

**New York
Grievance Procedures**

A. Grievances.

Our Grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at 877-897-4328 or the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of benefits for urgent care. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:

(A claim for a service or treatment that has already been provided.)

In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances:

(That are not in relation to a claim or request for a service or treatment.)

45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 877-897-4328 or the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

<u>Expedited/Urgent Grievances:</u>	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
<u>Pre-Service Grievances:</u> (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
<u>Post-Service Grievances:</u> (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
<u>All Other Grievances:</u> (That are not in relation to a claim or request for a service or treatment.)	30 calendar days of receipt of Your Appeal.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
www.communityhealthadvocates.org

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 877-897-4328 or the number on your ID card. The toll-free number is available at least 40 hours a week with an after hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 877-897-4328 or visit Our website at www.ameritas.com.

B. Preauthorization Reviews

We do not require Preauthorization Reviews under this Policy. If we do in the future:

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization benefit estimates the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. If only a portion of the additional

information is received, We will request the missing information, in writing, within five business days of receipt of the partial information. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal.

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Full and Fair Review of an Appeal

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: 1-888-614-5400, or email cha@cssny.org
www.communityhealthadvocates.org

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Policy; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. 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 for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For 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 condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our 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 Us. 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; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We may charge You a fee of \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

E. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.