

Child Health Plus Subscriber Contract 2009



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Child Health Plus

SUBSCRIBER CONTRACT

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

NOTICE OF TEN-DAY (10) CANCELLATION POLICY

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

IMPORTANT NOTICE:

All services covered under this Contract must be provided, arranged, or authorized by your Primary Care Physician. You must contact your Primary Care Physician in advance in order to receive benefits, except for (a) emergency care described in Section Five; (b) certain obstetric and gynecological care described in Section Four, paragraph G; (c) vision care described in Section this Contract.

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1. SECTION ONE: INTRODUCTION

A. The Child Health Plus Program This Contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. We will enroll you in the Child Health Plus Program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. You and/or the responsible adult, as listed on the application, must report to us any change in residency or health care coverage that may make you ineligible for participation in Child Health Plus within 30 days of the change.

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

It is your responsibility to select a Primary Care Physician (PCP) from the list of PCPs when you enroll for this coverage. You may change your PCP by calling our Member Services Department at 1-800-300-8181. The PCP you have chosen is referred to as "your PCP" throughout this Contract.

C. Words We Use Throughout this Contract, (name of health plan) will be referred to as "we", "us" or "our". The words "you", "your" or "yours" refer to you, the child to whom this Contract is issued and who is named on the identification card.

D. Definitions The following definitions apply to this Contract:

1. **Contract** means this document. It forms the legal agreement between you and us. Keep this Contract with your important papers so that it is available for your reference.
2. **Emergency Condition** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment of such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.
3. **Emergency Services** means those physicians and outpatient Hospital services necessary for treatment of an Emergency Condition.
4. **Hospital** means a facility defined in Article 28 of the Public Health Law which:
 - a. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
 - b. has organized departments of medicine and major surgery;
 - c. has a requirement that every patient must be under the care of a physician or dentist;
 - d. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
 - e. if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USCA 1395x[k]);
 - f. is duly licensed by the agency responsible for licensing such hospitals; and

- g. is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts or alcoholics, or a place for convalescent, custodial, education or rehabilitatory care.
- E. Medically Necessary** means services or supplies that are necessary for the diagnosis or treatment of a medical condition, provided in accordance with generally accepted professional standards of medical care, requested and authorized in accordance with our requirements, and not provided primarily for your convenience or the convenience of a Participating Provider.
- F. Participating Hospital** means a hospital that has an agreement with us to provide covered services to our members.
- G. Participating Pharmacy** means a pharmacy that has an agreement with us to provide covered services to our members.
- H. Participating Physician** means a physician who has an agreement with us to provide covered services to our members.
- I. Participating Provider** means any participating physician, hospital, home health care agency, laboratory, pharmacy, or other entity that has an agreement with us to provide covered services to our members. We will not pay for health services from a non-participating provider except in an emergency or when your PCP sends you to that non-participating provider with our approval.
- J. Primary Care Physician (PCP)** means the Participating Physician you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.
- K. Service Area** means the following counties: Brooklyn, Manhattan, The Bronx, Queens, Staten Island, and Nassau County. You must reside in the Service Area to be covered under this Contract. You can call us to learn if other counties have been added to our Service Area. You must recertify once each year, unless another child in your family applies for coverage with us. Then, all children in the family must be recertified when that child applies for coverage. There after, all the children in the family covered by us will be recertified once each year on the same date.

II. SECTION TWO: WHO IS COVERED

- A. Who is Covered Under this Contract** You are covered under this Contract if you meet all of the following requirements:
 1. You are younger than age 19.
 2. You do not have other health care coverage.
 3. You are not eligible for Medicaid.
 4. You are a New York State resident and a resident of our Service Area.

Your parent or guardian is not a public employee with access to family health insurance coverage by a state health benefits plan and the state or public agency pays all or part of the cost of family coverage.

You are not an inmate of a public institution or a patient of an institution for mental diseases.

- B. Recertification** We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. Annually, you must resubmit an application to us so that we can determine whether you still meet the eligibility requirements. This process is called “recertification”. If more than one child in your family is currently covered by us, then the recertification date for all the children in your family will be the same. **If another child in your family applies for coverage with us, then all other children will be recertified when that child's coverage is effective. Thereafter, all the children in your family covered by us will recertify once each year on the same date.**
- C. Change in Circumstances** You must notify us of any changes to your residency or health care coverage that might make you ineligible for this contract. You must give us this notice within thirty (30) days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.

III. SECTION THREE: HOSPITAL BENEFITS

- A. Care In a Hospital** You are covered for medically necessary care as an inpatient in a Hospital if all the following conditions are met:
1. Except if you are admitted to the Hospital in an Emergency or your PCP has arranged for your admission to a non-participating hospital, the hospital must be a Participating Hospital.
 2. Except in an emergency, your admission is authorized in advance by your PCP.
 3. You must be a registered bed patient for the proper treatment of an illness, injury or condition that cannot be treated on an outpatient basis.
- B. Covered Inpatient Services** Covered inpatient services under this Contract include the following:
1. Daily bed and board, including special diet and nutritional therapy;
 2. General, special and critical care nursing service, but not private duty nursing service;
 3. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;
 4. Oxygen and other inhalation therapeutic services and supplies;
 5. Drugs and medications that are not experimental;
 6. Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;
 7. Blood products, except when participation in a volunteer blood replacement program is available;
 8. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations;
 9. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;
 10. Facilities, services and supplies and equipment related to radiation and nuclear therapy;
 11. Facilities, services, supplies and equipment related to emergency medical care;
 12. Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services;
 13. Chemotherapy;
 14. Radiation therapy, and

15. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.

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

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

D. Limitations and Exclusions

1. We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not medically necessary
2. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, the difference between the cost of a private room and a semi-private room must be paid by you unless the private room is medically necessary and ordered by your physician.
3. We will not pay for non-medical items such as television rental or telephone charges.

IV. SECTION FOUR: MEDICAL SERVICES

- A. Your PCP must provide, arrange or authorize all Medical Services,** except in an emergency or for certain obstetric and gynecological services, dental and vision care. You are covered for the medical services listed below only if your PCP provides, arranges or authorizes them.

You are entitled to medical services provided at one of the following locations:

1. your PCP's office;
2. another provider's office or a facility if your PCP determines the care from that provider or facility is appropriate for the treatment of your condition;
3. the outpatient department of a Hospital;
4. As an inpatient in a Hospital, you are entitled to medical, surgical and anesthesia services.

- B. Covered Medical Services** We will pay for the following medical services:

1. **General medical and specialist care, including consultations**
2. **Preventive health services and physical examinations** We will pay for preventive health services including:
 - a. Well child visits in accordance with the visitation schedule established by the American Academy of Pediatrics,
 - b. Nutrition education and counseling,
 - c. Hearing testing,
 - d. Medical social services,

- e. Eye screening,
 - f. Routine immunizations in accordance with the **Advisory Committee on Immunization Practices recommended immunization schedule**,
 - g. Tuberculin testing,
 - h. Dental and developmental screening,
 - i. Clinical laboratory and radiological testing; and
 - j. Lead screening.
- 3. Diagnosis and treatment of illness, injury or other conditions.** We will pay for the diagnosis and treatment of illness or injury including:
- a. Outpatient surgery performed in a provider's office or at an ambulatory surgery center, including anesthesia services,
 - b. Laboratory tests, x-rays and other diagnostic procedures,
 - c. Renal dialysis,
 - d. Radiation therapy,
 - e. Chemotherapy,
 - f. Injections and medications administered in a physician's office,
 - g. Second surgical opinion from a board certified specialist,
 - h. Second medical opinion provided by an appropriate specialist, including one affiliated with a specialty care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer, and
 - i. Medically necessary audiometric testing.
- 4. Physical and Occupational Therapy** We will pay for short term physical and occupational therapy services. The therapy must be given by certified skilled personnel. **Short Term** means that visits are limited to twenty (20) sessions per calendar year.
- 5. Radiation Therapy, Chemotherapy and Hemodialysis** We will pay for radiation therapy and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.
- 6. Obstetrical and gynecological services including prenatal, labor and delivery and postpartum services** are covered with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from a qualified Participating Provider of obstetric and gynecologic services. You may also receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:
- a. Up to two annual examinations for primary and preventive obstetric and gynecologic care; and
 - b. Care required as a result of the annual examinations or as a result of an acute gynecological condition.
- 7. Cervical Cancer Screening** For females eighteen years old, we will pay for an annual cervical cancer screening, an annual pelvic examination, pap smear and evaluation of the pap smear. If you are a female under the age of eighteen years and are sexually active, we will pay for an annual pelvic examination, pap smear and evaluation of the pap smear. We will also pay for screening for sexually transmitted diseases.

V. SECTION FIVE: EMERGENCY CARE

- A. Hospital Emergency Room Visits** We will pay for Emergency Services provided in a Hospital emergency room. You may go directly to an emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval. If you

go to the emergency room, we recommend that you or someone on your behalf contact us within 24 hours of your visit or as soon as it is reasonably possible.

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

C. Ambulance Services. We will cover pre-hospital emergency medical services, including prompt evaluation and treatment for an Emergency Condition and/or non-airborne transportation to a hospital. Evaluation and treatment services must be for an Emergency Condition as defined in this Contract, Section One, item 4D.

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

VI. SECTION SIX: MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

A. Inpatient Mental Health and Substance Use Disorder Services We will pay for inpatient mental health services and inpatient substance use disorder services when such services are provided in a facility that is:

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

B. Outpatient Visits for Treatment of Mental Health Conditions and for Treatment of Substance Use Disorder We will pay for the outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if such visits are related to your mental health or substance use disorder treatment.

VII. SECTION SEVEN: OTHER COVERED SERVICES

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

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Data management systems;
4. Test strips for monitors and visual reading;
5. Urine test strips;
6. Injection aids;
7. Cartridges for the visually impaired;
8. Insulin;
9. Syringes;
10. Insulin pumps and appurtenances thereto;
11. Insulin infusion devices;
12. Oral agents; and

13. Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

B. Diabetes self management education We will pay for diabetes self management education provided by your PCP or another participating provider. Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education is medically necessary as determined by us. We will also pay for home visits if medically necessary.

C. Durable medical equipment, prosthetic appliances, and orthotic devices

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

- a. Canes;
- b. Crutches;
- c. Hospital beds and accessories;
- d. Oxygen and oxygen supplies;
- e. Pressure pads;
- f. Volume ventilators;
- g. Therapeutic ventilators;
- h. Nebulizers and other equipment for respiratory care;
- i. Traction equipment;
- j. Walkers, wheelchairs and accessories;
- k. Commode chairs and toilet rails;
- l. Apnea monitors;
- m. Patient lifts;
- n. Nutrition infusion pumps; and
- o. Ambulatory infusion pumps.

2. Prosthetic Appliances We will pay for appliances and devices ordered by a qualified practitioner which replace any missing part of the body except that there is no coverage for cranial prostheses (i.e. wigs). Further, dental prostheses are excluded from coverage under this section, except those: (a) made necessary due to an accidental injury to sound, natural teeth and provided within twelve months of the accident and/or (b) needed in the treatment of a congenital abnormality or as part of reconstructive surgery.

3. Orthotic Devices We will pay for devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. There is no coverage for orthotic devices that are prescribed solely for use during sports.

D. Prescription and Non-prescription Drugs

1. Scope of Coverage We will pay for those FDA approved drugs which require a prescription, are medically necessary and are listed in our Formulary. Our Formulary is established and updated by us in consultation with the company that manages our prescription drug program. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low

in protein or contain modified protein. Coverage for such modified solid food products shall not exceed \$2,500 per calendar year.

2. **Over-the-counter drugs** We will only pay for non-prescription medications for use outside of a Hospital that have been authorized by a Participating Provider licensed to write prescriptions for preventive and therapeutic purposes and are on the approved New York State Medicaid Formulary. B. Participating Pharmacy. We will only pay for prescription drugs and non-prescription drugs for use outside of a Hospital. Except in an emergency, the prescription must be issued by a Participating Provider and filled at a Participating Pharmacy.
3. **Participating Pharmacy** We will only pay for prescription and non-prescription drugs for use outside of a hospital. Except in an emergency, the prescription must be issued by a Participating Provider and filled at a Participating Pharmacy.

E. Exclusions and Limitations Under this Section we will not pay for the following:

1. Administration or injection of any drugs.
2. Replacement of lost or stolen prescriptions.
3. Prescribed drugs used for cosmetic purposes only unless medically necessary.
4. Experimental or investigational drugs, unless recommended by an external appeal agent.
5. Nutritional supplements taken electively.
6. Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications:
 - a. AMA Drug Evaluations;
 - b. American Hospital Formulary Service;
 - c. U.S. Pharmacopoeia Drug Information; or
 - d. A review article or editorial comment in a major peer-reviewed professional journal.
7. Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.
8. Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
9. Prescription drugs used for the purposes of treating erectile dysfunction.

F. Home Health Care We will pay for up to forty (40) visits per calendar year for home health care provided by a licensed or certified home health agency that is a Participating Provider. We will pay for home health care only if you would have to be admitted to a Hospital if home care was not provided. Home care includes one or more of the following services:

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

G. Pre-admission Testing We will pay for pre-admission testing when performed at a Hospital where surgery is scheduled to take place, if

1. reservations for a Hospital bed and for an operating room at that Hospital have been made, prior to performance of tests;
2. your physician has ordered the tests; and
3. surgery actually takes place within seven (7) days of such pre-admission tests.

If surgery is canceled because of the pre-admission test findings, we will still cover the cost of the tests.

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

I. Hospice Services We will cover Hospice Services. Such services may be provided in the patient's home or an inpatient facility to persons who are terminally ill and who are expected to live six (6) months or less. Hospice services are non-curative and may include pain management and supportive care to a patient and family during the final stages of illness and death. Family members are eligible for up to five (5) visits for grief counseling. Hospice Services must be provided through a certified Hospice Program.

VIII. SECTION EIGHT: VISION CARE

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

1. Vision Examinations. We will pay for vision examinations for the purpose of determining the need for corrective lenses, and if needed to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to:

- a. case history;
- b. external examination of the eye or internal examination of the eye;
- c. ophthalmoscopic exam;
- d. determination of refractive status;
- e. binocular distance;
- f. tonometry tests for glaucoma;
- g. gross visual fields and color vision testing;
- h. summary findings and recommendation for corrective lenses.

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

3. Frames We will pay for standard frames adequate to hold lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.

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

IX. SECTION NINE: DENTAL CARE

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

- B. Emergency Dental Care** We will pay for emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
- C. Preventive Dental Care** We will pay for preventive dental care, which includes procedures which help to prevent oral disease from occurring, including:
1. Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
 2. Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
 3. Sealants on unrestored permanent molar teeth.
- D. Routine Dental Care** We will pay for routine dental care, including the following.
1. Dental examinations, visits and consultations covered once within a six (6) month consecutive period (when primary teeth erupt);
 2. X-ray, full mouth x-rays at thirty-six (36) month intervals if necessary, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals if necessary, and other x-rays as required (once primary teeth erupt);
 3. all necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care;
 4. in-office conscious sedation;
 5. amalgam, composite restorations and stainless steel crowns; and
 6. other restorative materials appropriate for children.
- E. Endodontics** We will pay for endodontic services, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
- F. Periodontics** We will pay for periodontal services, except for those services in anticipation of, or leading to, orthodontia.
- G. Prosthodontics** We will pay for prosthodontic services as follows.
1. Removable complete or partial dentures, including six (6) months follow-up care. Additional services include insertion of identification slips, repairs, refines and rebases and treatment of cleft palate;
 2. Fixed bridges are not covered unless they are required:
 - a. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
 - b. For cleft-palate stabilization; or
 - c. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
 3. Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

X. SECTION TEN: ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

- A. When a Specialist Can be Your PCP** If you have a life threatening condition or disease or a degenerative and disabling condition or disease, you may ask that a specialist who is a Participating Provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.
- B. Standing Referral to a Network Specialist** If you need ongoing specialty care, you may receive a “standing referral,” to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist.

We will consult with the specialist and your PCP and decide whether a “standing referral” would be appropriate in your situation.

- C. Standing Referral to a Specialty Care Center** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease you may request a standing referral to a specialty care center that is a Participating Provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.
- D. When Your Provider Leaves the Network** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to ninety (90) days after you are notified by us of the provider’s leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former provider through delivery and postpartum care directly related to the delivery. However, in order for you to continue care for up to ninety (90) days or through a pregnancy with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.
- E. When New Members Are In a Course of Treatment** If you are in a course of treatment with a non-Participating Provider when you enroll with us, you may be able to receive care from the non-Participating Provider for up to sixty (60) days from the date you become covered under this Contract. The course of treatment must be for a life threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract. You may continue care through delivery and any post-partum services directly related to the delivery. However, in order for you to continue care for up to sixty (60) days or through pregnancy, the non-participating provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

XI. SECTION ELEVEN: LIMITATIONS AND EXCLUSIONS

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

- A. Care That is Not Medically Necessary** You are not entitled to benefits for any service, supply, test or treatment which is not Medically Necessary or appropriate for the diagnosis or treatment of your illness, injury or condition (See Sections Fifteen and Sixteen).
- B. Accepted Medical Practice** You are not entitled to services which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.
- C. Care Which Is Not Provided, Authorized or Arranged by Your PCP** Except as otherwise set forth in this Contract, you are entitled to benefits for services only when provided, authorized, or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.
- D. Inpatient services in a nursing home, rehabilitation facility, or any other facility not expressly covered by this Contract.**
- E. Physician services while an inpatient in a nursing home, rehabilitation facility, or any other facility not expressly covered by this Contract.**

- F. Experimental or investigational services,** unless recommended by an external appeal agent. (See Section Sixteen.)
- G. Cosmetic Surgery** We will not pay for cosmetic surgery unless medically necessary, except that we will pay for reconstructive surgery:
1. When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or
 2. When required to correct a functional defect resulting from congenital disease or anomaly.
- H. In vitro fertilization, artificial insemination or other assisted means of conception.**
- I. Private duty nursing.**
- J. Orthodontia.**
- K. Autologous blood donation.**
- L. Physical Manipulation Services** We will not pay for any services in connection with the detection and correction—by manual or mechanical means—of: structural imbalance; or distortion; or subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
- M. Routine Foot Care.**
- N. Other Health Insurance, Health Benefits and Governmental Programs** We will reduce our payments under this Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children’s Program and the Early Intervention Program.
- O. No-Fault Automobile Insurance** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.
- P. Other Exclusions** We will not pay for:
1. sex transformation procedures, unless medically necessary; or
 2. custodial care.
- Q. Workers’ Compensation** We will not provide coverage for any service or care for an injury, condition or disease if benefits provided to you under a Workers' Compensation Law or similar legislation.
- R. Non-emergency medical transportation.**

XII. SECTION TWELVE: PREMIUMS FOR THIS CONTRACT

- A. Amount of Premiums** The premium amount for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.
- B. Your Contribution Toward the Premium** Under New York State Law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any
- C. Grace Period** All premiums for this Contract are due one month in advance. However, we will allow a grace period for the payment of all premiums, except the first month's. This means that, except for the first month's premium for each child, if we receive payment within the grace period, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the grace period, the coverage under this Contract will terminate as of the last day of the month of the grace period.
- D. Agreement to Pay For Services if Premium is Not Paid** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.
- E. Change in Premiums** If there is to be an increase or decrease in the premium or your contribution toward the premium for this Contract, we will give you at least thirty (30) days written notice of the change.
- F. Changes in Your Income or Household Size.** You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling Member Services at 1-800-300-8181 or by calling the Child Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the form and documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within ten (10) business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than forty (40) days from receipt of the review request and supporting documentation.

XIII. SECTION THIRTEEN: TERMINATION OF COVERAGE

- A. For Non-Payment of Premium** If you are required to pay a premium for this Contract, this Contract will terminate at the end of the grace period if we do not receive your payment. For example, if your premium is due on July 1, and it is not paid by July 31, the end of the grace period, no payment will be made under this Contract for any service given to your after July 31.
- B. When You Move Outside the Service Area** This Contract shall terminate when you cease to reside in the Service Area.
- C. When You No Longer Meet Eligibility Requirements,** this Contract shall terminate as follows:
 - 1. on the last day of the month in which you reach the age of 19; or
 - 2. the date on which you are enrolled in the Medicaid program; or
 - 3. the date on which you become covered under other health care coverage, including an uninsured or self-insured program through an employer group, union, or other association or gain access to a state health benefits plan; or

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

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

E. Our Option To Terminate This Contract We may terminate this Contract at any time for one or more of the following reasons:

1. fraud in applying for enrollment under this Contract or in receiving any services.
2. such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than thirty (30) days prior written notice of such termination.
3. discontinuance of the class of Contracts to which this Contract belongs upon not less than five months prior written notice of such termination.
4. if you do not provide the documentation that we request within sixty (60) days of your enrollment or recertification date.
5. You do not provide the application we request for recertification.
6. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process within the sixty (60) day temporary enrollment period.

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

G. On Your Death This Contract will automatically terminate on the date of your death.

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

1. a date on which you are no longer totally disabled; or
2. a date twelve months from the date this Contract terminates.

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

XIV. SECTION FOURTEEN: RIGHT TO A NEW CONTRACT AFTER TERMINATION

Health Plus cannot offer a direct payment contract after your coverage ends when you turn 19. However, Health Plus will provide you with a list of other insurance companies or HMOs that offer health coverage to individuals and assist you in determining eligibility for our Family Health Plus and Health Care Plus programs.

XV. SECTION FIFTEEN: GRIEVANCE PROCEDURES AND UTILIZATION REVIEW APPEALS

Complaint Process

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

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

You also have the right to contact the New York State Department of Health about your complaint at 1-800-205-8125 or write to: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may call the New York State Insurance Department at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-800-300-8181 Monday through Friday from 8am to 8pm. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form.

It should be mailed to:
Member Services Manager
Health Plus
241 37th Street, 4th Floor
Brooklyn, New York 11232

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

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

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

After we review your complaint:

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

Complaint Appeals:

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

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

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

If we have all the information we need you will know our decision in 30 working days. If a delay would risk your health you will get our decision in 2 working days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

Grievances: A grievance is a type of complaint. You may file a grievance if the member was denied a referral or denied coverage because a benefit is not covered, or a claim was denied in

part or in full. For example, you may file a grievance if the plan denies referral to a particular specialist or an out of network provider, or the plan determines that a service is not covered because it is cosmetic or you have used all of the visits allowed under your benefit package.

Members have a right to file grievances by telephone by calling Member Services at: 1-800-300-8181.

If a delay would increase the risk to member's health, such as coverage for surgery, the plan will decide on the grievance within 48 hours. Grievances concerning referrals and benefits determinations will be resolved within 30 calendar days from receipt of all necessary information. Grievances not concerning referrals or benefits determination will be resolved within 45 calendar days.

Qualified personnel will review the grievance. When the grievance pertains to a clinical matter, the grievance will be reviewed by one or more licensed or registered health care professionals.

Utilization Review Appeals:

Action Appeals

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

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

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have [60 business days] after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at 1-800-300-8181 if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing.

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

- If you or your doctor asks to have your appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your appeal:

- Within 15 days, we will send you a letter to let you know we are working on your appeal.
- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case;
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals:

- Standard appeals: If we have all the information we need we will tell you our decision within 30 days from your appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.
- Fast track appeals: If we have all the information we need, fast track appeal decisions will be made in 2 working days from your appeal. We will tell you in 3 working days after giving us your appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

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

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest;
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-300-8181 or writing.

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

If your original denial was because we said the service was not Medically necessary or was experimental or investigational and we do not tell you our decision about your appeal, the original decision against you will be reversed. This means your service authorization request will be approved.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, you can ask New York State

for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; **or**
2. If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan or go directly to an external appeal; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at 1-800-300-8181 if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-800-300-8181

Your external appeal will be decided in 30 working days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

XVI. SECTION SIXTEEN: EXTERNAL APPEALS

- A. Unnecessary Care** The Plan will not cover any health care service that the Plan, in its sole judgment, determines is not medically necessary. If an External Appeal Agent certified by the State overturns the Plan's denial, however, the Plan shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Subscriber Contract. For further information on external appeals, consult your Member Handbook.

B. Experimental/Investigational Treatments The Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments provided in such clinical trial. (For further information on external appeals, consult your Member Handbook.)

XVII. SECTION SEVENTEEN: GENERAL PROVISIONS

- A. No Assignment** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.
- B. Legal Action** You must bring any legal action against us under this Contract within twelve (12) months from the date we refused to pay for a service under this Contract.
- C. Amendment of Contract** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least thirty (30) days written notice of any change.
- D. Medical Records** We agree to preserve the confidentiality of your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.
- E. Who Receives Payment Under This Contract** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.
- F. Notice** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

If to us: Health Plus
 Attn: Child Health Plus Program
 241 37th Street, Suite 412,
 Brooklyn, NY 11232-9810

If to you: To the latest address provided by you on enrollment or
 official change-of-address form.

Information for Families that Pay a Premium

If your family income or household size has changed since you applied, you may qualify for a reduced premium or no premium at all. Please review the enclosed Premium Level Chart. If you think you qualify for a lower premium, call Member Services at 1-800-300-8181 to request a review of your premium. You will be asked to provide proof of your current income. A list of acceptable documentation is enclosed.

Within ten business days of receiving your request for review of premium and documentation of current income, we will notify you whether your family qualifies for a lower premium. If your premium is reduced, we will adjust your next bill and send you a refund if one is due. Call Member Services at 1-800-300-8181 if you have any questions about how to request a review of your premium level.

Child Health Plus B Premium Levels Chart (Effective July, 2009)							
Monthly Income by Family Size							
Premium Categories	1	2	3	4	5	6	Each Add'l Person
Free Insurance	\$1,443	\$1,942	\$2,441	\$2,939	\$3,438	\$3,937	+ \$499
\$9/Child/Month (Max \$27/Family)	\$2,004	\$2,696	\$3,388	\$4,080	\$4,772	\$5,464	+ \$692
\$15/Child/Month (Max \$45/Family)	\$2,257	\$3,036	\$3,815	\$4,594	\$5,373	\$6,153	+ \$780
\$30/Child/Month (Max \$90/Family)	\$2,708	\$3,643	\$4,578	\$5,513	\$6,448	\$7,383	+ \$935
\$45/Child/Month (Max \$135/Family)	\$3,159	\$4,250	\$5,341	\$6,432	\$7,523	\$8,613	+ \$1,091
\$60/Child/Month (Max \$180/Family)	\$3,610	\$4,857	\$6,104	\$7,350	\$8,597	\$9,844	+ \$1,247
Full Premium/ Child/Month	Over \$3,610	Over \$4,857	Over \$6,104	Over \$7,350	Over \$8,597	Over \$9,844	

*The full premium varies, depending on the health plan chosen by the family.

Acceptable Documentation of Income

Wages and Salary Paycheck stubs (4 consecutive weeks) Letter from employer on company letterhead, signed and dated Income tax return** Business records Self-Employment Signed and dated income tax return and all schedules** Records of earnings and expenses Unemployment Benefits Award letter/certificate Benefit check Correspondence from NYS Dept. of Labor Private Pensions/Annuities Statement from pension/annuity	Social Security Award letter/certificate Benefit check Correspondence from Social Security Administration Child Support/Alimony Letter from person providing support Letter from court Child Support/Alimony check stub Worker's Compensation Award letter Check stub Veteran's Benefits Award letter Benefit check stub Correspondence from Veteran's Administration	Military Pay Award letter Check stub Interest/Dividends/Royalties Statement from the bank, credit union or financial institution Letter from broker Letter from agent Income from rent or Room/Board Letter from roomer, boarder, tenant Check stub Support from Other Family Members Signed statement of letter from family member
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**Income tax returns for other than self-employed may be used for applications prior to April of the following year. If later, you must include another form of documentation.