



Child Health Plus Program

Subscriber Contract

1-877-SHP-6789

www.suffolkhealthplan.com

CHILD HEALTH PLUS SUBSCRIBER CONTRACT

This is your Child Health Plus Contract with Suffolk Health Plan ("SHP"). 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:

Except as stated in this Contract, all services must be provided, arranged or authorized by your Primary Care Provider. You must contact your Primary Care Provider 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 Eight, and except for dental care described in Section Nine of this Contract.

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SECTION ONE - INTRODUCTION

1. 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 the 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.

2. 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 Provider (PCP). Except for emergency care and for certain obstetric and gynecological services, behavioral health, vision care 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 requests and receives approval from SHP to refer you to a non-participating provider. SHP must approve your referral 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 SHP Member Services. The PCP you have chosen is referred to as "your PCP" throughout this contract.

3. Words We Use Throughout this Contract, Suffolk Health Plan 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.

4. Definitions The following definitions apply to this Contract:

A. 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.

B. 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 condition in serious jeopardy, or in the case of a 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.

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C. Emergency Services means those physician and outpatient Hospital services necessary for treatment of an Emergency Condition.

D. 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 inpatients, 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 of 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 rehabilitative care.
- SHP Emergency and urgently needed services are not covered in countries outside the United States, Mexico and Canada.

E. Medically Necessary means health care services and supplies that are necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal living or threaten some significant handicap.

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

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

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

I. Participating Provider means any participating physician, hospital, home health care agency, laboratory, pharmacy, or other entity which has an agreement with us to

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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 that non-participating provider with our approval.

J. Primary Care Provider (“PCP”) means the Participating Provider you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.

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

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SECTION TWO - WHO IS COVERED

1. 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;
- you are not eligible for Medicaid; and
- you are a New York State resident and a resident of our Service Area.

2. Recertification We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. Each year 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 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 that same date.

3. Change in Circumstances You must notify us of any changes to your residency or health care coverage that might make you ineligible for this Contract. You must give us this notice within thirty 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.

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SECTION THREE - HOSPITAL BENEFITS

1. Care In A Hospital You are covered for medically necessary care as an inpatient in a Hospital if all the following conditions are met:

- A. Except if you are admitted to the Hospital in an Emergency or your PCP has obtained approval from SHP to arrange for your admission to a non-Participating Hospital, the Hospital must be a Participating Hospital;
- B. Except in an emergency, your admission is authorized in advance by your PCP or the hospital; and
- C. 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.

2. Covered Inpatient Services Covered inpatient services under this Contract include the following:

- A. Daily bed and board, including special diet and nutritional therapy;
- B. General, special and critical care nursing service, but not private duty nursing service;
- C. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;
- D. Oxygen and other inhalation therapeutic services and supplies;
- E. Drugs and medications that are not experimental;
- F. Sera, biological, vaccines, intravenous preparations, dressing, casts, and materials for diagnostic studies;
- G. Blood products, except when participation in a volunteer blood replacement program is available;
- H. 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;
- I. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;
- J. Facilities, services, and supplies and equipment related to radiation and nuclear therapy;

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- K. Facilities, services, supplies and equipment related to emergency medical care;
- L. Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services;
- M. Chemotherapy;
- N. Radiation therapy; and
- O. 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.

3. 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 Cesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Cesarean 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 hours (96 hours for Cesarean 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 a delivery by Cesarean 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 Seven of this Contract.

4. Limitations and Exclusions

- A. 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.
- B. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, the difference between the cost of a private room and a semi-private room must be paid by you, unless the private room is medically necessary and ordered by your physician.
- C. We will not pay for non-medical items such as television rental or telephone charges.

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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 participating 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 participating Hospital, or
- As an inpatient in a participating hospital, you are entitled to medical, surgical, and anesthesia services.

Suffolk Health Plan reimburses its participating providers in different ways. Most Primary Care Providers are paid on a capitated basis. This means that the PCP receives a per member per month amount for each member that selects the PCP. Specialist providers are paid a fee for each service they provide. Most SHP hospitals are paid a flat rate for each hospital admission.

2. Covered Medical Services We will pay for the following 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;

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- Routine immunization 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.

Deleted: ¶

C. Diagnosis and treatment of illness, injury or other conditions. We will pay for the diagnosis and treatment of illness or injury at a participating provider's office or facility including:

- Outpatient surgery performed in a participating provider's office or at a participating ambulatory surgery center, including anesthesia services;
- Laboratory tests, x-rays and other diagnostic procedures at a participating provider's office or facility;
- Renal dialysis at a participating provider's office or facility;
- Radiation therapy at a participating facility;
- Chemotherapy at a participating provider's office or facility or at home;
- Injections and medications administered in a participating provider's office;
- Second surgical opinion from a board certified participating specialist;
- Second medical opinion provided by an appropriate participating 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 at a participating provider's office or facility.

D. Physical and Occupational Therapy We will pay for Short Term physical and occupational therapy services. The therapy must be skilled therapy with a participating provider. Short Term means up to twenty visits per calendar year for physical therapy, and up to twenty visits per calendar year for occupational therapy.

E. Radiation Therapy, Chemotherapy and Hemodialysis We will pay for radiation therapy and chemotherapy, including injection and medications provided at the

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time of therapy. We will pay for hemodialysis services in your home or at a participating 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. We will pay for an annual pelvic examination, pap smear and evaluation of the pap smear by a Participating Provider. 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.

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SECTION FIVE - EMERGENCY CARE

1. 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, in our sole judgment, 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 and urgently needed services are not covered in countries outside the United States, Mexico, and Canada.

2. 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 possibly. 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.

3. Ambulance Services We will pay for pre-hospital emergency medical services, including prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a hospital. Services must be provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law. Evaluation and treatment services must be for an Emergency Condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, 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.

Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in: (i) placing the health of the person afflicted with such a condition in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; and/or (iv) serious disfigurement of such person.

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SECTION SIX - MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE SERVICES

1. Inpatient Mental Health and Alcohol and Abuse Services We will pay for a combined thirty days per calendar year for inpatient mental health services, inpatient detoxification and inpatient rehabilitation when such services are provided in a participating facility that is:

- Operated by the Office of Mental Health under sec. 7.17 of the Mental Hygiene Law;
- Issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law; or
- A general hospital as defined in Article 28 of the Public Health Law.

All behavioral health services must be arranged and approved by your PCP or SHP by calling 1-800-922-3626.

2. Outpatient Visits For Treatment of Mental Health Conditions and For Treatment of Alcoholism and Substance Abuse We will pay for up to an aggregate of sixty outpatient visits in each calendar year for the diagnosis and treatment of alcohol and substance abuse and mental illness. Twenty of the sixty visits are available to your family members if such visits are related to your alcoholism or substance abuse.

All behavioral health services must be arranged and approved by your PCP or SHP by calling 1-800-922-3626.

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SECTION SEVEN - OTHER COVERED SERVICES

1. 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.

2. Diabetes Self Management Education We will pay for diabetes self-management education provided by you PCP or another Participating Provider.

Education will be provided upon the diagnosis of diabetes, a significant change in your 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.

3. Durable Medical Equipment, Prosthetic Appliances, and Orthotic Devices

A. Durable Medical Equipment We will pay for devices and equipment ordered by a participating provider who has obtained approval from SHP, including equipment servicing, for the treatment of a specific medical condition. The durable medical equipment must be supplied by a participating vendor. 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;

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- Traction equipment;
- Walkers, wheelchairs and accessories;
- Commode chairs and toilet rails;
- Apnea monitors;
- Patient lifts;
- Nutrition infusion pumps; and
- Ambulatory infusion pumps.

B. Prosthetic Appliances We will pay for appliances and devices ordered by a qualified participating provider who has obtained approval from SHP 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.

C. Orthotic Devices We will pay for devices ordered by a qualified Participating Provider who has obtained approval from SHP 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. There is no coverage for orthotic devices that are prescribed solely for use during sports.

4. Prescription and Non-prescription Drugs

A. Scope of Coverage We will pay for those FDA approved drugs which require a prescription. We will pay for those non-prescription drugs which are authorized by a professional licensed to write prescriptions and which appear in the Medicaid 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.

B. 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.

C. 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;
- Nutritional supplements taken electively;
- Prescription drugs and biologicals and the administrations 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 the purpose of treating erectile dysfunction;

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- 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 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;
 - Pharmacopoeia Drug Information; or
 - A review article or editorial comment in a major peer-reviewed professional journal; and
 - Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.

5. 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, or have to extend your stay in 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.

6. Preadmission Testing We will pay for preadmission testing when performed at the Participating Hospital where surgery is scheduled to take place, if:

- reservations for a Hospital bed and for an operating room at that Hospital have been made, prior to performance of tests;
- your physician has ordered the tests; and
- surgery actually takes place within seven days of such preadmission tests.

If surgery is canceled because of the preadmission test findings, we will still cover the cost of these tests.

7. Speech and Hearing We will pay for speech and hearing services, including hearing aids, hearing aid batteries, and repairs ordered by a Participating Provider. These services include one hearing examination per year to determine the need for corrective action. Speech therapy required for a condition amenable to significant

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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.

8. Hospice Services and Expenses We will pay for a coordinated hospice program. Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.

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SECTION EIGHT - VISION CARE

A. 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 preventive vision care if you seek such care from a qualified Participating Provider of vision care services.

B. Vision Examinations We will pay for vision examinations 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;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

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

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

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

SECTION NINE - DENTAL CARE

1. Dental Care Except for emergency dental care we will pay for the dental care services set forth in this contract only when you seek care from your Primary Care Dentist or your care is arranged by your Primary Care Dentist.

2. 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.

3. 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.

4. 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 pre-operative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

5. 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.

6. Periodontics We will pay for periodontal service, except for those services in anticipation of, or leading to, orthodontia.

7. 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;

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- Fixed bridges are not covered unless they are required:
 - a. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth;
 - b. For cleft-palate stabilization; or
 - c. 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.

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SECTION TEN - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. When a Specialist Can Be Your PCP If you have a life threatening condition or disease, or a 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.

2. 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.

3. 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.

4. 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 postpartum care directly related to the delivery. You may request continued care from us and we will consult with your PCP and the former Participating Provider to decide whether such services are appropriate.

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.

5. 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 a degenerative and disabling disease or condition. 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 postpartum services directly related to the delivery.

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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.

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SECTION ELEVEN - LIMITATIONS AND EXCLUSIONS

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, and where indicated, by SHP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, and where indicated, by SHP, 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.

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. Personal or comfort items.

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

10. Private duty nursing.

11. Orthodontia.

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12. Autologous blood donation.

13. 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.

14. Routine Foot Care.

15. Other Health Insurance, Health Benefits and Governmental Programs

We will reduce our payments under this 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 the Physically Handicapped Children's Program and the Early Intervention Program.

16. 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.

17. Other Exclusions We will not pay for:

- A. Sex transformation procedures;
- B. Custodial care; or
- C. Non-emergency transportation.

18. Worker's 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 Worker's 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 Worker's Compensation Law.

19. Prescription Drugs used for the purpose of treating erectile dysfunction.

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SECTION TWELVE - PREMIUMS FOR THIS CONTRACT

1. Amount of Premiums The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.

2. 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.

3. 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 month's. 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 when payment is due.

4. 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.

5. 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.

6. 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 1-877-SHP-6789 or by calling the Child Health Plus Hotline at 1-800-698-4543. At any 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 receipt of the completed review request and supporting documentation.

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SECTION THIRTEEN - TERMINATION OF COVERAGE

1. For Non-Payment of Premiums If you are required to pay a premium for this Contract, this contract will terminate at the end of the 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 enroll in the Medicaid program; or
- C. The date on which you become covered under other health care coverage or gain access to a state health benefits plan; or
- D. The date you become an inmate in a public institution or a patient in an institution for mental disease; or
- E. You do not provide the application we request for recertification; or
- F. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process within the 60 day temporary enrollment period."

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 or 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 Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than (30) days prior written notice of such termination.

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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. If you do not provide the documentation we request for recertification.

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 this 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 date on which you are, in our sole judgment, no longer totally disabled; or
- A date twelve months from the date this Contract terminates.

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

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SECTION FOURTEEN - RIGHT TO A NEW CONTRACT AFTER TERMINATION

1. When You Reach Age 19 If this contract terminates because you reach age 19, then you may purchase a new contract from another insurer as a direct payment subscriber. We will make a list of other insurers available to you. You may also be eligible for the Family Health Plus program. For more information, please call 1-877-934-7587.

2. If Child Health Plus Ends If this Contract terminates because the Child Health Plus program ends, you may purchase a new contract from another insurer as a direct payment subscriber. We will make a list of other insurers available to you.

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SECTION FIFTEEN - GRIEVANCE PROCEDURE AND UTILIZATION REVIEW APPEALS

Grievance Procedure We hope you will be satisfied with Suffolk Health Plan. If you are having a problem with your PCP or any other SHP provider, please try to discuss it with that particular provider first to see if a solution can be worked out. If this does not solve the problem, you can file a complaint with us at Suffolk Health Plan. SHP will not retaliate or take any discriminatory action against any member because they filed a complaint or appeal. You have a right to designate a representative to file a complaint or appeal on your behalf.

1. As soon as possible, you should first contact SHP and discuss the problem with a Member Services Representative. You have the right to file any complaint orally by calling Member Services at 1-877-SHP-6789. However, you can write to SHP Member Services at P.O. Box 19769 Charlotte, North Carolina, 28219-9769. You can also call and request a Complaint Form and we will help you fill out the form.
2. If the problem is not immediately resolved to your satisfaction (for example, if you call and we cannot fix the problem over the phone), your verbal or written complaint will be reviewed by Suffolk Health Plan and within 15 days, you or your designee will receive a letter with a solution, or a letter stating that Suffolk Health Plan is still working to resolve the problem. Complaint determinations regarding clinical decisions will be made by qualified clinical personnel.

SHP is required to resolve your complaints within the following time frames:

- 48 hours after the receipt of all necessary information when a delay would significantly increase the risk to a member's health;
- 30 days after the receipt of all necessary information in the case of requests for referrals or disputes involving member contract benefits; and
- 45 days after the receipt of all necessary information in all other complaints. SHP sends determination notices to members or their designee within 3 business days after a determination is made.

3. If you disagree with SHP's decision about your complaint, you may file an appeal. You have up to 60 business days after receipt of the notice of the complaint determination to file a written appeal. You can write to SHP Member Services at P.O. Box 19769 Charlotte, North Carolina, 28219-9769.

Within 15 business days of receipt of the appeal, SHP will provide written acknowledgment to you including the name, address and phone number of the SHP staff member designated to respond to your appeal. SHP will indicate what additional
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information, if any, you must provide. An appeal of clinical matters must be decided by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination.

SHP must decide appeals and notify our members or their designee in no more than:

- 2 business days after the receipt of all necessary information when a delay would significantly increase the risk to a member's health; and
- 30 business days after the receipt of all necessary information in all other instances.

Any notices of an appeal determination will include detailed reason for the determination, the clinical rationale, if appropriate, and any additional appeal rights, if any. SHP will provide to all members or their designee written notice that describes the complaint procedure, including all the above information and related information in your Member Handbook, anytime SHP denies access to a referral, or requires that a requested benefit is not covered by the member's contract.

4. If you are not satisfied with the appeal decision, you can file an appeal with the New York State Department of Health.

5. We encourage you to resolve your problems or complaints with Suffolk Health Plan. However, at any time if you have a problem with the care or services provided by SHP, you can telephone the New York State Department of Health at 1-800-206-8125 or the New York State Department of Insurance at 1-800-342-3736. You can write to the New York State Department of Health/Bureau of Certification and Surveillance, Corning Tower, Albany, NY 12237. You can also write to the New York Insurance Department/Consumer Services Bureau, Agency Building One, Empire State Plaza, Albany, NY 12257.

6. Utilization Review Appeals Utilization review happens when SHP makes judgments about the services provided or treatment given to a SHP member.

SHP performs utilization review (UR) in the following cases:

- before planned hospital admissions
- before a member receives outpatient services, such as:
 - ❖ home health care;
 - ❖ durable medical equipment (DME) prosthetics and orthotics;
 - ❖ physical, occupational, and speech therapy;
 - ❖ MRIs; and
 - ❖ obesity management services.

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SHP also does utilization review before it approves:

- use of a specialist as a PCP;
- a standing referral to a specialist;
- planned out-of-network services;
- transitional care for new members; and
- transitional care for current members when their provider leaves the network.

Utilization review is also performed during the time when a member:

- has a planned or emergency hospital admission;
- received any of the outpatient services listed above (whether the services are planned or is an emergency); and
- receives planned or emergency out-of-network services.

Utilization review is also performed during the time when a member receives inpatient or outpatient care. The toll free phone number for the SHP Utilization Review Department is 1-800-250-5007. The UR program operates from 9 a.m. to 5 p.m., Monday through Friday. On weekends, holidays and at other times, an answering machine will take calls.

Prospective or "pre-authorization" UR decisions are those that SHP makes before services start. When SHP makes prospective decisions, the Plan will inform the member or member's designee and provider by telephone and in writing. This will happen within 3 business days of SHP receiving all the material SHP needs to make the decision.

Concurrent UR decisions are those that SHP makes during the time that services are going on. When SHP makes concurrent decisions, the member's designee and provider will be notified by telephone and in writing. This will happen within 1 business day of SHP receiving all the material SHP needs to make the decision.

Retrospective UR decisions are those that SHP makes after services are given. These decisions will be made within 30 days of SHP receiving all the material it needs to make the decision. You have a right to ask SHP to change its decision if you do not agree with its decision, and if SHP made the decision without trying to talk to your provider about the matter. SHP will re-review the decision within 1 business day of your request, except in cases of retrospective reviews.

SHP members and providers have a right to appeal any UR decision. The types of appeals that are available to you are an "expedited" appeal and a "standard" appeal.

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An "expedited" appeal is used for UR decisions involving:

- continued or extended health care services, procedures or treatments;
- additional services for a member undergoing a continued treatment course; or
- a decision in which the provider believes an immediate appeal should be made. SHP will provide reasonable access to a clinical peer reviewer within 1 day of receiving notice of the appeal. SHP will decide expedited appeals within 2 business days after receiving the information needed for the review.

You, your designee, or your provider can file a "standard" appeal of a UR decision within 45 days from the date you were informed of the UR decision.

You, your designee, or your provider can write to SHP at Medical Management Appeals, 4944 Parkway Plaza Blvd, Suite 110, Charlotte, North Carolina, 28217, for "standard" appeals. SHP will tell you its appeal decision within 60 days of receipt of the information we need to conduct the appeal. SHP will notify you and your provider within 2 business days of our decision.

You have the right to designate someone to represent you in making an appeal. You must notify SHP in writing of the name of this person.

Denials or negative decisions will be made by qualified clinical personnel. UR denials or negative decisions will be made in writing and will include information about the basis of the decision and your appeal rights.

7. External Appeals

I. Your Right To An External Appeal Under certain circumstances you have the right to an external appeal for 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.

II. 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 this Subscriber Contract; and
- You must have received a final adverse determination through the first level of 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.

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III. Your Right 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 first level of 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 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 (18), 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.

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IV. 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 45 days from receipt of such notice to file a written request for an external appeal. If you and the 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 writing 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 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 the 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. Immediately after reaching a decision, the External Appeal Agent must try to notify you and the Plan 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 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

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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.

V. 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.

COVERED SERVICES/EXCLUSIONS

In general the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by the External Appeal Agent in accordance with Section 15.7 of this Subscriber Contract. 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 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.

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SECTION SIXTEEN - GENERAL PROVISIONS

1. 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.

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

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

4. 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.

5. 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.

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

IF TO US:

***Suffolk Health Plan/Child Health Plus
P.O. Box 19769
Charlotte, NC 28219-9769
Attn: Member Services***

IF TO YOU:

To the latest address provided by you on enrollment or official change-of-address form(s).

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