

Looking Out For You

Health Maintenance Organization (HMO)

Point of Service (POS)

Traditional Indemnity

Preferred Provider Organization (PPO)

Exclusive Provider Organization (EPO)

HMO/POS Members have a two level grievance procedure which is outlined below.

Traditional Indemnity/PPO/EPO Members have a one level grievance procedure with the following time frames for notification of the grievance decision:

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



Looking Out For You

Resolving Differences

If you are dissatisfied with any aspect of your care or coverage, call Customer Service. If we cannot resolve your problem by phone, we have other procedures to help you.

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

The Grievance Procedure

Our grievance and appeal procedure ensures a timely review of:

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

When can I file a grievance?

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

- denial of a referral to a specialist;
- denial of coverage for a referred service;
- denial because a benefit is not covered according to the terms of your contract(s);
- denial of a benefit because it was provided by an ineligible provider or at an ineligible place of service;
- determination that you were not a member of the plan at the time services were rendered.
- We will not take any discriminatory action against you because you have filed a grievance or an appeal.

Can I have someone represent me in the grievance and appeal procedure?

Yes. If you designate a representative, we will communicate with you and your representative, unless directed otherwise. To appoint a representative, you must complete, sign, and return the Appointment of Authorized Representative Form. Call Customer Service to request this form. In cases involving urgent care, a healthcare professional with knowledge of your medical condition may act as your authorized representative without completing the Appointment of Authorized Representative Form.

How do I file a grievance?

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

Telephone: Call Customer Service to initiate the grievance toll free at 1-800-459-7587, 8:00 a.m. to 7:00 p.m., Monday through Friday. When our offices are closed, you may notify us about your grievance by leaving a detailed message with our answering service. We will acknowledge receipt of your oral grievance by phone within one business day of receipt of the message. We can communicate with non-English speaking members through the AT&T translator service.

Written: Please send your written requests for a grievance to:

BCBSWNY/BSNENY Grievance Unit
Customer Service Department
PO Box 15013
Albany, New York 12212-5013



What happens after I file a grievance?

We will send you a notice of receipt of your grievance within 15 calendar days. This letter will include the name, address and phone number of the department that is handling your grievance. We may need additional information before we can review your grievance. If so, we will contact you.

A customer service representative who was not involved in the initial determination and who is not a subordinate of the initial reviewer will thoroughly research the case by contacting all appropriate departments and providers. The customer service representative will review all relevant documents, records and other information including any written comments, documents, records and other information you or your representative have submitted.

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

When will I be notified of the grievance decision?

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

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

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

Our response will include:

- A written detailed explanation and reasons for the determination resulting from the investigation
- The clinical rationale for those determinations with a clinical basis, without releasing protected peer review information
- Or a written statement that insufficient information was presented or available to make a determination
- Notice of the right to appeal a grievance determination, the procedures and forms needed for filing such an appeal.

The Appeal Process - What can I do if I still don't agree with the decision?

If you are not happy with our decision about your grievance, you may file an appeal. Your request for an appeal should include any additional information you feel is necessary. You have 60 business days from the time you receive the grievance determination to submit an appeal to us. You may submit your request for an urgent appeal verbally or in writing. For a non-urgent appeal, you may submit your request verbally, written in the form of a letter or you may use our appeal form. You will receive a copy of our appeal form with the original grievance decision. You may submit any written comments, documents, records or other additional information with your appeal.

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

Denials of requested out-of-network service

You may appeal a denial of a requested out-of-network service when denied on the basis that it is not materially different from an alternate in-network service. In order to initiate an appeal, the following information must be submitted:

- A written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the enrollee for the health service sought and that the requested out-of-network health service is materially different from the health service that the health care plan approved to treat the insured's health care needs; and
- Two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the enrollee than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

Who will review my appeal?

Non-clinical matters will be reviewed by a panel from our Network Management, Customer Service, Quality Management and Medical Management areas who were not previously involved in your grievance.

If your appeal involves a clinical matter, it will be reviewed by a panel of personnel qualified to review clinical matters. This includes licensed, certified or registered healthcare professionals who did not make the initial determination.

At least one of the healthcare professionals reviewing your appeal will be a clinical peer reviewer. A clinical peer reviewer is a licensed physician or a licensed, certified, or registered healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. All adverse determinations, including claim denials, will be made by the clinical peer reviewer. All final adverse determinations will be made by a clinical peer reviewer other than the clinical peer reviewer who made the initial adverse determination.

Notice of the adverse determination will be in writing and will include the reasons for the determination and instructions on how to initiate standard or expedited appeals and an external appeal.



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When will I be notified of the appeal decision?

Pre-service (before service is provided)

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

Post-service (after service is provided)

- For post-service claims, a written decision will be provided within 30 calendar days from receipt of the appeal.

Our notification to you regarding your appeal will include the detailed reasons for our determination, the provisions of the contract, policy, or plan on which the decision was based, and the clinical rationale in cases where the determination has a clinical basis.

What is Utilization Review?

Utilization Review Policies and Procedures review is a process used to determine if services are or were medically necessary, experimental or investigational.

Utilization review occurs when judgments are made regarding medical necessity and the provision of services or treatments. All decisions are made by qualified clinical personnel. Denial notices will include the reason for their decision and if there are further appeal rights.

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

- For chiropractic services, call toll free 1-888-774-7601.
- For behavioral health and chemical dependency services call toll free 1-877-837-0814.

How Do I Initiate Utilization Review?

For questions about the UM review process, including UM decision making, or to request a utilization review, you may contact us by phone or in writing at:

BCBSWNY/BSNENY
Customer Service Department
PO Box 15013
Albany, New York 12212-5013
1-518-220-5800 or 1-800-459-7587

The request should include the name and ID number of the member for whom the review is requested and the facts relating to the case. Our telephones are staffed Monday through Friday during normal business hours. All other times leave a message on our confidential voice mail. We will contact you by telephone within one business day after receipt of your message.

What is a Pre-Service Claim?

Pre-service claims are for procedures or treatments that require prior authorization. We will make a determination regarding your pre-service claim and provide notice by telephone and/or writing to you or your representative and/or your doctor within 3 business days after receiving all necessary information.

If all necessary information to render a decision has not been provided, we may give you an opportunity to submit the missing information. If so, we will notify you in writing within 3 business days after receipt of your claim of the specific missing information. We will allow you up to 45 calendar days from the date of our notice to provide the missing information.

If we receive all information requested, we will make a decision and provide notice by telephone and in writing within 3 business days of receipt of the information. If we do not receive any information by the end of the 45-day period, we will make a decision and provide notice by telephone and in writing within 15 calendar days from the end of the 45-day period.

If you or your authorized representative fail to follow our procedures for properly filing a pre-service claim, we will notify you or your authorized representative verbally or in writing within 3 business days after receipt of your claim of the proper procedures for filing a pre-service claim. If the pre-service claim involves urgent care, we will notify you within 24 hours after receipt of your claim. We will only provide this notice if the following requirements are satisfied:

- The initial communication by you or your authorized representative is received by the Medical Management Area at 1-800-422-7333;
- The communication includes the name of the claimant;
- The specific medical condition or symptom is indicated; and
- A specific treatment, service or product is requested.

What is a Concurrent Care Claim?

Concurrent care claims involve continued or extended healthcare services or additional services for a member undergoing a course of continued treatment prescribed by a doctor/practitioner for a specific period of time or a specified number of treatments.

For non-urgent concurrent care claims, we will render a decision and provide notice to you or your designee by telephone and in writing within one business day of receipt of all necessary information, except with respect to Home Health Care (HHC) following inpatient hospital admission, within 72 hours when the day subsequent to the request falls on a weekend or holiday (provided the request for HHC is submitted prior to discharge from an inpatient hospital admission).



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

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

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

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

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

What is an Urgent Care Claim?

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

We will make a decision and provide notice by telephone and in writing to you or your representative within 24 hours after receipt of all necessary information.

If you fail to provide all necessary information, we will notify you within 24 hours after receipt of your claim of the information necessary to complete the claim. You will have 48 hours to give us the missing information. We will notify you of our decision within 48 hours after receiving the missing information or by the end of the 48-hour period afforded you to provide the additional information, whichever is earlier.

What is a Post-Service Claim?

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

- If all necessary information is not provided, we may provide you with an opportunity to submit the missing information. If we allow the extension, we will notify you in writing within 30 calendar days after receipt of your claim of the specific missing information. We will allow you up to 45 calendar days from the date of our notice to provide the missing information.
- If we receive any of the information requested, we will render a decision within 15 calendar days after receipt of the information. If no information is received, we will render a decision within 15 calendar days after the end of the 45 calendar day period.
- If we fail to make a utilization review decision within the timeframe above, it will be deemed an adverse determination subject to the internal appeals process.

Right to Reconsideration

In situations where there has been a denial of services as not medically necessary and we have not discussed the matter with the provider who recommended the services, procedure or treatment under review, the provider has the right to request a reconsideration of the denial. The reconsideration review shall occur within 1 business day of receipt of the request, except when the reconsideration request is for services already provided.

Reversal of a Pre-Authorized Treatment Service or Procedure Retrospectively

- when the relevant medical information presented to us is materially different from the information that was presented during the preauthorization review; and
- the relevant medical information presented to us upon the retrospective review existed at the time of the pre-authorization but was withheld from or not made available to us; and
- we were not aware of the existence of the information at the time of the pre-authorization review; and
- if we had been aware of this information, the treatment, service, or procedure being requested would have not been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the pre-authorization review.

Use Management (UM) Appeals Process

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

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



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

- Initiate a standard appeal
- Initiate an expedited appeal
- Request an external appeal
- Request a written statement of clinical rationale, including the clinical review criteria used.

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

Can I Have Someone Represent Me for My Appeal?

Yes. If you designate a representative, we will communicate with you and your representative, unless directed otherwise. To appoint a representative, you must complete, sign, and return the Appointment of Authorized Representative Form. Call Customer Service at 1-800-459-7587 for a form. If the case involves urgent care, a healthcare professional with knowledge of your medical condition may act as your authorized representative and does not need to complete the Appointment of Authorized Representative Form.

Requesting a standard appeal

Once you receive our adverse decision, you or someone you designate may file an appeal in writing or by phone. You have 180 calendar days from the date of receipt of our initial adverse determination to request an appeal. The notice we send you explains why we made an adverse decision and includes the phone number you can call to request an appeal. Once we receive the appeal request, we'll obtain a copy of the medical record. We will let you know that we received the appeal request by sending you, or your representative, an acknowledgement letter within 15 calendar days of the date we receive the request. Our medical director, or a physician consultant who is in the same profession and same or similar specialty as the doctor who typically manages the medical condition or disease or provides the healthcare service or treatment under review, will review your records. The reviewer will not have been involved in the original decision, and will not report to the person who made the initial determination.

When will I be notified of the appeal decision?

We will provide a written decision to you, your representative, and where appropriate, your doctor within 2 business days of the decision, but not later than 30 calendar days after receipt of your appeal for pre-service claims and 60 calendar days after receipt of your appeal for post-service claims. If we do not change our original decision, we will give you the medical reason for the decision. When you receive our final adverse determination, you may request an external review.

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

1. A clear statement describing the basis and the specific, scientific, or clinical rationale for the denial.
2. Reference to the evidence or documentation used as a basis for the decision, including whether any internal rule, guideline, protocol or similar criterion was used in making the determination. In cases involving a denial of services, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used will be provided.
3. The provisions of your policy, contract or plan on which the determination is based.
4. A clear statement that the notice is the final adverse determination.
5. Our contact person and his/her phone number.
6. Your coverage type.
7. The name and full address of our utilization review agent.
8. The utilization review agent's contact person and his/her phone number.
9. A description of the health service that was denied, including, where applicable and available, the name of the facility and/or physician proposed to provide the treatment/or the developer/manufacturer of the healthcare service.
10. A statement that you may be eligible for an external appeal and the time frames for requesting the appeal.
11. A statement that you are entitled to receive, on request and free of charge:
 - Reasonable access to and copies of all documents, records and other information relevant to the claim.
 - A copy of each internal rule, guideline, protocol or similar criterion that was used to make the determination on appeal.
 - The name of any medical or vocational experts whose advice was obtained in connection with the determination without regard to whether the advice was relied upon in making the determination.
12. The information supplied by the Commissioner of the Department of Financial Services describing the external appeal process.
13. A statement you may have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).



What is an Expedited Appeal and when can I request one?

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

- continued or extended healthcare services;
- procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her doctor; or
- a situation where your doctor believes an immediate appeal is needed.
- any situations in which a delay in the appeal process would increase risk to your health.
- Home Health Care Services following discharge from an inpatient hospital admission.

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

We encourage physicians and specialty providers to share information by phone and/or fax. You, or the person acting for you, can contact both the nurse and physician to talk about the appeal. You can do this within 1 business day of the date we receive the notice of expedited appeal. We will make a decision and call you about the expedited appeal within 2 business days after receipt of all necessary information or within 72 hours, whichever is less. We'll also send you written notice within 24 hours of the decision.

The notification will include the information referenced above for a final adverse determination.

When you receive our final adverse determination on the expedited appeal, you may request a standard appeal or an external review.

Your grievance/appeal and utilization appeal rights

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

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

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

The NYS External Appeals Process

- If you receive a final adverse determination, you have the right to an NYS external appeal of certain coverage determinations made by us. An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by New York State, and may not have an affiliation with any health insurer, Health Maintenance Organization (HMO), medical facility, member or doctor associated with the appeal.
- In general, you may not request an external appeal unless you have:
 1. received a final adverse determination as a result of our first level UR standard or expedited appeal process; or
 2. we both have jointly agreed to waive the internal process; or
 3. you have filed both an expedited appeal request with us and an expedited external appeal at the same time; or
 4. we did not comply with the internal appeal requirements for your appeal.
- Standard external appeals: The External Appeals Agent will make a decision within 30 calendar days after receiving your completed application for appeal. 5 additional business days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by the plan, the plan will have 3 additional business days to reconsider or affirm its decision. You and the plan will be notified within 2 business days of the external review agent's decision.
- Expedited external appeals: You may have the right to an expedited external appeal if your doctor can attest that a delay in providing the requested service would pose an imminent or serious threat to your health or the denial concerns an admission, availability of care, continued stay or health care service for which you have received emergency services and remain hospitalized. The time frames for expedited external appeals are shorter than the time frames for standard external appeals. The expedited external appeal shall be completed within no more than seventy-two (72) hours of the request and the external appeal agent shall make every reasonable attempt to immediately notify you and us of its determination by telephone or facsimile, followed immediately by written notification of such determination.

What services are eligible for an external appeal?

To be eligible for external appeal, the final adverse determination must be based on a determination that:

- such health care service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or
- the service is experimental and/or investigational (includes clinical trials and rare disease treatments); or



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- a request for an out-of network service was denied on the basis that an alternate in-network service was available and your provider certifies that the requested service is materially different from, and likely to be more beneficial than, the in-network service, and the adverse risk of the requested service would likely not be substantially increased over the in-network service.

You do not have the right to an appeal of any other determinations, even if those other determinations affect your coverage.

Denial Involving Medical Necessity

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

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

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

Denial Involving Medical Necessity

You may ask for an external appeal if a requested service has been denied because it has been determined to be medically unnecessary. If the requested service is to be provided by a hospital, public health center, diagnostic and treatment center, or other health care facility, the facility must be licensed in New York State. However, if the facility is not licensed in New York State, you may request an external appeal only if we have referred you to the facility, or have pre-authorized or pre-certified services provided by the facility.

Experimental or Investigational Treatment Denials

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

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

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

Clinical Trials

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

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

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

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

Materially Different Out-of Network Request

The member or the member's designee may request an External Appeal when a preauthorization request for a particular out-of-network health service is denied because the out-of-network service is not materially different for the available in-network health service. This does not include a denial for 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 the member.

Rare Disease

An enrollee who may require "rare disease treatment" may seek an external review for an adverse determination. Treatments of "rare diseases" would be approved, upon external review, if they contain all of the following:

- A physician certification and evidence presented by the insured or the insured's physician
- The treatment for the rare disease would be "likely to benefit" the enrollee, and
- The benefit of such treatment outweighs the risk of said service or procedure.



What happens after the external appeal is requested?

After you, or your representative, or your attending physician applies for an external appeal:

- the appeal shall be screened by the NYS Department of Financial Services;
- you and/or us must release all pertinent medical information concerning the member's medical condition and request for services;
- an independent external appeal agent approved by the state will review the requests to determine if the denied services are medically necessary and should be covered by us;
- all external appeals will be conducted by clinical peer reviewers

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

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

Please note that if an external appeal of a concurrent adverse determination decides that the services are not medically necessary, the health care provider cannot collect payment from you except the required copayments

How do I request an external appeal?

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

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

Web site: www.dfs.ny.gov

Mail: New York State Department of Financial Services
One Commerce Plaza
Albany, NY 12257

Telephone: 1-800-400-8882

You shall have 4 months to initiate an external appeal after you receive notice from us, or our utilization review agent, if applicable, of a final adverse determination or denial or after we have jointly agreed to waive any internal appeal. Regardless of whether or not you participate in additional internal plan appeals (if available), an application for an external appeal must be filed with the NYS Department of Financial Services within 4 months of receipt of the notice of a final adverse determination from a first level internal plan appeal to be eligible for review by an external appeal agent.

You will lose the right to an external appeal if you do not file an application for an external appeal within 4 months of receipt of the final adverse determination from the first level internal plan appeal.

You (and your doctors) must sign an appropriate authorization to release all pertinent medical information concerning your medical condition and request for services.

If you have any questions, please call Customer Service.

Quality of Care Access Review

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

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

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



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Unresolved Disputes

We always recommend that you follow our grievance or utilization review process to remedy any issues concerning your coverage. If you are not satisfied with any BCBSWNY/BSNENY decision, you have the right to contact the New York State Department of Financial Services or New York State Department of Health. The addresses and phone numbers for these agencies are:

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

DOH hotline 1-800-206-8125

New York State Department of Financial Services
One Commerce Plaza
Albany, NY 12257

1-800-342-3736

What are my rights as an HMO member?

As a member, you have rights and responsibilities that will help you make the most of your health benefits. These rights range from being treated with respect and dignity, to confidentiality of your medical records and having the chance to voice complaints or appeals about the HMO or your care. These rights include, but are not limited to:

- You have the right to obtain complete and current information regarding a diagnosis, treatment or prognosis from a physician or other provider in terms that are easy to understand.
- If it is not advisable to give such information to the enrollee, the information shall be made available to an appropriate person acting on the enrollee's behalf.
- 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 can review the list in its entirety at our web site or contact Customer Service for a copy.

Planning in Advance

Per the New York Code Rules and Regulations 700.5(b)(1) you have the right to formulate advance directives. Advance directives may include:

- designating a health care proxy,
- designating a health care agent,
- a living will, or
- an order not to resuscitate

For more information on how to plan in advance, please visit the New York State Department of Health web site at www.health.state.ny.us or discuss with your doctor.

Additional Information Available on Request

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

- The names, business addresses and official positions of the officers and board of directors of BlueShield of Northeastern New York;
- A copy of our most recent annual certified financial statement including a balance sheet and summary of receipts and disbursements;
- Copies of our individual direct payment contracts;
- Information related to consumer complaints as reflected in the Annual Consumer Guide published by the New York State Department of Financial Services;
- Procedures for protecting the confidentiality of your medical records and membership information
- A description of organizational arrangements and ongoing procedures of our Quality Assurance program;
- A description of how determinations are made about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
- The specific written clinical review criteria relating to a particular condition or disease (this request must be in writing);
- A copy of our written application procedures and minimum qualification requirements for providers to be considered for participation with our plan;
- Information about specific individual provider affiliations with participating hospitals;
- Information on how we determine the usual and customary or reasonable charge. This includes the percentile upon which the schedule is based. This also includes the specific amount of reimbursement for a particular elective surgery or treatment;
- For members with prescription drug coverage, information about whether a specific drug is covered under your contract(s). You also have the right to review our drug formulary. A drug formulary is a list of quality, cost-effective medications that, if prescribed by your physician, will be covered under your prescription drug rider.



Physician Reimbursement

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

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

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

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

Agreed-upon Amount - A negotiated rate agreed to by a provider or medical facility and BCBSWNY/BSNENY.

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

Withhold - When we pay a doctor for the services he or she provides, we may withhold a small portion of the payment. We return this amount to doctors if they successfully operate within the established medical budget.

Protected Health Information

We work hard to protect your confidential information. We have established and enforce corporate security and privacy policies and procedures for oral, written and electronic data. All employees undergo privacy awareness training and are required to use appropriate physical, administrative and technical safeguards to ensure the privacy of your information.

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