MOLINA® HEALTHCARE

Child Health Plus

New York State's Health Plan for Kids

# CHILD HEALTH PLUS

## SUBSCRIBER CONTRACT

For information regarding your contract please call Molina Healthcare of New York, Inc. Member Services at:

1-800-223-7242
TTY: New York Relay: 1-800-662-1220


## CHILD HEALTH PLUS SUBSCRIBER CONTRACT

This is your Child Health Plus Contract with Molina Healthcare of New York, Inc. ("Molina Healthcare"). It entitles you to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

## NOTICE OF 10-DAY RIGHT TO EXAMINE CONTRACT

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

## IMPORTANT NOTICE

All services covered under this Contract must be provided, arranged or authorized by your Primary Care Physician. You must contact your Primary Care Physician in advance in order to receive benefits, except for emergency care described in Section Five, for certain obstetric and gynecological care described in Section Four, vision care described in Section Six, and except for dental care described in Section Seven of this Contract.

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# SECTION ONE:
# INTRODUCTION

## Child Health Plus Program

This Contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. We will enroll you in the Child Health Plus Program if you meet the eligibility requirements established by New York State and you will be entitled to health care services described in this Contract. 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 30 days of the change.

## Health Care through an HMO

This contract provides coverage through an HMO. In an HMO, all care must be medically necessary and provided, arranged or authorized in advance by your Primary Care Physician (PCP). Except for emergency care, for certain obstetric and gynecological services, and for vision and dental services there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when your PCP refers you to a non-participating provider.

It is your responsibility to select a PCP from the list of PCPs when you enroll for this coverage. You may change your PCP by calling the Member Services Department at 1-800-223-7242 (TTY: New York Relay at 1-800-662-1220). The PCP you have chosen is referred to as "your PCP" throughout this Contract.

## Words We Use

Throughout this Contract, Molina Healthcare of New York, Inc. will be referred to as "we", "us" or "our". The words "you", "your" or "yours" refer to you, the child to whom this Contract is issued and who is named on the identification card.

## Definitions

The following definitions apply to this Contract:

**Contract** means this document. It forms the legal agreement between you and us. Keep this Contract with your important papers so that it is available for your reference.

**Emergency Condition** means 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 a condition in serious jeopardy, or in the case of behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment of such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person, or (D) serious disfigurement of such person.

**Emergency Services** means those physicians and outpatient Hospital services necessary for treatment of an Emergency Condition.

**Hospital** means a facility defined in Article 28 of the Public Health Law which:

- is primarily engaged in providing, by or under the continuous supervision of physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a physician or dentist;
- provides 24-hour nursing service by or under the supervision or a registered professional nurse (R.N.);
- 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});
- is duly licensed by the agency responsible for licensing such hospitals; and

- 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.

**Medically Necessary** means services and supplies which are necessary to prevent, diagnose, correct or cure conditions in a person that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person's capacity for normal activity, or threaten some significant handicap.

**Participating Hospital** means a hospital that has an agreement with us to provide covered services to our members.

**Participating Pharmacy** means a pharmacy that has an agreement with us to provide covered services to our members.

**Participating Physician** means a physician who has an agreement with us to provide covered services to our members.

**Participating Provider** means any participating physician, hospital, home health care agency, laboratory, pharmacy, or other entity, which has an agreement with us to provide covered services to our members. We will not pay for health services from a non-participating provider except in an emergency or when your PCP sends you to a non-participating provider with our approval.

**Primary Care Physician (PCP)** means any Participating Physician you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all of your covered health care services.

**Service Area** means the following counties:

- Onondaga County
- Oswego County
- Tompkins County
- Cortland County

You must reside in the Service Area to be covered under this Contract.

## SECTION TWO:
## WHO IS COVERED?

### Who is Covered Under this Contract?

You are covered under this Contract if you meet all of the following requirements:

- You are younger than age 19.
- You do not have other health care coverage, which covers most of the services covered under this Contract ("equivalent coverage").
- You are not eligible for Medicaid.
- You are a permanent New York State resident and a resident of our Service Area.
- Your parent or guardian is not a public employee 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 coverage.
- You are not an inmate of a public institution or a patient of an institution for mental diseases.

**Recertification:** We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. Annually, you must resubmit an application to us so that we can determine whether you still meet the eligibility requirements. This process is called "recertification". If more than one child in your family is currently covered by us, then the recertification date for all the children in your family covered by us will be the same You must recertify once each year unless another child in your family applies for coverage with us after you are covered. If another child in your family applies for coverage with us, then all other children will be recertified when that child's coverage is effective. Thereafter, all the children in your family covered by us will recertify once each year on the same date.

**Change in Circumstances:** You must notify us of any changes to your income, residency or health care coverage that might make you ineligible for this contract. You must give us this notice within 30 days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.

**Care in a Hospital, Mental Health or Alcohol/Substance Abuse Facility:** You are covered for medically necessary care as an inpatient in a Hospital if all the following conditions are met:

- Except if you are admitted to the Hospital in an Emergency or your PCP has arranged for your admission to a non-Participating Hospital, the Hospital must be Participating Hospital.
- Except in an emergency, your admission is authorized in advance by your PCP.
- You must be a registered bed patient for the proper treatment of an illness, Injury or condition that cannot be treated on an outpatient basis.

## Covered Inpatient Services

Covered inpatient services under this Contract include the following:

- Daily bed and board in semi-private room, including special diet and nutritional therapy;
- General, special and critical care nursing service, but not private duty nursing service;
- Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;
- Oxygen and other inhalation therapeutic services and supplies;
- Drugs and medications that are not experimental;
- Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;
- Blood products, except when participation in a volunteer blood replacement program is available;
- 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 electroencephalographic studies and examinations;

- Facilities, services, and supplies related to physical medicine and occupational therapy and rehabilitation;
- Facilities, services, supplies, and equipment related to radiation and nuclear therapy;
- Facilities, services, supplies, and equipment related to emergency medical care;
- Chemotherapy;
- Radiation therapy;
- Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services; and
- 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.

## Maternity Care

Other than for perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a Caesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Caesarean Section. Maternity care coverage includes parent education, assistance and training in breast or bottle-feeding and performance of necessary maternal and newborn clinical assessments.

You have the option to be discharged earlier than 48 hour (96 hours for Caesarean Section). If you choose an early discharge, we will pay for one home care visit if you ask us to within 48 hours of delivery (96 hours for delivery by Caesarean Section). The home care visit will be delivered within 24 hours of the later of your discharge from the Hospital or your request for home care. The home care visit will be in addition to the home care visits covered under Section 9 of this Contract.

## Limitations and Exclusions

We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not medically necessary.

Benefits are paid in full for semi-private room. If you are in a private room at a Hospital, the difference between the cost of a private room and semi-private room must be paid by you unless the private room is medically necessary and ordered by your physician.

Mental Health or Alcohol and Substance Use disorder limited to thirty (30) days per calendar year.

We will not pay for non-medical items such as television rental or telephone charges.

## SECTION FOUR:
## MEDICAL SERVICES

### 1. Your PCP Must Provide, Arrange or Authorize all Medical Services

Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:

- Your PCP's office.
- Another provider's office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition.
- The outpatient department of a Hospital.
- As an inpatient in a Hospital, you are entitled to medical, surgical and anesthesia services.

### 2. Covered Medical Services

We will pay for the follow medical services:

**A. General medical and specialist care, including consultations.**

**B. Preventive health services and physical examinations.**

We will pay for preventive health services including:

- Well child visits in accordance with the visitation schedule established by the American Academy of Pediatrics,
- Nutrition education and counseling,
- Hearing testing,
- Medical social services,
- Eye screening,

- Routine immunizations in accordance with the Advisory Committee on Immunization Practices recommended immunization schedule,
- Tuberculin testing,
- Dental and developmental screening,
- Clinical laboratory and radiological testing; and
- Lead screening.

**C. Diagnosis and treatment of illness, injury or other conditions.**

We will pay for the diagnosis and treatment of illness or injury including:

- Outpatient surgery performed in a provider's office or at an ambulatory surgery center, including anesthesia services,
- Laboratory tests, x-rays and other diagnostic procedures,
- Renal dialysis,
- Radiation therapy,
- Chemotherapy,
- Injections and medications administered in a physician's office,
- Second surgical opinion from a board certified specialist,
- Second medical opinion provided by an appropriate specialist, including one affiliated with a specialty care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer, and

Medically necessary audiometric testing.

**D. Physical and Occupational Therapy.**

We will pay for Short Term physical and occupational therapy services. The therapy must be skilled therapy. Short Term means (provide your Plan's definition).

**E. Radiation Therapy, Chemotherapy and Hemodialysis.**

We will pay for radiation therapy and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

**F. 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 a qualified Participating Provider of obstetric and gynecologic services. You may also receive the following services from a qualified Participating Provider 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.

**G. 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.

**H. Screening, Diagnosis, and Treatment of an Autism Spectrum Disorder.**

**1. Autism Spectrum Disorder.** We will provide coverage for the following services when such services are prescribed or ordered by a participating network 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 section, "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).

**2. Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

**3. Assistive Communication Devices**. We 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 assistive communication devices 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. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktops, or tablet computers. We 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. We 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, we 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. We 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 your Contract.

4. **Behavioral health treatment.** We 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. We will provide such coverage when provided by a licensed provider. We 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.

Our coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

**5. Psychiatric and Psychological care.** We 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.

**6. Therapeutic care.** We 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 therapists or social workers under this Contract.

**7. Pharmacy care.** We 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. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Contract.

We 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.

**8. Hospice.** We will pay for hospice services. To be eligible for hospice services, a child must be certified by a physician as terminally ill, defined as having a medical prognosis for a life expectancy of six months or less if the illness runs its normal course. Hospice services may include pain and symptom management and family counseling provided by specially trained hospices staff. If a child elects to receive hospice services, the child also may continue to receive curative services.

Hospice services are provided to a patient to meet the special needs which are experienced during the final stages of illness and during dying and bereavement.

## SECTION FIVE:
## EMERGENCY CARE

### Hospital Emergency Room Visits

We will pay for Emergency Services provided in a Hospital emergency room. You may go directly to any emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval.

If you go to the emergency room, you or someone on your behalf should notify us within 24-hours of your visit or as soon as it is reasonably possible. If the emergency room services rendered were not in treatment of an Emergency Condition as defined in Section One, the visit to the emergency room will not be covered.

### Emergency Hospital Admissions

If you are admitted to the Hospital, you or someone on your behalf must notify us within 24-hours of your admission, or as soon as it is reasonably possible. If you are admitted to a non-Participating Hospital, we may require that you be moved to a Participating Hospital as soon as your condition permits.

### Pre-hospital Emergency Medical Services

We will pay for pre-hospital emergency medical services, including prompt evaluation and treatment for an emergency condition, and/or non-air-borne transportation of you to a hospital. Coverage for such 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 (i) 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; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

## Inpatient Mental Health and Alcohol Substance Use Disorder Services

We will pay for inpatient mental health services and inpatient substance use disorder services when such services are provided in a facility that is:

- Operated by the Office of Mental Health under section 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 Visits for Treatment of Mental Health Conditions and for Treatment of Substance Use Disorder

We will pay for up the outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if such visits are related to your mental health or substance use disorder treatment.

## SECTION SEVEN:

### OTHER COVERED SERVICES

### Diabetic Equipment and Supplies

We will pay for the following equipment and supplies for the treatment of diabetes, which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title 8 of the New York State Education Law:

- Blood glucose monitors;
- Blood glucose monitors for visually impaired;
- Data management systems;
- Test strips for monitors and visual reading;
- Urine test strips;
- Injection aids;
- Cartridges for visually impaired;
- Insulin;
- Syringes;
- Insulin pumps and appurtenances thereto;
- Insulin infusion devices;
- Oral agents; and
- Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

### Diabetes Self- Management Education

We will pay for diabetes self- management education provided by your PCP or another Participating Provider.

Education will be provided 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 as determined by us. We will also pay for home visits if medically necessary.

## Durable Medical Equipment

We will pay for devices and equipment ordered by a participating provider, including equipment servicing, for the treatment of a specific medical condition. Covered durable medical equipment includes:

- Canes;
- Crutches;
- Hospital beds and accessories;
- Oxygen and oxygen supplies;
- Pressure pads;
- Volume ventilators;
- Therapeutic ventilators;
- Nebulizers and other equipment for respiratory care;
- Traction equipment;
- Walkers, wheelchairs and accessories;
- Commode chairs and toilet rails;
- Apnea monitors;
- Patient lifts;
- Nutrition infusion pumps; and
- Ambulatory infusion pumps.

## Prosthetic Appliances

We will pay for appliances and devices ordered by a qualified practitioner which replace any missing part of the body, except that there is no

coverage for cranial prostheses (i.e. wigs). Further, dental prostheses are excluded from coverage under this section, except those: (1) made necessary due to an accidental injury to sound, natural teeth and provided within twelve months of the accident and/or (2) needed in the treatment of a congenital abnormality or as part of reconstructive surgery.

## Orthotic Devices

*Scope of Coverage*

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.

*Level of Coverage*

Devices prescribed solely for use during sports are not covered.

## Prescription and Non-Prescription Drugs

*Scope of Coverage*

We will pay for those FDA approved drugs, which require a prescription and are listed in our formulary. Our formulary is available by contacting Molina Healthcare of New York, Inc..

Member Services Department. We will pay for those non-prescription drugs which are authorized by a professional licensed to write prescriptions and which appear in the Medical drug formulary. We will also pay for medically necessary enteral formulas for the treatment of specific diseases and for modified solid food products used in the treatment of certain inherited diseases of amino acid and organic acid metabolism.

*Participating Pharmacy*

We will only pay for prescription drugs prescribed for use outside of a Hospital. Except in an emergency, the prescription must be issued by a Participating Provider and filled at a Participating Pharmacy.

*Exclusions and Limitations*

Under this Section, we will not pay for the following:

- Administration or injection of any drugs.
- Replacement of lost or stolen prescriptions.
- Prescribed drugs used for cosmetic purposes only.
- Experimental or investigational drugs.
- Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which the FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications:

- AMA Drug Evaluations;
- American Hospital Formulary Service;
- U.S. Pharmacopoeia Drug Information; or

- A review article or editorial comment in a major peer-reviewed professional journal.
- Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.
- Prescribed drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
- Prescription drugs used for purposes of treating erectile dysfunction.

## SECTION SEVEN:

### OTHER COVERED SERVICES

### Home Health Care

We will pay for up to forty visits per calendar year for home health care provided by a certified home health agency that is a Participating Provider. We will pay for home health care only if you would have to be admitted to a Hospital if home care was not provided.

Home care includes one or more of the following services:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, occupational or speech therapy if provided by the home health agency; and
- Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered if the covered person had been in a Hospital.

### Preadmission Testing

We will pay for preadmission 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 the Hospital have been made, prior to performance of tests;
- Your physician has ordered the tests;
- Surgery actually takes place within seven days of such preadmission tests.
- If surgery is canceled because of preadmission test findings, we will still cover the cost of these tests.

## Speech and Hearing

We will pay for speech and hearing services, including hearing aids, hearing aid batteries, and repairs. These services include one hearing examination per year to determine the need for corrective action. Speech therapy required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy, will be covered when performed by an audiologist, language pathologist, a speech therapist, and/or otolaryngologist.

## SECTION EIGHT:

## VISION CARE

### Emergency, Preventive and Routine Vision Care

We will pay for emergency, preventive, and routine vision care. You do not need your PCP's authorization for covered vision care if you seek such care from a qualified Participating Provider of vision care services.

### Vision Examinations

We will pay for vision examinations 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 examination of the eye or internal examination of the eye
- Opthalmoscopic exam
- Determination of refractive status
- Binocular distance
- Tonometry tests for glaucoma
- Gross visual fields and color vision testing
- Summary findings and recommendation for corrective lenses

### Prescribed Lenses

We will pay for quality standard prescription lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

### Frames

We will pay for standard frames adequate to hold lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation.

If medically warranted, more than one pair of glasses will be covered.

## Contact Lenses

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

## SECTION NINE:
## DENTAL CARE

### Dental Care

We will pay for the dental care services set forth in this contract when you seek care from a qualified Participating Provider of dental services.

### Emergency Dental Care

We will pay for emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

### Preventive Dental Care

We will pay for preventive dental care, which includes procedures which help to prevent oral disease from occurring, including:

- 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;
- Sealants on unrestored permanent molar teeth.

### Routine Dental Care

We will pay for 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.

## Endodontics

We will pay for endodontic services, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

## Periodontics

We will pay for periodontal services.

## Prosthodontics

We will pay for prosthodontic services 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 an otherwise full complement of natural, functional and/or restored teeth;
- For cleft-palate 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.

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.

## Orthodontia

Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to 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 the child does not meet the criteria described above.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE)
- Placement of component parts (e.g. brackets, bands)
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)
- Removable appliance therapy
- Orthodontic retention (removal of appliances, construction and placement of retainers)

## When a Specialist Can Be Your PCP

If you have a life threatening condition or disease or degenerative and disabling condition or disease, you may ask that a specialist who is a Participating Provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.

## Standing Referral to a Network Specialist

If you need ongoing specialty care, you may receive a "standing referral," to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether a "standing referral" would be appropriate in your situation.

## Standing Referral to a Specialty Care Center

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease you may request a standing referral to a specialty care center that is a Participating Provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.

## When Your Provider Leaves the Network

If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to 90 days after you are notified by us of the provider's leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former provider through delivery and post-partum care directly related to the delivery.

However, in order for you to continue care for up to 90 days or through a pregnancy with a former Participating Provider, the provider must agree to accept our payment and adhere to our procedures and policies, including those for assuring quality of care.

## SECTION TEN:
## ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

### When New Members Are In a Course of Treatment

If you are in a course of treatment with a non-Participating Provider when you enroll with us, you may be able to receive care from the non-Participating Provider for up to 60 days from the date you become covered under this Contract. The course of treatment must be for a life threatening disease or condition or degenerative and disabling condition or disease. You may also continue care with a non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract.

You may continue care through delivery and any post-partum services directly related to the delivery.

However, in order for you to continue care for up to 60 days or through pregnancy, the non-Participating Provider must agree to accept our payment and adhere to our policies and procedures including those for assuring quality of care.

## SECTION ELEVEN:
## ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

In addition to the limitations and exclusions already described, we will not pay for the following:

1. **Care that is Not Medically Necessary:** You are not entitled to benefits for any service, supply, test or treatment which is not Medically Necessary or appropriate for the diagnosis or treatment of your illness, injury or condition (See Section Fifteen).

2. **Accepted Medical Practice:** You are not entitled to services, which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.

3. **Care Which Is Not Provided, Authorized or Arranged by Your PCP:** Except as otherwise set forth in this Contract, you are entitled to benefits for services only when provided, authorized, or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.

4. **Inpatient services in a nursing home, rehabilitation facility, or any other facility not expressly covered by this contract.**

5. **Physician services while an inpatient of a nursing home, rehabilitation facility, or any other facility not expressly covered by this contract.**

6. **Experimental or investigational services unless recommended by an external appeal agent.**

7. **Cosmetic Surgery:** We will not pay for cosmetic surgery, except that we will pay for reconstructive surgery:

   - When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or

   - When required to correct a functional defect resulting from congenital disease or anomaly

8. **In vitro fertilization, artificial insemination or other assisted means of conception.**

9. **Private duty nursing.**

10. **Autologous blood donation.**

11. **Physical Manipulation Services.** We will not pay for any services in connection with the detection and correction (by manual or mechanical means) of:

    - Structural imbalance; or
    - Distortion; or
    - Subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

12. **Routine foot care.**

13. **Other Health Insurance, Health Benefits, and Governmental Programs:** We will reduce our payments under Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except Medicaid.

14. **No-Fault Automobile Insurance:** We will not pay for any service, which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.

15. **Other Exclusions.** We will not pay for:

    - Sex transformation procedures unless medically necessary;
    - Custodial care;
    - Transportation (non-Emergency);

- Over-The-Counter Drugs, except as defined;
- Personal or comfort items; or
- Durable medical equipment and supplies, except as listed.

16. **Workers' Compensation:** We will not provide coverage for any service or care for an injury, condition or disease if benefits are available to you under a Workers' Compensation Law or similar legislation. We will not provide benefits even if you do not claim the benefits you are entitled to receive under the workers' Compensation Law.

## SECTION TWELVE:
## PREMIUMS FOR THIS CONTRACT

### Amount of Premiums

The amount of premium for this Contract is determined by us and approved by the Superintendent of Financial Services of the State of New York.

### Your Contribution Toward the Premium

Under New York State Law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any.

### Grace Period

All premiums for this Contract are due one month in advance. However, we will allow a grace period for the payment of all premiums, except the first months.

This means that, except for the first month's premium for each child, 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, the coverage under this Contract will terminate as of the last day of the month of the grace period.

### Agreement to Pay For Services if Premium is Not Paid

You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.

### Change in Premiums

If there is to be an increase or decrease in the premium or your contribution toward the premium for this Contract, we will give you at least thirty days written notice of the change.

### Changes in Your Income or Household Size

You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at **1-800- 223-7242** or by calling the Child Health Plus Hotline at **1-800-698-4543**. At that time, we will provide you with

the form and documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within 10 business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than 40 days from the completed review request and supporting documentation.

## SECTION THIRTEEN:
## TERMINATION OF COVERAGE

### 1. For Non-Payment of Premium

If you are required to pay a premium for this Contract, this Contract will terminate at the end of the grace period if we do not receive your payment.

### 2. When You Move Outside the Service Area

This Contract shall terminate when you cease to reside permanently in the Service Area.

### 3. When You No Longer Meet Eligibility Requirements This Contract shall terminate as follows:

A. On the last day of the month in which you reach the age of 19; or

B. The date on which you are enrolled in the Medicaid program; or

C. The date on which you become covered under another health benefits program (including an insured or self-insured program through an employer group, union or other association) which is considered equivalent to coverage under this Contract.

D. The date you become an inmate of a public institution or a patient in an institution for mental disease.

### 4. Termination of the Child Health Plus Program

This Contract shall automatically terminate on the date when the New York State law which establishes the Child Health Plus program is terminated or the State terminates this Contract or when funding from New York State for this Child Health Plus program is no longer available to us.

### 5. Our Option to Terminate This Contract

We may terminate this Contract at any time for one of more of the following reasons:

A. Fraud in applying for enrollment under this Contract or in receiving any services.

B. Such other reasons on file with the Superintendent of Financial Services at the time of such termination and approved by him. A copy of such other reasons shall be forward to you. We shall give you no less than 30 days prior written notice of such termination.

C. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five months prior written notice of such termination.

D. You do not provide the documentation we request within sixty (60) days of your enrollment or recertification date.

E. You do not provide the application we request for recertification.

F. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process with the sixty (60) day temporary enrollment period."

## 6. Your Option to Terminate This Contract

You may terminate this Contract at any time by giving us at least one month's prior notice. We will refund any portion of the premium for the Contract that has been prepaid by you.

## 7. On Your Death

This Contract will automatically terminate on the date of your death.

## 8. Benefits After Termination

If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:

A. A date on which you are no longer totally disabled; or

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

## SECTION THIRTEEN:
## TERMINATION OF COVERAGE

We will not pay for more care than you would have received if your coverage under this Contract had not terminated.

## 1. When You Reach Age 19

If this contract terminates because you reach age 19, you will be given information on coverage available through other insurers and HMOs with covered benefits

## 2. If Child Health Plus Ends

If this Contract terminates because the Child Health Plus program ends, you will be given information on coverage available through other insurers and HMOs with covered benefits

## SECTION FIFTEEN: GRIEVANCE (COMPLAINT) PROCEDURE AND UTILZATION REVIEW APPEALS

### Grievance (Complaint) Procedure

Molina Healthcare of New York, Inc. hopes to serve you well. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

NYS Department of Health
Division of Health Plan Contracting and Oversight
Bureau of Managed Care Certification and Surveillance
Corning Tower ESP Room 2019,
Albany, NY 12237.

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

### How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-800-223-7242 Monday – Thursday 8:00 AM to 5:00 PM, Friday 9:00 AM to 5:00 PM. (TTY: New York Relay at 1-800-662-1220).

If you call us after hours, leave a message. We will call you back the next workday. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to

Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY
13212-6501

## What happens next:

If we do not solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 workdays. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

## After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 workdays.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we do not have enough information, we will send a letter and let you know.

## SECTION FIFTEEN: GRIEVANCE (COMPLAINT) PROCEDURE AND UTILZATION REVIEW APPEALS

### Complaint Appeals:

If you disagree with a decision we made about your complaint, you or someone you trust can file a complaint appeal with the plan.

### How to make a complaint appeal:

If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal;

- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form, which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

### What happens after we get your complaint appeal?

After we get your complaint appeal, we will send you a letter within 15 workdays. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

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

If we have all the information we need you will know our decision in 30 workdays. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical

rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

## Records

Molina Healthcare of New York, Inc. shall maintain a file on each complaint and appeal, if any. The file shall include:

- Date the complaint was filed;
- Copy of the complaint, if written;
- Date of receipt of and copy of the member's acknowledgment, if any;
- Complaint determination including the date of the determination and the titles of the personnel and credentials of clinical personnel who reviewed the complaint;
- Date and copy of the member's appeal;
- The titles and credentials of clinical staff, of the personnel who reviewed the appeal.

## Utilization Review Appeals

### Action Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action.

If you are not satisfied with our decision about your care, there are steps you can take.

## SECTION FIFTEEN: GRIEVANCE (COMPLAINT) PROCEDURE AND UTILZATION REVIEW APPEALS

**Your provider can ask for reconsideration:**

If we made a decision that your service authorization request was not medically necessary or was experimental or Investigational; and we did not talk to your doctor about It, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

**You can file an action appeal:**

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have you have no less than 60 business days but not more than 90 calendar days after hearing from us to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services 1-800-223-7242 if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of your phone action appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

**Your action appeal will be received under the fast track process if:**

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your action appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or

- If your request was denied when you asked for home health care after you were in the hospital.

- Fast track action appeals can be made by phone and do not have to be followed up in writing.

**What happens after we get your action appeal:**

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.

- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

- Nonclinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

- You can also provide information to be used in making the decision in person or in writing. Call Molina Healthcare of New York, Inc. at 1-800-223-7242 if you are not sure what information to give us.

- If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us: a written statement that the service you asked for is different from the service we have in our network; and two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

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

## SECTION FIFTEEN: GRIEVANCE (COMPLAINT) PROCEDURE AND UTILZATION REVIEW APPEALS

**Time-frames for Action Appeals:**

- Standard action appeals: If we have all the information we need we will tell you our decision in thirty days from your action appeal. A written notice of our decision will be sent within 2 workdays from when we make the decision.

- Fast track action appeals: If we have all the information we need, fast track action appeal decisions will be made in 2 working days from your action appeal. We will tell you in 3 work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.

- Tell you why the delay is in your best interest;

- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-223-7242 or in writing.

You or someone your trust can file a complaint with the plan if you do not agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said:

- the service was not medically necessary; or

- the service was experimental or investigational; or

- the out-of-network service was not different from a service that is available in our network; and

- We do not tell you our decision about your action appeal on time, the original denial against you will be reversed.

This means your service authorization request will be approved. To file an action appeal, write to

Molina Healthcare of New York, Inc.
5232 Witz Drive
North Syracuse, NY
13212-6501

To file an action appeal by phone, call
1-800-223-7242

## SECTION SIXTEEN:
## EXTERNAL APPEALS

### Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

### Your Right to Appeal a Determination That a Service is Not Medically Necessary

If the Plan has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

- The service, procedure or treatment must otherwise be a Covered Service under the Subscriber Contract; and
- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

### Your Rights to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and
- You must have received a final adverse determination through the Plan's internal appeal process and the Plan must have upheld the denial or you and the Plan must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening

condition or disease" is one which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by the Plan or one for which there exists a clinical trial (as defined by law).

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

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or

A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

## The External Appeal Process

If, through the [first level of the] Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the

## SECTION SIXTEEN:
## EXTERNAL APPEALS

Plan have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the [first level of the] Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State at 1-800- 400-8882. Submit the completed application to the State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the External Appeal Agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or the Plan. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of your completed application. The External Appeal Agent must try to notify you and the Plan by telephone or facsimile immediately after reaching a decision.

If the External Appeal Agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the

other terms and conditions of this Subscriber Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs 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 Subscriber Contract for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

## Your Responsibilities

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. The Plan has no authority to grant an extension of this deadline.

## SECTION SEVENTEEN:
## GENERAL PROVISIONS

### 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.

### Legal Action

You must bring any legal action against us under this Contract within six (6) months from the date we refused to pay for a service under this Contract.

### Amendment of Contract

We may change this Contract if the change is approved by the Superintendent of Financial Services of the State of New York. We will give you at least 30 days written notice of any change.

### Medical Records

We agree to preserve the confidentiality of your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.

### Who Receives Payment Under this Contract?

We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider. we reserve the right to pay either you or the provider.

### Notice

Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

| **If to us:** | **If to you:** |
| --- | --- |
| Molina Healthcare of New York, Inc.<br>5232 Witz Drive<br>North Syracuse, NY<br>13212-6501 | To the latest address provided by you on enrollment or official change-of-address form |


5232 Witz Drive | North Syracuse, NY | 13212-6501
Member Services: 1-800-223-7242
Fax: 315-234-9812 | **www.molinahealthcare.com**

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