Examples of services not covered by Anthem, Medicaid, or Medicare are:

- Cosmetic surgery if not medically necessary
- Personal and Comfort items
- Infertility Treatment
- Provider services that are not part of the plan (unless Anthem sends you to that provider)

If you have any questions, call Member Services at 855-661-0002 (TTY 711).

OBTAINING COVERED SERVICES

During the care planning process, your Care Management Team will work with you, your family/caregiver, and your healthcare providers to determine the services you require. Your Care Manager will then authorize the services you will receive from Anthem, and your Service Coordinator will make referrals to participating Anthem providers and arrange services for you. When a physician order is required, your Care Team will work with your physician and other providers to ensure that the proper order is obtained. We do the work for you to ensure that everything you need is in place.

Requesting Service Authorization

When you ask for approval of a treatment or service, it is called a **service authorization request**. If you feel at any time you need a certain covered service, you or your provider on your behalf may request authorization for the service by making a verbal or written request to your Care Manager, by calling Member Services at 855-661-0002 (TTY 711), or by sending the request in writing to:

Care Management
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

Authorization is the process by which the requested service is determined to be medically necessary by Anthem. Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period.**

Prior Authorization
All covered services require prior authorization (approval in advance) from Anthem except for the following services which members can self-refer for evaluation or for routine services:

- Dental care – routine referrals and services covered under Liberty Dental Plan
- Vision care – routine vision exam and services covered under Superior Vision

Concurrent Review
You can also ask Anthem to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review
Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

After You Request Service Authorization

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a

qualified healthcare professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse, or a healthcare professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **expedited** process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Time frames for Prior Authorization Requests

Standard Review

We will make a decision about your request within three workdays of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

Expedited Review

We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Time frames for Concurrent Review Requests

When a request is made for an increase in the number or duration of service already being provided, the request is called a **Concurrent Review**.

Standard Review

We will make a decision within one (1) workday of when we have all the information we need, and you will hear from us no later than fourteen (14) days after we received your request.

Expedited Review

We will make a decision within one (1) workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within one (1) workday if we need more information.

Time frames for Extensions

If we need more information to make either a standard or expedited decision about your service request, the time frames above can be extended up to fourteen (14) days. We will:

- Write and tell you what information is needed. If your request is in an expedited 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 as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone representing your interests may also ask us to take more time to make a decision. This may be because you have more information to provide us to help decide your case. This can be done by calling Member Services at 855-661-0002 (TTY 711), or sending the request in writing to:

Care Management
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

You or someone you trust can file a complaint with Anthem if you do not agree with our decision to take more time to review your request. You can also file a complaint about the review time with the New York State Department of Health by calling 866-712-7197.

If our answer is yes to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is no to part or all of what you asked for, we will send you a written notice that explains why we said no. See *"How do I File an Appeal of an Action?"* below for more information on how to make an appeal if you do not agree with our decision.

ACTIONS AND APPEAL OF ACTIONS

What is an Action?

When Anthem denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends, or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required time frames, those are considered plan "actions." An action is subject to appeal. (See *"How do I File an Appeal of an Action?"* below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend, or terminate a

service that is authorized, our letter will be sent at least ten (10) days before we intend to change the service.

Contents of Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take
- Cite the reasons for the action, including the clinical rationale, if any
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process)
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational
- Describe the information, if any, which must be provided by you and/or your provider in order for us to render a decision on appeal

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing.
- It will say that you must file an appeal before asking for a Fair Hearing.
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service, the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued, you must ask

for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I file an Appeal of an Action?

If you do not agree with an action that Anthem has taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within sixty (60) business days of the date on our letter notifying you of the action. If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 855-800-4683 (TTY 711), or by writing to:

Appeals and Grievances
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

How do I Request to Continue Service during the Appeal Process?

If you are appealing a restriction, reduction, suspension, or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension, or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see *"How do I File an Appeal of an Action?"* section above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take Anthem to Decide My Appeal of an Action?

Unless your appeal is expedited, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review, you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend, or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request an "expedited" appeal. (See "*Expedited Appeal Process*" Section below.)

Expedited Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of our appeal of the action. We will respond to you with our decision within two business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the time frames under "*How Long Will It Take the Plan to Decide My Appeal of an Action?*" above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending, or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

Online Request Form: otda.ny.gov/oah/FHReq.asp

Mail a Printable Request Form

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, NY 12201-2023

Fax a Printable Request Form: (518) 473-6735

Request by Telephone

Standard Fair Hearing line: 800-342-3334
Emergency Fair Hearing line: 800-205-0110
TTY line: 711 (request that the operator call 877-502-6155)

Request in Person

New York City
14 Boerum Place, 1st Floor
Brooklyn, NY 11201

Albany
40 North Pearl St., 15th Floor
Albany, NY 12243

For more information on how to request a Fair Hearing, please visit: otda.ny.gov/hearings/request/.