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Healthy New York Amendment

This document amends coverage under your Health Care Certificate (Certificate) with Preferred Care. Unless specifically changed by this Amendment, all terms and conditions of your Certificate apply. Effective January 1, 2008, your Preferred Care Healthy New York Certificate is amended to provide the following changes:

The section of your certificate that is entitled GRIEVANCE PROCEDURE AND UTILIZATION REVIEW has been amended as follows:

GRIEVANCE PROCEDURE

1. **Grievance Procedure.** You may file a grievance regarding any dispute you may have with Preferred Care, provided that the dispute does not involve a denial of benefits or services on the basis that the service is not medically necessary and/or denial based on the experimental or investigational nature of the service. You will have one-hundred eighty (180) calendar days from the date of the initial denial to file a grievance. You or a representative appointed by you may file a grievance verbally or in writing. Should you choose to submit your grievance in writing you may request a Subscriber Grievance Form and it will be mailed to you, or you may come to Preferred Care and it will be given to you. Upon completion of the form, you are advised to return the form to the Preferred Care Service Recovery Administrator. If the request for reconsideration of denied services or claims is received verbally Preferred Care will begin processing the dispute immediately and the Service Recovery Administrator will complete the Subscriber Grievance Form. This completed form will be forwarded to you for your review and signature. For more information, contact Member Services at (585) 325-3113 or (800) 950-3224. TTY users may call (585) 325-2629 or (800) 252-2452. If it is after hours, please leave a message and a Member Services representative will respond to you within 1 business day of your call.
 - a. Preferred Care will review and respond to grievances and appeals within the following timeframes:
 - (i.) A determination will be made forty-eight (48) hours after the receipt of all necessary information, when a delay would significantly increase the risk to your health. You will be notified of the determination within the same business day via phone. You and your health care provider will also be notified within twenty four (24) hours in writing of the expedited outcome.
 - (ii.) A decision and notification will be rendered within fifteen (15) calendar days for all Pre-service determinations and within thirty (30) calendar days for all Post-service determinations from the receipt of the grievance/appeal.
 - (iii.) Preferred Care will acknowledge receipt of all grievances/appeals within five (5) days of their receipt.
 - b. Preferred Care will send you a written notice of the grievance determination, which shall include the following:
 - (i.) The reasons for the decision, including medical rationale where applicable;
 - (ii.) The procedures for appealing the decision.

- c. You or a representative appointed by you may appeal an adverse grievance determination.
 - (i.) You have sixty (60) business days after receipt of the notice of grievance determination to file an appeal. Appeal forms are available through the Member Services Department. If the appeal is taken over the phone the form will be completed and mailed to you to amend, acknowledge and sign. If the appeal is submitted verbally, the appeal process begins immediately.
 - (ii.) Preferred Care will send you an acknowledgment of the receipt of your appeal within five (5). A notice shall be sent to you if additional information is needed. You have 45 calendar days to provide the requested information. You must voluntarily agree to extend the grievance time frame.
 - (iii.) Any dispute involving a clinical issue or a medical adverse determination will require a medical director or other qualified clinician in the review and/or processing of your dispute.
 - (iv.) If the dispute involves an administrative (non-clinical), benefit or service issue, the Service Recovery Administrator may seek consultation with Preferred Care staff.
 - (v.) On second level non-clinical disputes, the Service Recovery Administrator will involve management at a higher level. These individuals will not have been involved in the original determination of the grievance.
 - (vi.) Appeals shall be decided and notification provided to you within two (2) business days after receipt of all necessary information, when a delay would significantly increase the risk to your health, within fifteen (15) calendar days for all Pre-service determinations, and within thirty (30) calendar days for all Post-service determinations from the receipt of the appeal..
 - (vii.) The notice of an appeal determination shall include the detailed reasons for the determination and the rationale for the determination, the name and number of the utilization review agent, and any further available appeal rights and timeframes for requesting an appeal as applicable.
 - (viii.) At anytime during the appeal process you may request a review by the New York State Department of Health (DOH) and/or Insurance (DOI). If Preferred Care receives a complaint from the DOI or DOH on behalf of a member who is dissatisfied with the results or processing of their grievance/appeal, we will, with authority from the member, explain the circumstances regarding our decision(s) in the grievance/appeal to the appropriate department. The DOI or DOH's decision is binding on both you and us. If instructed to reverse our decision we will comply.

UTILIZATION MANAGEMENT/ REVIEW

- 2. **Utilization Management/Review:** is a process used to determine if services are or were medically necessary. As discussed above, Preferred Care will only extend coverage for health services or treatments you have or will receive if that care is medically necessary.
 - a. **Initial Review.** When Preferred Care has received all of the necessary information with regard to your utilization review, a determination will be made according to the following time frames:
 - (i.) Procedures or treatment involving services which require pre-certification (a process of obtaining certification or authorization of requests or referrals for certain services or procedures made by PCP's, specialists or other providers within a specified period of time.) shall be decided and notice of a determination sent to you or your designee and/or the your health care provider by telephone and/or in writing, within three (3) business days of receipt of all necessary information;
 - (ii.) For situations involving continued or extended health care services, or additional services for a member undergoing a course of continued treatment prescribed by a health care provider, a decision shall be made and notice of such decision provided to the member, the

member's designee or the member's health care provider, by telephone and/or in writing within one (1) business day of receipt of all the necessary information. This notice shall include the number of extended services authorized to begin and the date the next utilization review is scheduled to take place;

- (iii.) A utilization review determination involving services, which have already been provided, will be made within thirty (30) days of receipt of all necessary information.
 - (iv.) If Preferred Care fails to make a decision within the above-mentioned timeframes, then the healthcare service and/or treatment is considered denied and you or a representative appointed by you may appeal the decision. Our failure to meet the timeframes set forth above for an appeal of an adverse determination shall result in the reversal of the adverse determination.
- b. **Denial Notices.** In the case of a denial for medical necessity, all decisions will be made by qualified clinical personnel. Notices of denials will include information about the basis of the decision and further appeal rights. All denial notices will also inform you that you, or someone you choose as a representative, and/or your health care provider may request, in writing, the clinical review criteria used in making the decision on the service or treatment being denied.
 - c. **Right to Reconsideration.** In situations where there has been a denial of services as not medically necessary without attempting to discuss the matter with the provider who recommended the service, procedure or treatment under review, the provider shall have the opportunity to request a reconsideration of the denial. 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 the provider within three (3) business days of the reconsideration.
 - d. **Utilization Review Appeals (Standard).** All adverse determinations (as evidenced by a denial notification) based upon medical necessity may be appealed by you and, in more limited circumstances, the requesting physician. You also have the right to designate a representative for the purpose of initiating an appeal of denied services. Appeals must be submitted within one-hundred eighty (180) days of your receipt of the denial notification. Preferred Care will acknowledge the receipt of the request for appeal within five (5) days. Preferred Care will render a decision within thirty (30) days of the receipt of the appropriate information needed to conduct the appeal. Notification of Preferred Care's decision on the appeal will be provided to you in writing, and your health care provider, if appropriate, within two (2) business days of the determinations. This notification will be deemed a final adverse determination for purposes of initiating an external appeal (see below, "External Appeal").
 - e. **Utilization Review Appeals (Expedited).** Expedited or immediate appeals are available to the member, if he wants to appeal an adverse determination based upon medical necessity that involves:
 - (i.) Continued or extended healthcare services;
 - (ii.) Procedures, treatments or additional services for a member who is undergoing a course of continued treatment prescribed by his or her healthcare provider; or
 - (iii.) A situation where the member's healthcare provider believes an immediate appeal is needed. However, this does not apply in situations where we originally paid the member's claim before we had all the information needed.

We will reach a decision with regard to the expedited appeal within two (2) business days of the time we receive all the necessary information we need to conduct the appeal, but no later than seventy-two (72) hours from receipt of the claim. We will notify you immediately of our decision by telephone. We'll send a written notice within one (1) business day of the decision. If you do not receive a satisfactory answer through our expedited appeals process, you may use the standard appeal process described above or apply to New York State for an external appeal.

The section of your certificate that is entitled EXTERNAL APPEAL has been amended as follows:

EXTERNAL APPEAL

1. **Your Right to an External Appeal.** Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if we have 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, which is an independent entity certified by the State to conduct such appeals.
2. **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 satisfy the following two (2) criteria:
 - a. The service, procedure or treatment must otherwise be a Covered Service under this Certificate; and
 - b. You must have received a final adverse determination through our internal appeal process and we must have upheld the denial or you and Preferred Care must agree in writing to waive any internal appeal.
3. **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 Certificate; and you must have received a final adverse determination through our internal appeal process and Preferred Care must have upheld the denial or we both 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 (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 us or one for which there exists a clinical trial. In addition, your attending physician must have recommended one of the following:

- a. 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
- b. 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.

4. The External Appeal Process. If, through the first level of our 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 forty-five (45) days from receipt of such notice to file a written request for an external appeal. If we both have agreed in writing to waive any internal appeal, then you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process (Clinical Peer Review) or with the written waiver of an internal appeal.

You may also request an external appeal application from New York State at the Department of Insurance at 1-800-400-8882 or Website(www.ins.state.ny.us) or New York State Department of Health Web site(www.health.state.ny.us) or Preferred Care Member Services at (585) 325-3113 or (800) 950-3224 or for TTY users (585) 325-2629 or (800) 662-1220. Submit the completed application to the New York State Insurance Department 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 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 appeal (described below), we do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within thirty (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, they will have five (5) additional business days to make their decision. The External Appeal Agent must notify you in writing of their 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 us by telephone or facsimile immediately after reaching a decision.

If the External Appeal Agent overturns our decision and determines that a service is medically necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to the other terms and conditions of this Certificate. 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 costs of services required to provide treatment to you according to the design of the trial. We 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 Certificate for non-experimental or non-investigational treatments provided in such 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.

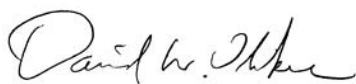
We will charge you a fee of Fifty Dollars (\$50.00) for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. We will waive the fee if we determine that paying the fee would pose a hardship for you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

5. **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 Insurance Department. 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 forty-five (45) days of either the date upon which you receive written notification from us that we have upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. We have no authority to grant an extension of this deadline.

The benefits under this Amendment will end if your Certificate is terminated, you fail to pay your full Premium, you leave the Group through which your Certificate is issued, or the Group through which your Certificate is issued discontinues purchasing the Health Care Plan.

PREFERRED CARE



President and Chief Executive Officer