Laws and Notices

Notice Of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and How You can get access to this information. Please review it carefully.

The health plans or options sponsored by Catholic Health Services of Long Island (referred to in this Notice as the "Health Plans") may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by CHS employees who are responsible for overseeing the operation of the Health Plans, while other functions may be performed by other companies under contract with the Health Plans (those companies are generally referred to as "service providers"). Regardless of who handles health information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, "Plan" to refer to each Health Plan sponsored by Catholic Health Services of Long Island, including any CHS employees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. This Notice applies to each Health Plan maintained by Catholic Health Services of Long Island, including plans or programs that provide medical, vision, prescription drug, dental, long term care and health care flexible spending account benefits. However, if any of the Plan's health benefits are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's use of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning March 1, 2013 and will remain in effect until it is revised.

If the Plan's health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Privacy Notice.

A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information possessed by the Plan that includes identifying information about an individual. Such information, regardless of the form in which it is kept, is referred to in this Notice as Protected Health Information or "PHI". For example, any health record that includes details such as your name, street address, date of birth or Social Security number would be covered. However, information taken from a document that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow a person who receives or accesses that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and may be used for any purpose that is consistent with applicable law and with the Plan's policies and requirements.

How the Plan Uses or Discloses Health Information

Protected Health Information may be used or disclosed by the Plan as necessary for the operation of the Plan. For example, PHI may be used or disclosed for the following Plan purposes:

- TREATMENT: If a provider who is treating you requests any part of your health care records that the Plan possesses, the Plan generally will provide the requested information. (There is an exception for psychotherapy notes. If the Plan possesses any psychotherapy notes, those documents, with rare exceptions, will be used or disclosed only according to your specific authorization.)

  For example, if your current physician asks the Plan for PHI in connection with a treatment plan the physician has for you, the Plan generally will provide that PHI to the physician.

- PAYMENT: The Plan's agents or representatives may use or disclose PHI about you to determine eligibility for plan benefits, facilitate payment for services you receive from health care providers, to review claims and to coordinate benefits. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's payment function.

  For example, if the Plan needs to process a payment to your current physician, but requires additional PHI to process that payment, it may request that PHI from the physician.

- OTHER HEALTH CARE OPERATIONS: The Plan also may use or disclose PHI as needed for various purposes that are related to the operation of the Plan. These purposes include utilization review programs, quality assurance reviews, contacting providers regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan. This includes, if appropriate, disclosing information to the Plan Sponsor, as needed to facilitate the Plan's health care operations function.

  For example, if the Plan wishes to undertake a review of utilization patterns under the Plan, it may request necessary PHI from your physician.

In addition to the typical Plan purposes described above, PHI also may be used or disclosed as permitted or required under applicable law for the following purposes:

- USE OR DISCLOSURE REQUIRED BY LAW: If the Plan is legally required to provide PHI to a government agency or anyone else, it will do so. However, the Plan will not use or disclose more information than it determines is required by applicable law.

- DISCLOSURE FOR PUBLIC HEALTH ACTIVITIES: The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

  The Plan also may disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

  In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

  Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- DISCLOSURES ABOUT VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: (The following does not apply to disclosures regarding child

abuse or neglect, which may be made only as provided under Disclosure for public health activities.)

If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

- HEALTH OVERSIGHT ACTIVITIES: The Plan may disclose protected health information to a health oversight agency (this includes federal, state or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.
- DISCLOSURES FOR JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: The Plan may disclose protected health information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.
- DISCLOSURES FOR LAW ENFORCEMENT PURPOSES. The Plan may disclose protected health information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.
- DISCLOSURES TO MEDICAL EXAMINERS, CORONERS AND FUNERAL DIRECTORS FOLLOWING DEATH. The Plan may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. The Plan also may disclose PHI to a funeral director as needed to carry out the funeral director's duties. PHI may also be disclosed to a funeral director, if appropriate, in reasonable anticipation of an individual's death.
- DISCLOSURES FOR ORGAN, EYE OR TISSUE DONATION PURPOSES. The Plan may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
- DISCLOSURES FOR RESEARCH PURPOSES. If certain detailed restrictions are met, the Plan may disclose protected health information for research purposes.
- DISCLOSURES TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.
- DISCLOSURES FOR SPECIALIZED GOVERNMENT FUNCTIONS. If certain conditions are met, the Plan may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission. Also, the Plan may use and disclose the PHI of individuals who are foreign military personnel to their appropriate foreign military authority under similar conditions.

  The Plan may also use or disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by federal law relating to those protective services.

  The Plan may disclose an individual's PHI to a correctional institution or a law-enforcement agency that has custody of the individual if necessary (1) for the institution to provide health care; (2) to protect the individual's health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- DISCLOSURES FOR WORKERS' COMPENSATION PURPOSES. The Plan may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures That Are Not Permitted Without Your Authorization

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned in this Notice, except as specifically authorized by you. In particular, note that the Plan will never sell PHI without your authorization and that the Plan also will not use or disclose PHI for marketing purposes without your authorization, except that no authorization is required for face-to-face marketing communications between the Plan and you or for the Plan to provide promotional gifts of nominal value. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your authorization.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will not apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

No Use or Disclosure of Genetic Information for Underwriting

Under applicable law, the Plan generally may not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is permitted based on the above rules, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return

for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any pre-existing condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

Your Health Information Rights

Under federal law, you have the following rights:

- You may request restrictions with regard to certain types of uses and disclosures. This includes the uses and disclosures described above for treatment, payment and other health care operations purposes. If the Plan agrees to the restrictions you request, it will abide by the terms of those restrictions. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan or is otherwise inappropriate, it may decline the restriction. If you want to request a restriction, you should submit a written request describing the restriction to the Privacy Contact Person listed in this Notice.
- You may request that certain information be provided to you in a confidential manner. This right applies only if you inform the Plan in writing (submitted to the Privacy Contact Person listed in this Notice) that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such a request if it is reasonable, but reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.
- You may request access to certain medical records possessed by the Plan and you may inspect or copy those records. This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage. However, there are certain limited exceptions. Specifically, the Plan may deny access to psychotherapy notes and to information prepared in anticipation of litigation.
- If you want to request access to any medical records, you should contact the Privacy Contact Person listed in this Notice. If you request copies of any records, the Plan may charge reasonable fees to cover the costs of providing those copies to you, including, for example, copying charges and the cost of postage if you request that copies be mailed to you. You will be informed of any fees that apply before you are charged.
- You may request that protected health information maintained by the Plan be amended. If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide information to the Plan to establish that the originator of the information is not in a position to amend it. If you want to request that any medical record maintained by the Plan be amended, you should provide your request in writing to the Privacy Contact Person listed in this Notice. Your request should describe the records that you want to be changed, each change you are requesting and your reasons for believing that each requested change should be made.
- The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.
- If the Plan denies your request, you will have the opportunity to prepare a statement to be included with your health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.
- You have the right to receive details about certain non-routine disclosures of health information made by the Plan. You may request an accounting of all disclosures or health information, with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operations, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made more than 6 years before the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12 month period.
- You have the right to request and receive a paper copy of this Privacy Notice. If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one. You should contact the Privacy Contact Person identified at the end of this Notice if you want a paper copy.
- You have the right to be notified of a breach of unsecured PHI. If unsecured PHI is used or disclosed in a manner that is not permitted under applicable federal law, you will receive a notice about the breach of unsecured PHI, if such a notice is required by applicable law. Unsecured PHI is PHI that is either in paper form or is in an electronic form that is not considered secure.

Privacy Contact Person and Complaint Procedures

After reading this Notice, if you have questions or complaints about the Plan's health information privacy policies or you believe your health information privacy rights have been violated, you should contact the Corporate Compliance Helpline at 1-866-272-0004.

In addition to your right to file a complaint with the Plan, you may file a complaint with the U.S. Department of Health & Human Services. (Details are available on the Internet at http://www.hhs.gov/ocr/privacy). You will never be retaliated against in any way as a result of any complaint that you file.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Premium Assistance Under Medicaid & The Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone 609-631-2392
CHIP Website www.njfamilycare.org/index.html
CHIP Phone 1-800-701-0710

NEW YORK – MEDICAID

Website www.nyhealth.gov/health_care/medicaid/
Phone 1-800-541-2831

PENNSYLVANIA – MEDICAID

Website http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone 1-800-692-7462

To see if any more States have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, you can contact either:

U.S. DEPARTMENT OF LABOR

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

General Notice of Continuation Coverage

Coverage Rights

You are receiving this notice because you have recently become covered under your company's group health plan(s), collectively known as the "Plan." This notice contains important information about your right to continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Note that the Plan is considered a "Church Plan" and is therefore not subject to the continuation of coverage rules under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, even though the Plan is not required to comply with COBRA, it does provide continuation coverage similar to COBRA. Continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan, you should contact your Human Resources Representative.

What is Continuation Coverage?

Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect continuation coverage must pay for continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is Continuation Coverage Available?

The Plan will offer continuation coverage to qualified beneficiaries only after your Human Resources Representative has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Human Resources Department must be notified of the qualifying event.

How is Continuation Coverage Provided?

Once your Human Resources Representative receives notice that a qualifying event has occurred, continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect continuation coverage on behalf of their children.

Continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify your Human Resources Representative in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month on continuation coverage and sent to your Human Resources Representative.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

NYS Continuation of Coverage

Under a special New York State law, you may be permitted to extend your continuation coverage to 36 months. New York State law provides that an individual who has exhausted continuation coverage is permitted to maintain coverage for up to 36 months, if the individual is entitled to less than 36 months of continuation benefits. Please contact your Human Resources Representative for more information.

If You Have Questions

Questions concerning your Plan or your continuation coverage rights should be addressed to your Human Resources Representative.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your Human Resources Representative informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Human Resources Department.

Catholic Health Services of Long Island Health & Welfare Benefits Plan Notice of Special Enrollment Periods

If you are declining enrollment in the Catholic Health Services of Long Island Health & Welfare Benefits Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Also, if you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. If you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

Notice of Required Coverage Following Mastectomies

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Please contact the Plan Administrator for more detailed information regarding deductibles and coinsurance for these benefits under the Plan.

Newborns' & Mothers' Health Protection Act Model Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

To obtain more information on these notices, contact your Plan Administrator.

Claims Procedures for Health and Welfare Benefits

In order to receive health and welfare plan benefits, you must follow the procedures established by the plan and/or the insurance company which has the responsibility for making the particular benefit payments to you.

If a request for health and welfare plan benefits is denied, you, or a beneficiary or a duly authorized representative, may file a claim for program benefits to which you believe you are entitled. For more information on the plan's claims procedures, contact your Human Resources representative.

Claims Procedure Detail

The following summary of the Plan's claims procedures incorporates the applicable requirements of regulations issued under the federal health care reform law and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures will apply instead of the claims procedures described below. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a termination of coverage that is retroactively effectively for fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the section(s) of this summary describing those benefits.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures.

A. Claims for Benefits under Medical Coverage.

(i) Urgent Care Claims. If the claim is for urgent care medical benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A medical claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. For any claim for benefits under coverage that is subject to the Affordable Care Act, the Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Medical Claims. For any medical claim not described above:

(a) For a pre-service medical claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A medical claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(b) For a post-service medical claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A medical claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

B. All Other Benefit Claims. For all claims other than medical plan claims, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or

denied, unless the Claimant receives written notice from the Reviewer before the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond the day which is 180 days after the day the claim is filed.

C. Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed); and

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial.

In addition, for a denial of medical benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that a copy will be provided without charge upon request); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that an explanation will be provided without charge upon request).

For an adverse determination involving an urgent care claim, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

A. Medical Claims. The procedures in this section (A) apply only to medical claims. A Claimant whose initial claim for benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

The Plan's review will meet the following requirements:

(i) The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(ii) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(iii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iv) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(v) The Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following requirements:

(a) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(b) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(vi) Urgent Care Claims. For urgent care medical claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(vii) Other Medical Claims.

(a) For a pre-service medical claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(b) For a post-service medical claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination.

B. All Other Benefits. For claims other than medical claims, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after the Reviewer receives the request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

C. Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision; and

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based.

In addition, for medical plan claims, any notice of an adverse determination on review will include:

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;

(v) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vi) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or

clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

The Plan will make reasonable good faith efforts to comply with requirements (1) through (4) above. However, the plan will not be treated as in violation of any requirement of the Plan's claims procedures because a notice fails to satisfy all of those requirements, to the extent that an enforcement grace period applies under Department of Labor Technical Release 2011-01 (or any later guidance that extends that enforcement grace period).

Also, for all claims involving coverage that is subject to the Affordable Care Act, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for benefits (other than urgent care benefits), the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits that are not subject to the Affordable Care Act, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under applicable state law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim for benefits under coverage that is subject to the Affordable Care Act you are deemed to have exhausted the Plan's internal claims and appeals process if the Plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services), except for certain minor violations. For this purpose, the Plan's failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this "minor violation" exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon Claimant's receipt of the notice.

In cases where you are deemed to have exhausted the Plan's internal claim procedures, you have the right to pursue any available remedy under applicable state law.

External Review

A. External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

B. Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage;

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

C. Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

D. Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The Adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

E. Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is

accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(d) The terms of the Plan, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(f) A statement that judicial review may be available to the Claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

E. Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

A. Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

B. Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Experimental/ Investigational Treatments

Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:

- Experimental or investigative
- Obsolete or ineffective

Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:

- Not of proven benefit
- Not generally recognized by the medical community (as reflected in published medical literature)

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state. Refer to the Complaints, Appeals and Grievances Section.

In addition, your plan provides coverage to certain qualified individuals for approved clinical trials, and certain costs in connection with such clinical trials, as required by the Affordable Care Act. Please contact the Plan Administrator for more information regarding coverage of clinical trials.