

DISCLOSURE POLICY

Policy Number: ADMINISTRATIVE 037.11 TO

Effective Date: September 1, 2018

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Related Policies

None

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

PURPOSE

The purpose for this policy is to help ensure compliance with the Department of Labor ("DOL") regulations promulgated under the Employee Retirement Income Security Act of 1972("ERISA"), and the individual state laws that require disclosure of certain information to covered Members regarding their claims for benefits covered under their certificates or appeals of adverse benefit determinations.

ERISA rights apply to:

- All Commercial lines of business except individuals, church groups and municipalities; and
- Certain Group Retiree Plans as described below*

***Note:** For Group Retiree benefits and Claimants to be governed by ERISA, a Group Retiree Member must be covered by an employer group health plan AND the benefit must be a group-only benefit provided under the plan in addition to the basic plan benefits. ERISA requirements apply only to the extent of those benefits.

DEFINITIONS

Term	Applicable State(s)	Definition
Claimant	CT, NJ, & NY	A covered member or the member's authorized designee covered under an employee benefit plan governed by ERISA. Note: A designee can be any person the Claimant has authorized to act on his or her behalf. The request for a designee must be in writing and submitted to Oxford at the time of the request for services. During a medical emergency, a provider, who has knowledge of a Claimant's medical condition, may act on behalf of the Claimant.

Term	Applicable State(s)	Definition
Adverse Determination	CT & NY	A denial, reduction or termination of, or failure to provide or make payment in whole or in part for a benefit or service requested by the Claimant pursuant to his or her certificate.
	NJ	A denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-network exception, as well as a failure to cover an item or service for which benefits are otherwise provided because Oxford determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO/carrier has rescinded the coverage.
Claim For Benefits	CT & NY	Any request submitted by a Claimant for pre-service, concurrent, or post service benefits.
	NJ	A request by a member, a participating health care provider or a nonparticipating health care provider who has received an assignment of benefits from the member, for payment relating to health care services or supplies covered under a health benefits* plan issued by Oxford.
Post-Service Claim (Retrospective Determinations)	CT & NY	A claim for benefits/services that have already been rendered. Occurs when notification is after the fact of care/service/delivery. The need for "retro-review" is most often created by late or non-notification.
	NJ	Any claim for a benefit that is not a "pre-service claim."
Pre-Service Claim (Request for Services such as Pre-Certification)	CT & NY	Any benefit under a health plan, which must be approved before any services are rendered. This includes any request for benefits, which need pre-certification. If there would be a reduction in benefits as a result of a Claimant's failure to receive pre-certification, this will be considered a pre-service claim.
	NJ	Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

POLICY

ERISA Department of Labor (DOL) regulations, state laws and NCQA require health plans to disclose, when requested certain information to Members and Claimants regarding their claims for benefits covered under their certificates, or in connection with the Member's Adverse Determination or appeal of that determination.

Oxford® is required to disclose when requested:

- Any administrative rule, benefit provision, guideline, protocol, policy, criteria, statement or procedure, on which the denial decision was based; and
- Under the ERISA DOL regulations, all information relevant to the claim. This includes, but is not limited to internal communication events, authorizations, and records (clinical and non-clinical) relating to the claim at issue that were developed, considered or generated in the course of making the determination.

PROCEDURES AND RESPONSIBILITIES

Initial Adverse Determination

All Members and Claimants are entitled to receive copies of the criteria, protocols and/or the internal guidelines used in making the initial Adverse Determination.

The above information will be downloaded or pulled from archives by the disclosure associate and sent to the Member. The disclosure associate will provide this information to the requestor within **fifteen (15) calendar days** of receipt of the request.

Inquiries should be sent in writing to:

UnitedHealthcare
Attn: ERISA Disclosure Request
PO Box 29133
Hot Springs, AR 71903

Appeals of Adverse Determinations

Whenever a Claimant receives a decision on an appeal of an Adverse Determination, ERISA allows the Claimant to obtain a copy of the criteria, protocols and procedures used in making the initial Adverse Determination, and/or in resolving their claim on appeal. ERISA also allows a Claimant to obtain a copy of all information relevant to making the appeal determination. Information pertaining to an Adverse Determination is limited to the particular claim at issue.

Requests for information will be provided to the requestor within the following timeframes:

Information Requested	Will Be Provided to the Requestor Within...
Policy	Fifteen (15) calendar days of receipt of the request
Files and Medical Documentation	Thirty (30) calendar days of receipt of the request

Inquiries should be sent in writing to:

UnitedHealthcare
Attn: ERISA Disclosure Request
PO Box 29133
Hot Springs, AR 71903

A disclosure associate will be responsible for coordinating materials in response to Member requests for information pursuant to ERISA/Department of Labor regulations. This employee will also maintain a tracking system by sorting, indexing and responding to customer inquiries in an efficient and timely manner.

Information will be sent to Claimants free of charge.

REFERENCES

Department of Labor Regulations, ERISA. 29 C.F.R. § 2520.102-3.

NCQA 2004/2005 MCO Standards & Guidelines.

N.J. Admin. code § 11:24-1.2

N.J. Admin. code § 11:24A-1.2

N.J. Admin. code § 11:24A-2.3

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
09/01/2018	<ul style="list-style-type: none">Updated definition for New Jersey plan members to indicate an Adverse Determination is a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, <i>denial of a request for an in-network exception</i>, as well as a failure to cover an item or service for which benefits are otherwise provided because Oxford determine the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO/carrier has rescinded the coverageUpdated supporting information to reflect the most current referencesArchived previous policy version ADMINISTRATIVE 037.10 T0