Coordinator** by:

- Mail: 6 Wellness Way, Latham, NY 12110
- Phone: 1-844-391-4803 (for TTY/TDD services, call 711)
- Fax: (518) 641-3401
- In person: 6 Wellness Way, Latham, NY 12110
- Email: https://www.cdphp.com/customer-support/email-cdphp

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web: Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

This notice is available at CDPHP's website: https://www.cdphp.com/legal/non-discrimination.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-800-388-2994 (TTY:711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-800-388-2994 (TTY:711).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-800-388-2994 (TTY:711)。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-800-388-2994 (TTY:711).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-800-388-2994 (TTY:711) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-800-388-2994 (TTY:711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-800-388-2994 (TTY:711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-800-388-2994 (TTY:711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-800-388-2994 (TTY:711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 1-800-388-2994 TTY:711.	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-800-388-2994 (TTY:711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-800-388-2994 (TTY:711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-800-388-2994 (TTY:711) এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-800-388-2994 (TTY:711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-800-388-2994 (TTY:711).	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-800-388-2994 (TTY:711)۔	Urdu

Welcome To The CDPHP Child Health Plus (CHPlus) Program

Thank you for selecting Capital District Physicians' Health Plan, Inc. (CDPHP®) for your health care coverage. We are glad to have you as a member and are committed to providing you with quality health coverage that's easy to use. This member handbook will help you understand your CHPlus coverage. Please take some time to review it. Although this handbook contains a great deal of information about CDPHP, it is only a brief summary of how to use your benefits. For more details, please refer to your membership contract.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

CDPHP has a contract with the State Department of Health to meet the health care needs of children eligible for the CHPlus program. In turn, we choose a group of health care providers to help us meet your child's needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you do not have a provider directory, call 1-800-388-2994 to get a copy or visit Find-A-Doc at www.cdphp.com.

If you 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 change your PCP, register a change of address, order a new ID card, or check the status of claims.

When you join CDPHP one of our providers will take care of you. That person will be your PCP (Primary Care Provider) and will provide most of your care. If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message with the PCP's answering service and let them how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 7 for details.

HOW TO USE THIS HANDBOOK

This member handbook will help you understand your CHPlus coverage. It will tell you how your new health care system will work and how you can get the most from CDPHP. This handbook is your guide to health services and tells you the steps to take to make the plan work for you. Please take some time to review it. Although this handbook contains a great deal of information about CDPHP, it is only a brief summary of how to use your benefits. For more details, please refer to your membership contract.

The first several pages will tell you what you need to know **right away.** The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this handbook or call our Member Services department.

HELP FROM MEMBER SERVICES

If you have any questions about your coverage, please call our Member Services department at (518) 641-3800 or 1-800-388-2994. Member

Services representatives are available Monday through Friday, 8 a.m. to 6 p.m., to assist you. Members may also come to see a Member Services representative at CDPHP, 6 Wellness Way, Latham, NY 12110, 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 6 Wellness Way, Latham, NY 12110 or visit us on the web at www.cdphp.com. Help is available to answer questions and address any concerns you may have. For example, Member Services can explain policies and benefits, accept complaints and appeals, and help resolve bills. If you call after business hours you may leave a message and someone will call you back the next business day.

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us at 1-800-388-2994 and we will use an interpreter who speaks your language. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services such as:
  - TTY machine (our TTY phone number is 711).
  - Information in large print
  - Case management
  - Help in making or getting to appointments
  - Names and addresses of providers who specialize in your disability

YOUR HEALTH PLAN ID CARD

Your CDPHP ID card should arrive within 14 days after your enrollment date. If anything is wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member.

KEEP US INFORMED

It is important that you notify CDPHP and the NY State of Health, The Official Health Plan Marketplace ("Marketplace") of any of the following changes to ensure your continued eligibility in the Child Health Plus program:

- Changes to your name, address, telephone numbers or email addresses
- Changes in your health insurance coverage
- Changes to your household, such as pregnancy, marriage and changes to your income
- Obtaining other health insurance coverage
- Cancelling your coverage

You can call the Marketplace at 1-855-355-5775 or visit their website at www.nystateofhealth.ny.gov, to make any of these changes.

If you need assistance making any of these changes, CDPHP is here to assist you with Marketplace Facilitated Enrollers. You can reach our Facilitated Enrollers by calling 1-844-237-4773 (TTY: 711), or you can request an appointment by going to https://www.cdphp.com/members/health-plan/government-plans/child-health-plus.

RENEWAL OF COVERAGE

At the end of Your Plan Year, the Marketplace will check to see if you continue to be eligible for coverage under the Child Health Plus Program. The Marketplace will inform you of your eligibility and whether additional information is needed to make this determination. If additional information is needed, you can provide this information by:

PART

1

First Things You Should Know

- Calling the Marketplace at 1-855-355-5775.
- Visiting the Marketplace website at nystateofhealth.ny.gov and renew your coverage through your online account.
- Calling CDPHP at 1-844-237-4773 (TTY: 711) and the CDPHP Marketplace Facilitated Enrollers can assist you with providing the additional information and renewing your coverage.

HOW TO CHOOSE YOUR PCP

You may have already picked your PCP (Primary Care Provider) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for your child(ren), you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Member Services can help you choose a PCP.

Our provider directory is a list of all the doctors, clinics, hospitals, labs, and others who work with CDPHP. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

- Whom you have seen before,
- Who understands your health problems,
- Who is taking new patients,
- Who can serve you in your language, or
- Who is easy to get to.

We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs, because the centers have a long history in the neighborhood. Maybe you want to try them, because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or, you can sign up with a primary care physician at one of the FQHCs that we work with, listed in the next column. Just call Member Services at 1-800-388-2994 for help.

Whitney M. Young, Jr. Health Center
Lark & Arbor Drives, Albany, NY
(518) 465-4771

Whitney M. Young Troy Health Center
6 102nd Street, Troy, NY
(518) 833-6900

Hometown Health Centers
1044 State Street, Schenectady, NY
(518) 370-1441

Moreau Family Health Center of Glens Falls
10154 Territorial Park, Fort Edward, NY
(518) 761-6961

If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change up to once every 6 months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

Your doctors generally must all be CDPHP providers. However, in some cases you can continue to see another doctor that you had before you joined CDPHP, even if he or she does not work with our plan. You can continue to see your doctor if:

- You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
- At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

In both cases, however, your doctor must agree to work with CDPHP.

If you have a long-lasting illness or other long term health problems, you may be able to **choose a specialist to act as your PCP (primary care provider).** Your PCP, after speaking with the CDPHP medical director and a specialist, may issue a referral/authorization to a specialist with experience in treating your condition. That specialist will be able to provide and assist with your primary and specialty care. A referral/authorization will be made, along with a treatment plan approved by CDPHP after talking to your PCP, the specialist, and you. The specialist shall be able to treat you without a referral/authorization from your PCP, under the terms of the treatment plan.

If your **provider leaves CDPHP**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at (518) 641-3800 or 1-800-388-2994.

As part of your dental benefit, you will have a **Primary Care Dentist, or PCD.** This PCD must be a participating dentist in the network of the dental company CDPHP contracts with. This dental company is called Delta Dental. Delta Dental assigns members to dentists they have seen in the last year, if that dentist participates in our network. If you have not seen a dentist in the last year, and do not make a selection within 30 days of receiving their welcome letter, Delta Dental will assign you a PCD based on your address. You can change your PCD assignment at any time by calling Delta Dental. Your PCD will provide most of your dental care and will refer you to a specialist for dental services when you need one.

If you need to find a dentist or **change your dentist**, please call Delta Dental at 1-800-542-9782 (TTY: 711).

Delta Dental representatives are there to help you. You can also visit www.AllSmilesWelcome.com to find a dentist. Many speak your language or have a contract with interpreter services. You may also call CDPHP Member Services at 1-800-388-2994 with any questions or concerns.

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

HOW TO OBTAIN INFORMATION ABOUT PRACTITIONERS

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

HOW TO GET REGULAR CARE

Regular care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. As soon as you choose a PCP, call to make a first appointment. If you can,

prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)

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

- Baseline and routine physicals: within 12 weeks,
- Urgent care: within 24 hours,
- Non-urgent sick visits: within 3 days,
- Routine, preventive care: within 4 weeks,
- First pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd),
- First newborn visit: within 2 weeks of hospital discharge,
- First family planning visit: within 2 weeks,
- Follow-up visit after mental health/ substance abuse or inpatient visit: 5 days,
- Non-urgent mental health or substance abuse visit: 2 weeks.

Your care must be **medically necessary.** The services you get must be needed:

- To prevent, or diagnose and correct what could cause more suffering,
- To deal with a danger to your life,
- To deal with a problem that could cause illness, or
- To deal with something that could limit your normal activities.

HOW TO GET URGENT OR EMERGENCY CARE

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

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

You can get an appointment for an **urgent care** visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at (518) 641-3800 or 1-800-388-2994. Tell the person who answers what is happening. They will tell you what to do.

If you believe you have an **emergency**, call 911 or go to the emergency room. You do not need approval from CDPHP or your PCP before getting emergency care, and you are not required to use our hospitals or doctors. If you're not sure, call your PCP or CDPHP. Tell the person you speak with what is happening. Your PCP or member services representative will:

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room.

If you are out of the area when you have an emergency:

- Go to the nearest emergency room.

NON-EMERGENCY CARE OUTSIDE THE SERVICE AREA

Non-emergency services delivered outside the CDPHP network are not covered unless they are previously authorized. If you are traveling and have a medical need that is urgent but not an emergency—such as a sore throat or infection—call the CDPHP resource coordination department at 1-800-274-2332. They will advise you and approve needed care. Routine preventive care—such as a checkup—is not covered out of the service area.

CARE OUTSIDE OF THE UNITED STATES

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

HOW TO GET SPECIALTY CARE AND REFERRALS

If you need care that your PCP cannot give, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask CDPHP to approve *before* you can get them. Your PCP will be able to tell you what they are. If you are having trouble getting a referral you think you need, contact Member Services at (518) 641-3800 or 1-800-388-2994.

If we do not have a specialist in CDPHP who can give you the care you need, we will get you the care you need from a specialist outside CDPHP. You will need prior authorization from CDPHP. This is true even if the CDPHP network does not have the right specialist to meet your particular health care needs. To ask for an out-of-plan referral, call CDPHP at (518) 641-4100 or 1-800-274-2332. Your PCP will be contacted and asked to supply a treatment plan explaining why you need an out-of-plan referral. We will assess the treatment plan and consult with your PCP and the out-of-plan provider and make a decision. When a decision is made, you will receive a letter from a CDPHP medical director telling you whether your request has been approved or denied. If it is denied, specific information needed to file an appeal will be explained in the denial letter. If your PCP or CDPHP refers you to a provider outside our network, you are not responsible for any of the costs except any copayments as described in this handbook.

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

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

- Your specialist to act as your PCP; or
- A referral to a specialty care center that deals with the treatment of your problem.

GET THESE SERVICES FROM CDPHP CHILD HEALTH PLUS WITHOUT A REFERRAL

Covered Health Care Services That Do Not Require a Referral:

- Office visits, including periodic health examinations when the services are rendered by your Primary Care Provider or designated participating OB/GYN practitioner.
- Emergency room health services.
- Urgent care facility services.
- Reproductive health care when the services are rendered by your designated participating OB/GYN practitioner.
- Emergency, Preventive, and Routine Vision Care when the services are rendered by a network provider.
- Emergency, Preventive and Routine Dental Care.
- Outpatient Acute Mental Health Care Services rendered by a psychologist or social worker that are coordinated by CDPHP. Services rendered by a psychiatrist still require a referral from your Primary Care Provider.

- Outpatient Chemical Abuse and Dependency Treatment Services that are coordinated by CDPHP.

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

WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

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

Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out more and get a list of upcoming classes or visit our website www.cdphp.com.

YOUR RIGHTS

As a member of CDPHP Child Health Plus, you have a right to:

- You have the right to receive information about CDPHP, its services, practitioners/providers, and member rights and responsibilities.
- You have a right to be treated with respect and recognition of your dignity and right to privacy.
- You have a right to participate with practitioners in making decisions about your health care.
- 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.
- You have a right to obtain, from a practitioner, complete and 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.
- 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.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- You have the right to formulate advance directives (such as naming a health care proxy form and living will) about your care.
- You have the right to voice complaints, grievances, or appeals about CDPHP or the services it provides.
- You have a right to make recommendations regarding the CDPHP member rights and responsibilities policies.

YOUR RESPONSIBILITIES

As a member of CDPHP Child Health Plus, you agree that:

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

Member Services (518) 641-3800 or 1-800-388-2994, TTY/TDD 711. This notice is available in other formats for members with special needs or who speak languages other than English. Call the Member Services Department for help.

PART 2

Your Benefits and Plan Procedures

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

SERVICES COVERED BY CDPHP CHILD HEALTH PLUS

You must get these services from the providers who are in CDPHP. All services must be medically necessary and provided or referred by your PCP.

Regular Medical Care

- Office visits with your PCP.
- Eye/hearing exams.

Preventive Care

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

Specialty Care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists, audiologists.
- Midwives.
- Cardiac rehabilitation.
- Podiatrists (if you are diabetic).

Hospital Care

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

Emergency Care

You are always covered for emergencies. An emergency means a medical or behavioral condition:

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

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

Examples of an emergency are:

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

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

Maternity Care

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

Dental Care

- CDPHP believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Delta Dental, an

expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, X-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

Orthodontics

- This benefit includes procedures which help to restore oral structures to support health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if you do not meet the criteria described above. Prior approval is required for orthodontia services. Please review your subscriber contract for additional details on covered procedures.

Emergency, Preventive and Routine Vision Care

- We will pay for emergency, preventive and routine vision care. This includes vision examinations performed by a participating physician or participating practitioner optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation.

We will pay for:

- Quality standard prescription lenses provided by a participating physician, participating practitioner optometrist, or participating practitioner optician once in any 12-month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.
- Standard frames adequate to hold lenses once in any 12-month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
- Contact lenses—only when deemed medically necessary.

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

Prescription Drugs

- Coverage for prescription drugs is subject to the conditions listed in your contract. Please review the contract for details of your prescription coverage. As a highlight, CDPHP only covers medically necessary prescription drugs. Prescriptions must be written by a participating provider, and they must be filled at a participating pharmacy. Coverage is subject to the CDPHP Prescription Drug Formulary that is in effect on the date the prescription is filled. Non prescription drugs which appear on the Medicaid drug formulary are covered.
- The following types of prescription drugs may require prior approval: injectibles, recombinant DNA products, immune-modulating agents, monoclonal antibodies, enteral formulas/modified solid food products, weight loss agents, cosmetic agents used for non-cosmetic medical diagnoses, compounded prescriptions and COX-2 inhibitors. It is your responsibility to obtain prior approval for these drugs.

Failure to obtain prior approval will result in you being responsible for the total cost of the drug. You also may contact the Member Services Department at (518) 641-3800 or 1-800-388-2994 or may consult the CDPHP website at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is covered or if prior approval is required.

Home Health Care (must be medically needed and arranged by CDPHP)

- Up to 40 visits per calendar year by a certified participating Home Health Care agency provider when medically necessary, ordered by your participating provider and approved in writing by a CDPHP medical director as an alternative to hospitalization or treatment in a skilled nursing facility. A care plan must be established in writing and approved by your participating provider and a CDPHP medical director. The medical necessity of Home Health Care Services is determined on a case-by-case basis.

Professional Ambulance Services.

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

Inpatient Mental Health Care and Alcohol and Substance Abuse Services

- We will pay for all medically necessary facility, diagnostic and physicians' charges for mental health services, inpatient detoxification and inpatient rehabilitation for alcohol and substance abuse services when such services are provided in a facility that is operated by the Office of Mental Health under sec. 7.17 of the Mental Hygiene Law, issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law, or a general Hospital as defined in Article 28 of the Public Health Law.

Outpatient Mental Health Care and Alcohol and Substance Abuse Services

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

  Please note: Mental and behavioral health benefits and alcohol and substance abuse benefits are performed by CDPHP Behavioral Health. You can call us 24 hours a day, seven days per week, at 1-888-320-9584. TTY/TDD users, call 711.

Autism Spectrum Disorder

- CDPHP will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be medically necessary for the screening, diagnosis, and treatment of autism spectrum disorder. Autism spectrum disorder means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). Please review your subscriber contract for more details about this coverage.

EXCLUSIONS FROM COVERAGE

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

If you have any questions, call Member Services at (518) 641-3800 or 1-800-388-2994.

RESOLVING DIFFERENCES— CLAIMS AND APPEALS PROCEDURES

How to File a Complaint

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

You can file a verbal complaint:

- To file a complaint by phone, call the Member Services department at (518) 641-3800 or 1-800-388-2994. If we need more information to make a decision, we will tell you.

You can file a written complaint:

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

To get a complaint form, call us at (518) 641-3800 or 1-800-388-2994. Mail your complaint (form or letter) to:

CDPHP Attn: Quality Enhancement Department
6 Wellness Way
Latham, NY 12110

Timeframes

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

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

We will give you or your designee a written decision on your complaint within 30 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 workday, we will send you a letter telling you why. We will then make a decision based on the information we have, and inform you of the decision within the next 15 workdays.

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

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

Claim (Non-Utilization Review) Determinations

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

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

- Pre-service claims are requests for care, which has not yet been provided to you and needs CDPHP 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 decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file a grievance.

How to File a Grievance

If you do not like a decision CDPHP 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) 641-3800 or 1-800-388-2994. 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) 641-3800 or 1-800-388-2994. Mail your grievance (form or letter) to:

CDPHP Attn: Appeals Department
6 Wellness Way
Latham, NY 12110.

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

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

If your grievance involves pre-service claims (request for care not yet given) we will decide it within 15 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 workdays after hearing from us to file an appeal. You can do this yourself or ask a designee to file the appeal for you. The appeal may be in writing or by phone. You can call, write a letter, or use the CDPHP complaint form.

Send your appeal letter or form to:

CDPHP, Attn: Appeals Department
6 Wellness Way
Latham, NY 12110

Or call Member Services at (518) 641-3800 or 1-800-388-2994 for help.

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

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

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

For all other appeals, CDPHP 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 has a utilization review (UM) team made up of doctors and nurses. Qualified health care professionals make all UM decisions. If you disagree with a UM decision, our resource coordination department (1-800-274-2332) 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 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 let you or your designee and your doctor know our decision by telephone and in writing. We will let you know of any decision to reduce or end our coverage for ongoing care approved by us earlier. We will give you enough time to appeal our decision and get a decision before coverage for the benefit is reduced or ended.

Retrospective Review

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

Urgent Review

An urgent (fast) decision can be made in some prior approval, prospective review, and concurrent review cases. We will make a fast decision when waiting for the above 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.

Urgent care utilization review 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 the approved period of time or number of treatments, a decision will be made as soon as possible, taking your medical needs into account. We will tell you our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

Reconsideration of Reviews

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

Notice of Appeal Rights

All notices of decisions from CDPHP 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 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) 641-3800 or 1-800-388-2994 to appeal any CDPHP 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 practitioner/provider by telephone and in writing of what we need. A clinical peer reviewer will be available to talk with you or your designee within one workday after we get notice of the UR appeal. The decision on your appeal will not be made by the same reviewer who decided it the first time.

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

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

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

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

- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
- If we do not make a fast track or standard decision within the above 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. CDPHP turned down your request for service, saying that it was not medically necessary. The service must otherwise be covered under your contract;
2. CDPHP denied coverage for a health care service because we believe it is experimental or investigational; or
3. CDPHP turned down your request for a service, on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network.

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

- Your 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:
  a. recommended a service or pharmaceutical product (as described in New York Public Health Law § 4900(5)(b)(B)) that is more likely to help 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 State Insurance Department to find out more; or
  b. in the case of a rare disease, provided a certification (as described in New York Public Health Law § 4900(7-g)) that the requested health service or procedure is likely to benefit you in the treatment of your rare disease and that the benefit to you outweighs the risk of the service or procedure; or
  c. recommended a clinical trial for which you are eligible (only certain clinical trials are covered).
- 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:
  a. certified that the out-of-network health service is materially different than the alternate recommended in-network service; and
  b. recommended a health care service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.

If you wish, 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 who are certified by the Commissioner of the New York State Department of Health. These agents are randomly assigned to conduct external appeals.

You or your designee has 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. Or, if it is a situation where the care has already been delivered, your doctor may file for the external appeal.

If you and CDPHP agree in writing to waive the UR appeal step, you have four months after filing the waiver to submit a written request for an external appeal.

External appeal requests must be in writing on a standard New York State Department of Financial Services (DFS) form. 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 (518) 641-3800 or 1-800-388-2994 or DFS at 1-800-400-8882. It is also available online at www.dfs.ny.gov or www.health.ny.gov.

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

You, your designee, and your doctor may submit supporting documents to the external appeal agent during the same four-month period. 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.

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 workdays to decide your case. The agent will notify you and CDPHP, in writing, of the decision within two workdays after the decision is made.

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

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

Under New York State law, a completed request for appeal must be filed within 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 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 grievance committee. This option is not available if you have an external review. You must ask us for a hearing (verbal or written) within 60 workdays after we tell you of our appeal decision.

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

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

A hearing will be held within 45 days after you make your request. The hearing will be led by the chairperson of the CDPHP 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 grievance committee will send you or your representative a letter with its decision within five workdays after the hearing. The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision.

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

Board of Directors

If you do not agree with the decision made by the CDPHP grievance committee, you can ask that the CDPHP board of directors review the decision. You must ask in writing within 30 days of when you get the CDPHP grievance committee decision. After we get your letter, the board of directors will review your request at its next regularly scheduled meeting. The CDPHP board of directors will only consider the full record of the CDPHP 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, you may also file a complaint anytime by contacting:

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

or

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

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary.** The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many—or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service.** This means they get a Plan-agreed-upon fee for each service they provide.

FILING A CLAIM

Even though you should not be billed for services covered through CDPHP, if you do receive covered services and pay for them out of your own pocket, you may file a claim with us to be reimbursed. Please send the itemized bill and a receipt to: CDPHP, 6 Wellness Way, Latham, NY 12110. Claims should be sent within 90 days of receiving care.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out how you can help.

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at (518) 641-3800 or 1-800-388-2994.

- A list of names, addresses, and titles of the CDPHP Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about CDPHP
- How we keep your medical records and member information private.
- In writing, we will tell you how CDPHP checks on the quality of care to our members.
- We will tell you which hospitals our health providers work with.
- If you ask us, we will tell you the guidelines we use to review conditions or diseases that are covered by CDPHP.
- If you ask, we will tell you the qualifications needed and how health care providers can apply to be part of CDPHP.
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

TERMINATION OF YOUR CONTRACT

Described below are reasons why your Contract may terminate.

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

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

We will require you or the adult to provide documentation each year to certify that you still meet the Child Health Plus eligibility

requirements. Failure to provide the requested documentation may result in termination of your contract.

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

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

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

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

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

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

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

E. If you move outside our Service Area, your Contract will terminate. Our Service Area is the counties of Albany, Broome, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington in the State of New York.

Benefits After Termination. If you are, in our sole judgment, totally disabled on the date this Contract terminates, and you have received service or care for the illness, condition, or injury that caused your total disability while you were covered under this Contract, we will continue to provide care relating to the total disability covered under this Contract during an uninterrupted period of total disability until the first of the following dates:

A. A date you are, in our sole judgment, no longer totally disabled.

B. A date 12 months from the date this Contract terminates.

However, we will not pay for more care than you would have been entitled to receive if your coverage under this Contract had not terminated.

IMPORTANT PHONE NUMBERS

Your PCP	
THE PLAN	www.cdphp.com
Member Services	(518) 641-3800 or 1-800-388-2994
Member Services TTY/TDD	711
Resource Coordination	(518) 641-4100 or 1-800-274-2332
CDPHP Behavioral Health Services	1-888-320-9584
CDPHP Behavioral Health Services TTY/TDD	711
Your nearest Emergency Room	
New York State Department of Health (Complaints)	1 800-206-8125
New York Health Options	1-855-693-6765
Local Pharmacy	
Other Health Providers:	

Member Services (518) 641-3800 or 1-800-388-2994, TTY/TDD 711. This notice is available in other formats for members with special needs or who speak languages other than English. Call the Member Services Department for help.

A plan for life.

CHILD HEALTH PLUS CONTRACT

New York State's Health Plan for Kids

THIS IS YOUR CHILD HEALTH PLUS CONTRACT

Issued By CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

This is your Child Health Plus Contract (the "Contract") with Capital District Physicians' Health Plan, Inc. (CDPHP®). It is issued to the child named on the CDPHP Identification Card. The Contract will continue unless it is terminated for any of the reasons described in the Contract. The coverage under this Contract begins on the effective date shown on the records of CDPHP.

IMPORTANT NOTICE

All care provided under this Contract, except for emergency care, must be provided by your primary care physician or by another participating practitioner pursuant to a referral requested by your primary care physician and approved by us, if applicable. If services are unavailable from a participating practitioner, your primary care physician may refer you to a non-participating practitioner if approved in advance by us. In order to receive benefits under this Contract you must contact your primary care physician before the services are rendered, except in cases of emergency conditions and certain obstetrical and gynecological services (in Section Five of this Contract), vision services (in Section Eight of this Contract) and dental services (in Section Six of this Contract).

This is a special kind of health insurance that only covers children who meet the eligibility requirements for coverage under the New York State Child Health Plus program.

You have the right to return this Contract. Examine it carefully. If you are not satisfied with this Contract, you may return it and ask us to cancel it. This request must be in writing and must be made within ten days from the date you receive this Contract. We will then refund to you any amount you paid for this Contract. If you return this Contract in this manner, we will not provide any benefits under this Contract.

CDPHP
6 Wellness Way
Latham, NY 12110
Attn: President

CHILD HEALTH PLUS CONTRACT

TABLE OF CONTENTS

SECTION ONE—INTRODUCTION

CDPHP is a Health Maintenance Organization. CDPHP is a Health Maintenance Organization or "HMO" for short. Under the HMO concept, all care must be provided, arranged or authorized by your primary care physician. Except in certain emergencies and certain obstetrical and gynecological services (see Section Five), vision services (see Section Eight) and dental services (see Section Six) you will not receive any benefits under this Contract unless you first contact your Primary Care Physician.

Legal Relationship. This Contract establishes a legal relationship between the adult, you (the enrollee), and CDPHP, for your benefit. CDPHP will only provide coverage for the benefits described in this Contract.

SECTION TWO—DEFINITIONS

1. Accidental Dental: trauma to sound natural teeth caused by something other than a natural function including chewing and grinding of the teeth.
2. Injury: an unforeseen and unintended injury.
3. Adult: the adult individual or head of household who applied to CDPHP to obtain health care coverage on behalf of the child covered under this Contract.
4. Benefit Period: the 12-month period indicated on the cover page of the Contract.
5. Calendar Year: is a 12-month period beginning January 1 and ending December 31 of each year.
6. CDPHP: Capital District Physicians' Health Plan, Inc. Throughout this Contract, CDPHP will also be referred to as: "we," "us," or "our."
7. Contract: this document representing the agreement between CDPHP and the adult on your behalf to provide you with the benefits listed below.
8. Coverage or Covered: the Health Services paid for under the Contract.
9. Diagnosis: an act or process of identifying or determining the nature of disease or injury through examination.
10. Effective Date: the date from which you are entitled to receive health services from CDPHP.
11. Eligible Expense: the fees for Health Services Covered under the Contract. Eligible expenses only include fees for services actually provided to you.
12. Emergency: a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.
13. Health Services/Health Care Services: Medically Necessary services to treat Accidental Injuries or sickness, or Medically Necessary preventive care. Health Services do not include services, which are not actually provided to you.
14. Home Health Care: a program of care provided by an agency engaged in providing Home Health Care Services including, but not limited to, skilled nursing services and having a valid existing agreement with CDPHP to provide said services to you.
15. Hospice Care: the care and treatment of you when you have been certified by your Primary Care Physician as having a life expectancy of six months or less and which is provided by a hospice organization certified under the New York Public Health Law or under a similar certificate process required by the state in which the hospice is located.
16. Hospital means a facility defined in Article 28 of the Public Health Law which: (a) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; (b) has organized departments of medicine and major surgery; (c) has a requirement that every patient must be under the care of a physician or dentist; (d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (e) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USCA 1395x(k)); (f) is duly licensed by the agency responsible for licensing such hospitals; and (g) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education or rehabilitory care.
17. Identification or ID Card: the card that CDPHP issued to you showing that you are entitled to receive Health Services from Participating Practitioners/Providers under the terms of the Contract.
18. Medically Necessary: those Health Services defined by CDPHP's Medical Director, or his/her designee, that are necessary to treat and/or alleviate symptoms of an illness, disorder or condition, are rendered at an appropriate level of intensity, can reasonably be expected to promote effective outcomes, are provided efficiently and facilitate quality of care. More specifically, this includes treatments needed to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life resulting in illness or infirmity, interfere with such person's ability for normal activity, or threaten a major handicap.
19. Mental Health Condition: acute mental, nervous or emotional disorder, which is susceptible to short-term treatment and poses a serious threat to your mental or physical well-being.

20. Non-Covered Service: the Health Services not Covered under the Contract.
21. Participating Physician/Practitioner: any licensed physician or practitioner who has agreed under contract with CDPHP to provide Health Services to you.
22. Participating Provider: any Hospital, Home Health Care agency, ambulance service, laboratory, or other health care provider that has agreed under contract with CDPHP to provide Health Services to you.
23. Physical Therapy: Medically Necessary therapy, which can result in significant clinical improvement in your condition.
24. Prescription Drugs: legend drugs that can only be legally dispensed when they are ordered by a physician or other duly licensed health care practitioner/provider legally authorized to prescribe under Title Eight of the Education Law. This includes Medically Necessary enteral formulas which have been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which, if left untreated, cause chronic disability, mental retardation or death, if prescribed by a physician or other duly licensed health care practitioner/provider legally authorized to prescribe under Title Eight of the Education Law.
25. Primary Care Physician: a Participating Physician who agrees under contract with CDPHP to assume primary responsibility for coordinating your overall health care. You must choose a Primary Care Physician who is a Participating Physician practicing in a primary care specialty as defined by CDPHP. You must notify CDPHP of any change in your Primary Care Physician prior to or within 5 days after any services are rendered by your new Primary Care Physician. If you do not notify CDPHP of your change in Primary Care Physician within 5 days of the services being rendered, you will be responsible for the cost of those services. If you do not select a Primary Care Physician, we may select one for you.
26. Semi-Private Room: a room with two or more beds in a Hospital, Skilled Nursing Facility or other health care facility.
27. Service Area: the geographic area approved by the New York State Department of Health in which CDPHP has arranged to provide Health Services to Members. You must receive Health Services within that area. At the time the Contract is issued, you agree, except in cases of Emergency, to use services of practitioners/providers in the Service Area.
28. Surgical Procedures: those medical procedures consisting of: (a) operating procedures for the Diagnosis and treatment of an illness or injury; (b) endoscopies; (c) correction of dislocations; (d) treatment of fractures; and (e) any puncture or incision of tissue or skin requiring the use of surgical instruments, including any pre- and post-operative care usually rendered in connection with such operation or procedure.
29. Totally Disabled: a condition when, by reason of Accidental Injury or illness, you are incapable of per-forming tasks of any employment, or if you were not previously working when, by reason of injury or illness, you are wholly unable to engage in the normal activities of a person of the same sex and age.
30. Urgent Care Facility: a licensed facility which provides medical assistance to treat minor and non-life-threatening Accidental Injuries, illnesses, disorders or conditions.
31. You: The word "you," "your," "yours" or "enrollee" refers to the child to whom this Contract is issued and whose name appears on the CDPHP Identification Card.

SECTION THREE—WHO IS COVERED

Who Is Covered Under this Contract. You, the child to whom this Contract is issued, are covered under this Contract. In order to be covered under this Contract you must meet all of the criteria listed below:

- be under the age of 19;
- not have other health insurance coverage;
- the parent or guardian of the applicant child shall not be a public employee of the State or a public agency with access to family health insurance coverage by a State health benefits plan and the State or public agency pays all or part of the cost of family health insurance coverage;
- not be eligible for the Medicaid Program;
- must be a permanent New York State resident and a resident of our service area; and
- the applicant child is not an inmate of a public institution or a patient of an institution for mental diseases.

When you or the adult apply for this Contract, we will review the application form to determine if you meet the criteria above. Each year you or the adult must resubmit an application so that we can determine if you still meet the above criteria.

SECTION FOUR—PREMIUMS FOR THIS CONTRACT

1. The Child Health Plus Program. The Child Health Plus program is offered by a New York State law that provides funding for children's health insurance. The program is administered by the Department of Health.

   Under the New York State law, you may have to contribute toward the premium for this coverage. The amount that you must contribute, if any, is based on the gross annual income of your family or household. Each year you must resubmit an application so that we can determine if you still have to pay the same amount for this Contract. If your income changes during the year, you must notify us so that we can determine if you still have to pay the same amount for this Contract.

2. Amount of Premiums. The premiums for this Contract are determined from time to time by CDPHP. The premiums must also be approved by the Superintendent of Financial Services and the New York State Department of Health.
3. Change In Premiums. If there is to be either an increase or a decrease in the premiums for this Contract, we will give you or the adult written notice that there will be a change at least 30 days before the new premiums go into effect.
4. Payment of Premiums and Grace Period. All premiums for this Contract are due in advance. However, we allow *a grace period* for the payment of all premiums, except the first premium. This means that, except for the first premium, if we receive payment within *the grace period*, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within *the grace period*, your coverage under this Contract will terminate as of the last date for which your premium has been paid. You will not become covered under this Contract until the first premium payment has been paid to us.

SECTION FIVE—COVERED HEALTH CARE SERVICES

A. Health Care Services from Participating Practitioners and Approved Non-Participating Practitioners.

1. Office and Home Visits, including periodic health examinations. Please see Section Nine.D. for information regarding services, which do not require a referral from your Primary Care Physician.
2. Diagnostic Services, including, but not limited to:
   a. Radiology and Imaging Services.
      i. X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs, and CT scans.
      ii. Other Surgical or Medical Diagnostic Radiology and Imaging Services.
   b. Electroencephalograms.
   c. Electrocardiograms.
   d. Organ Scans.
   e. Laboratory Services.
3. Well Child Visits from birth through the attainment of 19 years of age scheduled as follows or as otherwise recommended by the American Academy of Pediatrics:
   a. Visits at: l month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months.
   b. Ages 2 to 19: One visit per Calendar Year.

   Well child visits shall include: a medical history; physical examination; health education; tuberculin testing (mantoux), hearing testing, dental and developmental screening; eye screening; lead screening; anticipatory guidance; necessary and appropriate immunizations (consistent with the Advisory Committee on Immunization Practices recommended immunization schedule); and clinical laboratory and radiological tests ordered at the time of the visit.
4. Medical Consultation Services.
5. Medical Referral Services to Participating Physicians.
6. Reproductive health services. No referral is required if services are rendered by your designated Participating OB/GYN Practitioner (see also Section Nine.D.).
7. Casts and Dressings.
8. Obstetrical and Gynecological Services including prenatal, labor and delivery and postpartum services are covered with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from your designated Participating Practitioner of obstetric and gynecologic services. You may also receive the following services from your designated Practitioner of obstetric and gynecologic services without your PCP's authorization: up to two annual examinations for primary and preventive obstetric and gynecologic care; and care required as a result of the annual examinations or as a result of an acute gynecological condition.

   Cervical Cancer Screening: If you are a female who is eighteen years old, we will pay for an annual cervical cancer screening; an annual pelvic examination, Pap smear and evaluation of the Pap smear. If you are a female under the age of eighteen years and are sexually active, we will pay for an annual pelvic examination, Pap smear and evaluation of the Pap smear. We will also pay for screening for sexually transmitted diseases.
9. Immunizations (see also Section Ten, Exclusion 14).
10. Allergy Tests.
11. Allergy Injections.
12. Health Education and Nutritional Counseling.
13. Hearing Examinations ordered by a Participating Physician.
14. Dental Services for the treatment of Accidental dental Injuries to sound natural teeth and for dental care or treatment necessary due to congenital disease or anomaly. Treatment must be provided within 12 months of the Accidental Injury. This Coverage ends if you leave CDPHP, even if 12 months have not elapsed. Except in an Emergency, services must be authorized in writing by CDPHP's Medical Director (see Section Ten, Exclusion 9).
15. Surgical Procedures when performed in the office.

B. Physicians' Services when billed separately by the Practitioner, not by the facility, when you are either in the Hospital or at a facility as an Outpatient.

1. Surgical Procedures.

2. Assistant Surgeon. A Participating Practitioner who assists another Participating Practitioner during the course of the operation, when the surgical procedure requires assistance.
3. General and Local Anesthesia Services.
4. Radiotherapy Treatment.
5. In-facility consultations and visits.
6. Surgical Pathology.
7. Obstetrical Services.
8. Initial Newborn Care.
9. Diagnostic Test Result Interpretation Services.

C. Inpatient Hospital Services.

1. Semi-Private Room.
2. General, special and critical care nursing service, but not private duty nursing service.
3. Use of Operating, Recovery and Delivery Rooms.
4. Anesthetic Materials.
5. Laboratory Services.
6. Dressings and Casts.
7. Diagnostic Radiology and Imaging Services.
8. Intravenous Injections and Infusion Therapy.
9. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations.
10. Oxygen and other inhalation therapeutic services and supplies.
11. Short-Term Physical Medicine and Occupational Therapy and Rehabilitation.
12. Intensive/Cardiac Care.
13. Central Supply Items.
14. Chemotherapy, Radiation and Nuclear Therapy.
15. Organ Scans.
16. Blood and blood products, but only when there is a charge by the facility.
17. Maternity care Coverage, (other than for perinatal complications), including parent education, assistance and training in breast or bottle Feeding, and the performance of any necessary maternal clinical assessments, for at least 48 hours after childbirth for any delivery other than a caesarean section, and at least 96 hours following a caesarean section. You shall have the option to be discharged earlier than the 48 or 96 hours. In such case, one Home Health Care visit, which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of caesarean section), shall be delivered within 24 hours: (a) after discharge; or (b) of the time of your request, whichever is later.
18. Drugs, medications, biologicals and vaccines used in the Hospital.
19. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.

D. Outpatient Hospital Services.

1. Use of Operating and Recovery Rooms.
2. Anesthetic Materials.
3. Laboratory Services.
4. Casts and Dressings.
5. Diagnostic Radiology and Imaging Services.
   a. X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs, and CT scans.
   b. Other Surgical or Medical Diagnostic Radiology and Imaging Services.
6. Intravenous Injections.
7. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations.
8. Oxygen and other inhalation therapeutic services and supplies.
9. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation.
10. Central Supply Items.
11. Chemotherapy and Radiation Therapy and Nuclear Therapy.
12. Organ Scans.
13. Pre-admission Testing: We will pay for pre-admission testing when performed at the Hospital where surgery is scheduled to take place, if: reservations for a Hospital bed and for an operating room at that Hospital have been made prior to performance of tests; your physician has ordered the tests; and surgery actually takes place within seven days of such pre-admission tests. If surgery is canceled because of the pre-admission test findings, we will still cover the cost of these tests.
14. Drugs, medications, biologicals and vaccines used in the Hospital.

E. Emergency Services.

1. Emergency Room Services. In and Out of the Service Area. No referral is required (see also Section Nine.B.).
2. Participating Provider Urgent Care Facility Services. No referral is required. (see also Section Nine.D.).
3. Professional Ambulance Services. No copayment. Pre-Hospital Emergency medical services, including prompt evaluation and treatment of an Emergency condition and/or non-airborne transportation to a Hospital. Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law. Evaluation and treatment services must be for an Emergency condition as defined in Section Two of this Contract. Coverage for non-airborne Emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: 1) placing the health of the person afflicted with such a condition in serious jeopardy; 2) serious impairment to such person's bodily functions; 3) serious dysfunction of any bodily organ or part of such person; and/or 4) serious disfigurement of such person.

F. Freestanding Laboratory, Radiology/Imaging, and Ambulatory Surgery Facility Services.

All services provided by Participating Provider freestanding laboratory, radiology/imaging, and ambulatory surgery facilities.

G. Inpatient Mental Health Care and Alcohol and Substance Abuse Services.

We will pay for all Medically Necessary facility, diagnostic and physicians' charges for mental health services, inpatient detoxification and inpatient rehabilitation for alcohol and substance abuse services when such services are provided in a facility that is operated by the Office of Mental Health under sec. 7.17 of the Mental Hygiene Law, issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law, or a general Hospital as defined in Article 28 of the Public Health Law.

H. Outpatient Mental Health Care and Alcohol and Substance Abuse Services.

No copayment. Visits may be for family therapy related to mental health care or the alcohol or substance abuse care.

Outpatient Mental Health Services—You must contact CDPHP or your Primary Care Physician prior to receiving services from a psychologist or social worker. A referral from your Primary Care Physician is still required for services rendered by a psychiatrist.

Outpatient Alcohol and Substance Abuse Services—Services must be provided by certified and/or licensed professionals. The services must be ordered by your Primary Care Physician and must be coordinated by CDPHP.

I. Home Health Care Services.

Up to 40 visits per Calendar Year by a certified Participating Home Health Care agency Provider when Medically Necessary, ordered by your Participating Physician and approved in writing by CDPHP's Medical Director as an alternative to hospitalization or treatment in a skilled nursing facility (as defined in 42 USC § 1395 et. seq.). The Covered services include: 1) part-time or intermittent nursing care services by or under the supervision of a registered professional nurse; 2) part-time or intermittent home health aide services, which consist primarily of caring for you; 3) physical, occupational or speech therapy if provided by the home health service or agency; 4) medical supplies, drugs and medications prescribed by a Participating Physician; and 5) laboratory services by or on behalf of the home health agency. Home Health Care Services are Covered to the extent such items would have been Covered or provided if you were hospitalized or confined in a skilled nursing facility. A care plan must be established in writing and approved by your Participating Physician and CDPHP's Medical Director. CDPHP's Medical Director has the right to determine if Home Health Care is the most cost-effective approach to care. This determination can be made at any time during an episode of care. The medical necessity of Home Health Care Services is determined on a case-by-case basis.

J. Non-Participating Practitioners/Providers' Services.

Subject to Section Nine, non-Participating Practitioners/Providers can provide Medically Necessary Covered Health Services. CDPHP must approve such referrals in advance and in writing, except in Emergency situations.

K. Referral for Second Opinions.

1. Second surgical opinions when referred to a Participating Physician.
2. Second Medical Opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. Such Coverage shall include a second medical opinion from a non-Participating Practitioner specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, at no additional cost to you. The attending Participating Physician must provide a written referral to the non-Participating Practitioner specialist and the services are subject to prior written approval by CDPHP's Medical Director.

L. Prosthetic and Orthotic Devices and Durable Medical Equipment.

Durable Medical Equipment (DME): devices and equipment ordered by a practitioner for the treatment of a specific medical condition which: 1) can withstand repeated use for a protracted period of time; 2) are primarily and customarily used for medical purposes; 3) are generally not useful in the absence of illness or injury; and 4) are usually not fitted, designed or fashioned for a particular person's use. DME intended for use by one person may be custom-made or customized. DME Coverage includes equipment servicing (labor and parts) if it is not Covered under a manufacturers warranty or purchase agreement. CDPHP shall decide whether replacement or repair is more appropriate. However, in CDPHP's sole discretion, repair or replacement of parts may be used as an alternative to purchase or rental. The benefit must be recommended by a Participating Physician, and it must be approved in writing by CDPHP's Medical Director. CDPHP reserves the right to determine whether rental or purchase is more appropriate. CDPHP shall cover the purchase or rental once during your lifetime of a particular piece of equipment or prosthesis.

Prosthetic Appliances: are those appliances and devices ordered by a qualified practitioner, which replace any missing part of the body. Coverage is not provided for cranial prostheses (i.e. wigs) and dental prostheses, except those made necessary due to Accidental Injury to sound, natural teeth and provided within 12 months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstructive surgery. Replacement, repair and maintenance of equipment or prosthesis is Covered when functionally necessary.

Orthotic Devices: are those devices, which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Devices prescribed solely for use during sports are not covered.

M. Physical and Occupational Therapy Services.

Includes Medically Necessary therapy ordered by a licensed physician, up to an aggregate of 20 visits for physical therapy and up to an aggregate of 20 visits for occupational therapy, per Calendar Year for a condition amenable to significant clinical improvement within a two month period, beginning with the first day of therapy.

N. Speech and Hearing Services.

Includes hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist. One hearing examination per Calendar Year is Covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be Covered. Hearing aids, including batteries and repairs, are Covered. If Medically Necessary, more than one hearing aid will be Covered.

Covered speech therapy services, up to an aggregate of 20 visits per Calendar Year, are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy.

O. Diabetic Services.

1. Medically Necessary diabetic supplies and equipment, when prescribed or recommended by a Participating Physician or other Participating Practitioner legally authorized to prescribe under Title 8 of the New York State Education Law:
   a. Pre-authorization by CDPHP's Medical Director is required for Medically Necessary Durable Medical Equipment. This equipment includes items such as: injection aids, insulin pumps and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors and blood glucose monitors for the legally blind.
   b. Up to a 30-day supply of insulin and oral agents for controlling blood sugar, test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, and cartridges for the legally blind.
   c. Additional equipment and supplies designated by the Commissioner Health as appropriate for the treatment of diabetes.
2. Medically Necessary self-management education and education relating to the diet of persons diagnosed with diabetes when provided by the physician or his/her staff, as part of an office visit for diabetes Diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, is available upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education is Medically Necessary.

P. Organ Transplant Services.

1. Covered services include all Medically Necessary Hospital care at a CDPHP-approved transplant center and all Medically Necessary medical, surgical and other care otherwise Covered under this Contract.
2. Organ donation—CDPHP will cover the expense for donor hospitalization and related services directly related to the donation of an organ used in a Covered organ transplant (see Section Ten, Exclusion 37).
3. Bone Marrow Searches—When the National Marrow Donor Program or the International Bone Marrow Transplant Registry or an equivalent registry or bank is utilized by a CDPHP-approved transplant center, CDPHP will provide Coverage for confirmatory typings for up to 10 individual potential donors. This Coverage will be provided once per bone marrow transplant.

Q. Outpatient Dialysis Services.

If you have chronic kidney failure and need hemodialysis or peritoneal dialysis, benefits are available for these services on an ambulatory or home basis as follows:

1. In a Participating Provider Hospital-based or freestanding facility, dialysis treatment on a walk-in basis will be Covered if the facility and its programs are approved by the appropriate governmental authorities.
2. For home treatment, benefits will be provided for the reasonable rental cost of equipment, as determined by CDPHP, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by your physician and approved by CDPHP's Medical Director. However, Covered benefits do not include any furniture, electrical or other fixtures, plumbing or professional assistance needed to perform the dialysis treatments at home.
3. For these home and facility-based benefits to be Covered, the treatments must be provided, supervised or arranged by your Participating Practitioner.

R. Laboratory Services.

1. CDPHP will provide Coverage for laboratory services when ordered by a Participating Practitioner and received through a Participating laboratory Provider designated by CDPHP.
2. CDPHP will also provide Coverage for laboratory services performed in conjunction with inpatient, outpatient, preadmission testing, ambulatory surgery and Emergency room services.

S. Hospice Services.

Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.

1. Inpatient Services—Care in a Participating Provider hospice or in a Participating Provider Hospital.
2. Outpatient Services—Home Health Care and outpatient services provided by a Participating Provider hospice including drugs and medical supplies.
3. Family Visits—Five visits for bereavement counseling, either before or after the terminally ill Member's death.
4. Limitations—Hospice organizations must be certified under Article 40 of the NYS Public Health Law. Services are subject to prior authorization, and must be provided according to a written plan of care.

T. Breast Reconstruction Surgery.

Coverage for breast reconstruction surgery after a mastectomy for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of mastectomy, including lymphedemas; in the manner determined by the attending physician and the patient to be appropriate.

U. Autism Spectrum Disorder.

CDPHP will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this paragraph, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

1. Screening and Diagnosis. CDPHP will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
2. Assistive Communication Devices. CDPHP will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of an assistive communication device when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; CDPHP will only cover devices that generally are not useful to a person in the absence of a communication impairment. CDPHP will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. CDPHP will, however, cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. CDPHP will determine whether the device should be purchased or rented.

   Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, CDPHP will cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. CDPHP will not provide coverage for delivery or service charges or for routine maintenance.

   Prior approval of assistive communication devices is required. Refer to the prior approval procedures in this Contract.
3. Behavioral health treatment. CDPHP will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. CDPHP will provide such coverage when provided by a licensed provider. CDPHP will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention) in objective and measurable terms.

   CDPHP coverage of applied behavior analysis services is limited to $45,000 per Member per Calendar Year. This maximum annual benefit will increase by the amount calculated from an increase in the medical component of the Consumer Price Index (CPI) as required by New York law.

4. Psychiatric and Psychological care. CDPHP will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.
5. Therapeutic care. CDPHP will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.
6. Pharmacy care. CDPHP will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law when prescription drugs are otherwise covered under this Contract. CDPHP coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Contract.

   CDPHP will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The parent or guardian of the child to whom this Contract is issued agrees to provide CDPHP, upon request, with a copy of the child's individualized education plan so that CDPHP can determine its coverage obligations under this section.

SECTION SIX—DENTAL CARE

CDPHP will pay for dental treatment that is medical in nature (e.g., fracture repair, tumor removal, treatment of accidental injury, and congenital disease management.

CDPHP's designated dental care organization will pay for the following services:

1. Emergency Dental Care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
2. Preventive Dental Care, which includes procedures that help to prevent oral disease from occurring, including, but not limited to:
   - Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
   - Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
   - Sealant on unrestored permanent molar teeth.
   - Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
3. Routine Dental Care, including:
   - Dental examinations, visits and consultations covered once within a six (6) month consecutive period (when primary teeth erupt);
   - X-ray, full mouth x-rays at thirty-six (36) month intervals if necessary, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals if necessary, and other x-rays as required (once primary teeth erupt);
   - All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care;
   - In-office conscious sedation;
   - Amalgam, composite restorations and stainless steel crowns; and
   - Other restorative materials appropriate for children.
4. Endodontics, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
5. Prosthodontics as follows:
   - Removable complete or partial dentures, including six (6) months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate;
   - Fixed bridges are not covered unless they are required:
     - For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with otherwise full complement of natural, functional and/or restored teeth;
     - For cleft palate treatment or stabilization; or
     - Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

SECTION SEVEN—PRESCRIPTION DRUGS

A. Coverage for Prescription Drugs is subject to the following conditions:

1. The prescription for the drug must be written by a Participating Practitioner, or approved in advance by CDPHP's Medical Director or his/her designee if the prescription for the drug is written by a non-Participating Practitioner.
2. The prescription for the drug must be filled at a pharmacy, which is a pharmacy within CDPHP's designated pharmacy benefit manager's network.

3. Only Medically Necessary doses of Prescription Drugs are Covered.
4. The maximum supply shall be limited to a 30-day supply, the amount prescribed, or the commonly accepted unit of use, whichever is less.
5. You must present a signed prescription for the drug from your Primary Care Physician, another Participating Practitioner, or a non-Participating Practitioner if prior approved by CDPHP's Medical Director or his/her designee, at the time you receive the initial supply of a Covered Prescription Drug.
6. You must show your ID Card for each supply or refill of a Covered Prescription Drug.
7. Unless otherwise indicated by the prescribing provider, all Prescription Drugs will be filled with generic Prescription Drugs. For the purposes of this Coverage, "generic" Prescription Drugs are those drugs classified as "generic" by CDPHP's designated pharmacy benefits manager; "brand" Prescription Drugs are those drugs classified as "branded" or "non-generic" by CDPHP's designated pharmacy benefits manager. See Section A.12 below for information on CDPHP's formulary.
8. Refills of Prescription Drugs shall be dispensed only as ordered by a Participating Practitioner or non-Participating Practitioner if approved by CDPHP's Medical Director or his/her designee, subject to the maximum supply limitations in paragraph A.4 above.
9. In the event that no pharmacy within CDPHP's designated pharmacy benefit manager's network is able to provide the ordered Prescription Drug within a reasonable time, you may, with CDPHP's prior approval, go to any other pharmacy in the Service Area that can fill the prescription. Upon receipt from you of a completed Claim Form or documentation deemed acceptable by CDPHP, CDPHP will pay you the Eligible Expense for such Prescription Drug.
10. Injectable or implantable contraceptive drugs prescribed for non-contraceptive purposes, and intra-venous (IV) and intra-muscular (IM) Prescription Drugs or biologicals, which are usually considered to be self-administered, are Covered and must be prior approved by CDPHP's Medical Director or his/her designee. This includes intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals, which are usually considered to be self-administered, but are being administered by the practitioner in his/her office for reasons other than medical necessity.
11. Compounded medications must contain at least one legend ingredient, which has a valid NDC number.
12. Coverage is subject to the CDPHP Prescription Drug Formulary that is in effect on the date the prescription is filled. The following types of prescription drugs may require prior approval: injectibles, recombinant DNA products, immune-modulating agents, monoclonal antibodies, enteral formulas/modified solid food products, weight loss agents, cosmetic agents used for non-cosmetic medical diagnoses, compounded prescriptions and COX-2 inhibitors. It is your responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in you being responsible for the total cost of the drug. You also may contact the Member Services Department at (518) 641-3800 or 1-800-388-2994 or may consult the CDPHP Web site at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is Covered or if prior approval is required.
13. Enteral formula prescriptions are subject to prior approval by CDPHP.
14. Prescription Drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Coverage for such modified food products for any continuous period of 12 months for any Member shall not exceed $2,500.
15. Non Prescription Drugs which appear on the Medicaid drug formulary are Covered.
16. Certain Covered Prescription Drugs that are prescribed generally to promote increased quality of life and are not generally prescribed for daily use to treat a potentially life-threatening or disabling progressive medical condition may be limited in Coverage based on medical necessity. All requests for potentially non-Medically Necessary supplies of these drugs will be subject to CDPHP's utilization review process including all avenues of appeals (see Section 13).
17. Contraceptive drugs and devices that require a prescription and/or insertion by a Participating Practitioner and are approved by the Federal Food and Drug Administration are Covered when prescribed for contraceptive or non-contraceptive purposes.

B. The following items are excluded from Coverage:

1. Over-the-counter drugs or any drug not requiring a prescription, except as explicitly Covered in paragraph A.15 above.
2. Injectibles, except as described in paragraph A.10 above, and biological serum.
3. Vitamins, except those requiring a prescription, even if they are ordered by a Participating Practitioner.
4. Experimental and/or investigative drugs. All determinations regarding requests for potentially experimental and/or investigative drugs will be subject to Section Ten, Exclusions, and the review procedures in the Member Contract including all avenues of appeals (see Section 13).
5. Devices of any type (except those devices specifically Covered in paragraph A.17) such as, but not limited to, syringes, therapeutic devices, appliances and hypodermic needles, even if they must be ordered by the provider.
6. Refills will not be Covered if they are needed because you lose or misuse your supply of Prescription Drugs, even if such a refill is ordered by the Practitioner.
7. Prescription refills in excess of the number specified by the provider or dispensed more than one year from the date of the Practitioner original order.
8. Any drug, medicine or medication used for cosmetic purposes. All determinations regarding requests for potentially cosmetic drugs, medicine or medication used for cosmetic purposes will be subject to Section Ten, Exclusions 10 and the review procedures in the Member Contract including all avenues of appeals (see Section 13).
9. Drugs used in connection with a non-Covered service or a non-Covered benefit.
10. Drugs or pharmacological therapies recognized by CDPHP as being not Covered per paragraph A.12. above.

11. Drugs used for weight loss and/or the management of obesity require prior approval by the Medical Director or his/her designee in conjunction with approved medical management guidelines.
12. Elective nutritional supplements.

SECTION EIGHT—EMERGENCY, PREVENTIVE AND ROUTINE VISION CARE

A. Emergency, Preventive and Routine Vision Care. We will pay for emergency, preventive and routine vision care. You do not need your Primary Care Physician's authorization for covered vision care if you seek such care from a qualified participating provider of vision care services.

B. Vision Examinations. We will pay for vision examinations performed by a Participating Physician or Participating Practitioner optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to:
- Case history
- External or internal examination of the eye
- Ophthalmoscopic exam
- Determination of refractive status
- Binocular balance
- Tonometry tests for glaucoma
- Gross visual fields and color vision testing
- Summary findings and recommendations for corrective lenses

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

D. Frames. We will pay for standard frames adequate to hold lenses once in any 12-month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.

E. Contact Lenses. We will pay for contact lenses only when deemed medically necessary.

F. Limitations. Coverage for standard prescribed lenses, frames and contact lenses is limited to the following amounts:

$25 Frames
$30 Single Lenses
$50 Double Lenses
$60 Triple Lenses
$75 Contact Lenses
NO Dispensing Fee

Full coverage for standard lenses and frames is available within these limits from Participating Practitioners.

We will not pay more than these amounts for lenses, frames and/or contact lenses. If you would like to purchase a more expensive line of lenses, frames and/or contact lenses, you are responsible for any amounts due above and beyond these amounts.

SECTION NINE—LIMITATIONS OF COVERAGE

A. Referred Health Services

1. Referral by a Primary Care Physician to a Participating Practitioner: In the event that Covered Health Services cannot be provided by your Primary Care Physician, you shall be referred to another Participating Practitioner for Health Services. Such Health Services must be authorized in advance by your Primary Care Physician and be Covered by CDPHP, subject to the limitations and exclusions of the Contract. CDPHP will not pay for referral Health Services not authorized in advance by your Primary Care Physician except for necessary Emergency care as described in Section Nine.B. and other Medically Necessary services as described in Section Nine.D.
2. Referral by Participating Physician to a non-Participating Practitioner: In the event that Covered Health Services cannot be provided by a Participating Practitioner, you shall be referred to another physician or practitioner for Health Services. Such Health Services must be authorized in advance by your Primary Care Physician, and approved in writing by CDPHP's Medical Director prior to the services being rendered. The services provided will be subject to the limitations and exclusions of the Contract. CDPHP will not pay for any referral Health Services without prior approval by CDPHP's Medical Director and advance authorization from your Primary Care Physician, except for necessary Emergency care as described in Section Nine.B. and other Medically Necessary services as described in Section Nine.D.
3. a. When you have a medical condition that requires ongoing care from a specialist, a referral may be issued to that specialist for up to one year, provided that CDPHP, or your Primary Care Physician in consultation with CDPHP's Medical Director and a specialist, if any, determines that such a referral is appropriate.
   b. If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, which requires specialized medical care over a prolonged period of time, you may receive a referral to a specialist with expertise in

treating the life-threatening or degenerative and disabling disease or condition. Such specialist shall be responsible for and capable of providing and coordinating your primary and specialty care, provided that CDPHP, or your Primary Care Physician in consultation with CDPHP's Medical Director and a specialist, if any, determines that your care would most appropriately be coordinated by such a specialist. Such a referral shall be made pursuant to a treatment plan approved in advance by CDPHP, in consultation with your Primary Care Physician, if appropriate, the specialist and you or your designee. Such specialist shall be permitted to treat you without a referral from your Primary Care Physician and may authorize such referrals, procedures, tests and other Health Services as your Primary Care Physician would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

c. If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, which requires specialized medical care over a prolonged period of time, you may receive a referral to a specialty care center with expertise in treating your life-threatening or degenerative and disabling disease or condition, provided that CDPHP, or your Primary Care Physician, or the specialist designated pursuant to paragraph A.3.b. above, in consultation with CDPHP's Medical Director, determines that your care would most appropriately be provided by such a specialty care center. Such a referral shall be made pursuant to a treatment plan developed by the specialty care center and approved in advance by CDPHP, in consultation with your Primary Care Physician, if appropriate, the specialist designated pursuant to paragraph A.3.b. above and you or your designee.

B. Emergency Room Health Services

1. Covered in the United States, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and Canada: Emergency department Health Services are Covered in the event of an Emergency (as defined in Section Two). You are responsible for the Emergency Copayment for Emergency department Health Services, even if authorized by a Participating Practitioner or Provider, unless you are admitted to the Hospital for observation or as an inpatient within 24 hours of the Emergency department Health Services for the same illness or injury. You should contact your Primary Care Physician within 48 hours of receiving Emergency department Health Services, or as soon thereafter as is reasonably possible. Full details of the Emergency department Health Services provided shall be made available to CDPHP at its request. If you are hospitalized at a non-Participating Provider Hospital, you may be transferred to a Participating Provider Hospital, upon request of the Primary Care Physician and/or CDPHP's Medical Director, as soon as it is medically appropriate in the opinion of the attending physician. Emergency department Health Services are not subject to prior approval.

C. Hospital and Home Health Care Services

1. You must notify CDPHP to arrange and authorize care if, on the Member Effective Date of the Contract, you:
   a. were admitted to a Hospital under another plan and are currently an inpatient or admitted to that Hospital; or
   b. are scheduled to be admitted to a Hospital or other health care facility; or
   c. are receiving Home Health Care.

D. Covered Health Care Services That Do Not Require a Referral

The following Covered Health Care Services do not require a referral as described in Section Nine.A.1. and A.2:

1. Office and Home Visits, including periodic health examinations when the services are rendered by your Primary Care Physician or designated Participating OB/GYN Practitioner as described in Section Five.A.1;
2. Reproductive Health Services when the services are rendered by your designated Participating OB/GYN Practitioner as described in Section Five.A.6;
3. Obstetrical Services, including but not limited to, prenatal care, delivery and postpartum care when the services are rendered by your designated Participating OB/GYN Practitioner as described in Section Five.A.8;
4. Emergency, Preventive, and Routine Vision Care when the services are rendered by a Participating Practitioner as described in Section Eight;
5. Medically Necessary treatment and diagnostic testing for the sole purpose of inducing pregnancy when the services are rendered by your Primary Care Physician or designated Participating OB/GYN Practitioner as described in Section Five.A.6;
6. Participating Provider Urgent Care Facility Services as described in Section Five.E.2;
7. Emergency Room Health Services as described in Sections Five.E.1. and E.2.(see also Section Nine.B.).
8. Dental Care as described in Section Six.
9. Outpatient Acute Mental Health Care Services rendered by a psychologist or social worker that are coordinated by CDPHP as described in Section Five.H. Services rendered by a psychiatrist still require a referral from your Primary Care Physician.
10. Outpatient Chemical Abuse and Dependency Treatment Services that are coordinated by CDPHP as described in Section Five.H.
11. If your Primary Care Physician has referred you to receive Health Services from a Participating Practitioner specialist practicing in one of the following specialties, the Participating Practitioner specialist may refer you to receive Physical and/or Occupational Therapy Health Services as described in Section Five.M., subject to all other terms and limitations in this Contract: neurology, pediatric neurology, neurosurgery, orthopedic surgery, physiatry, rheumatology, vascular surgery, pulmonary medicine and hand surgery. Participating Practitioner podiatry specialists are also included in this list for referrals for Physical Therapy only;
12. Your designated Participating OB/GYN Practitioner may refer you to receive Health Services from other Participating Practitioners, which are specifically related to obstetrical and/or gynecological Diagnoses, subject to all other terms and limitations of this Contract.

E. Case Management Program

1. Case Management.
   Case Management is the use of an individualized approach to assist Members in obtaining Medically Necessary Health Services. CDPHP may provide case management for Members with a chronic, debilitating or catastrophic injury or illness. The CDPHP representative providing the case management will be a licensed, certified or registered health professional.
2. Alternative or Additional Benefits.
   Notwithstanding any other provisions in this Contract, CDPHP may review your health status and the plan of care of your practitioner to determine whether certain levels of care, providers or services, which are not included in your contract, may be desirable or appropriate.
   CDPHP may make available alternative or additional care, which, in the judgment of the CDPHP representative, is an appropriate alternative or addition to inpatient or surgical Health Services. The provision of this alternative or additional care is a substitute for the Health Services Covered by the Contract. You may reject or discontinue CDPHP's proposal of any alternative or additional care at the time of the proposal or at any time thereafter.
   You agree that CDPHP may have access to and review on a concurrent basis any of your Hospital and other medical records to evaluate alternative or additional care possibilities. Any proposal of alternative or additional care is limited to the facts and circumstances of the particular case reviewed and does not apply to any other case of yours or to any other Member. Case Management is not a substitute for the advice and guidance of your provider.
3. Termination of Program Participation.
   Either you or CDPHP may terminate participation in the case management program at any time for any reason. CDPHP will provide you with at least 30 days' prior written notice of termination of the provision of any alternative or additional care under this Section. After such termination, CDPHP will provide Coverage for Health Services subject to the terms and conditions of this Contract.

F. Organ Transplant Services.

1. Pre-Certification Review of Organ Transplant Services.
   You or your physician must notify CDPHP's Utilization Management Department when your physician recommends organ transplant services. The following organ transplant services must be performed at a center in CDPHP's designated specialty care network: Transplantation of any organ or tissues, including bone marrow and stem cell transplantation.
   It is your responsibility to make sure that this review process is followed. After review, CDPHP will notify you, your physician, and the Hospital or facility that the care is determined to be Medically Necessary and appropriate. If CDPHP's Medical Director or his/her designee determines that it is not Medically Necessary for you to have the proposed services, CDPHP will telephone your physician. If the physician provides CDPHP with additional information, CDPHP's Medical Director or his/her designee may reconsider the medical necessity of the service. If CDPHP's Medical Director or his/her designee does not give approval for the service, you will be notified.

SECTION TEN—EXCLUSIONS

In addition to certain exclusions and limitations already described in this Contract, we will not provide coverage under this Contract when any of the following apply to you:

1. Any Accidental Injury or sickness for which benefits, settlement(s), award(s), or damages are:
   a. received from a claim under:
      i. Workers' Compensation;
   b. received or payable from a claim under:
      i. Employer's Liability, or Occupational Disease Law; or
      ii. Medicare.

   Notwithstanding any other law or agreement to the contrary, and except in the case of a child or children who also becomes eligible for medical assistance, benefits under this title shall be considered secondary to any other plan of insurance or benefit program, except the physically handicapped children's program and the early intervention program, under which an eligible child may have coverage.
2. No benefits will be paid under the Contract for any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.
3. Health Services for the treatment of Mental Health Conditions, except for the following: acute mental, nervous, or emotional disorders, which are susceptible to short-term treatment and pose a serious threat to your mental or physical well-being; medication management; and neuropsychological testing related to a medical Diagnosis (see Sections Five.G. and H. of the Contract).
4. Any Health Services rendered after the termination of Coverage unless otherwise provided by this Contract. (see Section Eleven).
5. Prosthetic and orthotic devices, Durable Medical Equipment, and supplies, except as explicitly provided under the Contract (see Section Five.L.). Duplicate equipment or devices (e.g. one for home and one for school). Repair or replacement of Durable Medical Equipment, prosthetic devices or orthotic devices due to loss, misuse or neglect. Environmental control items including, but not limited to, air conditioners, humidifiers, dehumidifiers and/or air purifiers. Repairs of equipment or devices that are subject to manufacturer warranty. Charges related to the shipping, handling and/or delivery of Covered

equipment or devices. Equipment or devices prescribed solely for use during sports or for employment. Computer assisted communication devices or electronic communication devices that are not implanted into the body. Medical supplies, except for supplies associated with Covered devices or equipment that are included in the rental fee or purchase price of the device or equipment.

6. Any dental care and treatment except for the treatment of sound natural teeth needed as a result of an Accidental Injury occurring within 12 months from the date of the Accidental Injury and except for dental care or treatment necessary due to congenital disease or anomaly, and except as explicitly provided under the Contract (see Section Six).
7. Coverage for temporomandibular joint disease (TMJ) is excluded when it is dental in nature.
8. Non-Medically Necessary Cosmetic Services, including plastic surgery, and elective treatment for aesthetic improvement of non-disabling physical defects or problems. This exclusion shall not apply to a cosmetic operation when it is Medically Necessary, or reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly which results in a functional impairment. Reconstructive surgery shall not include surgery for scar repair/revision only, where no functional defect is present. Nothing herein shall be interpreted to preclude the application of Insurance Law § 4303 regarding breast reconstruction surgery after a mastectomy. Requests for potentially cosmetic procedures and services will be subject to CDPHP's Utilization Review process, including all avenues of appeals (see Section 13).
9. Health Services, which are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or illness or to maintain your health. The Contract only covers Medically Necessary services.
10. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as "Procedures") not proved to be safe and/or efficacious, or, because of your condition, an efficacious procedure that will have no effect on the outcome of your illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized United States authorities or United States governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Procedures that are ineffective or are in the stage of being tested or researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures, which are proven to be safe and efficacious for a particular illness, injury or disease, which have received approval from the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment are Covered. CDPHP reserves the right to determine Coverage on a case-by-case basis. Nothing herein shall be interpreted to preclude the application of Insurance Law Section 4303 regarding cancer drugs (See Section 7 (B)(4)). CDPHP's Medical Director shall have the authority to determine issues of Coverage raised under this Paragraph 11, and such determination is final as long as it is neither arbitrary nor capricious. CDPHP's Medical Director's determination is subject to the Resolving Differences procedures outlined in the Member Handbook.

    In general, CDPHP does not cover experimental or investigational treatments. If, in accordance with the Member Handbook, an external appeal agent overturns CDPHP's denial, CDPHP shall Cover the experimental or investigational treatment. If the external appeal agent approves Coverage for an experimental or investigational treatment that is part of a clinical trial, CDPHP will only Cover the costs of services required to provide treatment to you according to the design of the trial. CDPHP shall not be responsible for the cost of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.
11. Health Services received from a non-Participating Practitioner unless recommended by your Primary Care Physician with CDPHP's prior written approval, except in an Emergency (see Section Nine).
12. Personal conveniences while an inpatient in a Hospital or other health care facility, such as private room, television, barber or beauty services, guest services and similar incidental services and supplies which are not Medically Necessary as part of your care.
13. Services performed by your immediate family including spouse, brother, sister, parent or child.
14. Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research, travel, school or camp.
15. Free care or care where no charge, in the absence of the Contract, would be made to you.
16. Services for which, in the absence of any Health Services plan or insurance plan, no charge would be made to you.
17. Any injury or illness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage for such injury or illness is provided through any governmental plan or program.
18. Inpatient and outpatient Hospital services, unless arranged in advance by a Participating Physician or Medically Necessary because of an Emergency.
19. Hospital clinic services unless arranged in advance by a Participating Physician and prior approved by CDPHP's Medical Director.
20. Benefits otherwise provided in the Contract which CDPHP is unable to provide because of any law or regulation of the federal, state or local government, or any action taken by any agency of the federal, state or local government in reliance on said law or regulation.
21. Long-term Physical Therapy or long-term rehabilitation.
22. Non-Emergency Health Services rendered outside the Service Area where you should have reasonably foreseen the need for such services prior to leaving the Service Area, unless CDPHP approves such services in writing, in advance.
23. Any expense as a result of your failure to vacate your Hospital bed beyond the discharge time or date established by the Hospital, Participating Physician and CDPHP.

24. Supplies (except for supplies used during a home care visit and contraceptive supplies for family planning), appliances, cosmetics, computer assisted communication devices or electronic communication devices which are not implanted into the body, convenience items such as: air conditioners, humidifiers, personal comfort items, wigs, cranial prostheses, hair replacements and athletic equipment even though prescribed by a physician. Not included here are supplies and equipment, which would be provided under Section Five.L.
25. Routine foot care. This includes, but is not limited to, services or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
26. Any Health Services resulting from your commission of a felony.
27. Custodial care or rest cures and services rendered for your or your provider's convenience.
28. Court-ordered treatment for Mental Health Conditions and/or Health Services, unless such treatment and/or services are rendered by a Participating Provider and are determined to be Medically Necessary.
29. Services required by an employer.
30. Payment will not be provided for services rendered in connection with an inpatient stay or portion of an inpatient stay for drug or alcohol addiction rehabilitation, except as explicitly provided in Section Five.G.
31. Intensive weight loss programs.
32. Storage of blood or blood products. This does not apply to autologous (one's own blood) blood donations. Benefits for transfusion services, including storage, for autologous donations of blood and blood components are available when associated with a scheduled, Covered Surgical Procedure.
33. Blood products (factors) are not covered on an outpatient basis or at home.
34. Infertility services and assisted reproductive services, including the following: in vitro fertilization; ZIFT (Zygote Intrafallopian Transfer); GIFT (Gamete Intrafallopian Transfer); and all expenses related to reversal of voluntary sterilization, including vasectomy and tubal ligation, sex change procedures, cloning, or medical or surgical procedures that are deemed experimental in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine.
35. Devices or equipment used primarily for the purpose of athletic activities.
36. Benefits or services prescribed by a physician but not expressly Covered by the Contract.
37. CDPHP will not provide Coverage for transplants of artificial or animal organs, travel, food, and lodging for transplant recipient or donor, or costs relating to searches or screenings beyond that provided for in Section Five.P., paragraph 3 for donors of organs to be transplanted. All requests for potentially experimental or investigative procedures and services will be subject to CDPHP's Utilization Review process including all avenues of appeals (see Section 13).
38. Laboratory services are not Covered unless provided in accordance with Section Five.
39. Treatment provided in a governmental Hospital, or other institution, which is owned, operated or maintained by the Veterans Administration, the federal government, a state government, or any local government, unless the Hospital is a Participating Provider. However, CDPHP will pay for care Covered under the Contract in a governmental Hospital, if because of serious injury or sudden illness, you are taken to such a Hospital for Emergency care because it is close to the place where you were injured or became ill. In this type of Emergency situation, CDPHP will continue to make payments only for as long as Emergency care is necessary and until it is possible for you to be transferred to a Participating Provider Hospital.
40. You are financially liable for services received from a non-Participating Practitioner/Provider (except with prior written approval from CDPHP), for services received from any practitioner/provider without the required authorization from CDPHP, or for any non-Covered procedure, treatment or service.
41. Transsexual surgery and all related services, unless it is Medically Necessary.
42. Orthodontia. We will not provide coverage for orthodontia services.
43. Private duty nursing.
44. Home health care, except as explicitly provided in Section Five.
45. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
46. Services in a skilled nursing facility or rehabilitation facility.

SECTION ELEVEN—TERMINATION OF THIS CONTRACT

Described below are reasons why this Contract may terminate.

1. Default in Payment of Premiums. If you are required to pay all or a portion of your premium under this Contract, this Contract will automatically terminate as of the date to which your premium has been paid if we do not receive the premium by the *end of the grace period*. If the premium is not paid by the *end of the grace period*, you will not be entitled to any service under this Contract given to you after the date to which your premium has been paid. If you receive care from a CDPHP physician following the date this Contract terminates, the adult must pay the CDPHP physician at his or her normal charges. However, if you are totally disabled on the date this Contract terminates you will continue to be entitled to service covered under this Contract for the condition, which caused the disability (See Paragraph "6" below).
2. If You No Longer Qualify. If you no longer meet the Child Health Plus eligibility requirements your coverage will end. You will no longer be eligible for Child Health Plus: on the last day of the month in which you reach the age of 19; or the date

on which you are enrolled in the Medicaid program; or the date on which you become covered under other health coverage. This Contract will terminate on the first day of the month following any event that results in your no longer meeting the Child Health Plus eligibility requirements.

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

3. When the State Child Health Plus Program Terminates. This Contract will terminate on the date when the State law that establishes and provides funding for the Child Health Plus Program is terminated, or on the date our participation in the Child Health Plus Program terminates.
4. Your Option to Terminate This Contract. You or the adult may terminate this Contract at any time by giving us at least 30 days prior written notice. If this Contract is terminated in this manner we will refund any portion of the premiums for the Contract, which have been prepaid.
5. Our Option to Terminate This Contract. We may terminate this Contract for any of the following reasons:
   A. If we discontinue the entire class of contract to which this Contract belongs. In other words, we may terminate this Contract if we also terminate the same contract held by everyone else. We will give you or the adult at least 5 months written notice that this Contract will be terminated in this manner.
   B. We may terminate this Contract for any reason, which is approved by the Superintendent of Financial Services. If this Contract is terminated in this manner, a copy of the reason will be provided to you upon request. We will give you or the adult at least 30 days written notice that this Contract will be terminated in this manner.
   C. We may terminate this Contract for fraud committed by you when you applied for this Contract or when you filed any claim under this Contract.
   D. If you move outside of the State you will no longer be eligible to participate in the Child Health Plus program and this Contract will be terminated.
   E. If you move outside our Service Area, this Contract will terminate. Our Service Area is the counties of Albany, Broome, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington in the State of New York.
6. Benefits After Termination. If you are, in our sole judgment, totally disabled on the date this Contract terminates, and you have received service or care for the illness, condition or injury which caused your total disability while you were covered under this Contract, we will continue to provide care relating to the total disability covered under this Contract during an uninterrupted period of total disability until the first of the following dates:
   A. A date you are, in our sole judgment, no longer totally disabled.
   B. A date twelve months from the date this Contract terminates.
   C. However, we will not pay for more care than you would have been entitled to receive if your coverage under this Contract had not terminated.

SECTION TWELVE—RIGHT TO NEW CONTRACT AFTER TERMINATION

If this Contract terminates under the circumstances described below, you may continue CDPHP coverage by purchasing a new contract.

1. If You Reach the Maximum Age For Coverage Under the Child Health Plus Program. If this Contract terminates because you reach the maximum age for coverage under the Child Health Plus program you are entitled to purchase a new contract as a direct payment subscriber.
2. Termination of the State Child Health Plus Program. If this Contract is terminated because the State Child Health Plus program terminates you are entitled to purchase a new contract as a direct payment subscriber.
3. When to Apply for the New Contract. If you are entitled to purchase a new contract, as described above, you must apply to us for the new contract within 31 days after termination of this Contract. You must also pay the first premium for the new contract within this same 31-day period.
4. The New Contract. The new contract will be the contract that is generally issued by us to direct payment subscribers.

SECTION THIRTEEN—CLAIMS AND APPEALS PROCEDURES

A. How to File a Complaint

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

You can file a verbal complaint:

To file a complaint by phone, call the Member Services department at (518) 641-3800 or 1-800-388-2994. If we need more information to make a decision, we will tell you.

You can file a written complaint:

- by writing us a letter, or

- by asking us for a complaint form to fill out.

To get a complaint form, call us at (518) 641-3800 or 1-800-388-2994. Mail your complaint (form or letter) to:

CDPHP
Attn: Quality Enhancement Department
6 Wellness Way, Latham, NY 12110

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

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

We will give you or your designee a written decision on your complaint within 30 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 workday, we will send you a letter telling you why. We will then make a decision based on the information we have, and inform you of the decision within the next 15 workdays.

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

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

B. 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'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 decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file a grievance.

C. How to File a Grievance

If you do not like a decision CDPHP 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) 641-3800 or 1-800-388-2994. 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) 641-3800 or 1-800-388-2994. Mail your grievance (form or letter) to:

CDPHP
Attn: Appeals Department
6 Wellness Way, Latham, NY 12110

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

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

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

D. Appeals

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

Send your appeal letter or form to: CDPHP, Attn: Appeals Department, 6 Wellness Way, Latham, NY 12110 or call member services at (518) 641-3800 or 1-800-388-2994 for help.

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

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

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

For all other appeals, CDPHP 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.

E. Utilization Management Decisions

CDPHP has a utilization review (UM) team made up of doctors and nurses. Qualified health care professionals make all UM decisions. If you disagree with a UM decision, our resource coordination department (1-800-274-2332) 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 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 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.

If you need home health care services following an inpatient hospital admission, we will notify you or your designee of our decision by telephone and writing within one business day of receipt of all necessary information; or, when the day subsequent to the request falls on a weekend or holiday, within 72 hours of receipt of all necessary information. When we receive a request for

home health care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home health care services, either on the basis of medical necessity or for failure to obtain prior authorization, while our decision on the request is pending.

Retrospective Review

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

Urgent Review

An urgent (fast) decision can be made in some prior approval, prospective review, and concurrent review cases. We will make a fast decision when waiting for the above 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.

Urgent care utilization review 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 the approved period of time or number of treatments, a decision will be made as soon as possible, taking your medical needs into account. We will tell you our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

Reconsideration of Reviews

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

Notice of Appeal Rights

All notices of decisions from CDPHP 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 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.

F. Utilization Review Appeals

You or your designee can appeal a utilization review (UR) decision. Just call member services at (518) 641-3800 or 1-800-388-2994 to appeal any CDPHP 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, or
- you want to appeal an adverse UR decision relating to home health care services following an inpatient hospital admission.

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 practitioner/provider by telephone and in writing of what we need. A clinical peer reviewer will be available to talk with you or your designee within one workday after we get notice of the UR appeal. The decision on your appeal will not be made by the same reviewer who decided it the first time.

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

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

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

- If we need any additional information to decide your UR appeal, we will send you or your practitioner/provider a letter within five days after we get your UR appeal.
- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
- If we do not make a fast track or standard decision within the above 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. You can also file an expedited external appeal at the same time you file a fast track internal appeal. See the following section.

G. External Appeals

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

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

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

- Your doctor tells us that you have a 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.
- Your doctor has:
  a. recommended a service or pharmaceutical product (as described in New York Public Health Law § 4900(5)(b)(B)) that is more likely to help 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 State Department of Financial Services to find out more; or
  b. recommended a rare disease treatment. In such case, your attending physician must certify that there is not standard treatment that is likely to be more clinically beneficial than the requested treatment, the recommended rare disease treatment is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the treatment; or
  c. recommended a clinical trial for which you are eligible (only certain clinical trials are covered).
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition. In addition, for a rare disease treatment, the attending physician may not be your treating physician.
- 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:
  a. certified that the out-of-network health service is materially different than the alternate recommended in-network service; and
  b. recommended a health care service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.
- You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

If you wish, 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 who are certified by the Commissioner of the New York State Department of Health. These agents are randomly assigned to conduct external appeals.

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

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

External appeal requests must be in writing on a standard New York State Department of Financial Services 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 (518) 641-3800 or 1-800-388-2994 or NYSDFS at 1-800-400-8882. It is also available online at www.dfs.ny.gov or www.health.ny.gov.

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

You, your designee, and your doctor may submit supporting documents to the external appeal agent during the same 45-day period. If these documents contain new information that is different from the facts 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.

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 workdays to decide your case. The agent will notify you and CDPHP, in writing, of the decision within two workdays after the decision is made.

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

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

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

H, CDPHP 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 grievance committee. This option is not available if you have an external review. You must ask us for a hearing (verbal or written) within 60 workdays after we tell you of our appeal decision.

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

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

A hearing will be held within 45 days after you make your request. The hearing will be led by the chairperson of the CDPHP 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 grievance committee will send you or your representative a letter with its decision within five workdays after the hearing. The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision.

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

I. Board of Directors

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

J. Complaints to New York State

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

New York State Department of Health
Corning Tower Building
Empire State Plaza
Albany, NY 12237
1-800-206-8125
www.health.ny.gov
or
New York State Department of Financial Services
1 Commerce Plaza
Albany, NY 12257
1-800-342-3736
www.dfs.ny.gov

SECTION FOURTEEN—GENERAL PROVISIONS

A. Entire Contract.

The Contract, shall constitute the entire Contract between the parties. All statements made by the adult or you shall be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Contract or be used in defense to a claim unless in writing signed by the adult and/or you.

B. Time Limit on Certain Defense.

No statement, except a fraudulent misstatement, shall be used to void the Contract after it has been in force for a period of two (2) years.

C. Alteration.

No alteration of the Contract and no waiver of any of its provisions shall be valid unless evidenced by an endorsement of an amendment attached to the Contract, which is signed by the President of CDPHP. No agent has authority to change the Contract or to waive any of its provisions.

D. Consent to Release Medical Information.

1. By accessing Coverage under this Contract, each Member consents to the release of all medical information, including any mental health, alcoholism and/or substance abuse treatment records and any confidential HIV related information, to CDPHP and to any professional or entity assisting CDPHP in providing services, including, but not limited to, managing health care services, administering claims and pursuing proper payment of claims to such an extent as may be reasonable to enable CDPHP to provide services under the Contract.
2. Unless otherwise prohibited by law, the adult and/or you give implied consent to release medical information upon presenting your CDPHP ID Card to any practitioner/provider.
3. CDPHP shall have the right to deny Health Services or to refuse reimbursement for Health Services to you if you refuse to consent to release medical information.
4. You agree to execute any releases for medical records and information which CDPHP requests of you.

E. Forms.

Application/Change Forms shall be made available to you during CDPHP's regular business hours.

F. Records.

1. The adult and/or you shall furnish CDPHP with all information and proofs, which CDPHP may reasonably require with regard to any matters pertaining to the Contract. All documents furnished by the adult and/or you and any other records, which may have a bearing on the Coverage under the Contract shall be open for inspection by CDPHP at any reasonable time.
2. The adult and/or you authorize and direct any person or institution that has examined or treated you to furnish CDPHP upon its request any or all information and records or copies of records relating to the examination or treatment rendered to you. CDPHP shall have the right to submit any and all records concerning Health Services rendered to you to appropriate medical review personnel.

   In the event of a question or dispute concerning the provision of Health Services or payment for such services under the Contract, CDPHP may reasonably require that you be examined, at CDPHP's expense, by a Participating Physician designated by CDPHP.

G. Notice.

All notices to the parties to the Contract shall be in writing, postage prepaid, and shall be deemed given when mailed. The notices shall be mailed to you at the address on file at CDPHP and to CDPHP at the address indicated on the cover page of this Contract or to such other address or person designated by either party, in writing, during the term of the Contract.

H. Covered Benefits.

In no event shall you be responsible to pay for Health Services Covered by the Contract except as otherwise provided in the Contract.

I. Severability.

The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

J. Workers' Compensation Not Affected.

The Coverage provided under the Contract is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

K. Pronouns.

All personal pronouns used in the Contract shall include either gender unless context indicates otherwise.

L. Conformity with Statutes.
The Contract shall be governed by the Laws of the State of New York.

M. Events Beyond Our Control.
In the event of circumstances not reasonably within the control of CDPHP (such as complete or partial destruction of health care facilities, war, riot, civil insurrection or similar causes), CDPHP shall not be responsible for the provision of Health Services.

N. Waiver.
Either party's waiver or failure to insist on strict performance of the Contract shall not be considered a waiver or act as a bar to any action for subsequent acts of non-performance.

O. Interpretation.
CDPHP may adopt and amend from time to time reasonable and uniform policies, procedures, rules, regulations, guidelines and interpretations in order to promote the orderly and efficient administration of the Contract, all of which shall be binding upon you upon reasonable notification of you.

P. Construction
CDPHP shall have final authority to construe and interpret all terms in the Contact, including any terms that may appear unclear or uncertain. Any construction of the provisions of the Contract adopted by CDPHP in good faith shall be binding upon you.

Q. Change in Status
You and/or the responsible adult, as listed on the application, must report to us any change in status, such as residency, income or other insurance, that may make you ineligible for participation in Child Health Plus, within 60 days of such change. Failure to report such change within 60 days may result in a penalty in the amount of your Child Health Plus subsidy.

R. Anti-Vesting
CDPHP retains the right to modify the Contract with the approval of the Superintendent of Financial Services. CDPHP will provide you with 90 days advance notice of any such modification. Any modification will be considered as a termination of this contract pursuant to Section Eleven. All rights vested under this Contract will be extinguished at the end of the Benefit Period during which this Contract is terminated.

S. No Assignment
You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.

T. Legal Action
You must bring any legal action against us under this Contract within 12 months from the date we refused to pay for a service under this Contract.

6 Wellness Way • Latham, NY 12110 • (518) 641-3800

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
6 Wellness Way
Latham, NY 12110
(518) 641-3000

RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

The Contract to which this Rider is attached is amended as follows:

Section Five – Covered Health Care Services is amended to add a new paragraph:

V. Blood Clotting Factor: We will pay for blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an outpatient basis. We will pay for blood clotting factor products and services when infusion occurs in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a child that is physically and developmentally capable of self-administering such products.

All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Capital District Physicians' Health Plan, Inc.

By:

John D. Bennett, MD
President and CEO

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
6 Wellness Way
Latham, NY 12110
(518) 641-3000

RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

The Contract to which this Rider is attached is amended as follows:

Section Five – Covered Health Care Services is amended to add a new paragraph:

W. Ostomy Equipment and Supplies: CDPHP will provide coverage for ostomy equipment and supplies when prescribed by a physician or other licensed health care provider.

Paragraph 24 of Section Ten – Exclusions is replaced by the following:

24. Supplies (except for supplies used during a home care visit and contraceptive supplies for family planning), appliances, cosmetics, computer assisted communication devices or electronic devices that are not implanted into the body, convenience items such as: air conditioners, humidifiers, personal comfort items, wigs, cranial prostheses, hair replacements and athletic equipment even though prescribed by a physician. Not included here are assistive communication devices, which would be provided under Section 5.U. Not included here are supplies and equipment, which would be provided under Section 5.L and Section 5.W.

All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Capital District Physicians' Health Plan, Inc.

By:

John D. Bennett, MD
President and CEO

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RIDER TO CHILD HEALTH PLUS CONTRACT

Issued by

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

The Contract to which this Rider is attached is amended as follows:

Paragraph U of Section Five – Covered Health Care Services is amended as follows:

Subparagraph 3 of Paragraph U– Autism Spectrum Disorder is replaced by the following:

3. Behavioral health treatment. CDPHP will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. CDPHP will provide such coverage when provided by a licensed provider. CDPHP will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

CDPHP coverage of applied behavior analysis services is limited to 680 hours per Member per Calendar Year.

All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Capital District Physicians’ Health Plan, Inc.

By:
John D. Bennett, MD
President and CEO

Form # 3705-0515

Important Information and Notes

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