IMPORTANT: This new Member Handbook replaces similar language in the enclosed Certificate of Coverage & Member Handbook (or individual contract).

IMPORTANT: All references to referrals contained within this document do not apply to members of our Non-Gated plans. (e.g. Select, Access, Direct, MyPlan, Exclusive Plans).
Welcome and Thank you for Choosing Oxford

The following Member Handbook has been created to assist you in obtaining your services through Oxford Health Plans. The detailed information provided below will help you to better understand your coverage, your rights as a Member and your responsibilities.

**IMPORTANT PHONE NUMBERS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CUSTOMER CARE</td>
<td>800-444-6222</td>
</tr>
<tr>
<td>MEDICAL EMERGENCIES</td>
<td></td>
</tr>
<tr>
<td>URGENT CARE</td>
<td></td>
</tr>
<tr>
<td>MEDICAL MANAGEMENT COORDINATOR</td>
<td>800-444-6222</td>
</tr>
<tr>
<td>OXFORD HEALTH PLANS (NY), INC</td>
<td>800-444-6222</td>
</tr>
<tr>
<td>AFTER 5 PM: BEHAVIORAL HEALTH LINE</td>
<td>800-201-6991</td>
</tr>
<tr>
<td>OXFORD-ON-CALL®</td>
<td>800-201-4911</td>
</tr>
<tr>
<td>TTY</td>
<td>800-201-4875</td>
</tr>
<tr>
<td>PHARMACY CUSTOMER CARE</td>
<td>888-201-4133</td>
</tr>
<tr>
<td>CLAIMS</td>
<td>800-444-6222</td>
</tr>
<tr>
<td>NY STATE DEPARTMENT OF HEALTH: QUALITY MANAGEMENT AND PROVIDER ACCESS ISSUES</td>
<td>800-206-8125</td>
</tr>
</tbody>
</table>

**IMPORTANT ADDRESSES**

**CLAIMS**
Oxford Health Plans (NY), Inc.
P.O. Box 29315
Hot Springs, AR 71903-29315

**APPEALS AND GRIEVANCES**
Correspondence Department
Oxford Health Plans
P.O. Box 29315
Hot Springs, AR 71903-29315

Grievance Review Board
Oxford Health Plans
48 Monroe Turnpike
Trumbull, CT 06611

Secretary of the Grievance Review Board
Oxford Health Plans
48 Monroe Turnpike
Trumbull, CT 06611

**Clinical Appeals**
Oxford Health Plans
P.O. Box 29139
Hot Springs, AR 71903-29139

Mental Health/Substance Abuse Clinical Appeals
OptumHealth Behavioral Solutions
Attn: Appeals Department
1900 E. Golf Rd.
Suite 300
Schaumburg, IL 60173

**OXFORD HEALTH PLANS INTERNET ADDRESS**
www.oxfordhealth.com

**WRITTEN CORRESPONDENCE**
New York State Department of Financial Services
One Commerce Plaza
Albany, NY 12257

**EXTERNAL APPEAL CONTACT INFORMATION**
To request an External Appeal Application contact either the New York State Department of Insurance by phone at: 800-400-8882, or its website (www.ins.state.ny.us) or the New York State Department of Health at its website (www.healthstate.ny.us) or Our Customer Care Department at 800-444-6222.

**CUSTOMER CARE**
Please feel free to contact Our Customer Care Department with any questions, issues or concerns you may have. In addition, we welcome your input and suggestions on how we can improve Our administrative polices. You can reach one of Our representatives Monday through Friday, from 8:00 to 6:00 at the number listed in the front of the handbook. If you have a question and prefer to speak in a language other than English, please call Our Customer Care Department to make arrangements to speak with one of Our translators. When the Customer Care Representative answers your call please say “Spanish (or the language you require).” The Representative will place your call on hold while they make arrangements with the appropriate translator. Do not hang-up! With the help of the translator, the Representative will be able to answer your questions.
SPANISH

Si necesita ayuda y prefiere información en Español por favor llame al 800-444-6222. Cuando nuestro representante conteste la llamada diga "Spanish, Please" o pida el lenguaje que usted necesite. Nuestro representante pondrá su llamada en espera, no cuelgue el teléfono. Nuestro representante regresará a la línea muy pronto y tendrá a su disposición un traductor. Con la ayuda de el traductor, nuestro representante podrá contestar sus preguntas.

CHINESE

如果 您 需要 协助，或 者 您 想 与 聯 語 客 戶 服 務 代表 洽 詢，請 致 電： 1-800-444-6222
當 客 戶 服 務 代 表 接 聽 電 話 時，請 說 明：“Chinese, Please.”（ 您 可 要 求 說 其 它 語 言）。
客服 服 務 代 表 會 請 您 稍 候，不 要 收 線！ 客 戶 服 務 代 表 會 儘 快 邀 請 翻譯員 參 與 對 話，在翻譯員的 協 助 下， 客 戶 服 務 代 表 便 可 回答 您 的 問 題。

RUSSIAN

Если Вам необходима помощь, и Вы хотите бы получить ее по-руски, пожалуйста, позвоните по телефону 800-444-6222. Когда Вам ответит представитель Бюро Обслуживания, сожгите: “Russian, please.” Вас попросят подождать. Не вешайте трубку! Через некоторое время представитель снова появится на линии с переводчиком. С помощью переводчика наш представитель сможет ответить на все Ваши вопросы.
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THE SELECTION AND ROLE OF A PRIMARY CARE PROVIDER (PCP)

Each person who enrolls in the Plan is required to select a Primary Care Physician (PCP). The PCP selected by you becomes your personal physician and health care advisor who will maintain a complete record of your medical history and health care needs. Your PCP is the gatekeeper for obtaining the care you need. If your PCP is unable to provide you the services you need he or she will refer to a Network Specialist that can. It is important to confirm that the Specialist you are being referred to is a Network Provider. In doing so you will only be responsible for the appropriate copayment indicated in your Member materials. If a referral to a Network Specialist is required, your PCP will provide you with a referral form that will need to be presented at the time of your visit. Except for cases involving Medical Emergencies and Precertified Urgent Care, any covered Service that you obtain without the use of your PCP or Primary Provider of OB/Gyn Care is not covered. You will be responsible for all of the costs. The only exception to this provision is when Our Medical Director determines that Our Network does not have an appropriate Network Provider who can deliver the care you need. In such instances, Our Medical Director will approve a referral to a non-Network Provider. All such referrals will be made only when Our Medical Director, after consulting with your PCP (or Network Specialist), the non-Network Provider and you, approves the treatment plan for the delivery of these services. Covered Services rendered by this Provider will be paid as if they were received in Network. You will be responsible only for any applicable Copayment. You, your PCP, or your Network Specialist may call Medical Management and initiate the request for this special referral.

In addition to providing appropriate referrals, your PCP is also responsible for Precertifying those services which require prior authorization. If you have an Out-of-Network benefit as part of your Coverage and choose to receive services from Non-Network Provider, you will be responsible for obtaining the necessary Precertification.

Please note: You cannot obtain Specialty Care without a referral from your PCP. Additionally, whenever the Certificate instructs you to obtain a referral from your PCP, you also have the option of calling Oxford On-Call® instead of your PCP to receive appropriate referrals. If you are not sure what care you may need (you are not sure if you need to see your PCP, or a Network Specialist, or need treatment or testing), you may call Oxford On-Call® instead of your PCP.

Referrals do not replace Precertification requirements. Failure to follow the proper protocols will increase your Out-of-Pocket expense as indicated in your Summary of Benefits.

If you fail to select a PCP the following will occur:

- We will return your Enrollment Form and ask you to select a PCP.
- If you receive Primary or Preventive Care from one of Our PCPs before We return the form, that PCP will automatically be assigned to you as your PCP.
- If you try to obtain Specialty Care without a referral from a PCP, the Specialty Care will not be Covered (with the exception of Medical Emergencies and Urgent Care).

SELECTION OF PRIMARY OB/GYN

In addition to a PCP, female members should select a Network OB/GYN or a Network Nurse Midwife. Female members may seek routine obstetrical and gynecological care without a referral from their PCP.

NETWORK SPECIALISTS AS PCP’S

Members who have a life-threatening condition or disease and Members who have a degenerative and disabling condition or disease may request to elect a Network Specialist as their PCP. The designated Network Specialist will become responsible for providing and coordinating all of the Member’s Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures and provide referrals and medical services in the same capacity as a PCP.

This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. The desired Network Specialist must have the necessary qualifications and expertise to treat the Member’s condition or disease. A Member may request this election at the time of enrollment or upon diagnosis. The election will be permitted only if Our Medical Director, after consulting with your PCP and Network Specialist (if applicable) agrees that your care would most appropriately be coordinated in this manner. All Covered Services must be delivered in accordance with a treatment plan that has been approved by Our Medical Director, your PCP and Network Specialist (if applicable). New Members may be asked to first elect a non-Specialist PCP who will work with them to find a Network Specialist, develop a treatment plan and consult with Our Medical Director. If a new Member’s current specialist is a Network Specialist, the Network Specialist may prepare the treatment plan and consult with Our Medical Director; election of a non-Specialist PCP will not be required. You, your PCP or Network Specialist may call Medical Management and request this election.

CHANGING YOUR PCP

You may change your PCP (or Provider of OB/GYN Care) at any time by selecting a new Provider from our Roster and either contacting Customer Care or accessing our Web Site. The change will become effective immediately.

Please note: If for any reason you are not satisfied with the care you are receiving from any of Our Network Specialists, you may ask your PCP to refer you to another Network Specialist of your choice.
EMERGENCIES AND URGENT CARE

MEDICAL EMERGENCY

If you have Medical Emergency, you should obtain medical assistance immediately. This includes calling 911 if necessary.

Although emergency room care is not subject to Our prior approval, only Medical Emergencies, as defined below, are Covered in an emergency room.

For purposes of your coverage with Oxford a Medical Emergency is defined as follows:

Medical Emergency: A medical or behavioral condition the onset of which is sudden that manifests itself by symptoms of sufficient severity including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the afflicted Member with such a condition placing the health of such Member or others in serious jeopardy; (b) serious impairment to the member’s bodily functions; (c) serious dysfunction of any bodily organ or part of such Member; or (d) serious disfigurement of such Member. Medical Emergencies include, but are not limited to, the following conditions:

- Severe chest pains
- Severe shortness of breath
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Severe or multiple injuries
- Loss of consciousness
- Sudden change in mental status (e.g., disorientation)
- Poisonings or convulsions

URGENT CARE

We define Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not a Medical Emergency.

Urgent Care is Covered in or out of the Service Area. You must first call your PCP. All Network Physicians are required to have a 24-hour backup or an answering service so that Members have access to medical care at all times. If you are unable to contact your PCP, contact Oxford On-Call® at 800-201-4911. You will be provided with instructions. Oxford On-Call® is available around the clock to help you in urgent medical situations.

In addition, you may be able to use one of several Urgent Care Centers in the Service Area. You must obtain Precertification from Our Medical Management Coordinators prior to seeking care at an Urgent Care Center. If you obtain Urgent Care Services without contacting your PCP or a Medical Management Coordinator, the services will not be Covered. If Urgent Care results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described in the Certificate.

PRECERTIFICATION REQUIREMENTS

PRECERTIFICATION

All admissions to health care facilities and certain diagnostic tests and therapeutic procedures must be Precertified by Us before you are admitted or receive treatment.

Precertification starts with a call to Our Medical Management Department by your PCP, Provider of OB/GYN Care or the Network Specialist involved. One of Our Medical Management professionals will examine the case, consult with your Provider and discuss the clinical findings. If all agree the requested admission, test or procedure is appropriate, the Precertification is provided. This comprehensive evaluation assures that the treatment you receive is appropriate for your needs and is delivered in the most cost effective setting.

Your Network Provider is responsible for obtaining any required Precertification and is aware of when Precertification is required. However, if you wish to double-check that your Network Provider has contacted us about your case, please feel free to call Customer Cares and inquire.

Please remember: Any Precertification you receive will not be valid if your coverage under the Plan terminates. This means that Covered Services received after your coverage has terminated will not be Covered even if they were Precertified (unless coverage is being continued in accordance with Section VII. of this Certificate).

UTILIZATION REVIEW

All services that you seek to have Covered under this Certificate are subject to Utilization Review. This means that our Medical Management Department reviews pertinent medical information in order to determine whether or not the proposed service, the service currently being provided, or the service that was provided is Medically Necessary and a Covered Service under the Certificate. For more information about Our Utilization Review Policies please see “Information About Your Oxford Coverage” which is attached to this Certificate.

SECOND OPINIONS

We reserve the right to require a second opinion for any surgical procedure. At the time of Precertification, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, We will refer you to a Network Provider for a second opinion.
In the event that the first and second opinions differ, a third opinion will be required. We will designate a new Network Provider. The third opinion will determine whether or not the surgery is Precertified. There will be no cost to you for the second opinion.

You may also request a second opinion. Please see Section III, 2, K. for a complete explanation.

**DIAGNOSTIC TESTING AND LABORATORY SERVICES**

Covered X-rays or diagnostic procedures performed at Network facilities will be provided by Us without any required Copayment. If your PCP recommends laboratory testing, remind him or her to use a Network Provider. Unless you are hospitalized or receiving preadmission testing, Hospitals are not Network Providers for these tests.

**REFERRALS**

**STANDING REFERRALS**

Standing Referrals to Network Specialists: Members who need ongoing Specialty Care may receive a “standing referral” to a Network Specialist. This means you will not need to obtain a new referral from your PCP every 90 days (but any applicable benefit limitations still apply). Our Medical Director will consult with your PCP and Network Specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that has been approved by Our Medical Director. Please note that the treatment plan may limit the amount of visits or the period of time during which the visits must occur. Further, the treatment plan may require the Network Specialist to provide your PCP with regular updates on the care being provided. **You, your PCP or Network Specialist may call Medical Management and request a standing referral.**

Standing Referrals to Network Specialty Care Centers: Additionally, Members who have a life-threatening condition or disease and Members who have a degenerative and disabling condition or disease may request a standing referral to a Network Specialty Care Center. This referral is available only if the condition or disease requires specialized medical care over a prolonged period of time. Further, the center must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the Medically Necessary care required for the treatment of the condition or disease. The services to be provided will be Covered only to the extent they are otherwise Covered under this Certificate.

Our Medical Director will consult with your PCP the Network Specialty Care Center and your Network Specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that has been developed by the Specialty Care Center and approved by Our Medical Director.

You, your PCP or Network Specialist may call Medical Management and request a standing referral.

**TRANSITIONAL CARE**

Your Provider Leaves the Network: If you are undergoing a course of treatment with your non-Network Provider at the time your coverage under this Certificate becomes effective, you may be able to receive Covered Services from the former Network Provider. In such instances, you may receive Covered Services for up to 120 days after you receive notification from Us that the Provider is no longer in the Network. Regarding pregnancy, if the Provider leaves the Network while you are in your second trimester, you may receive Covered Services through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available only if the Provider agrees to continue to accept as payment Our negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. Further, the Provider must agree to adhere to all of Our Quality Assurance procedures as well as all other policies and procedures required by Us regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments.

New Members Currently Undergoing a Course of Treatment: If you are undergoing a course of treatment with a non-Network Provider at the time your coverage under this Certificate becomes effective, you may be able to receive Covered Services from the non-Network Provider for up to 60 days from the effective date of your coverage under the Certificate. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester, you may receive Covered Services from your non-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available only if the Provider agrees to accept as payment Our negotiated fees for such services. Further, the Provider must agree to adhere to all of Our Quality Assurance procedures as well as all other policies and procedures required by Us regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments.

In order to obtain Transitional Care, you or your Provider should call Medical Management at 800-444-6222 and request this coverage.
GRIEVANCE PROCEDURE

HOW WILL THE PLAN HANDLE ANY QUESTIONS OR PROBLEMS?

Our Grievance Procedure provides for a meaningful, dignified and confidential procedure to hear and resolve Grievances between Members, Us and, when necessary, Network Providers. This Grievance Procedure also assures that Grievances are handled in a timely manner.

To make this process more accessible to non-English speaking Members, We will arrange to have an interpreter available who speaks your language. Because the interpreter will be an employee of an independent translating service, Our ability to provide this service depends on the availability of the interpreter. We may need to arrange to call You at a time when an appropriate interpreter is available. Additionally, You always have the right to designate a representative to represent You during the Grievance Procedure. You must provide us with a written consent in order for the designee to act on your behalf. A copy of the Grievance Procedure is available in many languages. Depending on availability, a copy in your language can be forwarded to You upon your request.

Important: All Complaints and First Level Appeals must be initiated 180 days from the receipt of the Explanation of Benefits, Denial Notice, or of the date when the Member became aware of the issue that initiated the Complaint or Appeal.

GRIEVANCE OVERVIEW

Grievances and Complaints are classified into two categories. The category of the specific issue will determine which process You will need to follow in resolving your issue. The two categories are:

BENEFIT ADMINISTRATIVE ISSUES – The types of items that fall under this category include, but are not limited to, problems with any of Our administrative policies, issues concerning access to providers, denials based on benefit exclusions or limitations, claims payment disputes, and administrative inquiries. If this relates to your issue, refer to section “I. Grievance Procedure for Benefit/Administrative Issues” for further information.

Utilization Review Issues – This category includes those items, which concern Medically Necessary determinations. The Utilization Review category also includes determinations involving treatment or services that are considered “Experimental or Investigational.” If this relates to your issue, refer to section “II. Grievance Procedure for Utilization Review Issues” for further information.

I. GRIEVANCE PROCEDURE FOR BENEFIT/ADMINISTRATIVE ISSUES

A. Time Frames for Initial Determinations for Benefit/Administrative Issues

- **Grievance regarding treatments which have not yet been provided:** We will inform You and your provider of Our decision, by telephone and in writing, no later than 15 days from receipt of the grievance.

- **Grievance regarding Coverage for a Service already rendered:** We will inform You of Our decision, within 30 days of Our receipt of the grievance.

- **Grievance regarding a request for Urgent Care:** We will inform you or your provider, subject to medical appropriateness, within 48 hours from the receipt of all necessary information or 72 hours from receipt of the grievance, whichever is shorter. This includes any claim for medical services that if subjected to the standard time frames, could seriously jeopardize the life or health of the Member.

Please note: We will inform You and your provider of Our decision, by phone and in writing, within the time frames stated above. Once the review is complete, he or she will provide You with Our written or electronic notification. Our response will include Our decision on the Initial Benefit Determination, as well as the detailed reasons for the decision, including the clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on how to file a First Level Grievance, and information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits. The time frames stated in this section might change if We need additional information from You in order to process your claim, or request for service.

We will notify You or your provider within the time frames stated above that there is a lack of information to process either your request for service or your claim for a service already rendered. You will have up to 45 days to provide the additional information. The 45-day period is calculated from the date You receive Our request for information. A determination will be rendered within 15 days of receipt of the information or 15 days from the expiration of the period of time allowed to provide the information. For Urgent Care Services, information will be requested by Us within 24 hours of receipt of the request; You will have 48 hours to provide Us with the information necessary to complete your request for service.
We will render a decision within 48 hours of receipt of the information, or the expiration of the original request for additional information, whichever is sooner.

In all cases, if no information is received within the required time frames, the claim or request for service will be denied.

Please note: The Grievance Procedure described below should be used when You have a problem with any of Our policies, procedures or determinations (Our administrative procedures, access to providers, failure to use a Network Provider, Covered benefits under the Certificate, etc.) except for issues concerning Medical Necessity. All issues concerning Our determination of Medical Necessity must be resolved through the Grievance Procedure for Utilization Review Issues process described in Section II.

There are two basic elements to the Grievance Procedure for Benefit Administrative Issues for Members, Complaints and Appeals as described below:

B. Complaints

You may advise Us of a problem by calling a Service Associate at 1-800-444-6222. The Service Associate will attempt to resolve your Complaint at the time of the call. If You remain dissatisfied, or for complaints that are not resolved at the time of the call, You may file a Grievance by following the procedure outlined below.

C. Grievance Appeal Procedure

First Level — Grievance

You have the right to request a review of Our initial determination. You or your designee must file a Grievance within 180 days of receipt of the Explanation of Benefits, Denial Notice, or of the date when You became aware of the issue that initiated the Grievance. You may file a Grievance, either by telephone or in writing, with Our Correspondence Department. The staff of the Correspondence Department will acknowledge receipt of the Grievance, in writing, within 5 business days of receipt. The acknowledgment will include the contact information for the Department, which has been designated to investigate the grievance and indicate if any additional information is needed. An individual in the Department will conduct a review of the Grievance. Once the review is complete, he or she will provide You with Our written or electronic notification. Our response will include Our decision on the Grievance as well as the detailed reasons for the decision, including clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on how to file a Second Level Appeal, and information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

We will advise You, your designee, or provider (if applicable) of Our decision:

- Not later than 30 days from the Correspondence Department’s receipt of a Grievance for services that have already been received.
- Not later than 15 days from the Correspondence Department’s receipt of a Grievance for the request for services or treatment that has not yet been received.
- Not later than 45 days of receipt of all necessary information for administrative matters concerning our participating providers.

If Oxford upholds its prior determination, the Member will receive Second Level Appeal rights in the determination letter.

Expedited Grievance Procedure

Occasionally, medical circumstances require that certain procedures be performed without significant delay. When the time frames of the normal Grievance process would seriously jeopardize the Member’s life or health, their ability to regain maximum function, or in the opinion of a doctor with knowledge of the health condition, cause the Member severe pain that can not be managed without the requested services, the Grievance Review Board will, upon notification, render a decision that will include written notification to the Member, within 48 hours from receipt of all necessary information or 72 hours from receipt of the Grievance, whichever is shorter. Grievances for determinations of services that have already been provided cannot be appealed on an expedited basis.

Second Level — Appeal Procedure

If You remain dissatisfied with the results of the Grievance determination, You or your designee may Appeal to the Grievance Review Board (the Board). You have 60 business days from the date on which You received notice of the Correspondence Department’s determination. We will acknowledge the receipt of the Member’s Appeal within 15 business days of the receipt of the Appeal requests. The acknowledgement will include the name, address and telephone number of the individual who has been designated to investigate your Appeal and indicate if any additional information is needed.

The Board will make its decision on the Second Level Appeal no later than:

- 30 days from the Board’s receipt of an Appeal for services that have already been received.
- 15 days from the Board’s receipt of an Appeal for services that has not yet been received.
- Two business days after receipt of necessary information when a delay would significantly increase the risk to an enrollee’s health.

The Board will:
NEW YORK HANDBOOK

- Rule that the Appeal is valid and recommend corrective action to resolve the matter; or
- Rule that the Appeal is without merit and does not require further action.

You will receive written notice of the Board's decision. Once the review is complete, We will provide You with Our written or electronic notification. Our response will include Our decision on the Appeal, as well as the detailed reasons for the decision, including the clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. And information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

The Board is a committee of Our employees appointed for the express purpose of reviewing and resolving Member Appeals. When an Appeal is clinical in nature, the Board will include a licensed, certified or registered individual who did not review the issue at the First Level Grievance. If the Appeal pertains to an administrative issue, individuals of a "higher level" than those who reviewed the First Level Grievance will resolve the Second Level Appeal. The ruling of the Grievance Review Board will be Our final position.

Members may write to either (or both) the New York State Insurance Department or the Department of Health, Office of Managed Care, Bureau of Managed Care Certification and Surveillance at any time during the Grievance process.

Consumer Services Bureau
New York State Insurance Department
25 Beaver Street
New York, NY  10004-2319
1-800-342-3736

Office of Managed Care
Bureau of Managed Care
Certification and Surveillance
New York State Department of Health
Corning Tower - Room 1911
Empire State Plaza
Albany, NY  12237
1-518-474-4156

Please note: You may also call the Department of Health at 1-800-206-8125 anytime during the Grievance Procedure process. You do not have to wait until the process is exhausted.

All information pertaining to each Complaint and Appeal will be fully documented, and we will retain such records for at least three years.

II. GRIEVANCE PROCEDURE FOR UTILIZATION REVIEW ISSUES

Please note: This procedure must be used whenever your issue concerns Our determination that a Covered Service is not Medically Necessary. Complaints, and Appeals concerning all other Non-Medical Necessity determinations will be addressed through the "Grievance Procedure for Benefit Administration Issues" as described above.

A. Utilization Review

Covered Services are subject to Utilization Review. This means that our Medical Management Department reviews pertinent medical information in order to determine whether or not the proposed service (request for Precertification), the service currently being provided ("Concurrent Review"), or the service that was provided ("Retrospective Review") is a Covered Service under the Certificate and Medically Necessary. If any of the following occur because We have made the determination that such service is not Medically Necessary ("Adverse Determination"), You may appeal that determination:

A request for Precertification. We will inform You and your Provider of Our decision, by telephone and in writing, no later than three business days from receipt of the necessary information.

Coverage for a current service for a Member in an ongoing course of treatment. We will inform You and/or your Provider of Our decision, by phone and in writing, within one business day of our receipt of all necessary information; Coverage for an urgent current service for a Member in an ongoing course of treatment shall be decided as soon as possible, taking into account the medical exigencies. We will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Coverage for a service already received is denied (Retrospective Review). We will inform You of Our decision within 30 days of Our receipt of the claim.

Please note: We will inform You and your provider of Our decision, by phone and in writing, within the time frames stated above. Once the review is complete, We will provide You with Our written or electronic notification. Our response will include Our decision on the Initial Benefit Determination as well as the detailed reasons for the decision, including the clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on how to file a First Level Appeal, and information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

If We fail to make a determination within these time frames, the request will be deemed an Adverse Determination subject to the appeals provisions below.
The time frames stated in this section might change if We need additional information from You in order to process your claim, or request for Precertification:

A request for Service (Pre-Service): We will notify You or your provider within 15 days that there is a lack of information to process your request for service. You will have up to 45 days to provide the additional information. The 45-day period is calculated from the date You receive Our request for information. A determination will be rendered within three business days of receipt of the additional information, if received within 45 days, or 15 days from the expiration of the period of time allowed to provide the information.

Coverage for a service already rendered. (Post-Service): We will notify You or your provider within 30 days that there is a lack of information to process your claim for a service already rendered. You will have up to 45 days to provide the additional information. The 45-day period is calculated from the date You receive Our request for information. A determination will be rendered within 15 days of receipt of the additional information, if received within 45 days, or 15 days from the expiration of the period of time allowed to provide the information.

A request for Urgent Care: For Urgent Care Services, information will be requested by Us within 24 hours of receipt of the request; You will have 48 hours to provide Us with the information necessary to complete your request for service. We will render a decision within 48 hours of receipt of the information, or the expiration of the original request for additional information, whichever is sooner.

In all cases, if no information is received within the required time frames, the claim or request for service will be denied.

B. Appeal Procedure for Utilization Review Issues; Appealing Adverse Determinations

The Member or the Member’s designee may appeal Adverse Determinations relating to Precertification and Concurrent Review. You must provide us with a written consent in order for the designee to act on your behalf. In the event that We render an adverse determination without attempting to discuss the matter with the Member’s health care provider who specifically recommended the health care service, procedure or treatment under review, The Member’s provider may request a reconsideration of the adverse determination. If We make such an Adverse determination without attempting to discuss the matter with the Member’s provider, We will respond within one business day of Our receipt of the request for reconsideration. Retrospective Adverse Determinations may be appealed by either the Member, the Member’s designee or the Member’s Provider. All Appeals may be initiated either in writing or by telephone. Clinical personnel who did not participate in the initial review will review all Appeals.

First Level Appeal

After You are informed of the Adverse Determination, You, your designee or your Provider (if applicable) have up to 180 days to initiate the Appeal process. The person initiating the Appeal must write or call Us within this 180-day period. To initiate an Appeal, please call Customer Care at 1-800-444-6222 or write to Our Clinical Appeals Department at P.O. Box 29139, Hot Springs, AR 71903-29139. We will acknowledge the receipt of your Appeal within five business days of the receipt of the Appeal requests. The acknowledgment will include the name, address and telephone number of the individual who has been designated to investigate your Appeal.

We will advise You, your Designee, or provider (if applicable) of Our decision:

- No later than 30 days from the Clinical Appeals Department’s receipt of an Appeal for services that have already been received.
- No later than 15 days from the Clinical Appeals Department’s receipt of an Appeal for the request for Precertification; or Concurrent Care.
- Within two business days of receipt of all necessary information, but in no event no later than 72 hours of receipt of a request for urgent Precertification or Concurrent Care.

If the Adverse Determination is upheld, You will receive written or electronic notification. Our response will include Our decision on the Appeal as well as the detailed reasons for the decision, including the clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on how to file a Second Level Appeal and/or an External Appeal, and information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

If You disagree with the first level appeal determination You may appeal to the Grievance Review Board described below under Second Level Appeal and/or go directly to the New York State external appeal process described in Section III. The 45-day time frame for requesting an external appeal begins upon the receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level Appeal is requested, by choosing to request a second level internal Appeal, the time may expire for You to request an external appeal. However, if You choose to pursue simultaneously an External Appeal and a Second Level Appeal, Oxford reserves the right to waive the Second Level Appeal process and, in lieu of a Second Level Appeal, Oxford will be bound by the decision of the external appeal agent. In such case, You will not be required to complete a Second Level Appeal in order to exercise any rights You may have under (ERISA).
If We fail to make an Adverse Determination Appeal decision within:

- Two business days of receipt of necessary information for Expedited Appeals; or
- 60 days of the receipt of necessary information for Utilization Review Appeals;

The original Adverse Determination will be reversed.

**Expedited Utilization Review Appeal**

If You are in an ongoing course of treatment and are seeking continued or extended services, or your provider believes that an immediate Appeal is necessary because the time frames of the Utilization Review Appeal process would significantly increase the risk to your health, then You, your Designee or your provider may request an Expedited Utilization Review Appeal. Retrospective Final Adverse Determinations cannot be appealed on an expedited basis.

The Appeal may be made in writing or by telephone. Within one day of Our receipt of the Appeal, We will provide reasonable access to Our clinical peer reviewer. We will provide access to Our facsimile machines or other services as needed. Oxford will render a decision to either uphold or reverse the Adverse Determination. The decision will include written notification to the Member within two business days from receipt of all necessary information or 72 hours from receipt of the Appeal, whichever is shorter. If You continue to be dissatisfied with the decision of the Expedited Appeal, You may Appeal that decision through the Appeal Procedure for Utilization Review Issues described above, or You may Appeal that decision through the External Appeal process described below. If You disagree with the Expedited Appeal determination, You may file a First Level Appeal and/or go directly to the New York State External Appeal process described in Section III. The 45-day time frame for requesting an external appeal begins upon the receipt of the final adverse determination of the Expedited Appeal, regardless of whether or not a First Level Appeal is requested, by choosing to request a First Level internal Appeal, the time may expire for You to request an External Appeal.

**Second Level Appeal**

If You are still dissatisfied with the results after the First Level Appeal has been completed, You or your Designee may file your written Appeal with the Grievance Review Board (the Board). This Appeal must be filed within 60 business days of the date on which You received notice of the First Level Appeal determination letter. We will respond to the receipt of the Member’s Appeal within 15 business days of the receipt of the Appeal requests. The response will include the name, address and telephone number of the individual who has been designated to investigate your Appeal.

The Board will make its decisions no later than:

- 30 days from the Board’s receipt of an Appeal for services that have already been received.
- 15 days from the Board’s receipt of an Appeal for the request for Precertification or Concurrent Care.

The Board will:

- Rule that the Appeal is valid and recommend corrective action to resolve the matter; or
- Rule that the Appeal is without merit and does not require further action.

You will receive written notice of the Board's decision. Once the review is complete, We will provide You with Our written or electronic notification. Our response will include Our decision on the Appeal, as well as the detailed reasons for the decision, including the clinical rationale if applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. And information on how the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimants claim for benefits.

The ruling of the Grievance Review Board will be Our final position.

Members may write to either (or both) the New York State Insurance Department or the Department of Health, Office of Managed Care, Bureau of Managed Care Certification and Surveillance at any time during the appeal process.

Consumer Services Bureau
New York State Insurance Department
25 Beaver Street
New York, NY  10004-2319
1-800-342-3736

Office of Managed Care
Bureau of Managed Care
Certification and Surveillance
New York State Department of Health
Corning Tower - Room 1911
Empire State Plaza
Albany, NY  12237
1-518-474-4156

Please note:  You may also call the Department of Health at 1-800-206-8125 anytime during the Grievance Procedure process.  You do not have to wait until the process is exhausted. All information pertaining to each initial adverse determination and Appeal will be fully documented, and we will retain such records for at least three years.

**III. EXTERNAL APPEAL**

**A. Your right to an External Appeal**

Under certain circumstances, You have a right to an External Appeal of a denial of coverage. Specifically, if We deny coverage on the basis that the service is not Medically Necessary or is an
experimental or investigational treatment, for your representative may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such Appeals.

B. Your right to appeal a determination that a service is not medically necessary

If We deny coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You satisfy the following two criteria:

The service, procedure or treatment must otherwise be a Covered Service under this Certificate; and

You must have received a Final Adverse Determination through Our internal review process, and We must have upheld the denial, or You and We must agree in writing to waive any internal Appeal.

C. Your right to appeal a determination that a service is experimental or investigational

If You have been denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the following two criteria:

The service must otherwise be a Covered Service under this Certificate; and You must have received a Final Adverse Determination through Our internal Appeal process and We must have upheld the denial, or You and We must agree in writing to waive any internal Appeal.

In addition, your attending physician must certify that You have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one, which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders You unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that You have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one for which there exists a clinical trial (as defined by law). A clinical trial for which You are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

D. The External Appeal Process

If, through Our internal review process, You have received a Final Adverse Determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, You have 45 days from receipt of such notice to file a written request for an external appeal. If You and We have agreed in writing to waive any internal Appeal, You have 45 days from receipt of such waiver to file a written request for an External Appeal.

We will provide an External Appeal application with the Final Adverse Determination issued through Our internal review process, or Our written waiver of any internal Appeal.

You may also request an External Appeal application from New York State at 1-800-400-8882. Submit the completed application to State Department of Insurance at the address indicated on the application. If You satisfy the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional information with your request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, theExternal Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three business days to amend or confirm Our decision. Please note that in the case of an Expedited Appeal (described below), We do not have the right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from You, your physician or Us. If the External Appeal Agent requests additional information, they will have five additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two business days.

Expedit ed External Appeal

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, You may request an Expedited External Appeal.
In that case, the External Appeal Agent must make a decision within three days of the receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to You according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare services, the costs of managing research, or the costs, which would not be Covered under this Certificate, for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent’s decision is binding on both You and Us. The External Appeal Agent’s decision is admissible in any court proceeding.

We will charge You a fee of $50 for an External Appeal. The External Appeal application will instruct You on the manner in which You must submit the fee. We will also waive the fee if We determine that paying the fee would pose a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to You.

E. Your Responsibilities

It is your responsibility to initiate the External Appeal process. You may initiate the External Appeal process by filing a completed application with the New York State Department of Insurance. An insured, the insured’s designee and, in connection with a retrospective adverse determinations, an insured’s healthcare provider, shall have the right to request External Appeal.

Under New York State law, your completed request for an Appeal must be filed within 45 days of either the date upon which You receive written notification from Us that We have upheld a denial of coverage during the internal Appeal process or the date upon which You receive a written waiver of any internal Appeal. We have no authority to grant an extension to this deadline.

**Employee Retirement Income Security Act (ERISA) Rights:** After all levels of Appeals have been completed, the Member may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if the Member’s coverage for health benefits was:

- Obtained through employment with a church or government group; or
- Purchased as an individual plan from Oxford.

Please Note:

**Utilization Review**

All services that You seek to have Covered under this Certificate are subject to Utilization Review. This means that Our Medical Management Department may review pertinent medical information to evaluate whether or not the proposed service, the service currently being provided, or the service that was provided is Medically Necessary and a Covered Service under the Certificate. Utilization Review is also required when We need to make a determination that a service is or is not experimental or investigational. For more information about Our Utilization Review Policies please see Information About Your Oxford Coverage which is attached to this Certificate.

**Unnecessary Care**

In general, We will not Cover any healthcare service that We in Our sole judgment, determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We shall Cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise Covered under the terms of this Certificate.

**Experimental/Investigational Treatments**

In general, We will not Cover experimental or investigational treatments. However, We shall Cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in such a clinical trial.

**OTHER IMPORTANT INFORMATION**

**Living Wills and Advance Directives**

You have the right to participate in decisions relating to your health care. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. That right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the hospital. This is done by the creation of an Advance Directive.

An Advance Directive is a written, signed document, that provides instructions for your care if you are unable to communicate your wishes directly. Depending on the state
where you reside or are receiving treatment, the most common forms of Advance Directives are Living Wills and Durable Powers of Attorney. These documents instruct your health care providers how to proceed if you are not able to communicate with them.

Additionally, The New York State Health Care Proxy Law allows an adult to designate another adult, such as a trusted friend or loved one who knows the person and his or her wishes, to make these treatment decisions if the adult becomes incapacitated and is unable to do so.

If you decide to execute an Advance Directive or Proxy, you should notify all of your regular providers and a copy of the item should be placed in the medical file maintained by your PCP. In addition, you should have some way of notifying police and emergency medical personnel that you have made an Advance Directive. For example, you may want to keep a card in your wallet or purse.

You are not required to make an Advance Directive or a Proxy. If you do decide to make one, please note that you are free to amend or cancel it at any time.

Patient/Provider Relationship

Network Providers are solely responsible for all health services that you receive. They will use their best efforts to render all necessary and appropriate professional services in a manner compatible with your wishes. All services are, of course, subject to the Network Provider's professional judgment. If you refuse to follow a recommended treatment, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither We nor the Network Provider will have any further responsibility to provide care for the condition under treatment.

PROVIDER REIMBURSEMENT AND QUALITY ASSURANCE

Quality Assurance

We carefully select the Providers who deliver services to our Members as Network Providers. This helps Us to insure that you receive consistent, quality care.

We are NCQA approved. This national accreditation organization has found that Our Quality Assurance Program meets its high standards. For more information about Our Quality Assurance Program, please see “Information About Your Oxford Coverage” which is attached to this Certificate.

Reimbursement

We reimburse our Network Providers in a variety of ways. The most common is a discount off the Provider’s usual fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider’s name appears in Our Roster which gives the Provider an opportunity to gain new patients from among our Membership. For more information on other types of reimbursement methodologies, please refer to “Information About Your Oxford Coverage” attached to your Certificate.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, you have the right to:

1. Obtain complete and current information concerning a diagnosis, treatment and prognosis from any Network Provider in terms that you or your authorized representative can readily understand.

2. Receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

3. Refuse treatment to the extent permitted by law. We and your PCP will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and We and your Network Provider believe no professionally acceptable alternative exists, We will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

4. Formulate advance directives regarding your care. To request a health care proxy form, please contact us.

5. Be given the name, professional status and function of any personnel delivering Covered Services to you.

6. Be provided with information about Our services and medical providers that accurately provides relevant information in a manner that is easily understood.

7. Quality health care services, provided in a professional and respectful manner.

8. Participate in decision-making regarding your health care.

9. Privacy and confidentiality of your health records, except as otherwise provided by law or contract.

10. Access your Medical Records as permitted by New York State Law.

11. Initiate disenrollment from the plan.

12. File a formal grievance if complaints or concerns arise about Our medical or administrative services or policies.

13. The right to emergency care when medically necessary without delay.
Be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

**You have the responsibility to:**

1. Enter into this Plan with the intent of following the policies and procedures as outlined in this Certificate.

2. Take an active role in your health care through maintaining good relations with your PCP and following prescribed treatments and guidelines.

3. Provide to the extent possible, information that professional staff need in order to care for you as a Member.

4. To notify the proper Plan representative of any change in name, address or any other important information.

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**INFORMATION AVAILABLE TO ENROLLEES UPON REQUEST**

As an Oxford Member, you automatically receive a Certificate, the attachment "Information About Your Oxford Coverage," a Summary of Benefits and a List of Network Providers. Upon your written request, Oxford will furnish you with the following additional information.

- Our Annual Report which contains: a list of the names, business addresses and official positions of Our Board of Directors, officers, controlling persons, and owners;

- Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements;

- A copy of Our Individual HMO Contract & Member Handbook or Personal Plan Contract;

- The information that We provide the State regarding Our consumer complaints as required by Section 210 of the Insurance Law;

- A description of Our procedures for maintaining confidentiality of medical records and other enrollee information;

- A copy of Our drug formulary. You may also inquire if a specific drug is Covered or excluded under this Certificate.

- A copy of Our Medical Policy regarding an experimental or investigational drug, medical device or treatment in clinical trials;

- A copy of Our Medical Policy regarding a specific disease or course of treatment. You may also request how this information, and any applicable Utilization Review guidelines, may be used during the Utilization Review process.

**Please note:** requests for Medical Policies are limited to two per letter and must relate to a valid need on your part to assess your coverage under this Certificate.

To obtain this information, please send Us a letter indicating the information you require. Please address your letter to: Managed Care Act, Oxford Health Plans, 48 Monroe Turnpike, Trumbull, CT 06611.