Provider Manual

A Guide to Healthier Insurance

CareConnect℠

Dear Valued Provider,

Welcome to the **North Shore-LIJ CareConnect Insurance Company, Inc. ("CareConnect")** network! Thank you for joining us in changing the way people experience health insurance and health care.

CareConnect was created by the North Shore-LIJ Health System in 2013 to help ensure that the communities it serves have affordable access to excellent care. As part of a fully integrated health care delivery system, CareConnect does things differently, like emphasizing customer service to make it easier for members to get and stay healthy. At the same time, our collaborative relationship with providers participating in the CareConnect network is designed to produce a less burdensome authorization process and a low denial rate, freeing Providers to deliver care they believe in. With your help, we are delivering on our vision as we offer commercial health insurance to individuals, families and employers.

This Provider Manual is meant to explain our vision, mission and approach, and make it easy for you to find and understand our policies and procedures. We invite you to reach out at any time with questions or comments, either by calling us at **855-706-7545** or by emailing us at **providerinquiry@nslijcc.com.** We will also update you regularly through a quarterly provider newsletter, and communicate with you as needed through real-time electronic notifications and formal postal mailings.

We value your participation in this partnership, and look forward to a long and successful collaboration. Together, we will provide our members with the excellent, affordable care they deserve.

Sincerely,

Alan J. Murray

President and CEO
CareConnect

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Chapter 1
Introduction

CareConnect℠

1.1 About CareConnect

For anyone involved with health care—receiving it, delivering it, paying for it or trying to improve it—one thing is clear: The current system is in need of improvement. Health care today is fragmented, confusing and, for many people, financially out of reach. At their most vulnerable times, people must figure out for themselves whether their doctor is in-network, go through phone trees to make appointments, follow up to make sure that test results do not fall through the cracks, and decipher bewildering explanations of what their insurance does and does not cover—difficulties that can be barriers to getting and staying well. All of this is in the context of a fee-for-service system that can make it difficult for doctors to deliver the preventive care, education and other services that can promote health.

As the first provider-owned commercial health plan in New York State, CareConnect was created to address these problems. Our integration with our parent company, the North Shore-LIJ Health System, one of the nation's largest health care systems and New York State's largest private employer, reflects our aim to simplify the health care experience for our Members at every point in the process (the term *Members* is defined in your provider agreement). Our focus on coordinating care is designed to help prevent illness and to facilitate the right care at the right time in the right setting. And our collaborative model allows providers participating in the CareConnect network ("Providers") to deliver the kind of care they believe in, while providing better control over costs and helping to keep our plans more affordable for more people.

1.2 Our Vision, Mission and Values

Vision

We make it easy for people to get and stay healthy. We simplify the confusing world of health care coverage and services and give people a smooth and stress-free connection to affordable, superior care.

Mission

We strive to improve the health of the communities we serve. We are committed to giving our Members access to the highest quality clinical care and wellness services; empowering the public through health education; partnering with health care professionals to ensure that care is delivered as effectively as possible; and searching for new and better ways to support the well-being of the people who put their trust in us.

Values

As we execute on our vision and mission, we base our approach on the following values:

- Building a "family ecosystem" for our employees: At CareConnect our employees are a family. We nurture each other and provide a safe and exciting environment in which to work. It is with this foundation that we can grow individually and together.
- Emphasizing affordability: We cannot have an impact on the health of our communities if insurance coverage is so expensive that it puts health care out of reach. So it is essential that CareConnect strive every day to build an organization that mitigates the rise in health care costs.

- Simplifying the customer experience: We try to see the health care universe through our customers' eyes, whether our customers are consumers, Providers or distribution partners. We work at all times to understand our customer's journey so we can make it a satisfying one.
- Building a "family ecosystem" for Providers: Communication and peer support are at the heart of CareConnect's approach. We trust our Providers and value their judgment about the care our Members require. We work with our Providers to identify the best clinical practices, medical policies and peer review resources in order to facilitate the best possible clinical outcomes.
- Acting with integrity: It is an honor to serve our Members. We work every day to be worthy of that honor and to ensure that our Members can entrust their personal health information and their health to us.

1.3 The CareConnect Experience

CareConnect emphasizes Member health, wellness and satisfaction. Therefore, we strive to ensure that our network offers easy access to Providers at multiple convenient locations. Our network comprises hospitals and professional, institutional and ancillary Providers. Our Service Connectors act as a single point of contact for Members, offering hands-on assistance with every step of the health insurance and health care process, including selecting a Provider, scheduling doctors' appointments and coordinating and managing care, as appropriate.

1.4 The CareConnect-Provider Partnership

As the first Provider-owned commercial insurance company in New York State, CareConnect is built on a collaborative relationship with our Providers. Our Chief Medical Officer and Medical Directors are physicians who continue to practice in the community that CareConnect serves. Our Chief Medical Officer also sits on the North Shore-LIJ Health System's Hospital Medical Directors Committee and its Combined Chairs Committee. This participation provides CareConnect with direct insight into the Health System's clinical, educational and research activities, as well as the needs of Providers in CareConnect's catchment area. Our Physician Advisory Group is made up of local physician leaders, who review CareConnect's medical policies and clinical practice guidelines. Finally, during our preauthorization process, every Provider has the opportunity to have a one-on-one conversation with a CareConnect Medical Director. This kind of input and access helps keep our denial rate low and allows our Providers to deliver the kind of care they deem appropriate for their patients.

1.5 Our Product Portfolio

CareConnect is a New York State insurance company that sells commercial health insurance to individuals and small employers on and off New York's health plan marketplace, New York State of Health, and to large group employers (51-plus; 101-plus as of January 1, 2016) off the exchange.

Chapter 2
The CareConnect Member

CareConnect℠

2.1 Member Rights and Responsibilities

CareConnect aims to simplify health care and health insurance for its Members while providing access to superior care, in all cases with sensitivity and respect. In order to achieve this aim, we believe it is important for our Providers to understand our Members' rights and responsibilities.

CareConnect Members have the right to:

- Have access to affordable, superior care, in line with their benefit plan, with a minimum of difficulty or stress
- Be treated with courtesy and respect
- Receive information about their health benefits that clearly explains the services that are covered and not covered, as well as any costs beyond the insurance premium
- Be protected from surprise bills
- Have easy access to a list of in-network doctors, hospitals and places where care may be received
- Receive seamless coordination of care through the continuum of their needs
- Receive emergency services with no additional charges beyond their in-network copayment, co-insurance or deductible
- Be covered for certain health care services if they are women
- Expect confidentiality regarding their personal identifiable data and medical information
- Learn who has access to their personal identifiable data and medical information, and understand the procedures CareConnect uses to ensure its security, privacy and confidentiality
- Participate in health care decisions, and have their health care professional provide information, in terms and language they understand, about their medical condition and treatment options, regardless of coverage or cost
- Ask questions about their health care and obtain any and all desired information about care they've received
- Refuse medical care (we urge Members to discuss their concerns with their primary care provider [PCP] or other participating health care professional, and ask that their health care professional describe potential consequences and offer advice; however, Members must ultimately make this decision)
- Have their concerns or complaints heard, receive a prompt and courteous response, and, if necessary, be guided through our appeals and grievance process
- Speak directly to a Service Connector, who will take personal responsibility for meeting their needs
- Make recommendations regarding CareConnect member rights and responsibilities

Members have the responsibility to:

- Review and understand the details of their health benefit plan, and call or visit the Customer Care Center in case of questions or concerns
- Understand how to obtain services and supplies that are covered under their plan
- Show their ID card before receiving care
- Provide honest, complete information to their health care Providers
- Understand their health condition and work with their doctor to develop treatment goals that both agree upon

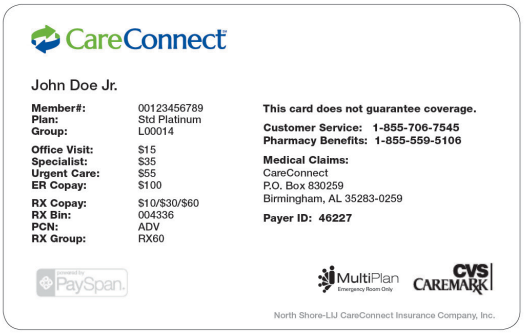
- Know what medicine they take, and why and how to take it
- Pay all copays, deductibles and coinsurance for which they are responsible at the time service is rendered or when due, and pay all charges, in a timely manner, for services that are not covered by their plan
- Keep scheduled appointments, and notify the health care professional's office ahead of time if they are going to be late or miss an appointment
- Notify, as soon as possible, their plan administrator (if applicable), CareConnect and their treating health professional about any changes in address, phone number or health benefit plan status

2.2 CareConnect Member Identification

Every CareConnect Member receives a CareConnect ID card, which is for identification purposes only and does not establish eligibility. We recommend that you review the card at every visit and ask that you keep a copy of its front and back. The card displays the Member's ID number and cost-sharing amounts, as well as the CareConnect claims address. You will also find CareConnect's telephone number, which you can use to reach our Medical Management Department for preauthorization, to speak with a Provider representative or for any other purpose.

Please check your patient's eligibility and benefits prior to rendering services. To confirm eligibility and benefits, please access our website at CareConnect.com.

Here is what your patient's CareConnect Member ID card will look like. (There is a magnetic stripe on the card's back, but no text.) Note that some CareConnect ID cards may also bear an employer name or logo.



2.3 Member Cost-Sharing

You can find information about Member cost-sharing for medical or prescription drug services on the CareConnect ID card and on CareConnect.com.

In accordance with the Affordable Care Act, Members are not required to pay a cost-share for certain preventive services. Examples of such services include the following, when they are provided in accordance with relevant guidelines: mammograms; colonoscopies; aspects of wellness visits; STD testing, screening and counseling; HIV testing, FDA-approved contraceptive methods; breastfeeding support and supplies; and domestic violence screening and counseling. More detailed information on preventive services available to Members without cost-sharing is at CareConnect.com.

CareConnect offers plans with a range of cost-sharing, and applies cost-share payments for each type of service rendered as outlined in the Member certificate. If a Member receives multiple services during a Provider visit, all relevant cost-share payments will apply. However, if a Member seeks services at a physician's office for an office visit *and* the physician performs and bills for evaluation and management services, only the office visit copayment will be applied. The Member will not be responsible for copayments for additional services rendered during the office visit (for example, a lab draw), which would be subject to separate copayments if delivered on distinct dates or in distinct places of service.

2.4 Language Interpretation Services

Members Who Require Language Interpretation Services

Members and Providers who require language interpretation services via telephone can contact us at 855-706-7545 for coordination of these services. Member materials are available in Spanish and Mandarin.

2.5 Impaired Members

Visually Impaired Members

CareConnect materials and communications are available on audiocassette and CD and in other media formats, as well as in documents in Braille, and can be provided to Members or Providers upon request.

Hearing- or Speech-Impaired Members

CareConnect offers TTY phone service at 855-226-7318 for Members and Providers who require coordination of telephonic communications. In addition, we can provide a professional sign language interpreter on request for individuals who are hearing-impaired.

CareConnect can also assist in making appointments for hearing-impaired Members. Providers or Members requiring this help should call us at 855-706-7545.

2.6 Member Grievances

At some point, you may be approached by a Member with questions about how to handle a concern or complaint regarding CareConnect. We provide the following information to all our Members with respect to concerns or complaints that are not related to a Medical Necessity determination but rather have to do with such things as contractual benefit denials, our administrative policies or access to Providers.

The Right to Voice Concerns or Complaints

To help ensure that our Members are satisfied with their health care coverage, we have a grievance process to address their concerns and complaints. (We have a separate appeal process that can be used to request review of decisions relating to a Medical Necessity or experimental or investigational determination. The appeal process is discussed in Section 5-6 of this Manual.)

The Customer Service Department

CareConnect was created to make it easier for our Members to get and stay healthy, and our commitment to customer service is key to executing on that vision. Our

Our Customer Service Connectors largely come from consumer-focused industries, such as the hospitality industry; living locally, they bring to interactions an intuitive awareness of Member needs and concerns. Staffing levels and training ensure that Member calls are answered within seconds, and our Customer Service Connectors are trained and empowered to take as much time as necessary to resolve any issue. We aim for a concierge level of customer service.

If a Member has questions or concerns or needs assistance for any reason, he or she is encouraged to call 855-706-7545 to speak with a Customer Service Connector. Members can also meet with Customer Service Connectors at our Customer Care Center, located at 2200 Northern Blvd., Entrance A, East Hills, NY.

Grievance Review Process

Members who would like to file a grievance may call us at 855-706-7545, contact us in person at our Customer Care Center or submit it to us in writing at:

CareConnect
Attn: Grievances and Appeals
2200 Northern Blvd., Suite 104
East Hills, NY 11548

If a Member submits an oral grievance in connection with a covered benefit determination, we may prepare a written acknowledgement of the oral grievance and require that he or she sign it. Members or their authorized representatives may file a grievance up to one hundred and eighty (180) days after they receive the decision from us that they wish to dispute.

When we receive a grievance, we will mail an acknowledgment letter within fifteen (15) business days. The acknowledgment letter will include the name, address and telephone number of the person handling the Member's grievance, and indicate what additional information, if any, must be provided.

Qualified staff at CareConnect will review the Member's grievance; if it is a clinical matter, the review will be conducted by CareConnect staff who are licensed, certified or registered health care professionals. We will respond in writing to all grievances that are not related to a claim or a request for service within forty-five (45) days of receipt of all necessary information, but no later than sixty (60) days after receipt of the grievance.

- We will respond in writing to grievances that relate to a pre-service claim determination (i.e., a determination of whether a service or treatment is a covered benefit, made before the service or treatment has been received by the member) within fifteen (15) days of receipt of the grievance; this period may be extended to within thirty (30) days of receipt of the grievance for individual Members.
- We will respond in writing to grievances that relate to a post-service claim determination (i.e., a determination of whether a service or treatment is a covered benefit, made after the service or treatment has been received by the member) within thirty (30) days of receipt of the grievance.
- Finally, for urgent grievances (e.g., relating to conditions that are emergencies or otherwise urgent in nature), we will respond by phone, within the earlier of forty-eight (48) hours of receipt of all necessary information or seventy-two (72) hours of receipt of the member's grievance. Written notice will be provided within seventy-two (72) hours of receipt of the member's grievance.

Grievance Appeals Process for Group Plan Members

Members in our group plans may file a grievance appeal if they remain dissatisfied after the initial grievance review. They must do so within sixty (60) business days of receipt of the initial grievance determination. This grievance appeals process provides another level of internal review by CareConnect personnel at a higher level than the staff who rendered the initial grievance determination.

When we receive a grievance appeal, we will mail an acknowledgement letter within fifteen (15) business days.

- If we request additional information regarding a grievance appeal that is not in relation to a claim or a request for service, we will respond in writing within thirty (30) business days of receipt of all necessary information.
- We will respond in writing to all grievance appeals that relate to a pre-service grievance determination within fifteen (15) days of receipt of the grievance appeal.
- We will respond in writing to grievance appeals that relate to a post-service grievance determination within thirty (30) days of receipt of the grievance appeal.
- Finally, for urgent grievance appeals, we will respond in writing within two (2) business days of receipt of all necessary information or seventy-two (72) hours of receipt of the member's grievance appeal, whichever is earlier.

Any group or individual member, if dissatisfied, may, at any time, call the New York State Department of Financial Services (DFS) at 800-342-3736, or write the department at:

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

Our members are also encouraged to contact the state independent Consumer Assistance Program for assistance with filing grievances. This program can reached at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
By phone: 888-614-5400 (toll-free)
By email: cha@cssny.org
Online: communityhealthadvocates.org

Chapter 3
Provider Basics

CareConnect℠

3.1 Provider Relations

CareConnect's Provider Relations Department maintains and supports its Provider network to ensure adequate access and availability for Members. The department is responsible for Provider recruitment, contracting, credentialing and re-credentialing. When a Provider joins our network, Provider Relations staff members schedule orientations to educate him or her about CareConnect programs, policies and procedures.

Provider Relations staff review and update all contracts, as needed, and investigate and help resolve Provider concerns. If you have any questions about the Provider Relations Department, please contact CareConnect at 855-706-7545.

3.2 Provider Manual and Updates

CareConnect updates its Providers through a variety of means. The Provider Relations staff may contact Providers by telephone or email to inform them of important changes in plan policies or procedures. CareConnect also periodically mails out Provider newsletters and notices. Providers have 24-hour access to alerts and information about policy/procedure changes on our secure Provider website; for registration and access to the secure website, visit CareConnect.com. CareConnect's Provider Manual can be found at CareConnect.com/provider.

We provide access to CareConnect rules, policies and procedures, as well as updates to same, so that Providers can ensure that their employees, and agents involved in the Providers' performance, comply with and abide by the rules, policies and procedures that CareConnect has established or will establish in the future. We make new rules, policies and procedures (or changes to existing ones) available to Providers at least thirty (30) days in advance of implementation.

3.3 Provider Directory and Vendor List

CareConnect Providers are required to refer Members only to other CareConnect Providers. The Provider Directory can be found at CareConnect.com/provider-search/. Additionally, CareConnect uses the following vendors for pharmacy, dental and vision services:

Provider Type	Vendor	Telephone Number	Website
Pharmacy	CVS/Caremark	855-559-5106	caremark.com/wps/portal
Dental	HealthPlex	888-468-5175	healthplex.com
Vision	Davis Vision	800-999-5431	davisvision.com

CareConnect maintains its own contracts directly with Providers for behavioral health (mental health, substance use and autism spectrum), laboratory services and radiology services.

3.4 Provider Credentialing and Re-Credentialing

Providers who wish to participate in the CareConnect network must have a valid and effective Provider agreement in place with CareConnect and successfully complete the required credentialing process.

Providers must also be appropriately licensed to practice in their area of clinical specialty and meet the requirements outlined in the standards set by the applicable regulatory bodies in New York and in any other applicable jurisdiction. The types of providers that must be credentialed are listed below.

CareConnect requires all practitioners who provide covered services and are interested in participating in its network to submit a credentialing application. Practitioners are required to answer all questions on the application, including those regarding current illegal drug use, any history of loss of license and/or felony convictions, any history of loss or limitation of privileges or disciplinary activity, current malpractice insurance coverage, and the ability to perform the essential functions of the position, with or without accommodation by a facility. Each applicant is required to disclose all requested information, including information about factors that may adversely impact his or her ability to provide care. The applicant is also required to sign the application in the section labeled "*Certification,*" attesting to the correctness and completeness of the information provided. This signature of attestation must be dated no more than 180 calendar days prior to presentation of the file for approval. If the signature of attestation is older than 180 calendar days, the practitioner must attest that the information is still correct but does not need to complete a new application. A signature stamp may not be accepted in place of an actual Provider signature.

The provider seeking participation is responsible for providing a complete application. CareConnect or its designee will not process an application that is incomplete.

Scope

CareConnect requires credentialing for all participating practitioners, including:

- Allopathic Physicians (MD)
- Clinical Psychologists (PhD or PsyD)
- Dentists (DDS or DMD)
- Licensed Acupuncturists
- Licensed Audiologists
- Licensed Chiropractors
- Licensed Clinical Social Workers (LCSW)
- Licensed Master Social Workers (LMSW)
- Licensed Nurse Practitioners (NP)
- Licensed Occupational Therapists
- Licensed or Certified Nurse Midwives (CNM)
- Licensed or Certified Optometrists (OD)
- Licensed or Certified Registered Nurse Anesthetists (CRNA)
- Licensed Physician Assistants (PA)
- Licensed Physical Therapists
- Osteopathic Physicians (DO)
- Other Licensed, Certified or Registered Behavioral Health Care Specialists
- Podiatrists (DPM)

Procedure

Credentialing and re-credentialing applications will be date-stamped or electronically acknowledged within seventy-two (72) hours of receipt. The credentialing staff will review the packet to confirm that it includes copies of the documents listed below (if applicable), or the information those documents contain, and that the documents and information meet relevant requirements, which are more fully described in CareConnect's Credentialing Policy and Procedures and in the applicable regulatory standards. Among others, these documents may include:

- A current, valid, unrestricted, and registered license or limited permit to practice medicine and/or another health care specialty in the State of New York
- A current and valid DEA certificate (if you are required to retain one)
- Proof of graduation from an accredited medical school or certified program
- Proof of the successful completion of a training program(s) in the specialty for which you are applying
- If you are a graduate of a foreign medical school, a current and valid Educational Council for Foreign Medical Graduates (ECFMG Certificate) or proof that you have successfully completed a Fifth Pathway or Sub-Internship program
- Proof of board certification (or board eligibility if you are not board certified)
- Proof of current professional liability coverage that shows the effective dates of coverage, amount of coverage, covered specialty, policy number and insurer's name
- Details regarding any malpractice claim, including date, nature and type of claim
- A written work history, resumé or curriculum vitae (CV), written in month and year format, with clear explanations of any gaps of more than six months

After the review, the Provider will receive a Notification of Receipt confirming that the application has been received. If the application packet is complete, the applicant's demographic information will be entered into the credentialing database and the verification process will begin. If elements are missing from the application, the Credentialing personnel assigned to the file will reach out to the Provider in an attempt to retrieve the necessary information.

During the verification process, CareConnect or its designee will authenticate the information contained in the application and requested documentation. If the application packet is deemed incomplete due to a failure to submit required information, or if verification fails to confirm the submitted information, CareConnect or its designee will notify the Provider to request clarification and/or updated information.

For any practitioner required to be licensed, CareConnect or its designee will verify the license during initial credentialing and during re-credentialing, following the procedures outlined below:

- CareConnect or its designee will query the New York State Education Department's Office of the Professions and the New York State Department of Health's Office of Professional Medical Conduct (OPMC) to confirm that the license is current, registered and valid. CareConnect or its designee will also check for any sanctions against the practitioner, or any restrictions of his or her practice, using the following lists, among others:
  - New York State Department of Health (DOH)/Office of the Medicaid Inspector General (OMIG) Exclusion List

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- U.S. General Services Administration System for Award Management (SAM.gov) (formerly EPLS)
- National Practitioner Databank (NPDB)

Note that if any current or previous disciplinary actions, denials, restrictions, suspensions or revocations to any license resulted in voluntarily relinquishment in any state, the event must be noted by the applicant on his or her credentialing application and will be reviewed during the credentialing process. If the practitioner notes such issues (or if CareConnect or its designee uncovers such issues), this information will be flagged for review by a Medical Director or his or her designee, and by the credentialing committee.

For Physicians (MDs, DOs):

- CareConnect or its designee will query the Federation of State Medical Boards (FSMB) during the credentialing and re-credentialing processes to determine if the practitioner is currently holding or has held a license in any other state or jurisdiction and if those licenses have or had any previous or pending adverse actions against them. If the FSMB indicates that the practitioner holds a license and has current or previous actions, this information will be flagged for review by a Medical Director or his or her designee, and by the credentialing committee.

Primary Source Data:

- All information contained in the application, other than licensing information, is subject to verification through various sources of primary data. In the event that primary source data appears to conflict with information submitted in the initial or renewal application packages, the Provider will be asked to correct the information or provide an explanation to the appropriate Credentialing personnel in a timely manner. All such corrections or explanations will be verified against primary sources.
- All findings from primary sources will be documented in the Provider's credentialing file and presented to a Medical Director or his or her designee, and, in certain circumstances, to the Credentialing Committee, within 180 days from the date that the queries are performed. If this deadline is not met, the queries will be re-run.

If Provider information is requested at any point during the credentialing process but not received within a reasonable timeframe, the credentialing application will be deemed abandoned and the credentialing application materials will be returned to the Provider.

Non-Discriminatory Credentialing Decisions

Providers will be accepted for participation in the CareConnect network based on the need for their services consistent with the objectives and programmatic requirements of CareConnect. Participation in the CareConnect network shall not be denied to any individual on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status, or any unlawful basis not specifically mentioned herein. CareConnect will not discriminate against Providers with a disability, except where that disability renders the person incapable, despite reasonable accommodation, of performing the essential functions required of participating Providers. Additionally, CareConnect will not discriminate against any

Provider on the basis of the risk of population he or she serves or against those who specialize in the treatment of costly conditions.

In order to further discourage discriminatory practices, the group of individuals participating in network selection decision-making will be multidisciplinary, and CareConnect will strive to include individuals of diverse backgrounds (*i.e.*, individuals representative of the protected categories of persons described above). Additionally, these individuals will strictly limit themselves to reviewing information related to the qualifications and credentials of each candidate. The information will not include demographic data.

Any Provider complaints of discrimination will be logged by CareConnect and will be thoroughly vetted by the appropriate parties.

Re-Credentialing

After initial credentialing, all network Providers must re-credentialed at least every thirty-six (36) months. In order to be re-credentialed, a Provider must send in updated information. In addition, the CareConnect re-credentialing process may involve a review of Provider performance indicators, which may include but is not limited to the following:

- Member/family complaints
- Information from quality improvement activities
- Member satisfaction surveys

If re-credentialing is denied, the Provider will be notified in writing of CareConnect's decision within sixty (60) days and informed of his or her right to appeal the decision.

3.5 Provider Demographic Information

Providers are responsible for contacting CareConnect to report any changes in their practice. It is essential that CareConnect maintain an accurate Provider database in order to ensure proper payment of claims, comply with Provider reporting requirements mandated by governmental and regulatory authorities, and provide Members with up-to-date information on Provider choices.

Providers must immediately notify CareConnect about changes to any of the following:

- Provider's name and Tax ID number(s)
- Provider's office address, including zip code
- Provider's telephone or fax number
- Provider's billing address
- Languages spoken in the Provider's office
- Board certification
- Affiliation with hospitals participating in the CareConnect network
- National Provider Identification number
- Office hours
- Ability to accept new patients

To update your information, please complete the Standardized Provider Information Change Form (available at CareConnect.com/provider) and email it to ProviderUpdates@nslijcc.com. For more information about updating demographic information, call 855-706-7545.

3.6 Provider Rights and Responsibilities

Provider Rights

CareConnect's Providers can act within the scope of their license, as permitted by law, to advise or advocate for Members and possess external appeal rights regarding concurrent or retrospective denial of coverage for health care services.

Provider Responsibilities

Providers must provide services that conform to accepted community medical and surgical practice standards. These community standards include, as appropriate, rules regarding ethical behavior and proper conduct, established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which physicians seek advice or guidance or to which they are subject for licensing and control.

Providers must also:

- Comply with all CareConnect administrative, patient referral, quality assurance, utilization management, clinical practice guidelines and reimbursement procedures
- Cooperate with and participate in all CareConnect peer review functions, including quality assurance, utilization review, administrative and grievance procedures
- Provide optimal care to Members without regard to age, race, sex, religious background, national origin, disability, sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status
- Comply with the Americans with Disabilities Act (ADA) guidelines set forth by the DOH, e.g. regarding wheelchair access
- Maintain telephone coverage for Members 24 hours a day, seven days a week
- Maintain documentation standards for medical records, including confidentiality policies
- Retain medical records for ten (10) years after the last date of service; records about minor patients must be retained for at least ten (10) years or until one year after the minor patient reaches 18, whichever is longer
- Provide CareConnect staff with access to clinical data for review of medical records, concurrent review, audits and site visits for credentialing
- Submit clean encounter data, using appropriate claim forms, in a timely fashion
- Notify CareConnect in writing, at least sixty (60) calendar days in advance, of any decision to terminate the relationship with CareConnect, or as required by the Provider's Agreement with CareConnect
- After terminating the relationship with CareConnect, continue an ongoing course of care and treatment for Members for a transitional period of up to ninety (90) days, at the CareConnect contracted rates

- Notify CareConnect immediately, or within three (3) calendar days, of:
  - The revocation, suspension or restriction of a medical license, DEA certification (if applicable) or Operating Certificate, or the requirement of a practice monitor or institution of any kind of limitation on practice
  - The occurrence of a reportable or adverse action, or the initiation of an investigation by any authorized Local, State or Federal agency, or
  - The filing of a malpractice action
  - Any change in hospital affiliation, including any reduction, restriction or denial of clinical privileges at any affiliated hospital
  - Any lapse in malpractice coverage or change in malpractice carrier or coverage amounts
  - The addition of a new associate to the practice
  - Any change to CLIA (Clinical Laboratory Improvement Amendments) certification for Providers offering in-office lab services
  - Any addition or deletion of office hours or change to office hours, or change in associates, billing address, telephone number, languages spoken or board certification

Under no circumstances will Providers hold a CareConnect Member liable for payment of any fees that are the legal obligation of CareConnect. Providers are prohibited from holding Members liable even in cases of non-payment by or insolvency of CareConnect or if covered services are denied in whole or in part; Providers cannot bill or seek or accept payment from a CareConnect Member. Providers may collect any copayment, coinsurance or deductible from the Member to the extent such copayment, coinsurance or deductible cost-sharing is permitted under the terms of the benefit plan under which the Member receives coverage.

CareConnect's Responsibilities to Providers

CareConnect recognizes its obligation to supply Providers with the following:
- Comprehensive orientation programs
- Timely and ongoing communication from knowledgeable staff
- Timely payment for covered services rendered to Members
- Assistance with complex Member issues
- Timely resolution of grievances and appeals
- Constructive feedback on performance and utilization

3.7 Provider Non-Disclosure and Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to Members is confidential pursuant to Federal and State laws, rules and regulations. PHI is to be used or disclosed by the Provider only for a purpose allowed or required by Federal or State laws, rules, and regulations.

PHI includes information related to enrollment with CareConnect, medical records and/or payment for the provision of health services that is derived in whole or in part from personally identifiable information. PHI must be safeguarded and held so as to comply with applicable privacy provisions of State and Federal laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Providers must take all reasonable measures to protect the privacy and confidentiality of the Member's PHI at all times, and to prevent its use by or disclosure to any non-affiliated third party. Providers must be aware that certain kinds of PHI are governed by a special set of confidentiality rules:

- PHI regarding the provision of substance abuse services
- PHI that identifies the presence of HIV-related illness
- PHI that relates to receiving certain kinds of mental health services
- PHI that relates to genetic conditions or tests

Release of any such PHI requires a special authorization and must not be made to anyone other than the patient except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of a CareConnect Member's PHI, please call our Privacy Officer at 516-405-7514.

Protecting the privacy of your patients—our Members—is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following the simple measures above.

3.8 Dispute Resolution

CareConnect's belief in a collaborative relationship with its Providers is a key part of our unique model, and we make every effort to work with Providers to resolve disputes regarding claims payment and service authorizations. In the event of a dispute or if you have concerns regarding your agreement with CareConnect, please contact Provider Relations.

If the issue cannot be resolved pursuant to the Dispute Resolution section of the Provider Agreement and you are no longer interested in participating with CareConnect, please call 855-706-7545 or follow the Termination Notice requirements outlined in your agreement.

3.9 Network Evaluation

The CareConnect Provider network is by design a select one which enable us to ensure the highest level of quality and efficiency for our Members. Our network consists of like-minded Providers who share our vision of simplifying health care and health insurance for our Members. Our aim is to provide Members with access to the appropriate service, in the appropriate setting, at the appropriate time, with the appropriate Provider. With this in mind, CareConnect reviews and analyzes its Provider network on an annual and ongoing basis.

Tracking and trending of utilization and services provide an opportunity for members of our medical management team to report positive efforts by Providers and their staff. Member and Provider data is logged, analyzed and used to identify best practices, as well as Provider and access issues, potential inadequacy of the network and areas in which the network could be expanded. Network evaluation may also alert CareConnect to the need to close recruitment of specific provider specialties, which we may do at our discretion.

3.10 Appointment Availability

We request that Providers adhere to the following appointment availability standards for medical and behavioral health services:

- Emergency care: immediately upon the Member's presentation at a service delivery site
- Urgent care: within 24 hours of the Member's request
- Non-urgent "sick" visit: within 48 to 72 hours of the Member's request, as clinically indicated
- Routine (non-urgent) preventive visit: within four (4) weeks of request
- Visit (non-urgent) to specialist: within two (2) to four (4) weeks of request
- Mental health or substance abuse follow-up visit with a Provider after discharge from an emergency department or hospital: within five (5) days of request, or as clinically indicated
- Non-urgent mental health or substance abuse visits with a Provider: within two (2) weeks of request
- Visit to Provider for a health, mental health, or substance abuse assessment for the purpose of receiving a recommendation regarding the Member's ability to perform work: within ten (10) days of request

Mental Health Clinics must provide a clinical assessment within five (5) days for individuals in the following designated groups:

- Individuals in receipt of services from a mobile crisis team not currently receiving treatment
- Individuals in domestic violence shelter programs not currently receiving treatment
- Homeless individuals and those present at homeless shelters who are not currently receiving treatment
- Individuals aging out of foster care who are not currently receiving treatment
- Individuals who have been discharged from an inpatient psychiatric facility within the last sixty (60) days who are not currently receiving treatment
- Individuals referred by rape crisis centers
- Individuals referred by the court system

CareConnect Members with appointments must not routinely be required to wait longer than one hour to see a Provider.

3.11 Adverse Reimbursement Change

CareConnect will give notice to Providers of any adverse reimbursement arrangement at least ninety (90) days prior to the arrangement's effective date. *Adverse reimbursement change* means a proposed adjustment that could reasonably be expected to have a negative impact on the aggregate level of payment to a Provider. This provision does not apply if the reimbursement change is required by law or as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions. The provision also does not apply if such a change is expressly provided for under the terms of your CareConnect provider agreement by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

3.12 Provider Audit

CareConnect performs periodic reviews of Provider records documenting evidence of service delivery to determine accuracy and pattern of error, and to guard against malfeasance.

Audits are based on a sampling of claims for a specific period. Provider selection is based on utilization. General methodology includes the following:

- Providers make available, with fourteen (14) days advance notice, requested documents, which are identified by invoice number, Member name and dates of service
- CareConnect develops a report of findings, including errors, if found, which will be shared with Provider
- Providers showing a trend of errors in excess of five percent (5%) are notified and are asked to develop a corrective action plan

Please note that failure to take corrective action may result in termination from the CareConnect network, with notification to regulatory agencies, as applicable. Cases of suspected fraud, abuse and malfeasance are referred to the appropriate agencies for investigation.

3.13 Non-Discrimination Policy

CareConnect ensures that its participating Provider network is accessible to persons with disabilities. CareConnect Providers must provide care to all CareConnect Members. Providers must not discriminate on the basis of:

- Age
- National origin
- Claims experience
- Race
- Disability
- Legally defined handicap
- Sex
- Economic, social or religious background
- Marital status
- Sexual orientation
- Health status
- Source of payment
- Veteran status

CareConnect may request information from our Providers to ensure that our Members have appropriate access to services, including physical access and the communications tools required to enable disabled individuals to receive needed services and to understand and participate in their care.

CareConnect monitors compliance with the non-discrimination provisions of Provider contracts through review of Member complaints, appeals, disenrollment, and responses to Member Service satisfaction surveys. Potential issues may also be identified by Medical Management during its ongoing care management services or service authorization process.

3.14 CareConnect's Notice of Privacy Practices

Please see Appendix A-2 for CareConnect's Notice of Privacy Practices.

Chapter 4
Billing Reimbursement Procedures

CareConnect℠

4.1 Claim Submission Procedures

Submitting Claims Electronically

CareConnect utilizes the Emdeon clearinghouse for electronic claims. Claims submitted electronically must be in the HIPAA-compliant 837p or 837i format. Each transaction must include:

- CareConnect Payer ID Number 46227
- Member ID number
- Valid ICD-10 diagnosis codes, indicating the Member's condition for which treatment was provided
- Valid CPT-4, HCPC, ICD-10 procedure codes, indicating the services provided to the Member
- A National Provider Identifier (NPI), which should reside in:
  - 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI)
  - 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI)

When a claim is submitted electronically, a status report will be generated, which will indicate that the claim has been accepted, rejected or pended, as well as the amount paid on the claim once it has been finalized. These reports are available to you through Emdeon or your current clearinghouse. CareConnect encourages Providers to review these reports frequently to ensure all claims are received and processed.

To sign up for electronic billing with Emdeon, Providers must contact their software vendor and request that their CareConnect claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon.

Providers automatically receive payments by mail; if you would prefer to receive payment via Electronic Funds Transfer (EFT), please follow the registration instructions on your check stub or call us at 855-706-7545 for assistance. You can access your Explanation of Payment (EOP) on the provider portal at CareConnect.com/provider.

Submitting Claims on Paper

All paper claims should be billed on standard CMS-1500 (professional) or UB-04 (facility) forms and mailed to:

CareConnect
Attn: Claims Department
P.O. Box 830259
Birmingham, AL 35283-0259

Paper claims should include the Tax Identification Number (TIN) and National Provider Identifier (NPI) of the Provider who rendered the service. In addition, the following elements must be included:

- Member name
- Member identification number
- Member date of birth
- Member gender

- Dates of service
- Current CPT-4, HCPC, or ICD-10 procedure codes with any appropriate modifiers
- Revenue codes (facility only)
- Current ICD-10 diagnosis codes
- Place of service (professional claims only)
- Number of units
- Total charges
- Servicing Provider name and address

Note for group practices and facilities: When submitting claims, please ensure that separate billing NPI and provider NPI numbers are entered in the appropriate fields. Office visit claims submitted for the group practice owner, with an organization NPI number instead of the individual NPI number, cannot be processed.

Time Frames for Claim Submission, Adjudication and Payment

Timely Claim Submission

You must submit claims within one hundred and twenty (120) days of the date of service for prompt adjudication and payment, unless otherwise noted in your provider agreement. In certain cases, CareConnect will process claims submitted outside of that time frame; these claims must be accompanied by a written explanation and appropriate documentation. Timely filing time frames begin as follows:

Initial or Corrected Claims	Time frame starts on the date of the initial CareConnect Explanation of Payment (EOP)/ Remittance Advice
Secondary Payer Filing (COB)	Time frame starts on the date on the Primary Carriers EOP
Claims Filed to Incorrect Carrier	Time frame starts on the date on the incorrect Carrier's EOP/RA

CareConnect adjudicates and pays all claims according to Section 3224-a of the New York State Insurance Law, also known as New York's "prompt pay" law.

Grace Periods

Provider payment is subject to the Member's insurance coverage status. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during the first 30 days will be processed according to prompt pay provisions. Claims submitted during days 31 through 90 of the Member's grace period will not be processed until the Member pays in full. If the Member's premium is paid in full by the end of the grace period, pended claims will be processed in accordance with the terms of the contract. If the Member premium is not paid in full by the end of the grace period, claims incurred during days 31 through 90 of the grace period will be denied. Providers are not permitted to balance-bill Members during days 31 through 90 of their grace period.

4.2 Claims Appeals for Payments/Review and Reconsideration

Providers can get claim status and payment information on our website at CareConnect.com/provider or by calling us at 855-706-7545. If you wish to have a claim reviewed for reconsideration, contact us within forty-five (45) days of the processing date on the Explanation of Payment (EOP). Use any of the following methods to reach us:

- Call us at 855-706-7545 Monday through Friday from 7:30 a.m. to 11 p.m., and Saturday and Sunday from 9 a.m. to 5 p.m.
- Mail a written request for review to:

  CareConnect
  Attn: Grievances and Appeals
  2200 Northern Blvd., Suite 104
  East Hills, NY 11548

- Fax a written request for review to Appeals and Grievances at 516-405-7857
- Go online to submit a request via ExpressRequest on our provider portal at CareConnect.com/provider

All written requests for review and reconsideration of a claim should include supporting documentation, including:

- A written statement of the reasons the claim payment may be incorrect
- Provider information, including name, Tax Identification Number and NPI
- Details of the claims in question, including:
  - Copies of relevant EOPs
  - CareConnect claim identification numbers
  - Member identification numbers and dates of service
- Contract rate sheets
- EOPs from other carriers, as appropriate

CareConnect will investigate all inquiries and issue a written response to the Provider within thirty (30) days, indicating the final disposition of the review.

4.3 Overpayment Recovery

CareConnect periodically reviews payments made to Providers, both to ensure the accuracy of claim payments pursuant to the terms of the Provider Agreement and appendices, and as part of its continuing utilization review and fraud control programs. In doing so, CareConnect may identify instances in which overpayments were made to a Provider. In such a case, CareConnect will provide notice to the Provider and recoup the overpayment, consistent with Section 3224-b of the New York State Insurance Law.

CareConnect does not pursue overpayment recovery efforts after more than twenty-four (24) months after the date of the original payment to a Provider unless:

- We have a reasonable belief of fraud, intentional misconduct or abusive billing
- Recovery is initiated at the request of a self-insured plan or required by the terms of such a plan
- Recovery is required by a state or federal government program

If we determine that an overpayment has occurred, we will provide thirty (30) days' written notice to the Provider of the overpayment and request repayment. The notice

will include the name of the Member who received service, service dates, payment amounts, proposed adjustments and a reasonably specific explanation of the reason for the overpayment and proposed adjustment. The Provider may dispute the finding or remit payment as outlined below. The notice will sent from:

CareConnect
Attn: Claims Overpayment Recovery Unit
P.O. Box 830259
Birmingham, AL 35283-0259

If a Provider Agrees that CareConnect Made an Overpayment

Upon the receipt of a request for repayment, Providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g. CareConnect) within thirty (30) days from the date the overpayment notice was mailed by CareConnect. Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

If a Provider Does Not Agree that CareConnect Made an Overpayment

If a Provider disagrees with the CareConnect determination concerning the overpayment, the Provider must submit, within 30 days from the date the overpayment notice was mailed by CareConnect, a written request for an appeal, including all supporting documentation. This material should be mailed to:

CareConnect
Attn: Claims Overpayment Recovery Unit
P.O. Box 830259
Birmingham, AL 35283-0259

If, upon reviewing the documentation submitted by the Provider, CareConnect determines that the overpayment determination should be upheld, the Provider may seek dispute resolution. CareConnect will offset the amount of the overpayment prior to the final determination made pursuant to the dispute resolution process.

If no response is received from the Provider within thirty (30) days from the date the overpayment notice was mailed by CareConnect, future claims may be offset in the amount equal to the overpayment.

4.4 Fraud, Waste and Abuse

It is the policy of CareConnect to comply with all applicable Federal and State laws regarding fraud, waste and abuse. CareConnect is committed to implementing and enforcing procedures to detect and prevent fraud, waste and abuse, and to provide protection for those who make a good-faith report of actual or suspected wrongdoing. CareConnect employees, officers and Providers are expected to fully comply with applicable laws, ethical standards and CareConnect policies and procedures, and to recognize and avoid actions and relationships that might violate those laws, standards and policies. In addition, CareConnect employees, officers and Providers are expected to report legal and ethical concerns using one of the methods described below.

To CareConnect, "fraud" means as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, including 18 U.S.C. § 1347 and New York Insurance Law § 403. "Waste" means an overutilization of health care services, or practices that result in unnecessary costs and do not rise to the level of abuse.

CareConnect views "abuse" as including Provider actions that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to us or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to us.

CareConnect's Special Investigations Unit

CareConnect maintains a Special Investigations Unit (SIU) to investigate allegations of fraudulent insurance activities. Specifically, our SIU is responsible for:

- Investigating suspected fraud or abuse by Providers
- Referring instances of suspected noncompliance that do not involve fraud or abuse to the Compliance Officer and other complaints to the appropriate CareConnect departmental leader
- Establishing the means for prompt responses to detected offenses and appropriate corrective action for confirmed findings of fraud or abuse

The SIU works with the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General of the United States Department of Health and Human Services (OIG), DOH and DFS Insurance Frauds Bureau, as appropriate. The SIU also works with local district attorneys, New York Medicaid Fraud Control Unit and United States Attorney General's office, as needed. In accordance with Article IV of the New York Insurance Law, the SIU helps ensure that the DFS Insurance Frauds Bureau is notified of all cases that CareConnect determines, after investigation, include suspected fraudulent insurance activities.

Reporting Fraudulent, Wasteful and Abusive Activities

CareConnect maintains a strict policy of zero tolerance toward fraud, waste, abuse and other inappropriate activities. As part of our commitment to this zero-tolerance policy, CareConnect wants our Providers to understand that we will investigate and address any alleged inappropriate activity. Corrective action may include, but is not limited to, disciplinary action up to and including termination of employment or a service agreement, or the pursuit of civil and criminal penalties through the court system.

If you suspect that a Provider, Member or CareConnect staff person(s) is engaged in fraud or abuse, we ask that you report it using any of the following channels:

You may call our Special Investigation Unit at 855-228-0549 or write to us at:

CareConnect
Attn: Special Investigations Unit
2200 Northern Blvd., Suite 104
East Hills, NY 11548

If you feel more comfortable sharing information in writing, please email us at siu@nslijcc.com.

CareConnect's EthicsPoint Helpline provides an alternative channel by which you may communicate your concerns confidentially and anonymously. Call our EthicsPoint Helpline at 800-894-3226 to report your concerns at any time of the day or night (after business hours, your call will go to voice mail, where you can leave a message). The information you provide will be forwarded within one (1) business day to CareConnect's Compliance Department for investigation.

You may also report suspected fraud to the DFS in writing using the DFS Report Fraud Form at www.dfs.ny.gov. Send the form by fax or mail to:

New York State Department of Financial Services
Insurance Frauds Bureau
One State Street
New York, NY 10004
Fax: 212-709-3555

Alternatively, you can call the toll-free hotline established by the OIG, at 800-HHS-TIPS (800-447-8477). For more information about this hotline and about other ways to contact the OIG, go to oig.hhs.gov/fraud/report-fraud/index.asp.

Protections for Whistleblowers

Whistleblower protection is authorized by the Federal False Claims Act (31 U.S.C. § 3730(h)) to shield employees and contractors (including Providers) from retaliation for reporting illegal acts of employers or principals. The Affordable Care Act extends employer liability under the Federal False Claims Act (31 U.S.C. §§ 3729-3733) to retaliation for claims made regarding "payments made by, through, or in connection with an Exchange....if those payments include any Federal funds." 42 U.S.C. § 18033(a)(6). Because many of our members receive premium tax credits and CareConnect may receive Federal subsidies through the reinsurance, risk corridor and risk adjustment programs, payments made to us from Federal sources and payments that we make to our Providers could be subject to the False Claims Act. According to the False Claims Act, an employer cannot rightfully retaliate against a whistleblowing employee in any way, such as by discharging, demoting, suspending or harassing the whistleblower. In case of retaliation, whistleblower protection might entitle the employee to file a charge with a government agency, sue the employer or both.

Chapter 5
Medical Management

CareConnect℠

5.1 Care Management

Our care management team collaborates with Providers to assist Members in accessing coordinated, high-quality health care services. In order to accomplish this goal, our care management team assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a Member's needs across the continuum of care. The care management process is characterized by advocacy, communication and resource management to promote high-quality, cost-effective and positive outcomes.

The care management process provides Members with referrals and coordinates services. It includes, but is not limited to, assisting Members in obtaining access to needed medical and behavioral health services, medical and/or psychiatric medications, and social, educational and psychological services.

CareConnect care management provides the Member with:

- Assistance in developing and following a Care Management Plan
- Education regarding available health care services and community resources
- Assistance in developing self-management skills needed to effectively access and use health care services
- Assistance in accessing needed medical and behavioral health services, preventive services, medications, social services and enhanced benefits

5.2 Coordination of Services

CareConnect Members are strongly encouraged to establish a positive relationship with a PCP, if they don't already have one, but are not required to designate a PCP. Our Service Connectors are available to assist Members in locating an in-network PCP or other Provider (Nurse Practitioners may function as PCPs, subject to scope of practice limitations under New York State Law).

A PCP may wish to arrange the transfer of a Member to another Provider under the following circumstances:

- A Member is persistently non-compliant with a therapeutic regime
- A Member is verbally or physically abusive to the physicians or staff
- A Member makes medically inappropriate demands or unreasonably refuses the physician's recommendations

Any of these situations should be clearly documented in the Member's medical record, and the Provider should send a letter to the Member informing him or her of the termination of the relationship and the reason for the change. The letter must indicate that the Member has 30 (thirty) days from receipt of the letter to select another PCP. The letter must also indicate that the Provider will continue to provide medical care during the 30-day period, as well as needed prescriptions. For more information regarding CareConnect's policy regarding reassigning a Member to another PCP, please contact us at 855-706-7545.

5.3 Case Management Services and Programs

Case management is the coordination of care and services provided to Members who have experienced a critical event, have recently been diagnosed with a chronic illness, or have multiple diagnoses or complications that require extensive use of resources, and who need help navigating the health care system to obtain appropriate care and services within covered benefits. The goal of case management is to help Members regain optimum health or improve functional capability, in the right setting and in a cost-effective manner.

CareConnect's Case Management Program is a Member-centric model built on an integrated continuum of care; it strives to address the totality of each Member's physical, behavioral, cognitive, and functional or social needs. It requires a comprehensive assessment of the Member's condition; determination of the available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

CareConnect identifies potential candidates for the Case Management Program by evaluating Members of a population defined by certain disease factors and claims history. Those found to be at risk for poor health outcomes are given the opportunity to opt-in to CareConnect's Case Management Program on a voluntary basis. In addition, Members are continually stratified and re-stratified according to their risk and potential needs, based on a predictive modeling tool that uses data from assessments, physician or Member referrals, and clinical information gleaned from claims, pharmacy or lab data.

CareConnect also receives requests to refer Members to the Case Management Program from the following sources:

- Discharge planners
- Utilization review nurses
- Members (self-referral)
- Providers (on behalf of their patients)

The CareConnect Case Management Program uses its findings from high-risk identification protocols along with comprehensive clinical assessments to assist Members with goal-setting, which may reduce inappropriate emergency room and inpatient admissions. Additionally, care managers use continuous evaluation tools to allow them to make time-sensitive referrals for Members when more intensive care is needed, minimizing symptom exacerbation. Problem-based, comprehensive case planning includes measurable, prioritized goals and interventions that are tailored to the Member and appropriate to his or her complexity level, as determined by initial and ongoing assessments. Other important approaches within the Case Management Program include:

- Coordination of care between PCPs and specialty providers
- Member empowerment through education, including self-care management strategies
- Facilitation of effective communication between Member and Provider

All of these measures are designed to help maximize Member health and may serve to reduce health care expenses.

If you have questions about Case Management or would like to refer a patient for Case Management services, please call us at 855-706-7545 and ask to speak with a Case Manager. If one of your patients is currently enrolled in a Case Management program and would like to discontinue those services, please call us at the same number; a Case Manager will assist you in closing the case.

Disease Management

CareConnect's disease management programs for Members who have been diagnosed with asthma (pediatric or adult) or diabetes (Type I or Type 2, pediatric or adult) aim to educate Members in order to help maximize health status, improve health outcomes and reduce health care costs. Our disease management programs were created and developed in accordance with current, nationally accepted evidence-based clinical practice guidelines, which are reviewed at least every two years. If you would like to refer a patient to one of our disease management programs, please call 855-706-7545 and request to speak with a disease manager. Members who are enrolled in a disease management program receive regular outreach calls from a disease manager who provides education on how to manage their chronic condition. They also receive educational materials in the mail.

5.4 Utilization Management (UM) Program

CareConnect's collaborative approach to medical management is an essential part of our model, which is designed to support care that is both effective and efficient. A cooperative and trusting relationship with our Providers provides the foundation for this approach. When a request for service is outside of practice guidelines, we offer peer-to-peer dialog with the prescribing physician. Frequently, a medical director will place a phone call to the prescribing doctor for a clinical discussion. This active, collaborative engagement creates a collegial atmosphere in which adverse determinations are minimized.

CareConnect conducts utilization management activities consistent with New York insurance laws and regulations. The goal of the UM Program is to achieve the following objectives:

- To ensure effective utilization of facilities and services through the use of an ongoing monitoring program designed to identify patterns of over-utilization, under-utilization and inefficient scheduling of resources
- To assist in the promotion and maintenance of optimal quality in member outcomes
- To ensure timely decision-making consistent with state and federal legal and regulatory requirements and the requirements of the National Committee for Quality Assurance

CareConnect uses MCG® (previously known as Milliman Care Guidelines®) as part of the basis for its clinical decision-making. In addition, Providers participating in the CareConnect Medical Management Committee review clinical criteria used to determine Medical Necessity to ensure that they represent sound medical practices. In applying Medical Necessity criteria, we assess the characteristics of the Member (such as age and co-morbidities) as well as of the local delivery system (including

the availability of facilities to support the Member's needs for care upon discharge). Clinical criteria used in making determinations are available to Providers and Members on request.

We believe that CareConnect Members and Providers, as well as persons acting on behalf of Members and Providers, should have input into the UM Program. Reactions, comments and suggestions may be provided through Member and Provider satisfaction surveys, focus groups and other forms of communication with CareConnect. We strive to act on input within a reasonable period of time, and provide feedback whenever possible.

Authorization Guidelines

Preauthorization is part of the Utilization Review process. It establishes, before a service or care is provided, whether the service, therapy, medication or supply is covered, and it specifies the conditions, medical setting, duration or other limits of coverage of the service or care. During the preauthorization process, Member eligibility and benefits are verified; a proposed service or care is evaluated, using MCG and nationally recognized clinical guidelines, and the service or care is deemed Medically Necessary or not Medically Necessary. A list of our clinical practice guidelines can be found at CareConnect.com/provider.

Services that require preauthorization by CareConnect or its designee can be found at CareConnect.com.

CareConnect requires preauthorization for all inpatient admissions and certain outpatient services. To request preauthorization, the admitting and/or referring physician or the facility or Provider rendering the service can submit the request in one of the following ways:

- By fax: Call 516-405-7857
- By phone: Call 855-706-7545 and ask for the Medical Management Department
- By email: Send to MedManageUMRequest@nslijcc.com
- Online: Submit through our Provider Portal at CareConnect.com/provider

To ensure a timely decision on preauthorization requests, the requesting Provider should provide the following information:

- Member name and CareConnect ID number
- Name, telephone and fax of the facility or Provider who will be rendering the service
- Proposed date(s) of service
- Diagnosis with ICD-10 code
- Name of procedure(s) with CPT and or HCPC code(s)
- Medical information to support the request:
  - Clinical presentation
  - Past and current treatment plans, including response to treatment plans
  - Medications, including dose and frequency
- Name and telephone number of contact person
- Tax ID Number (TIN) and NPI number

In order to reduce the administrative burden on Providers, CareConnect does not require notification or the completion of referral forms when a referral is made. Primary care and specialty care Providers may simply refer members to specialists, provided that such specialists are in-network.

Emergency/Urgent Care Services

Urgent Care

Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require care at an emergency department. If urgent care is indicated, medical assessment/screening should be completed and the Member's condition stabilized. The Member should be directed to coordinate follow-up care through their PCP.

- Urgent care does not include primary or routine care services, such as immunizations, annual wellness visits or other non-urgent services
- No authorization is required for care at participating urgent care facilities
- Members have coverage only for services received from participating urgent care centers
- If there are concerns that the Member will not comply with appropriate follow-up care, the Provider can initiate a request for care coordination by calling 855-706-7545

Emergency Care

An emergency is defined as a medical or behavioral condition characterized by the sudden onset of symptoms, including pain, of sufficient severity such that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the Member's health
- Serious jeopardy to the unborn child of a pregnant Member
- Serious jeopardy to the health of others (in the case of a behavioral condition suffered by a Member)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

In the event of an emergency, the Member should proceed directly to the closest emergency facility. Members are not required to obtain prior approval for emergency care, including emergency department visits or emergency admissions to a hospital.

Emergency Department Protocol for Hospitals

- If a Member is referred for emergency service by his or her physician, the physician or the designated staff must notify the Medical Management Department at 855-706-7545 within twenty-four (24) hours or one (1) business day of the referral.
- Treatment should be initiated and the Member's condition stabilized. The Member should be directed to coordinate follow-up care through their physician. If the emergency department is concerned that the patient will not comply with appropriate follow-up care, a request for care coordination can be initiated by calling 855-706-7545.
- If a hospital admission is indicated, the Member's PCP must be notified.

- If a Member requires an emergency inpatient admission, the admitting facility must notify CareConnect within twenty-four (24) hours, or the next business day if the admission occurs during a weekend or on a holiday. Notification is required in order to receive authorization for the inpatient stay.
- The inpatient admission request will be reviewed for Medical Necessity by a CareConnect Utilization Management employee. The disposition of the request will be communicated by telephone to the facility within twenty-four (24) hours of the initial request, assuming that we have received all necessary clinical information. We will send written notice of disposition within one (1) business day of receipt of the request, assuming that we have received all necessary clinical information.
- Members are not required to contact their PCP in emergent/urgent situations; however, Members are encouraged to do so if circumstances permit, so that the appropriate place of service can be determined. The emergency department staff will triage the Member to determine whether or not emergency care is required. So that the PCP can be notified, he or she must provide telephone coverage 24 hours a day, seven days a week.

All procedures required to evaluate and stabilize a Member with an emergency condition are covered by CareConnect. For example, if the attending physician orders a diagnostic pulmonary angiography as part of the evaluation for a Member treated in an emergency room for chest pain, then a retrospective review cannot deem the angiography unnecessary and refuse coverage. Members are entitled to receive timely and reasonable payment directly (or have payment made on their behalf) for services obtained from a Provider or supplier outside of the CareConnect network if those services were for emergency services.

Obstetrical Notification

When a CareConnect Member makes her first visit to an OB/GYN office for prenatal care, the office is required to notify the Medical Management Department by one of the following methods:

- By fax: Call 516-405-7857
- By phone: Call 855-706-7545 and ask for the Medical Management Department
- By email: Send to MedManagementUMRequest@nslijcc.com
- Online: Submit through our Provider portal at CareConnect.com/provider
- Second Opinions

At the request of a Member, CareConnect may provide for a second opinion from a qualified health care professional within the CareConnect network of Providers. The second opinion must be offered by a board-certified, appropriate specialist. In the event of a positive or negative diagnosis of cancer, a recurrence of cancer or a recommendation for a course of treatment for cancer, a Member may obtain a second opinion from a non-participating provider when the Member's attending physician provides a referral to that non-participating provider. CareConnect will also cover a second opinion from a non-participating, qualified physician when surgery has been recommended. In some instances, before we preauthorize a surgical procedure we may require that a Member seek a second opinion by a board-certified specialist who personally examines the Member.

If the first and second opinions do not agree, CareConnect will designate another Provider to render a third opinion. After completion of the "second opinion" process, CareConnect will preauthorize covered services supported by a majority of Providers who reviewed the case.

If a Member would like a second opinion, he or she should contact the Customer Service Department at 855-706-7545 and ask to speak with Medical Management for assistance in obtaining an authorization.

Hospital Notification

If a Member is admitted to a hospital, the facility is required to notify CareConnect within twenty-four (24) hours or the next business day.

Elective Inpatient Admissions

CareConnect will conduct preauthorization review of elective inpatient admissions within the timeframes specified in section 5-5.

Discharge Planning

To assist in coordinating the Member's discharge planning, CareConnect's Utilization Management nurse will work with:

- Hospital utilization review/discharge planning staff
- The attending physician
- Medical Management case management employees

The Utilization Management employee will work with the attending physician or designee to assist in coordinating the Member's follow-up care with his or her PCP.

For ongoing care, we work with the Provider to coordinate discharges to an appropriate setting, such as:

- Hospice
- Convalescent care
- Home health care
- Skilled nursing facility
- Acute rehabilitation

5.5 Medical Necessity

CareConnect regularly reviews 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 performed (concurrent) or after the service is performed (retrospective).

We cover benefits described in the Member policy as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "Service") is Medically Necessary.

We may base our decision on a review of:

- Medical records
- CareConnect medical policies and clinical guidelines
- Medical opinions of a professional society, peer review committee or other groups of Physicians
- Reports in peer-reviewed medical literature
- Reports and guidelines that include supporting scientific data and are published by nationally recognized health care organizations
- Professional standards, generally recognized in the United States, of safety and effectiveness in diagnosis, care, or treatment
- The opinion of health care professionals in the generally recognized health specialty involved
- The opinion of the attending Providers, which carry weight but do not necessarily overrule contrary opinions

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site and duration, and are considered effective for the Member's illness, injury or disease
- They are required for the direct care and treatment or management of that condition
- The Member's condition would be adversely affected if the services were not provided
- They are provided in accordance with generally accepted standards of medical practice
- They are not primarily for the convenience of the Member or the Member's family or Provider
- They are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results

When setting or place of service is part of the review, services that can be safely provided to the Member in a lower-cost setting will not be considered Medically Necessary if they are performed in a higher-cost setting. For example, CareConnect will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

Criteria for Medically Necessary services are reviewed and updated annually by the Medical Management Committee. These criteria will be applied to all covered services.

Cases will be referred to the Medical Director for the following reasons:

- Submitted documentation is unclear as to whether criteria for Medically Necessary services have been met; and/or
- Submitted documentation does not meet criteria for Medically Necessary services.

All determinations that services are not Medically Necessary (i.e., adverse determinations or denials) 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 the Member's medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of courses of treatment for substance use disorder. We do not reward or provide financial incentives to our employees or reviewers for determining that services are not Medically Necessary.

When services are denied partially or in full, Members and Providers will be notified in writing and, in certain cases, by telephone. The notification will, at a minimum, include reasons for any adverse determination; instructions on how to obtain additional information, including the entire copy of the clinical review criteria relied upon by CareConnect; what is involved in the internal and external appeals process; and what, if any, additional information must be provided to, or obtained by, the CareConnect reviewer to render a decision on an appeal.

Decisions on whether services are Medically Necessary are made upon receipt of required documentation within the following time frames:

- Non-urgent preauthorization: within three (3) business days of receipt of the request
- Urgent preauthorization: within seventy-two (72) hours of receipt of the request
- Concurrent requests: within one (1) business day of receipt of all necessary information
- Urgent concurrent requests: within twenty-four (24) hours of receipt of the request (assuming that the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment). If an urgent concurrent request is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, a decision will be made within the earlier of seventy-two (72) hours or one (1) business day of receipt of the request
- Inpatient substance use treatment: within twenty-four (24) hours of receipt of the request, assuming that the request is made at least twenty-four (24) hours before discharge from an inpatient substance use disorder treatment facility (we will provide coverage for inpatient substance use treatment while our determination is pending)
- Retrospective reviews: within thirty (30) days of receipt of the request

CareConnect may request extensions of these time frames under the following circumstances:

Preauthorization Review

If additional information is needed to make a determination regarding a preauthorization, CareConnect will request it within three (3) business days. The Member or Provider has forty-five (45) days to submit the information. If we receive the requested information within that time period, we will make a determination and provide it to the Member and Provider, by telephone and in writing, within three (3) business days of receipt of the information. If all necessary information is not received within forty-five (45) days, we will make a determination within fifteen (15) days of the end of the forty-five (45) day period.

Urgent Preauthorization

If additional information is needed to make a determination regarding an urgent preauthorization, CareConnect will request it within twenty-four (24) hours. The Member or Provider will then have forty-eight (48) hours to submit the information. CareConnect will make a determination and provide notice to the Member and Provider by telephone and in writing within forty-eight (48) hours of the earlier of CareConnect's receipt of the information or the end of the forty-eight (48) hour period.

Concurrent Review

If additional information is needed to make a determination regarding a concurrent review, CareConnect will request it within one (1) business day. The Member or Provider will have forty-five (45) days to submit the information. We will make a determination and provide notice to the Member or Provider, by telephone and in writing, within one (1) business day of receipt of the information or, if we do not receive the information, within fifteen (15) days of the end of the forty-five (45) day period.

Urgent Concurrent Reviews

If additional information is needed to make a determination regarding an urgent concurrent review, CareConnect will request it within twenty-four (24) hours. The Member or Provider will have forty-eight (48) hours to submit the information. We will make a determination and provide written notice to the Member and Provider within the earlier of one (1) business day or forty-eight (48) hours of the receipt of the information, or, if CareConnect does not receive the information, by the end of the forty-eight (48) hour time period.

Retrospective Review

If additional information is needed to make a determination for a retrospective review, CareConnect will request it within thirty (30) days. The Member or Provider will have forty-five (45) days to submit the information. We will make a determination and provide written notice to the Member and Provider within fifteen (15) days of the earlier of our receipt of the information or the end of the forty-five (45) day period.

Once we have all the information needed to make a decision, a 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 (as described below).

Retrospective Review of Preauthorized Services

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

- The relevant medical information presented to CareConnect upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to CareConnect upon retrospective review existed at the time of the preauthorization but was withheld or not made available to CareConnect;
- CareConnect was not aware of the existence of such information at the time of the preauthorization review; and
- Had CareConnect 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 during the preauthorization review.

Reconsideration

If CareConnect did not attempt to consult with the Provider before making an adverse determination, the Provider may request reconsideration by the same CareConnect reviewer who made the adverse determination. For preauthorization and concurrent reviews, 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 Member and Provider, by telephone and in writing.

5.6 Requesting an Appeal of a Coverage Decision

Members and, in retrospective review cases, their Providers, may request an internal appeal of an adverse determination (*e.g.,* denial of coverage) either by phone, in person or in writing. A Member can initiate an appeal in person at our Customer Service Department or by mail at:

CareConnect
Attn: Grievances and Appeals
2200 Northern Blvd., Suite 104
East Hills, NY 11548

Members can also initiate an appeal by calling a Customer Service Connector at 855-706-7545, or by faxing a letter to us at 516-405-7850. In all circumstances, the Member must indicate why he or she believes that the initial decision should be reviewed again, and include any documentation that supports the appeal.

Members, and as applicable, their Providers have up to one hundred eighty (180) days after receipt of notice of the adverse determination to file an appeal. We will acknowledge the request for an internal appeal within fifteen (15) days of receiving it. This acknowledgment will, if necessary, inform the Member (or Provider, as applicable) of any additional information needed before a decision can be made. A physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue will review the appeal; this reviewer will not be subordinate to the reviewer who made the initial adverse determination. If a Member would like additional information about requesting an appeal of a coverage decision, he or she can refer to the Certificate of Coverage or other benefits document or call the Customer Service Department.

When a request is made for an appeal of a coverage decision, the timing of our review and response will be as follows:

First Level Appeals: The first level of our internal appeals process includes both standard and expedited appeals. A failure to render a determination of the member's appeal within sixty (60) calendar days of our 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.

Appeal of an Out-of-Network Service or Referral Denial

a) Members have the right to appeal the denial of a preauthorization request for an out-of-network health service when CareConnect determines that the out-of-network health service is not materially different from an available in-network health service and the out-of-network service is not available from a participating Provider. Members cannot appeal the denial of a preauthorization request for an out-of-network health service on the basis of the in-network Provider having less experience in diagnosing or treating the Member's condition; such an appeal will be treated as a grievance as described in Section 2-6 (Member Grievances).

b) Members or their authorized representative must submit the following information when requesting an appeal for an out-of-network health service:

- **i** A written statement from the Member's attending physician (who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the Member's condition) that the requested out-of-network health service is materially different from the alternate health service available from a participating Provider who CareConnect has approved to treat the Member's condition; and
- **ii** Two documents from the available medical and scientific evidence showing that the out-of-network service is likely to be more clinically beneficial to the member than the alternate in-network service, and that the out-of-network service would likely not pose a substantially greater risk than the in-network health service.

c) Members also have the right to appeal the denial of a request for an authorization to use a non-participating Provider when CareConnect determines that it has a participating Provider with the appropriate training and experience to meet the Member's particular health care needs and provide the requested health care service. The Member or the Member's authorized representative must submit a written statement from the Member's attending physician (who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the Member's condition) that the participating Provider recommended by CareConnect does not have the appropriate training and experience to meet the Member's need for the health care service. The attending physician's written statement must also recommend a non-participating Provider with the appropriate training and experience to meet the Member's particular health care needs by providing the requested health care service.

Preauthorization Appeal: CareConnect will decide an appeal relating to a request for preauthorization within fifteen (15) or thirty (30) days of receipt of the appeal request, depending on whether the Member is part of a group or individual plan, respectively. Written notice of the determination will be provided to the Member or authorized representative and, where appropriate, the Member's Provider within two business days after the determination is made, but no later than fifteen (15) or thirty (30) days after our receipt of the appeal request depending on whether the member is part of a group or individual plan, respectively.

Retrospective Appeal: For appeals relating to a covered service that has already taken place, CareConnect will make a determination within thirty (30) or sixty (60)

days of our receipt of the appeal request, depending on whether the Member is part of a group or individual plan, respectively. Written notice of the determination will be provided to the Member or authorized representative and, where appropriate, the Member's Provider within two (2) business days after the determination is made, but no later than thirty (30) or sixty (60) days after our receipt of the appeal request, depending on whether the Member is part of a group or individual plan, respectively.

Expedited Appeal: Expedited appeals include appeals 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 for which a Provider requests an immediate review or any other urgent matter. An expedited appeal is *not* available for retrospective reviews. For an expedited appeal, the Member's Provider will have reasonable access (*e.g.,* by telephone or fax) to the CareConnect reviewer assigned to the appeal within one business day of our receipt of the request for an appeal. We will decide an expedited appeal within the earlier of seventy-two (72) hours of our receipt of the appeal or two (2) business days of our receipt of the information necessary to conduct the appeal.

Substance Use Appeal: If CareConnect denies a request for inpatient substance use disorder treatment that was submitted at least twenty-four (24) hours prior to discharge from an inpatient admission, and the Member or his or her Provider files an expedited internal appeal of our adverse determination, we will decide this appeal within twenty-four (24) hours of our receipt of the appeal request. If the Member or his or her Provider files this appeal and an expedited external appeal within twenty-four (24) hours of receipt of our adverse determination, we will provide coverage for the inpatient substance use disorder treatment while a determination of the internal appeal and external appeal is pending.

Second Level Appeals

(for members with coverage through their employers):

Our group plans permit Members or their authorized representatives to file another internal appeal if they disagree with the first level appeal determination.

- This second level appeal must be filed within forty-five (45) days of the Member's receipt of the final adverse determination of the first level appeal. We will acknowledge the Member's request for an internal appeal within fifteen (15) days of receipt. Because a four-month time frame for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal, CareConnect informs its group plan Members that if they choose to file a second level appeal, the time may expire to file an external appeal.
- If the second level appeal relates to a preauthorization request, we will decide the appeal within fifteen (15) days of our receipt of the appeal request. If it relates to a retrospective claim, we will decide within thirty (30) days. Written notice of the determination will be provided to the Member or his or her authorized representative and his or her Provider within two (2) business days after the determination is made, but no later than fifteen (15) or thirty (30) days after our receipt of the appeal request for a preauthorization or retrospective appeal, respectively.
- If the second level appeal relates to an expedited appeal, we will decide the appeal and notify the Member, or his or her authorized representative or Provider, by

phone within seventy-two (72) hours of receipt of the first level appeal request. We will provide written notice of our decision within seventy-two (72) hours of receipt of the second level appeal request.

Independent External Review

If the Member is not satisfied with the outcome of the internal appeals process, and if the appeal involves a covered service and coverage was denied because it did not meet our requirements for a Medically Necessary service, is an experimental or investigational treatment or is an out-of-network service, the Member may have the option to submit the dispute for resolution by an independent external reviewer, an independent review organization (IRO), through the DFS external appeal process. The IRO ensures that the Member has access to an objective third-party review that is not influenced by or affiliated with the health insurer. The decision of the IRO is binding upon CareConnect and the Member.

Circumstances Under Which a Dispute May Be Submitted to External Appeal

In order to submit a dispute to external review, the Member must have originally received a covered service and then must have received a final adverse determination letter. However, under the following circumstances, a Member may submit a dispute to external appeal even though he or she has not received a final adverse determination through the first level of our appeal process:

- We agree in writing to waive the internal appeal;
- The Member files an external appeal at the same time as he or she applies for an expedited internal appeal; or
- We fail to adhere to Utilization Review claim processing requirements (except in cases of a minor violation).

Providers may also request an external appeal on their own behalf when we make a concurrent or retroactive adverse determination. When making such a request, the Provider must include our initial denial and final adverse determination, and must obtain the consent of the Member to release his or her medical records. Providers appealing a concurrent adverse determination must pay the IRO the cost of the external appeal if our denial is upheld. If a Provider requests an external appeal of a concurrent denial, he or she is prohibited from pursuing reimbursement from the patient for services that are determined not to be Medically Necessary by the IRO, except to collect a copayment, coinsurance or deductible.

Process for Submitting an External Appeal

The Member (or the Provider in cases of pre-service and retrospective appeals) may start the external appeal process by filing a completed application with DFS. Under New York State law, the completed request for external appeal must be filed within four (4) months of either the date upon which the Member received a final adverse determination from us, the date upon which the Member received a written waiver of any internal appeal, or the date of our failure to adhere to claim processing requirements (other than certain minor violations). We have no authority to extend this deadline.

We will provide an external appeal application to the Member and Provider with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal. We will also send this application to a Member or his or her Provider within three (3) business days of the Member's request. In addition, the Member or his or her Provider, as applicable, may request an external appeal application from DFS by calling 800-400-8882 or emailing Externalappealquestions@dfs.ny.gov. A Member or Provider who needs help with an expedited external appeal on a holiday or weekend may call DFS at 888-990-3991.

As part of the application process, the Member must consent to the transfer of his or her medical or treatment records to the IRO. Once this consent is obtained and the IRO is assigned by the State, we will send the Member's medical or treatment records to the IRO.

As part of the appealing Member's or Provider's external appeal application, 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), the appealing Member's attending physician must certify that the Member's condition or disease is one for which there exists a clinical trial or rare disease treatment (as defined by law) and:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure covered by us.

In addition, the Member's attending physician must have recommended one of the following:

- A service, procedure or treatment that is likely to be more beneficial to the Member than any standard covered service (as substantiated by two documents selected from medical and scientific evidence deemed acceptable by the State); or
- A clinical trial for which the Member is eligible (only certain clinical trials will be considered); or
- A rare disease treatment for which the Member's attending physician certifies that: there is no standard treatment that is likely to be more clinically beneficial to him or her than the requested service; the requested service is likely to benefit him or her in the treatment of the rare disease; and such benefit outweighs the risk of the service. In addition, the Member's attending physician must certify that the condition is a rare disease that is or was 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 a rare disease treatment, the attending physician may not be the Member's treating physician.

If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, the Member may appeal to the IRO if he or she has requested preauthorization for the out-of-network treatment. In addition, the Member's attending physician must certify that:

- The out-of-network service is materially different from the alternate recommended in-network health service and is likely to provide a larger clinical benefit than the alternate in-network treatment (as substantiated by two documents selected from medical and scientific evidence acceptable by the State); and

- The adverse risk of the requested health service would likely not be substantially greater than that of the alternate in-network health service.

If we have denied a request for authorization to use a non-participating Provider because we determined that we have a participating Provider with the appropriate training and experience to meet the Member's health care needs who is able to provide the requested health care service, the Member's attending physician must:

- Certify that the participating Provider recommended by us does not have the appropriate training and experience to meet the member's particular health care needs; and
- Recommend a non-participating Provider with the appropriate training and experience to meet the member's health care needs who is able to provide the requested health care service.

For all certifications from the Member's attending physician discussed in this section, the attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat the Member's condition or disease.

In certain circumstances, the Member or Member's Provider may file an expedited external appeal. The grounds for filing an expedited external appeal include the following:

- The Member's attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Member's health; or
- The Member's attending physician certifies that the standard external appeal time frame would seriously jeopardize the Member's life, health or ability to regain maximum function; or
- The Member received emergency services and has not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay.

If criteria for an external appeal are met, the State will forward the request to the IRO.

When we receive notification that an external review is in progress, we are responsible for sending the IRO the clinical criteria used in Utilization Review within three business days; in the case of an expedited external appeal, we must send that information within 24 hours of receiving such notice. Assuming that the IRO has not yet rendered its determination, Providers and Members may submit information to the IRO, regardless of whether the IRO has requested any information, within four months from the date on which the Member received our final adverse determination, the date on which the Member received a written waiver of any internal appeal, or the date on which we failed to adhere to claims processing requirements (other than certain minor violations).

If the IRO determines that the information submitted represents a material change from the information on which we based our denial, we will have the right to reconsider our decision and will have three (3) business days to do so.

External Appeal Decisions

In general, the IRO must make a decision within 30 days of receipt of the completed external appeal application. If the IRO requests additional information, it will have

five additional business days to make its decision. The IRO must notify the appealing Member or, as appropriate, the Member's Provider and us of its decision, in writing, within two business days.

For expedited external appeals, the IRO must make a decision within 72 hours of receipt of the completed application. Immediately after reaching a decision, the IRO must notify the appealing Member or, as appropriate, the Member's Provider and us of that decision by telephone or fax. The IRO must also notify the Member or, as appropriate, the Member's Provider and us in writing of its decision.

5.7 Services Requiring Preauthorization

A full list of the procedures/services for which CareConnect requires preauthorization can be found at CareConnect.com/provider.

CareConnect and CCAS have delegated utilization management and claims payment to Davis Vision for vision services and to HealthPlex for dental services. Davis Vision can be reached at 800-999-5431; HealthPlex can be reached at 888-468-5175. Alternatively, Members calling Customer Service at 855-706-7545 will be redirected appropriately to Davis Vision or HealthPlex. CareConnect's Pharmacy Benefit Manager (PBM) is Caremark, which can be reached at 855-559-5106.

5.8 Behavioral Health Services

Members have access to routine and emergency behavioral health services and are not required to obtain prior approval for office visits or emergency care.

Inpatient Services

CareConnect's coverage of inpatient mental health services related to the diagnosis and treatment of mental, nervous and emotional disorders is comparable to its coverage of other similar hospital, medical and surgical services. Coverage for inpatient services for mental health care is limited to services received in facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

Outpatient Services

CareConnect covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to services:

- Received in a facility that has an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or, in other states (to the extent applicable), a similarly licensed or certified facility; and
- Provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who has at least three (3) years additional experience in psychotherapy; or a professional corporation or a university faculty practice corporation.

Mental Health Services Limitations

- We do not cover benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.
- We do not cover mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services.
- We do not cover services solely because they are ordered by a court.

Substance Use Services

Inpatient Services: We cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Coverage of inpatient substance use services is limited to those received in facilities in New York that are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) and, in other states (to the extent applicable), is limited to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services: We cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or dependency. Coverage is limited to such services received in facilities in New York that are certified or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs. In other states (to the extent applicable), coverage is limited to such services received in facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such services may also be provided by physicians who have been granted a waiver pursuant to the Drug Addiction and Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

We cover up to twenty (20) outpatient visits for family counseling (limits apply in certain plans). A family member will be covered when the family member identifies himself or herself as a family member of a person experiencing substance use and/or dependency, so long as that family member is covered under the same family certificate that covers the person receiving or in need of treatment.

Autism Spectrum Disorder Services

We cover appropriate and Medically Necessary evaluation and diagnostic and treatment services for autism spectrum disorder when such services are prescribed or ordered by a licensed physician or a licensed psychologist. Such services may include screening and diagnosis, assistive communication devices, behavioral health treatment (including applied behavioral analysis), psychiatric and psychological care, therapeutic care and pharmacy care, subject to certain limitations.

After-hours Care Coordination

Providers who would like to leave referral information after normal business hours can call 855-706-7545. Their referral request will be processed the following business day.

5.9 Transfer of Care

If a Member is admitted to a non-participating hospital in the New York Metropolitan area subsequent to an Emergency Room visit, CareConnect may transfer the Member to a participating hospital if the Member is stabilized and

- A needed service is not available at the admitting non-participating hospital, and the admitting hospital agrees to and arranges for the transfer; or
- A Member is hospitalized out-of-network, and the attending physician agrees that the Member can be safely transferred.

If there is disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding.

CareConnect covers post-stabilization care when it is related to an emergent condition/diagnosis, in order to maintain, improve or resolve the Member's condition/diagnosis. The post-stabilization care must be Medically Necessary and provided within network.

5.10 Transitional Care

When a Provider leaves the CareConnect network, the Provider must, at CareConnect's request, continue to provide covered services to Members until the date upon which CareConnect makes alternative arrangements for the provision of such services. During this period, CareConnect will compensate the Provider in accordance with the terms of the Provider's agreement with CareConnect, and the Provider must accept such compensation as payment in full for covered services.

Chapter 6
Quality Improvement Program (QIP)

CareConnect℠

6.1 Quality Overview

CareConnect is committed to providing its Members with access to high-quality services. As a part of our efforts to fulfill this commitment, we periodically conduct studies of the quality of care provided to Members. These studies are carried out under our Quality Improvement Program (QIP). The goal of the QIP program is to systematically monitor, evaluate and improve the quality and appropriateness of care provided to Members or coordinated for Members, in an effort to maximize Member satisfaction. QIP focuses on the services provided by participating CareConnect physicians. The following areas are reviewed annually:

- Quality and quantity of services
- Management of care, including the availability of care, access to care and continuity of care, as well as early identification of problems requiring a change in care
- Identification and correction of operational and clinical practice issues
- Outcomes in clinical and non-clinical areas

CareConnect tracks and reports on a variety of measures describing the care delivered to Members by Providers. Specifically, CareConnect reports on an annual basis to the DOH through the Quality Assurance Reporting Requirements (QARR) and to the National Committee for Quality Assurance through the Healthcare Effectiveness Data & Information Set (HEDIS). Quality is measured using encounter/claim data that may be supplemented by medical record reviews to determine the percentage of Members receiving certain preventive services, as well as the appropriateness of care for certain chronic diseases. Additional studies and medical record reviews are initiated by the DOH throughout the year targeting specific areas, such as prenatal care and chronic illnesses. CareConnect supports and fulfills its quality assurance and improvement functions through several cross-functional committees. All committee meetings are recorded and minutes are reported to the Board of Directors at its quarterly meetings.

6.2 QIP Work Plan Assessment Activities

CareConnect designs an annual work plan to ensure that the QIP is supported. Work plan activities include a review of all departments and selected operations that focuses on compliance with regulatory requirements and business and operational goals. Sources of data include record reviews, grievances, incidents, hospitalizations, nursing home admissions, high risk/high volume utilization, member satisfaction surveys and other customer service and Provider performance reports. Data is reported to the board-appointed Quality Improvement Committee.

6.3 Provider Quality Report Cards

CareConnect is committed to working in partnership with its Providers to ensure that quality care is delivered to Members, and that we meet Federal and State clinical quality standards, such as HEDIS and QARR. CareConnect gives Providers information that reflects their performance on a number of these standards, in order to help them identify gaps in care experienced by their patients and show the Providers how they compare to other Providers in the CareConnect network or to benchmarks. These reports are used as a foundation for efforts to educate Providers on how to improve quality scores in areas where they are below standard or just at benchmark. CareConnect works with these Providers to help them improve their scores for the following year.

Chapter 7
CareConnect Administrative Services

CareConnect℠

7.1 Plans Administered by CareConnect Administrative Services

CareConnect Administrative Services, Inc. (CCAS) administers self-insured plans for employer groups, including North Shore-LIJ Health System. In general, claims, preauthorization requests, and determination of eligibility are handled in the same manner as for CareConnect plans. The following is highlighted for ease of reference:

Claims Submission Procedures
See Section 4-1.

Services Requiring Preauthorization
See Section 5-7.

Determination of Eligibility
See Section 2-2.

List of Covered Drugs (Formulary)
See Appendix Section A-1.

Appendices

CareConnect℠

A.1

Drug formularies for CareConnect and CCAS can be found at CareConnect.com/prescription-drugs.

A.2

CareConnect Notice of Privacy Practices

This Notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: October 1, 2015

This Notice describes the privacy practices of CareConnect. We must follow the duties and privacy practices described in this Notice.

What is the Notice of Privacy Practices?

In order to provide you with the benefits to which you are entitled, CareConnect must collect, create and maintain protected health information about you. Protected health information ("PHI") is individually identifiable information about you, which may include:

- Information about your health condition (such as medical conditions and test results you may have);
- Information about health care services you have received or may receive in the future (such as a surgical procedure);
- Information about your health care benefits under an insurance plan (such as whether a prescription is covered);
- Geographic information (such as where you live or work);
- Demographic information (such as your race, gender, ethnicity, or marital status);
- Unique numbers that may identify you (such as your social security number, your phone number, or your driver's license); and
- Biometric identifiers (such as finger prints).

This Notice tells you about the ways we may use and share your PHI, as well as the legal obligations we have regarding that information. The Notice also tells you about your rights under federal and state laws. The Notice applies to all records held by CareConnect regardless of whether the record is written, computerized or in any other form. We are required by law to make sure that PHI is kept private and to make this Notice available to you. If you are a CareConnect member and an employee, information in your employment records is not covered by this Notice.

Overview

For your convenience, what follows is a summary of the key provisions in our Notice. This summary is not a complete listing of how we use and disclose your PHI. If you have any questions about any of the information contained in this summary, please read this full Notice of Privacy Practices or contact the CareConnect Privacy Officer for more information.

CareConnect may use and disclose your PHI without your consent, to:

- Process and pay your claims;
- Coordinate your benefits under the plan and other services, which may include such things as giving you appointment reminders and telling you about treatment alternatives or other health-related benefits;
- Ensure that we follow the rules of regulatory agencies regarding the quality of services we provide;
- Comply with all legal requirements, subpoenas, and court orders;
- Engage in certain pre-approved research activities;
- Assist in our own payment process and the payment activities of other health plans and health care providers; and
- Meet special situations as described in this Notice such as public health and safety.

You have a right to:

- See and obtain a copy of the PHI we have about you in the format of your choosing, with certain restrictions;
- Ask us to amend the PHI we have about you, if you feel the information we have is wrong or incomplete;
- Ask us to restrict or limit the PHI we use and share about you;
- Ask for confidential communications;
- Obtain a list of individuals or entities that have received your PHI from CareConnect, subject to limits permitted by law;
- Be notified if the privacy of your PHI is breached;
- Obtain a paper copy of the Notice; and
- Submit a complaint.

How We May Use and Share your PHI with Others

The following categories describe different ways that we may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every possible use or disclosure within each category will be listed. However, all of the ways we are permitted to use and disclose your information will fall within at least one of the following categories.

For Treatment. We may use or disclose PHI about you to facilitate treatment by health care providers. For example, if one of our participating health care providers is treating you, we may disclose to this provider PHI relating to other health care services you have received that may be relevant to the provider's treatment.

For Payment. We may use and disclose PHI about you for our own payment purposes and to assist in the payment activities of other health plans and health care providers. Our payment activities include collecting premiums, determining your eligibility for benefits, reimbursing health care providers that treat you and obtaining payment from other insurers that may be responsible for providing coverage to you. For example, if a health care provider submits a bill to us for services you received, we may use PHI about you to determine whether these services are covered under your benefit plan and the appropriate amount of payment to which the provider may be entitled. In addition, insurance companies and other third parties may require that we provide your social security number for verification and payment purposes.

For Healthcare Operations. We may use your PHI to support our business activities, which can include quality assessment and improvement activities, case management and care coordination, and the resolution of any complaints or grievances you may have. For example, we may use your PHI to review the treatment and services given to you by doctors and hospitals in order to see whether they have provided you with preventative treatment and other important health services that are recommended by medical authorities.

Underwriting. We may use or disclose PHI about you for certain underwriting purposes. However, we are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Appointment Reminders. We may use and share your PHI to remind you of appointments you have made to receive health care services or to encourage you to make such appointments.

Business Associates. We may share your PHI with a "business associate" that we hire to help us, such as a billing or computer company, or an accounting or law firm. Business associates will have assured us in writing that they will safeguard your PHI as required by federal law.

Plan Administration. We may disclose your PHI to your employer when needed to perform plan administration functions if appropriate language has been included in your plan documents. We may disclose summaries of your health information to your employer to assist with the bidding process or with modifying or terminating a group health plan.

Treatment Alternatives and Other Health-Related Benefits and Services. We may use your PHI to contact you about the management of your health care and to discuss treatment alternatives and other health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related products or services that are subsidized by a third party without your authorization.

Marketing Activities. We may use or share your PHI for marketing purposes when we discuss such products or services with you face to face or provide you with an inexpensive promotional gift related to a product or service. We also will never sell your PHI to third parties without your written authorization to do so. However, we may receive payment to disclose your PHI for certain limited purposes permitted by law, such as public health reporting.

Individuals Involved in Your Care or Payment for Your Care. Unless you say no, we may disclose PHI to people such as family members, relatives, or close personal friends who are helping to care for you or helping to pay your medical bills. Additionally, we may disclose information to a personal representative. If a person has the authority under the law to make health care decisions for you, we will treat that personal representative the same way we would treat you with respect to your PHI. Parents and legal guardians are generally patient representatives for minors unless the minors are permitted by law to act on their own behalf and make their own medical decisions in certain circumstances. If you do not want PHI about you disclosed to those involved in your care, please notify us.

Disaster-Relief Efforts. We may disclose your PHI to an organization, such as the American Red Cross, assisting in a disaster relief effort, so that your family can be notified about your condition, status and location. If we can reasonably do so while trying to respond to the emergency, we will try to find out if you want us to share this information.

Research. We may use or disclose your PHI for research purposes, such as studies comparing the benefits of alternative treatments received by our members. All research projects conducted through CareConnect must be approved through a special review process to protect plan member safety, welfare and confidentiality. Your PHI may be important to research efforts and may be used for research purposes in accordance with state and federal law.

Government Programs Providing Public Benefits. We may disclose your PHI relating to eligibility for or enrollment in CareConnect to an agency administering a government program providing public benefits, as long as sharing the PHI is required or otherwise authorized by law.

As Required By Law. We will share your PHI when federal, state, or local law requires us to do so.

De-identified Information and Limited Data Sets. We may use and disclose health information that has been "de-identified" by removing information that may identify you. We may also use and disclose certain health information about you known as a "limited data set" for the purposes of research, public health and health care operations. Limited data sets do not contain any information that would directly identify you. For example, a limited data set may include your city, county and zip code, but not your name or street address

Special Situations

Legal Proceedings, Lawsuits, and Other Legal Actions. We may share your PHI with courts, attorneys and court employees when we get a court order, subpoena, discovery request, warrant, summons or other lawful instructions from those courts or public bodies, and in the course of certain other lawful, judicial or administrative proceedings, or to defend ourselves against a lawsuit brought against us.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may disclose PHI:

- To identify or locate a suspect, fugitive, material witness or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- To report a crime that occurred on our premises; and
- In certain cases when we provide emergency treatment.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help stop or reduce the threat.

Public Health Risks. As required by law, we may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, injuries or disability; reporting suspected child abuse or neglect; reporting suspected domestic violence; reporting reactions to medications or problems with products; preventing or reducing a serious threat to someone's health and safety; notifying people of recalls, repairs or replacements of products they may be using; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and reporting to your employer findings concerning work-related illness or injury so that your workplace may be monitored for safety.

Worker's Compensation. We may share your PHI for Worker's Compensation or similar programs that provide benefits for work-related injuries or illness.

Specialized Government Functions. If you are a member of the armed forces (of either the United States or of a foreign government), we may share your PHI with military authorities so they may carry out their duties under the law. We may also disclose your PHI if it relates to national security and intelligence activities, or to providing protective services for the President or for other important officials, such as foreign heads of state.

Health Oversight Activities. We may disclose your PHI to local, state or federal governmental authorities responsible for the oversight of medical matters as authorized by law. This includes licensing, auditing, and accrediting agencies and agencies that administer public health programs such as Medicare and Medicaid.

Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI to a coroner or medical examiner as necessary to identify a deceased person or to determine the cause of death. We also may disclose PHI to funeral directors so they can carry out their duties.

Organ, Eye and Tissue Donation. If you are an organ donor, we may disclose your PHI to organizations that obtain organs or handle organ, eye or tissue transplantation. We also may disclose your information to an organ donation bank as necessary to facilitate organ, eye or tissue donation and transplantation.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your medical information to the correctional institution or law officer as authorized or required by law. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Incidental Disclosures. Although we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your information. These "incidental disclosures" are permissible.

Uses and Disclosures Requiring Your Written Authorization

Uses and Disclosures Not Covered in This Notice. Other uses and disclosures of your PHI not described above in this Notice or permitted by law will be made only with your written authorization. For example, we will generally not have access to

any psychotherapy notes about you without your written authorization. If we obtain any of these records, we will not use or disclose them except as permitted by your authorization or applicable law. When consent for disclosure is required by law, your authorization will be obtained prior to such disclosure. We may not refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form. If you give us authorization to use or share PHI about you, you may revoke that authorization in writing at any time. Please understand that we are unable to retract any disclosures already made with your authorization.

Your Rights Concerning Your PHI

Right to Ask to See and Obtain a Copy. With certain exceptions (such as information collected for certain legal proceedings and PHI restricted by law), you have the right to ask to see and copy the PHI we use to make decisions about your benefits. This information is maintained by us for use in enrollment, payment, claims settlement and case or medical management record systems, or it is part of a set of records that is otherwise used by us to make a decision about you. If the record is maintained electronically by CareConnect, you have the right to obtain an electronic copy of the record.

Your request must be in writing and must be given to the CareConnect Privacy Officer at the address listed on the last page of this Notice. Your request should describe the information you want to review and the format in which you want to review it. We may charge you a reasonable fee for the costs of copying, mailing, or other expenses associated with complying with your request. We may deny access in its entirety or in part under certain, limited circumstances. In some situations, if we deny your request, in part or in its entirety, you may request that the denial be reviewed.

Right to Ask for an Amendment or Addendum. If you feel that the PHI that we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment as long as the information is kept by or for CareConnect. You are required to submit this request in writing to CareConnect. We may deny your request for certain reasons, such as your failure to make the request in writing or to include a reason to support the request, or if we do not believe an amendment is appropriate. If we deny your request, we will give you a written explanation of why we did not make the amendment. You will have the opportunity to have certain information related to your request included in your records, such as your disagreement with our decision. We will also provide you with information on how to file a complaint with CareConnect or with the U.S. Department of Health and Human Services.

Right to Ask for an Accounting of Disclosures. You have the right to ask us for a listing of those individuals or entities who have received your PHI from CareConnect in the six years prior to your request, the times we have shared your PHI with them and why. This listing will not cover disclosures made:

- To you or your personal representative;
- To carry out treatment, payment or healthcare operations;
- Incident to a permitted or required use or disclosure;
- To parties you authorize in writing to receive your PHI;
- To your family members, relatives, or friends who are involved in your care;

- For national security or intelligence services;
- To correctional institutions or law enforcement officials; and
- As part of a "limited data set" for research purposes.

You must submit your request in writing to the CareConnect Privacy Officer at the address listed on the last page of this Notice. Your request must state the time period for the requested disclosures. The first list requested within a 12-month period will be free. We may charge you a reasonable fee for responding to any additional requests in that same period.

Right to Request Restrictions. You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment or healthcare operations. We are not required to agree to all such requests. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or a friend. For example, you could ask that we not disclose information to a family member about a surgery you had. You must submit your request in writing to the CareConnect Privacy Officer at the address listed on the last page of this Notice.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we contact you only at home or only by mail. You must clearly state how or where you wish to receive communications from us and how payment, if any, will be handled. We must accommodate reasonable requests that indicate that the disclosure of all or part of the protected health information could endanger you. Your request must be made in writing by submitting your request to the CareConnect Privacy Officer at the address listed on the last page of this Notice.

If we grant your request but are unable to contact you using the requested means or locations, we may contact you using whatever information we have.

Right to Receive Notice of a Breach. You have a right to be notified in the event of a breach of the privacy of your unsecured PHI by the CareConnect or its business associates. You will be notified as soon as reasonably possible, but no later than 60 days following our discovery of the breach. The notice will provide you with the date we discovered the breach, a brief description of the type of information that was involved, and the steps we are taking to investigate and mitigate the situation, as well as contact information for you to ask questions and obtain additional information.

Right to a Paper Copy of this Notice. Upon request, you may at any time obtain a paper copy of this Notice, even if you previously agreed to receive this Notice electronically. To request a copy, please contact the CareConnect Customer Service Department at 855-706-7545.

Additional Rights. This Notice explains the rights you have with respect to your health information under federal law. Some state laws provide additional rights, including increased protection for certain sensitive information such as information involving mental health, alcohol and drug abuse, HIV/AIDS, genetic tests, sexually transmitted diseases and reproductive health. If you reside in a state that has laws providing you with greater rights than as described in this Notice, we will comply with these laws.

Miscellaneous

Contact Information. If you have any questions about this Notice, you may contact the Customer Service Department at 855-706-7545 and ask to speak with the Privacy Officer or write to us at:

CareConnect
Attn: CareConnect Privacy Officer
2200 Northern Blvd., Suite 104
East Hills, NY 11548

How to File a Privacy Complaint. If you believe that your privacy rights have not been followed as directed by federal regulations and state law or as explained in this Notice, you may file a written complaint with us. Please submit your complaint to the CareConnect Privacy Officer at the following address:

CareConnect
Attn: CareConnect Privacy Officer
2200 Northern Blvd., Suite 104
East Hills, NY 11548

You will not be retaliated against or denied any health benefits if you file a complaint. If you are not satisfied with our response to your privacy complaint or you otherwise wish to file a complaint, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing, it must describe the subject matter of the complaint and the individuals or organization that you believe violated your privacy and it must be filed within 180 days of when you knew or should have known that the violation occurred. The complaint should then be sent to:

Region II - New York
Attn: Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Voice Phone 800-368-1019
FAX 212-264-3039
TDD 800-537-7697

Future Changes to this Notice. CareConnect may change the terms of this Notice at any time. If we change the terms of this Notice, the new terms will apply to all of your PHI, whether created or received by CareConnect before or after the date on which the Notice is changed. We will notify you of any material changes to this Notice by posting the change or the revised Notice on our CareConnect website and by mailing a copy to you. The current Notice will always be posted on the CareConnect website, CareConnect.com. If you would like additional information or want a copy of the Notice, please contact the CareConnect Customer Service Department at 855-706-7545.

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