Key Insurance
& Benefits Services

PPO Member Handbook and Other Important Information Inside

Business Works PPO is a managed care product brought to you by the Business Works unit of Key Insurance & Benefits Services, designed to coordinate the delivery of appropriate and medically necessary care for your work-related injuries and illnesses. This coordinated program is designed to provide an expedited recovery and facilitate return to productive employment for you, the employee.

Business Works provides medical case management for each injured employee. The nurse case manager is the injured workers' connection to timely, quality and appropriate health care services. Whenever possible, care is provided within our select network of quality providers. Our network includes physicians and other providers with expertise in occupational health and managed care of the injured workers.

As a member of a managed care program, you should receive all your care from our panel of participating providers, consultants and facilities. This panel is sometimes referred to as a preferred provider organization (PPO) or as a participating network. Except for emergency services or services from the New York State Occupational Health Clinics Network, all services should be provided within the participating panel. Requests for services outside the network require review and approval by our clinical staff. Generally, we approve requests to non-network specialists only when no participating specialist is qualified to provide the service. Once the request is reviewed, we will notify the specialist provider of the outcome. If the request is not approved, you will also receive a notice of denial.

This handbook has been designed to explain how Business Works functions to provide comprehensive medical care for you. Be sure to read through this handbook to become familiar with all the services available to you.

all states. KIB and KeyBank are separate entities, and when you purchase risk management services, business consulting services or insurance products you are doing business with KIB, and not KeyBank.

Business Works
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You and Your Case Manager

Working Together to Deliver Results...

It's easy for you to get the care you need through Business Works. A call to our Nurse Case Management staff gets the process started. This specially-trained nurse helps you get fast, easy access to quality health care providers and sees that you continue to receive the care you need.

This is how Business Works works:

Step 1
Immediately after any work-related injury occurs, you the injured worker and/or your employer representative calls a Business Works Nurse Case Manager at (585) 770-1600 and/or 1-800-811-2667. Care is provided 24 hours a day, seven days a week. For our non-English speaking members, Business Works will recruit the support of a telephone service that provides interpretation for most languages. Additionally, we utilize NYS Relay Services to communicate with the hearing impaired. Nurse Case Managers guide you through the process of medical treatment and recovery. Their top priority is to ensure immediate access to cost-effective and quality medical care for you, the injured worker.*

Step 2
The Nurse Case Manager, who is a registered nurse with experience in occupational health care and case management, will record all information related to the injury and recommend a choice of participating providers based on your injury and demographic location. Typically, the Nurse Case Manager calls the provider to schedule the first appointment for you - ensuring quick and easy access to care.

Step 3
The Nurse Case Manager assists you in choosing a provider and will confirm that your appointment is scheduled. If necessary, the Nurse Case Manager will arrange a same-day appointment for you.

Step 4
You will be examined either by the physician or the physician extender. After the visit, the physician contacts your Nurse Case Manager to discuss the recommended course of treatment, and together they develop an effective treatment plan and target a return-to-work date for you. When necessary, your Nurse Case Manager may arrange for appointments with specialists and for follow-up visits for you with a provider of your choice.

Step 5
The Nurse Case Manager stays in touch with you, your treating providers, your employer, and your employers workers' compensation insurance company throughout the course of treatment to make sure that treatment and return-to-work plans are understood and progressing as planned.

*For a situation that appears to be for an emergency medical condition, immediately go to emergency room of the nearest hospital. An emergency medical condition is defined as 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 placing the health of the person in serious jeopardy, or placing the health of others in serious jeopardy; or serious impairment to a bodily function; or serious dysfunction on any bodily organ or part; or serious disfigurement. You should notify your Nurse Case Manager of any emergency room visit. Your Nurse Case Manager must authorize follow-up services and continuing care. Some examples of conditions considered emergency medical conditions are severe chest pain, poisoning, or unconsciousness.

Participating Providers

As a member of Business Works, you should receive all your care from participating providers. A participating provider is a physician, physician extender, health care consultant or facility that enters into an agreement to offer care to our members. Participating providers are credentialed by Business Works and agree to abide by our policies and procedures with over site from the program's medical director.. Participating providers are listed in our Provider Directory. To obtain a copy of our Provider Directory, ask your employer or call our Express Line at 1-800-811-2667. This directory will also include the board certification status of physicians as well as addresses and phone numbers.

If your Nurse Case Manager determines that you need to see a specialist, he or she will generate a referral for you to a participating provider of your choice. ***Remember, in order for any specialist or hospital visit to be covered, the visit must be approved by your Nurse Case Manager***. If you need to see a nonparticipating provider with unique training and experience in your condition, or a specialty care center that is not a participating provider, you should contact our offices to discuss the request prior to scheduling any visit or treatment. This request will be reviewed by our Medical Director. If you have a life-threatening condition or a degenerative and disabling disease requiring ongoing care from a specialist or specialty care center over a long period of time, you may request a special standing referral by contacting our offices with the reason for the special referral. This request will also be reviewed by our Medical Director. In addition, our policies on standing referrals, the use of specialists as primary care providers, referrals to specialty care centers, continuity of care when your provider is no longer in our network, and continuity of care for new enrollees currently in treatment are available in our office for your review.

Periodically, a participating provider terminates participation status due to retirement, closing a practice, relocating or other changes. When this happens, and you have outstanding services to the provider, you will be notified with instructions on how to select a new participating provider.

***You, the employee, may change providers at any time throughout the course of treatment. Please contact the Nurse Case Manager for assistance in selecting a new provider from the participating panel. The Nurse Case Manager can assist you in guaranteeing timely appointments.*

Appropriate Medical Care

Business Works will only cover services that are medically necessary and appropriate for the diagnosis and treatment of your illness or injury. By medically necessary and appropriate we mean:

- Your tests, treatment, services and supplies must be consistent with the diagnosis and treatment of your illness or injury and provided in accordance with accepted medical practices in the community at the time.

- Care will be provided at the most appropriate level for inpatient, outpatient or out-of-hospital services and is not solely for the convenience of your health care provider, hospital, other provider, or for you.

- The fact that a health care provider prescribes, orders, recommends or approves a medical treatment, or length of time care is received, does not by itself make the services medically necessary.

Utilization Review

Business Works, as a managed care program, reviews proposed and rendered health services to determine whether the services are or were medically necessary. This process is called Utilization Review (UR). Utilization Review includes all review activities whether they take place prior to the service being rendered (prospective); when the service is being rendered (concurrent) or after the service is rendered (retrospective).

Utilization Review activities occur for several reasons. Certain requests to specialists and for hospital admissions will be reviewed to determine if the request or admission meets our guidelines. If the request or admission does not meet our guidelines, you will be notified in writing of the reason for the denial within three working days of the denial decision. If your request involved continuing your health services, you will be notified within one working day of receipt of all necessary information. Hospital and skilled care facility admissions are also reviewed concurrently during the admission to determine if the admission continues to be medically appropriate. If we determine that the admission is no longer medically appropriate, you will be notified prior to or on the date the admission is no longer medically necessary that the remaining admission days will not be covered. Hospital and skilled care facility admissions are also reviewed retrospectively to determine if each day of the admission was medically necessary. If we determine retrospectively that the admission was not medically necessary, you will not be held liable for any of the admission charges except for those not covered by your health insurer.

Business Works has developed Utilization Review policies to assist us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. We have also developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review at our office. For more information, you can always contact your nurse case manager.

If you disagree with any Utilization Review decision, you have the right to a reconsideration and may appeal the decision. We have adopted an expedited process to urgent situations. To help you do this, we will provide you a notice explaining the reason for the denial. If you feel you cannot appeal yourself, you can designate a representative to do so. Please refer to the Member Complaint and Grievance Section in this handbook for instructions on how to file a reconsideration request or appeal.

Returning to Work

The goal of Business Works is to return you to work as quickly as possible without risk to your health and safety. Every step of your treatment and care will be monitored and facilitated by your Business Works Case Manager to insure that there is an effective, coordinated plan to get you back on the job. Various work assessment tools will be used to gather information about your aptitude, skills and capabilities after a workrelated injury or occupational disease. Your Nurse Case Manager will then work closely with your employer and you to design the most comprehensive return-to-work plan for you.

Second Opinion Process

As a Business Works member, you may seek medical treatment from outside the participating panel only after 30 days (see opt out policy) from your first visit to a participating provider. Your Business Works Nurse Case Manager can assist you in arranging for a second medical opinion from another provider within the participating panel at any time. In addition, your employer can require a second opinion from another provider within the participating network of providers.

When You Need Assistance

Member Services
The Business Works PPO Administrator is an information and communications resource.

The primary function of this resource is to answer any questions you may have about Business Works Program benefits and services. We can also provide you with further information about your rights and responsibilities under this PPO program.
CONTACT: Liz Boehm, PPO Administrator, at 1-800-811-2667 or 585-770-1600

For our non-English speaking member, Business Works will recruit support of the telephone company's language line. Additionally, we utilize the NYS Relay system for our hearing impaired members.

Periodically, we review complaints, satisfaction information, new technology, and new procedures to determine if changes should be made to your benefits. If you would like to share in the development of benefits or policies, please write to the Business Works PPO with your ideas and suggestions.

Your Business Works Nurse Case Manager
If you have questions pertaining to the treatment of your job-related illness or injury, please contact your Nurse Case Manager as quickly as possible so that we can try to resolve your concern immediately. Remember, your Nurse Case Manager is an important liaison to your treating provider and is available to help you with your questions and concerns.
Business Works Nurse Case Managers are available at 1-800-811-2667 or 585-770-1600

Complaint and Grievance Procedures

If you have any concerns, complaints or problems about any aspect of Business Works, you should contact our Program Director at the toll-free number listed above. In most instances, informal discussions with the Program Director and/ or your Nurse Case Manager will satisfactorily resolve your concern. All discussions will remain confidential and no discriminatory action will be taken because of your complaint.

If informal discussions fail to resolve the problem or concern, you may request a formal grievance or appeal by contacting the Program Director for the appropriate paperwork. If your grievance is based on our denial of requested services, you should file your grievance within 60 days from receipt of our denial. There is a standard process for both standard and expedited grievances and your Nurse Case Manager will be happy to provide you with directions..

Standard Grievance

Your written or oral grievance (when the dispute is about a referral or covered benefit) will be reviewed by the Grievance Committee comprised of individuals not involved with the original decision. If you so desire, you may designate a representative or appear in person to present you grievance or appeal. If you cannot appear in person, arrangements can be made to present to the Committee by telephone or other mechanisms. You will receive acknowledgment that we have received your grievance within three business days of our receipt of your request. This acknowledgment will include the name, address, and phone number of the department handling the complaint. Your grievance will be resolved within 30 days from receipt. You,
your designee, and where appropriate, you health care provider, will receive notification of our decision within two business days of rendering our decision. The notification will include the detailed reasons for the decision; the clinical rationale for the decision, if applicable; and instructions on how to file an appeal including any required appeal forms.

If the matter is not resolved to your satisfaction, you may request an appeal to the second level committee. You have 60 days from receipt of the grievance denial to file your appeal. Similarly to level 1 grievance, once we receive your appeal, we will notify you within three working days that we have received your appeal and whom you can contact if you have any questions. Once reviewed, you will receive a written explanation as to the decision including your further appeal rights, if any, within two days of the grievance committee's decision but not more than 30 days from receipt of your appeal.

Expedited or Urgent Appeal

In certain circumstances, you may request an expedited or urgent appeal. This process is applicable to situations which:

- the denial involved continued or extended health care services, procedures, or treatments or additional services undergoing a course of continued treatment,
- the health care provider believes an immediate appeal is warranted, or □ a delay would significantly increase the risk to health.

You will receive notification on expedited appeals within 48 hours or our receipt of all information necessary to make the decision. You, your designee, and where appropriate, your health care provider, will

receive notification of our decision within two business days of rendering our decision. The notification will include the detailed reasons for the decision; the clinical rationale for the decision, if applicable; and instructions on how to file an appeal through the standard appeal process.

In either case, your grievance and appeal will be reviewed by qualified clinical personnel, if you grievance or appeal pertains to a clinical matter, who were not involved in the previous decision. In the case of an expedited appeal, reasonable access to our clinical reviewer will be provided within one business day of receiving the expedited appeal pertaining to a clinical matter.

If you remain dissatisfied with the decisions made by these committees, you may review your alternative options with your employee. Your employer may assist you in completing the appropriate Employee Notification Form for submission of your complaint to the New York State Workers' Compensation Board or Department of Health.

Notification of Complaint, Grievance and Appeal Procedures: We will notify you of our complaint, grievance and appeal procedure in this handbook. In addition, we will notify you in writing of this procedure at any time that we deny access to a referral.

Opting Out of Business Works

If you are dissatisfied with Business Works, you may opt out of the program by notifying your employer or Business Works of your decision to opt out. Each time you are injured, you may opt out after 30 days from receiving your first treatment from a PPO provider for that injury.

Other Important Information

Medical Record Release: New York State law regulates the release of information to patients and outside sources. If a situation arises that requires the release of information from your medical records, please submit a request in writing to your physician. Each adult must submit an individual request. You may be charged a per page fee by your physician for this service.

Advance Directives and Informed Consent: You have the right under New York State law to make medical care decisions, accept or refuse medical treatment and make advance directives about your medical care in the event you lack capacity to make such a decision. This right is often called Informed Consent and Advance Directives. New York Law allows for three types of Advance Directives: Do Not Resuscitate Orders (DNR), Health Care Proxies and Living Wills. For information on Advance Directives, or a copy of a Health Care Proxy, please call the Member Services Express Line at (585) 454-5010 for an Advance Directive brochure.

Your Financial Responsibilities: As a member of Business Works, you will not be liable for the cost of provider services or treatment of workers' compensation benefits, provided you do not seek care, other than emergency care, from a provider who does not participate in Business Works without our authorization prior to the date you are permitted to opt out.

How to Submit a Claim: Your claims will be submitted directly to us by the provider of service. If for any reason you receive a bill from a Business Works provider, please forward the original bill to your Nurse Case Manager:

Key Insurance & Benefits Services
c/o Business Works
777 Canal View Blvd. – Suite 100
Rochester, NY 14623

Other Information Available to You: The Nurse Case Manager is your information resource and can provide the following Business Works information:

- a list of names, business addresses and positions of our Business Works Advisory Committee
- information on consumer complaints
- a copy of our confidentiality policy
- a description of our quality assurance program
- a copy of our policy on determining if drugs and services are experimental or investigational
- information on your physician's hospital affiliations
- upon written request, our clinical review criteria on a particular disease or condition to assist you in evaluating coverage
- application procedures and minimum qualifications of providers to be participating providers
- other information that may be required by state law

Transitional Care

Existing Members: If your current provider no longer participates in our network, for reasons other than quality of care, you may continue to see this provider for up to 90 days from the date you receive notice from us that he or she is no longer participating in our network.

New Members: If you are a new member to our plan with a serious, degenerative, or disabling condition or disease, and the provider you are currently seeing is not a participant in our provider network, you may request to continue to see this provider for 60 days from your enrollment in our plan.

In any situation above, in order to continue with the non-participating provider, he or she must accept our reimbursement, adhere to our quality assurance program and follow our policies and procedures. To request transitional care, ask your Nurse Case Manager.

Your Rights and Responsibilities

Through Business Works, you have the right to:

- Receive all the benefits to which you are entitled under Business Works PPO program.
- Receive quality health care in a timely manner and medically appropriate setting.

- Considerate and respectful care.
- Participate in decision-making with your physician about your health care, including information on your diagnosis, treatment and prognosis.
- Request a second medical opinion for the treatment of your condition.
- Refuse treatment and be informed by your physician of the medical consequences.
- Refuse to participate in research.
- Complete information regarding diagnosis, treatment and prognosis.
- Confidentiality of medical records and condition, with the authority to approve or refuse the redisclosure by use of such information.
- All information needed to give informed consent for any procedure or treatment. □ Access to your medical records as permitted by New York State law.
- Express concerns and complaints about the care and services provided by physicians and other providers, and have Business Works investigate and respond to these concerns and complaints.
- Discussion of appropriate or medically necessary treatment options for your condition without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, medical problem, cost or benefit coverage.
- Voice complaints and recommend changes to staff, administration and/or the New York State Workers' Compensation Board, without fear of reprisal.
- Maintain a copy of your Health Care Proxy with your other medical records.
- Contact Fist Niagara Business Works' Program Director to obtain the names, qualifications and titles of providers who are responsible for your care.
- Opt out of the Business Works program after 30 days from receiving the first treatment of your injury for each injury.
- Maintain confidentiality for the reason you opt out.
- Access emergency and urgent care on a 24-hour basis, seven days a week.
- Access non-emergency care within 48 hours of your request to a participating provider and within 48 hours of your request to a non-participating provider if services cannot be arranged in the participating network.
- Choose your provider within the participating network.

You have the responsibility to:

- Immediately report your injury to your supervisor.
- Contact (or have your employer representative contact) your Business Works Nurse Case Manager.
- Seek care from the Business Works provider network as directed by your Nurse Case Manager.
- Provide complete and honest information about your health status and health concerns.
- Inform Business Works if there are any changes in your health status.
- Share with Business Works any concerns about the medical care or services that you receive.
- Permit Business Works to review your medical records in order to comply with federal, state and local regulations regarding quality assurance, and to verify the nature of services provided.
- Keep scheduled appointments with providers.
- Respect staff and providers.
- Follow the instructions and guidelines given by your providers.

Business Works Rights and Responsibilities

Business Works has the right to:

- Determine the providers who will participate in the Business Works program.
- Determine the appropriate treatment plan for your work-related injury or illness.
- Make referrals for specialists and follow-up visits with the input of the claimant.
- Target a return-to-work date.

Business Works has the responsibility to:

- Insure that emergency and urgent care is available and accessible 24 hours a day, seven days a week.
- Arrange non-emergency medical care within 48 hours of the request for treatment to a participating provider and within 48 hours of the request to a non-participating provider if services cannot be arranged within the participating network.
- Insure appropriate providers are accessible within a reasonable distance from your home or worksite.
- Provide a communication method for our non-English speaking and hearing impaired members.

Your Employer's Right and Responsibilities

Your employer has the right to:

- Be notified of your work-related illness or injury.
- Determine which preferred provider organizations will be offered to you.
- Be notified of your work status following your work-related illness or injury.

Your employer has the responsibility to:

- Post a written notice notifying you of participation in Business Works and your rights within the program and compliance poster.
- Report your illness or injury to the Workers' Compensation board.
- Provide you with an updated listing of providers in Business Works.
- Notify you of your right to be referred to the New York State Occupational Health Clinic Network.
- Insure a Business Works Nurse Case Manager is assigned to your case.

Glossary

Nurse Case Manager: A registered nurse case manager who is experienced in occupational health care and case management – who will advocate to ensure you get the care you need.

Claimant: an individual employed by or otherwise covered for workers' compensation benefits by a participating employer and eligible for medical care provided by a PPO who received treatment or applies for medical and/or health services for any accidental injury arising out of and in the course of employment or for occupational disease.

Opt Out: your option to withdraw from Business Works after 30 days from receiving the initial treatment of your injury, for each injury.

Preferred Provider Organization (PPO): a plan certified by the Workers' Compensation Law that provides or arranges for the coordination and delivery of services required by the Law to persons covered by the Plan.

Services: all services provided or arranged for under the Workers' Compensation Law to diagnose, treat and rehabilitate a claimant requiring medical treatment of an occupational disease or an accidental injury arising out of and in the course of employment.

Second Medical Opinion: A request for another medical opinion from a provider in the participating panel within 30 days or outside of the participating panel after 30 days from your first treatment by a participating provider. This request can also be made by your employer.