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Welcome to Affinity Health Plan!

We are pleased you have chosen Affinity for your health coverage. For 30 years, we have proudly served New Yorkers like you. Our focus is on providing you with quality and comprehensive healthcare coverage, and we are proud to welcome you as our member.

Affinity has one of the broadest networks of primary care doctors and specialists, hospitals and other health care facilities to serve you, right in your community. Instead of just treating you when you get sick, they can work with you to keep you healthy and manage any existing health conditions.

This Member Handbook describes your healthcare benefits through Affinity and is designed to make it easy for you to make the most of your benefits and services. Keep this handbook in a safe place for quick and easy reference.

I encourage you to use your Affinity benefits and get the care that you need to stay healthy. In whatever manner most convenient to you, we are available to help you understand the coverage and benefits available to you, help you find a doctor and answer any questions you may have. You can:

- Visit one of our Customer Service Centers – go to AffinityPlan.org to find a center near you.
- Call our Customer Service Department at 1-866-247-5678. (TTY/TDD users: 1-800-662-1220). Our staff is available Monday through Friday between 8:30 a.m. and 6:00 p.m.
- Browse our website, AffinityPlan.org, to find a doctor, learn more about programs available to help you stay healthy, and a variety of other useful information.

Once more, welcome to the Affinity community. We are glad you are here!

Sincerely,

Michael G. Murphy
President & Chief Executive Officer
Affinity Health Plan complies with Federal civil rights laws. Affinity Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Affinity Health Plan provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Affinity Health Plan at 1-866-247-5678. For TTY/TDD services, call 711.

If you believe that Affinity Health Plan has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Affinity Health Plan by:

- Mail: 1776 Eastchester Road, Bronx, New York 10461,
- Phone: (718) 794-7569 (for TTY/TDD services, call 711)
- Fax: (718) 536-3390
- In person: 1776 Eastchester Road, Bronx, New York 10461
- Email: 928notice@affinityplan.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

Affinity Health Plan is required by law to protect the privacy of your health information, and to provide you with a Notice of Privacy Practice (NPP) that outlines your rights and our duties with respect to your information. A copy of Affinity Health Plan’s NPP can be found on our website at http://www.affinityplan.org or you can request a paper copy by calling our Customer Service Department at 1-866-247-5678 (TTY: 711).
<p>| ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-247-5678 TTY/TDD: 711. | English |
| 注意：您可以免費獲得語言援助服務。請致電 1-866-247-5678 TTY/TDD: 711. | Chinese |
| ملاحظة: خدمات اللغة متوفرة من خلال الرقم 1-866-247-5678 (TTY/TDD: 711). | Arabic |
| ВНИМАНИЕ: то вам доступны бесплатные услуги перевода. Звоните 1-866-247-5678 (телетайп: 711). | Russian |</p>
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How Managed Care Works

Affinity Health Plan is a managed care plan. That means that we make arrangements with doctors, hospitals and others to provide our Members with high quality health services. We make sure the doctors you use are licensed and well-trained. We help you and your child’s doctor find the services your child needs. We send you information and answer your questions.

Affinity Health Plan covers all of the services provided under the Child Health Plus program. That means we are responsible for making sure that your child gets all the health services he or she needs. It also means that we pay for those services. A list of the services we cover is in Part II of this Handbook.

We have carefully selected a group of health care providers to help us meet your child’s needs. These doctors, hospitals, community health centers, labs and other health care facilities make up our “provider network.” You’ll find a list in our Provider Directory. If you don’t have our Provider Directory, call our Customer Service Department toll-free at 1-866-247-5678 to get a copy.

An important part of our managed care program is the “Primary Care Provider”…the PCP. When you joined Affinity Health Plan, you should have chosen a doctor or nurse practitioner from our provider network to be your child’s PCP. The PCP is your child’s personal doctor who will help keep your child healthy and care for your child when he or she is ill. The PCP will arrange for your child to have lab tests and X-rays, see a specialist, or go into the hospital, if needed. We work closely with the PCP to make sure your child receives high quality care.

Your child’s PCP is available by phone every day, 24 hours a day. You should call the PCP’s office to make appointments for regular care. If you need to speak to your child’s PCP when the office is closed, leave a message with the answering service explaining how you can be reached. The PCP, or another doctor or nurse who works with the PCP, will get back to you as soon as possible.

Even though the PCP is your child’s main source for health care services, in some cases, you can “self-refer” to a different doctor for specific services. This is explained in Part II of this Handbook, in the section called “Services That You Can Get Without a Referral.”
How to Use this Handbook

This Handbook explains how to use Affinity Health Plan. Parts I and II tell you what you need to know now. The rest of the Handbook gives you additional information. Read the whole Handbook now or check it out a bit at a time.

Need Help?

Our Customer Service Representatives are available by phone...

Monday through Friday
from 8:30 a.m. to 6:00 p.m.

toll-free at 1-866-247-5678

If you have hearing or speech problems, you can reach us, 24 hours a day, 7 days a week, at no charge to you. The toll-free numbers to call are:

- TTY users: 1-800-662-1220

Also, if you have hearing or speech problems, the Verizon Center for Customers with Disabilities has several products that may help you contact our Customer Service Department. These products include:

- weak speech handsets that increase the volume of a speaker’s voice;
- impaired hearing handsets that increase the volume heard through the telephone;
- high gain volume control handsets that amplify the calling person’s voice; and
- artificial larynx (voicebox) for people who cannot speak.

If you do not speak English, we can help. Call Customer Service, and we will find a way to talk to you in your own language. We will also help you find a doctor who speaks your language.
PART II:

YOUR PCP (PRIMARY CARE PROVIDER) AND HOW TO GET CARE

Your Identification Cards
Your child will have an Affinity Health Plan ID card that you should take with you when you take your child anywhere for medical care. Your child will also have another ID card to use for dental care.

The Affinity Health Plan ID Card shows your child’s name, ID number, date of birth, the name and phone number of your child’s Health Center or doctor’s office, and the name of your child’s PCP. Check this card carefully. Call our Customer Service Department if you find errors on the ID card or if you lose it. Carry the Affinity Health Plan ID card with you at all times, and show it every time you take your child for medical services.

If your child’s PCP works in a Health Center, your child will also get a Health Center ID Card when you register there. Your child’s medical record number is on this card. Give the card to the person at the desk when you take your child to the Health Center for care. Also, tell the receptionist your child’s Health Center ID number when you call for an appointment.

How to Choose Your PCP
Affinity Health Plan offers you a choice of hundreds of doctors and nurse practitioners to be your child’s PCP. Some of our PCPs work in private offices. Others work in neighborhood group practices, hospital-based practices, or Federally-Qualified Community Health Centers known as FQHCs.

FQHCs are neighborhood health centers that are approved by the Federal Government. In addition to PCPs, some FQHCs have physician specialists, dentists, social workers, labs, X-rays, and other types of services in the same building. Some people prefer to get their care from FQHCs because the centers have a long history in the neighborhood. Some FQHCs provide many types of services under one roof. Contact Customer Service toll-free at 1-866-247-5678 if you would like help finding an FQHC near your home.

Doctors who are trained in Family Practice or Pediatrics provide primary care for children. Internal Medicine doctors treat mostly adults, but may also provide primary care for older teenagers. Some PCPs are Nurse Practitioners. These are nurses who are trained to provide health screenings, physical exams, and other medical services.

The choice is yours. If you need help deciding which PCP is right for your child, call our Customer Service Department toll-free at 1-866-247-5678. They will help you make your choice.

In addition to a PCP, women can choose one of our OB/GYN doctors for routine women’s services such as OB/GYN checkups and care during pregnancy.

You should have already chosen an Affinity Health Plan PCP for your child. If you did not choose a PCP, we chose one for your child who is located near where you live.
As a new Affinity Health Plan Member, your child may keep seeing his or her old non-Affinity doctor for up to 60 days from the effective date of enrollment. Your child can do this, however, only if needed to continue a treatment your child is getting for a life-threatening, degenerative or disabling condition. Also, if your child is four or more months pregnant when she joins Affinity Health Plan, she can keep seeing her old non-Affinity doctor for her pregnancy until after her baby is born and she has completed her follow up care.

To continue using a non-Affinity doctor, however, that doctor must agree to follow Affinity Health Plan rules, including rules about payment, quality of care and reporting. Affinity Health Plan will only pay for services that we would pay for if the doctor were in our provider network.

**Changing Your Child’s PCP or Specialist**

Sometimes, you may need to choose a different PCP for your child. For example, your PCP may move to a new location that is not convenient for you. Or, you may just want to try a different PCP for personal reasons. That’s OK. You can change your child’s PCP at any time. We do not limit the number of times you can change.

If you want to choose another PCP for your child, here is what you should do.

1. Call Customer Service toll-free at 1-866-247-5678 and ask for help in choosing a PCP. The Representative can either send you a list of PCPs in the mail, or explain your choices over the phone. The list of PCPs includes information on where they are located and how you can get there by bus or train, what languages they speak, their telephone and fax numbers, and their office hours.

2. If you choose a PCP who your child is not already using, first make sure that PCP is taking new patients. You can find this out either from Customer Service or by calling the PCP’s office. If the PCP is not taking new patients, you will have to choose another PCP.

3. Make sure you let Customer Service know which PCP you chose for your child. If the PCP has more than one office, make sure to tell Customer Service which office you want to use.

4. The change to your child’s new PCP will take place on the first day of the next month.

5. If your child is a new patient for the PCP, call the PCP’s office to make an appointment for a “new patient visit” or a “baseline physical examination” for your child. You should do this as soon as possible, even if your child is not sick, so you, your child and the PCP can begin to get to know one another. Be sure to let the office know that you chose the PCP through Affinity Health Plan.

What happens if your child’s doctor leaves Affinity Health Plan? Within 15 days after we learn that the doctor is leaving, we will let you know so you can choose another PCP from our provider network. If your child is being treated by that doctor for a condition, your child can continue to use that doctor for up to 90 days before you have to select a new Affinity Health Plan doctor. If your child is three or more months pregnant, she can keep seeing that doctor for her pregnancy until after her baby is born and she has completed her follow up care.

To continue using a non-Affinity doctor, however, that doctor must agree to follow Affinity Health Plan rules, including rules about payment, quality of care and reporting. Affinity Health Plan will only pay for services that we would normally pay if the doctor were not leaving our provider network. If you think a specialist your child is using does not meet your child’s needs, talk to your child’s PCP. The PCP can choose another specialist for your child from our large provider network.
**You and Your Child’s PCP**

Your child's PCP will begin taking care of your child by making a record of his or her health history. The health history includes information on illnesses and injuries, hospital stays, allergies and medications your child uses. The PCP will also want to know about your family health history and your child’s health habits such as exercise and smoking. These facts help the doctor know you and your child better. The PCP will also want to hear any questions you may have about your child’s health.

In addition to our PCPs, our provider network includes doctors in every type of specialty. The PCP knows your child’s health history best, and will refer your child to one of these specialists if your child needs specialty care. If your child needs a type of doctor that we do not have in our provider network, we’ll find one for you...and we will pay the bill. There are a few special treatments and services that your PCP must ask Affinity Health Plan to approve before your child can get them. Your PCP will be able to tell you what they are.

All this works well for most Affinity Health Plan Members, but some may have serious long-term illnesses that require ongoing specialty care. These Members do not have to get a referral from their PCP each time they need to see a specialist. Instead, their PCP can give them a “standing referral.” In some cases, the specialist will even take over as the PCP. If your child has a long-term disease or a disabling illness that gets worse over time, the PCP may also be able to arrange for a referral to a specialty care center that deals with the treatment of that problem.

**Visiting Your PCP or Specialist**

If possible, always call the doctor's office to make an appointment. If you need help making an appointment, call Customer Service toll-free at 1-866-247-5678. Also, always bring your child's Affinity Health Plan ID card with you to your child’s doctors’ appointments.

When you call the doctor's office, tell the person who answers the phone:

- that your child is an Affinity Health Plan Member,
- your child's name,
- your child's doctor's name,
- why your child needs to see the doctor, and
- your child's Affinity Health Plan ID number.

**Always call to cancel if you cannot keep an appointment.** You can reschedule your child's appointment for another time. When you cancel, you are doing a favor for someone else because it lets the doctor use your cancelled appointment to see another patient.

**Types of Office Visits**

The type of visit you schedule with your PCP or specialist is defined by the type of service you need. In general, your care must be “medically necessary.” That means the services you get must be needed:

- to prevent, diagnose and correct a condition that could cause more suffering, or
- to deal with a danger to your child’s life, or
- to deal with a problem that could cause illness, or
- to deal with something that could limit your child’s normal activities.

“Baseline physical” or routine “new patient visit”: As soon as your child joins Affinity Health Plan, make an appointment for a baseline physical or a new patient visit. This gives the PCP a chance to start your child’s medical record when your child is not sick. It is the best time to discuss your child’s health history, and to get to know the PCP. Your child may have lab tests done or get prescriptions refilled. If your child is already on medications, bring the prescriptions with
you to show to the PCP. Since this is not an urgent visit, the appointment may be scheduled up to 12 weeks after you call for the appointment.

**Routine visits:** This is care you can plan on, and for which your child does not need to see a doctor right away. Examples include physical exams for school or work, flu shots, immunizations, or follow-up exams. The PCP should be able to give your child an appointment for a routine visit within 4 weeks of your request.

**Non-urgent sick visits:** These are visits for minor illnesses that are not urgent. Examples are a sore throat or minor injury. Although your child may be uncomfortable, he or she does not have to be seen right away. You should be able to get an appointment or a non-urgent sick visit within 3 days of your call.

**Urgent care:** An urgent problem is not an emergency, but it is a problem that needs attention within 24 hours. Examples include persistent low-grade fever, discharge, itching or persistent mild pain. When you call for an urgent appointment, tell the person you talk to about your child’s symptoms. If the PCP is not available, you will be given an appointment within 24 hours with another doctor, nurse practitioner or physician’s assistant who works with your child’s PCP.

**First family planning visit:** Family planning visits are visits with the PCP or OB-GYN doctor to discuss reproductive health, for example, birth control. You should be able to schedule the first family planning visit within 2 weeks of your request.

**Prenatal visits:** Prenatal visits are the care women receive from their PCP, OB/GYN doctor or midwife during pregnancy. Early prenatal care is important for the health of both the new mother and her baby. Women should make an appointment for their first prenatal visit as soon as they find out that they are pregnant. If the woman is less than 3 months pregnant when she makes that first appointment, she should be able to schedule the first prenatal visit within 3 weeks of request. If the woman is between 3 months and 6 months pregnant, her first visit will be within 2 weeks after her request. If the woman is over 6 months pregnant when she begins prenatal care, her first visit will be scheduled within 1 week of her request.

Pregnant women should follow the instructions they receive from the PCP, OB/GYN doctor or midwife, and make sure they go to all of their prenatal appointments.

Call the Affinity Health Plan Maternity Case Manager or Customer Service toll-free at 1-866-247-5678 if you need any help arranging pregnancy care.

**Post-partum visit:** The post-partum visit is the care women receive after giving birth. Even if she is feeling strong and well, the new mother should go to her PCP, OB/GYN doctor or midwife for a post-partum check-up. She should call…either at the end of her pregnancy or right after the baby is born…to schedule her post-partum visit. She should have her postpartum visit about 4 to 6 weeks after having the baby.

**Follow-up after a mental health or substance abuse ER visit or hospital stay:** If your child has an emergency room visit or a hospital stay for a mental health or substance (alcohol or drug) abuse problem, you should schedule a follow-up visit with your child’s PCP, specialist or mental health provider within 5 days after the ER visit or discharge from the hospital.

**Non-urgent mental health or substance abuse visit:** These are routine visits for which you do not need to see your PCP or mental health provider right away. You should be able to schedule a non-urgent visit within 2 weeks of your request.
Getting Referrals for Specialty Care

Your child’s PCP will refer your child to a specialist when your child needs a provider with special training and experience in a particular field of medicine. Examples are doctors with special training in heart disease, cancer or surgery. Most of these specialists are Affinity Health Plan providers. If we do not have a specialist in our provider network who can give your child the care he or she needs, we will get you one from outside the network.

Talk with your child’s PCP about how referrals work. The PCP may give you a referral form to bring with you when you take your child to see the specialist. Also, there are a few treatments and services that the PCP must get Affinity Health Plan to approve before your child can get them. The PCP will tell you what they are.

• If your child needs to see a specialist for ongoing care, the PCP may refer your child for a specific number of visits or length of time. If your child has a “standing referral”, you will not need a new referral each time your child goes to the specialist.
• If your child has a long-term disease or a disabling illness that gets worse over time, the PCP may arrange for a specialist to act as your child’s PCP, or the PCP may refer your child to a specialty care center that deals with the treatment of his or her problem.

Services That You Can Get Without a Referral

Although your child will need a referral from the PCP for most specialty services, there are some services that you can schedule for your child without a PCP referral. These are called “self-referred” services. You do not need a referral form from your child’s PCP for these services.

→ Women’s health services: Most Affinity Health Plan PCPs provide women’s health services. If preferred, however, your child may go to an Affinity Health Plan specialist without a PCP referral for:
  • care by an OB/GYN doctor or nurse-midwife for pregnancy;
  • OB/GYN services when not pregnant;
  • family planning services, for example, birth control; and
  • breast or pelvic exams, including pap smears.

→ Family planning: Most Affinity Health Plan PCPs provide family planning services. If preferred, however, your child may go to an Affinity Health Plan family planning specialist without a PCP referral for:
  • advice about birth control;
  • pregnancy tests,
  • sterilization, and
  • abortion.

During these visits, your child can also get tested for sexually transmitted diseases, HIV, and breast or cervical cancer (Pap smears). Call our Customer Service Department toll-free at 1-866-247-5678 if your child needs help finding a family planning provider.

HIV testing and counseling: Your child can get HIV testing and counseling during a family planning visit. Your child does not need a referral from the PCP for this service.

The PCP can also arrange for your child to receive HIV testing and counseling without a family planning visit. If you prefer to get HIV testing and counseling without going to the PCP, your child can visit an anonymous HIV testing and counseling site. For information on the location of these sites, call the NYS HIV Counseling Hotline toll-free at 1-800-872-2777 or 1-800-541-AIDS.
If your child needs HIV treatment after the testing and counseling service, the PCP can help your child get that care.

**Eye care:** Affinity Health Plan works with Superior Vision to provide vision services. Your child does not need a referral from his or her PCP for an eye exam or to get new glasses or to have glasses repaired. Instead, you can go directly to one of our vision network providers for these services.

Our vision network providers are listed in the Affinity Health Plan Provider Directory. You can also find a vision provider near where you live by calling Superior Vision toll-free at 1-800-428-8789.

If your child breaks his or her glasses, they can be repaired. Lost eyeglasses or broken eyeglasses that can’t be fixed will be replaced with the same prescription and style of frames.

The only time you need a referral from the PCP for eye care is if your child needs care from a physician specialist (an ophthalmologist) for an eye disease or defect.

**Mental health and alcohol or drug abuse services:** Affinity Health Plan works with Beacon Health Strategies to provide mental health and substance abuse services. Your child may receive 1 mental health visit and 1 alcohol or drug abuse assessment visit without a PCP referral in any 12-month period. You must, however, use mental health or substance abuse providers who participate in Beacon Health Strategies.

To find mental health, alcohol or drug abuse services, look in your Provider Directory, or call Beacon Health Strategies toll-free at 1-800-974-6831, or ask your child’s PCP. If your child needs additional visits, you or your mental health/substance abuse provider should contact Beacon Health Strategies.

**Dental care:** Affinity Health Plan works with HealthPlex to provide dental services. When your child joined Affinity Health Plan, either you chose a dentist or we assigned a dentist to your child. You do not need a referral from the PCP for your child to go to the dentist. To find a dentist or change dentists call HealthPlex toll-free at 1-800-468-0608 or 1-800-468-9868.

**What to Do When Your Doctor’s Office is Closed**

Medical problems can happen when you least expect them — day or night — even when the doctor’s office is closed. There is always a doctor on call to help you. You can call 24 hours a day, seven days a week. The office telephone number for your child’s PCP is printed on your child’s Affinity Health Plan ID card.

When you call, tell the operator:
- your child’s name
- the name of your child’s PCP or Health Center
- your child’s Affinity Health Plan ID number, and
- the reason for your call.

A doctor or nurse will return your call within an hour — sooner if the problem is urgent. The doctor or nurse may be able to give you medical advice over the phone or may tell you to bring your child to the doctor’s office the next day. If the problem is serious, the doctor or nurse may tell you to take your child to a nearby hospital emergency room.
What to Do in an Emergency

To go to the ER or not to go? It is sometimes hard to know!

A real emergency is an illness or injury that happens suddenly, and makes you fear death or permanent damage if you do not get medical help right away. In a real emergency, call 911 or go to the nearest hospital emergency room. When possible, you, a friend or a family member should call either your child’s PCP or Affinity Health Plan toll-free at 1-866-247-5678 to report your child’s ER visit. Our phone is answered 24 hours a day, seven days a week. We can arrange for follow up care.

The official definition of a real emergency is “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 affected with such condition in serious jeopardy, or, in the case of a behavioral condition, placing the health of the person or others in jeopardy; or
- serious impairment to such person’s bodily functions; or
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.”

Examples of real emergencies include if a person:

- has passed out and you can’t bring them around,
- is having a great deal of trouble breathing,
- is having a convulsion,
- is bleeding a lot and the bleeding won’t stop,
- is having symptoms of a stroke (suddenly can’t walk or speak, decreased movement on one side of the body)
- is badly burned,
- is threatening harm to himself/herself or suicide, or
- is threatening harm to others.

In cases like these, call 911 or go to the nearest hospital ER as soon as you can, anytime of the day or night. You do not have to call Affinity Health Plan or your child’s PCP first.

Bring your child’s Affinity Health Plan ID card with you to show the ER. Then call Affinity Health Plan...the phone number is on the front of the ID card. If you can’t make the call yourself, ask the person at the desk to call the PCP or Affinity Health Plan. When the emergency is over, make an appointment for your child to see his or her PCP for a follow-up visit. Do this even if the ER staff tells you to check back with their clinic at the hospital.

If your child has a real emergency when he or she is out of town, he or she should go to the nearest ER. Have the person at the desk call Affinity Health Plan. We will tell the hospital how to bill us for the visit.

Again, be sure you use the hospital emergency room only for real emergencies. Many other problems can worry you or cause your child to feel sick, but they can be handled better by your child’s PCP because the PCP knows about your child’s health. Conditions like a cold, flu, diarrhea, earache or a low-grade fever are not emergencies. For these, call your child’s PCP to make an appointment. Long waits in an emergency room are no fun, especially if you don’t really have to be there!
PART III:

YOUR BENEFITS AND PLAN PROCEDURES

Services Covered by Affinity Health Plan

Affinity Health Plan covers all services that are “medically necessary.” This means that we cover all medical care and supplies that Affinity Health Plan and your child’s doctor think your child must have either to prevent illness or treat your child when he or she is ill or injured. We use accepted professional rules to decide what is “medically necessary.”

The following is a list of the services covered by Affinity’s Child Health Plus program. Complete details are in your Child Health Plus Subscriber Contract. Your child can get many services right in the PCP’s office. There are other services that the PCP can order for your child.

Medical and Related Services

- PCP visits for regular check-ups, shots, and treatment of illness and injury
- Physician specialty services including surgery
- Prescriptions drugs and over-the-counter medicines (for example, aspirin) for which you have a prescription
- Maternity care, including prenatal, delivery and post-partum services
- Inpatient hospital care for medical or surgical conditions
- X-rays and lab tests
- Hearing exams and hearing aids
- Eye exams, and eyeglasses or contact lenses, if medically necessary
- Occupational, physical and speech therapy
- Limited home care visits, when used as an alternative to hospitalization
- Limited inpatient and outpatient mental health services, and treatment for alcohol and substance abuse
- Foot care (podiatry) for special health care needs such as diabetes
- Medical equipment, including prosthetics (for example, artificial limbs) and orthotics
- Family planning and reproductive services (for example, birth control advice and services)
- Dental services, except orthodontia
- Ambulance services for evaluation and treatment of an emergency condition, and transportation to a hospital.

Other Covered Services

- A doctor or nurse to call, 24 hours a day, seven days a week for advice or help.
- Affinity Health Plan Customer Service staff to provide information, answer your questions, help you make doctors’ appointments, and respond to your complaints.
- Affinity Health Plan Nurse Case Managers to work with you and your doctor in getting the services that your child may need.
- Free health education workshops on a wide variety of health and wellness topics.
- Our quarterly Member Newsletter, Healthy Streets, filled with interesting articles on health and wellness.
**Services for People with Disabilities**
If your child is in a wheelchair, is blind or has trouble hearing, call our Customer Service Department if you need extra help. We can tell you if a particular doctor’s office is wheelchair accessible or is equipped with communications devices for people who are blind or deaf.

**Call Customer Service if you need:**
- information in large print; or
- help in making appointments; or
- case management services for a complicated health problem; or
- the names and addresses of doctors who specialize in your child’s condition.

**Services Not Covered by Affinity Health Plan**
Affinity Health Plan does not cover the following services. If you get any of these services, you will have to pay the bill.
- Cosmetic surgery (this is surgery to improve appearance that is not needed for a medical condition)
- Regular foot care
- Personal and comfort items such as air conditioners and electric blankets
- Infertility treatments
- Orthodontia
- Services from a provider who is not in the Affinity Health Plan provider network, unless 1) we give approval, in advance, for that service, or 2) your child has a real emergency and has to go to a hospital emergency room that is not in our network.
- Services that were not ordered by an Affinity Health Plan PCP or specialist, except for 1) maternity and other women’s services, 2) your child’s first visit for mental health or substance abuse services, 3) eye exams, and 4) dental care.
- Nursing home and other long-term care, including hospice services.
- Non-emergency transportation.

**Checking Our Decisions (Utilization Review)**
Affinity Health Plan has a team of doctors and nurses who make sure that the treatment your child receives...or treatments that have been recommended for your child...are medically necessary and right for your child’s condition. They do this by checking your child’s treatment plan against medically accepted standards. This is called “Utilization Review”. Utilization review will occur whenever judgments are made about medical necessity or experimental services.

Our Utilization Review staff may review your child’s past care (we call this “retrospective review”), care that you are seeking (we call this “prior approval or prospective review”), or care that your child is now getting and want to continue to receive (we call this “concurrent review”). You, your legal designee (for example, a family member or friend who you have asked to represent you) or your child’s doctor can ask us to review our decision about a specific service. If you want to know the outcome of a review, call Customer Service at 1-866-247-5678 and ask for Utilization Review.

We have deadlines for completing that review. After the review has been completed and the service is not approved and you still want to go ahead with the service, you, your designee or your child’s doctor can ask for an appeal. We must respond to your appeal. Our failure to make a timely decision has the same effect as a denial. Therefore, if we don’t give you a decision in the allowed time, you can ask for an appeal.
You or your child's doctor must get Utilization Review approval from Affinity Health Plan before receiving certain services. Those treatments and services are:

- elective admissions (non-emergency admissions)
- home health visits
- organ transplants and pre-transplant evaluations
- out-of-network referrals
- durable medical equipment
- prosthetics
- physical, occupational and speech therapies
- cardiac rehabilitation services
- contact lenses (call Superior Vision at 1-800-243-1401)
- cardiac catheterization
- nutritional supplements (call CareMark at 1-855-465-0031)
- hospice care
- prescriptions for the following drugs: (check if on formulary)
  
  Synagis  
  Lupron  
  Botox  
  Non-Formulary drugs  
  Growth Hormone  
  Viagra  
  Monarch-M

To get approval for these treatments or services, you need to do the following:

→ Your child's PCP or specialist must give us information explaining why your child needs the requested service. The PCP or specialist can call our Utilization Department at 1-866-247-5678 or fax the information to us at (718) 794-7822. We will decide whether or not to approve the service within 3 workdays after we get that information. We will let you or your designee and your child's doctor know our decision by telephone and in writing.

→ If your child is getting care or treatment that the doctor thinks should continue, or if your child's doctor thinks your child needs more services, we will review the request and make our decision within 1 workday after we get the information we need. We will let your or designee and your child's doctor know whether or not we approve the request by telephone and in writing.

→ If we are checking on care that your child has already received, we will decide whether or not to approve payment within 30 days of the request.

→ Your child's doctor may ask to speak to our Medical Director about the requested service and our decision. The Medical Director will talk to your child's doctor within 1 workday of your doctor's call. If we do not approve your request, we will tell you the reason in writing, and we will tell you or your designee and your child's doctor how you can appeal our decision. We will explain your options for asking for an appeal from us or from the State.

**Utilization Review Appeals**

→ Your child's doctor, or someone else who you trust, can appeal our Utilization Review decision.

→ There are 2 kinds of Utilization Review appeals: “fast track” and “standard.”

→ Use fast track appeals when:
  
  • you need an OK to continue health services your child is already getting; or
  • your child needs more services added to those he or she is getting; or
  • your child's doctor thinks we should look at the request again right away.

→ Use a standard appeal if your child does not have an urgent need for the service you are requesting. To use a standard appeal:
  
  • you must file the appeal (by phone or in writing) within 45 days of getting our decision;
  • within 15 days, we will send you a letter to let you know we are working on it;
  • after we get the information we need, we will decide within 60 days, and tell you and/or
  • your child’s doctor within two days of making our decision.
If we do not make a decision within the 60 days, we will allow you to get the service that you or your child’s doctor asked for.

If we deny your appeal, we will tell you why in writing.

People with qualified clinical training consider your appeal. If you are still not satisfied, however, we will tell you how to make further appeals, including how to use the external appeal process.

**External Appeal**

If Affinity Health Plan decides to deny coverage for a medical service because we think it is not medically necessary, you can submit an application for external appeal to the New York State Insurance Department. The service you are appealing, however, must be either a Covered Service that was ordered by your child’s doctor or an experimental treatment.

When you ask the State for an appeal, it is called an “External Appeal” because it is reviewed and decided by clinicians who do not work for Affinity Health Plan or the State. These reviewers are qualified people who are approved by New York State. You do not have to pay for an External Appeal.

To appeal to the State, you must first complete the Utilization Review appeal process described above. You have forty-five (45) days after you receive our final decision from the Utilization Review appeal process to ask for an External Appeal. If you and Affinity Health Plan agree to skip our Utilization Review appeals process, you must ask for the External Appeal within forty-five (45) days.

Additional appeals to Affinity Health Plan may be available to you if you want to use them. However, if you want an External Appeal, you must still file the application with the State Insurance Department within forty-five (45) days from the time we give you notice that we did not approve the service you requested through our Utilization Review process.

**You will lose your right to an External Appeal if you do not file an application for an External Appeal within forty-five (45) days after you receive notice of our decision on your Utilization Review appeal.**

To ask for an External Appeal, fill out an application and send it to the State Insurance Department. You and your child’s doctors will have to give information about your child’s medical condition. You can get the application by contacting:

- the NYS Insurance Department toll-free at 1-800-400-8882 or www.ins.state.ny.us, or
- the NYS Department of Health’s web site at www.health.state.ny.us, or
- our Customer Service Department toll-free at 1-866-247-5678.

Your External Appeal will be decided within thirty (30) workdays. More time (up to five (5) workdays) may be needed if the External Appeal reviewer needs additional information. You and Affinity Health Plan will be told the final decision within two days after the decision is made by the External Appeal reviewer.

You can get a faster decision if your child’s doctor says that a delay will cause serious harm to your health. This is called an “expedited appeal.” The External Appeal reviewer will decide an Expedited Appeal in three (3) days or less. The reviewer will tell you and Affinity Health Plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

The External Review decision is a final decision for Affinity Health Plan and for you.


**Complaints**

We hope Affinity Health Plan serves you and your child well. But, if you have a problem with our service or services your child receives from an Affinity Health Plan provider, we encourage you to call or write our Customer Service Department. We will do our best to solve any problem you may have with our program.

Most problems can be solved right away on the telephone. Those problems that are not solved right away over the telephone, and those complaints that we receive by mail will be handled according to our complaint procedure described below. You can ask someone you trust (like a legal representative, a family member or friend) to file the complaint for you. Our Customer Service Representatives can help you file your complaint if you have difficulty because of a hearing or vision impairment, or if you need translation services. We will not make things hard for you or take any action against you for filing a complaint.

**How to File a Complaint**

*To file a complaint by phone,* call Customer Service toll-free at 1-866-247-5678 anytime Monday through Friday from 8:30 a.m. to 6:00 p.m. If you call us when we are closed, leave a message. We will call you back the next workday. We will tell you if we need more information to make a decision.

If needed, we will ask you to sign a written statement of the complaint you made over the telephone. This puts the basic facts of your complaint on paper and makes your concerns clear. After your call, we will send you a form that states your complaint. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

*To file a complaint in writing,* either write us a letter or ask us for a complaint form to fill out. Mail your complaint form or letter to:

**Affinity Health Plan**  
**Customer Service Department**  
**Metro Center Atrium**  
**1776 Eastchester Road**  
**Bronx, NY 10461**

or

FAX the complaint to (718) 794-7800.

**What Happens Next?**

We will send you a letter within fifteen (15) workdays after we get your complaint. The letter will tell you:

- who is working on your complaint;
- how to contact that person; and
- any other information we may need to handle your complaint.

After we get all the information we need:

- we will call you with our decision within forty-eight (48) hours if a delay would risk your child’s health; then we will send you a letter in three (3) working days;
- if your complaint is about a referral or about covered services, we will send you our decision in writing within thirty (30) days;
- if it is any other type of complaint, we will send you our decision in writing within forty-five (45) days.

When we call or write you about what we decide, we will tell you the reasons for our decision. We will also tell you how to appeal our decision if you are not satisfied, and include any forms you need to fill out.

You may also file a complaint anytime by:

- calling the New York State Department of Health toll-free at 1-800-206-8125; or
- writing the NYS Department of Health, Bureau of Certification and Surveillance, ESP- Corning Tower, Albany, NY 12237.
**Complaint Appeals**

If you are not satisfied with our decision on your complaint, you have sixty (60) working days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you.

The appeal must be in writing. You can write a letter or use our complaint form. Call Customer Service toll-free at 1-866-247-5678 for help.

We will send you a letter within fifteen (15) working days after receiving your appeal. The letter will tell you:

- who is working on your appeal;
- how to contact that person; and
- if we need more information.

Your appeal will be decided these ways:

- Appeals on medical matters (for example, a complaint about a provider) will be decided by qualified health care professionals who did not work on your original complaint.
- Appeals that are not about medical matters will be decided by people who work for Affinity Health Plan at a higher level than those who worked on your original complaint.

After we get all the information we need:

- we will let you know our decision in two (2) working days if a delay would risk your child’s health;
- for all other appeals, we will let you know our decision within thirty (30) days.

We will give you the reasons for our decision.

If you are still not satisfied with our response, you can file a complaint by:

- calling the New York State Department of Health toll-free at 1-800-206-8125; or
- writing to the NYS Department of Health, Bureau of Certification and Surveillance, ESP – Corning Tower, Albany, NY 12237.

**Terms of Membership, Joining and Dropping Out of the Plan**

**Annual enrollment renewal:** Under State law, you must apply to renew your child’s enrollment every twelve months. At least three months before the renewal date, we will send you a form to complete. We will also ask for documents we need from you to decide if your child is still eligible for Child Health Plus coverage. Affinity Health Plan staff are available, by phone or in person, to help you complete the renewal application process.

**Choosing to drop out of Affinity Health Plan during the enrollment year:** If, for any reason, you decide to have your child drop out of Affinity Health Plan before the end of the enrollment year, you need to request “disenrollment.” Call our Customer Service Department toll-free at 1-866-247-5678 to get a disenrollment form. Fill out the form and mail it to Affinity Health Plan. It will take between two and six weeks to process, depending on when your request is received. You can ask for a faster disenrollment if you believe that the timing of the regular process will damage your child’s health.

**Losing Child Health Plus coverage:** There are several reasons why your child may have to drop out of Affinity Health Plan. A detailed explanation of these reasons is in your Child Health Plus Subscriber Contract. Briefly, the major reasons include:

- you are responsible for paying a portion of the monthly premium, and you fail to make payment on time;
- we determine that your child is no longer eligible for Child Health Plus;
- you do not complete the annual re-enrollment process;
• your child becomes eligible for Medicaid or Medicare;
• your child turns 19 years old;
• you move out of our service area;
• your child enters an institution such as a nursing home, jail, or Veterans’ Administration Hospital; or
• your child is placed in foster care.

We can ask you to drop out of Affinity Health Plan if you:
• frequently refuse to cooperate with your child’s doctor;
• frequently fail to keep your child’s doctors’ appointments and do not call to cancel;
• frequently take your child to the hospital emergency room for non-emergency care;
• constantly refuse to follow the rules of Affinity Health Plan; or
• give false information, use your child’s ID cards improperly or fraudulently, or submit false claims for payment.

Membership Rights and Responsibilities

Rights — As an Affinity Health Plan Subscriber, you have the right to . . .
• get quality health services for your child, with care and respect regardless of your race, color, religion, sex, age, country of origin, sexual orientation, physical or emotional state.
• receive information from your child’s PCP and other providers that is clear, complete and in your language about what is wrong and what can be done for your child.
• know what is to be done in any medical procedure, and have the chance to agree to it before anything is started.
• refuse treatment for your child when the law allows, and be told clearly what will happen if you do so.
• express your opinions to Affinity Health Plan staff, including any complaints you may have, and receive a thoughtful, helpful response.
• receive a copy of your child’s medical record and discuss it with your child’s doctor, have your child’s treatment and records kept private (except as the law or a contract may require.)
• make a written or spoken complaint to Affinity Health Plan at any time.
• appoint someone you trust to decide about your child’s treatment, if you are too sick to know what to do.
• be considered for Affinity Health Plan’s Member Advisory Board which helps decide Plan policies. To find out more about the Member Advisory Board, call Customer Service toll-free at 1-866-247-5678.

Responsibilities — As an Affinity Health Plan Subscriber, you are expected to:
• talk over your child’s health care needs with your child’s Affinity doctor and follow the treatment you both agree on.
• use the hospital emergency room only for the real emergencies that might cause death or permanent damage to your child.
• call your child’s PCP or Affinity Health Plan if your child needs care at night or on the weekend.
• let Affinity Health Plan staff know if your child’s rights have not been honored.
• keep your child’s appointments, or call to cancel if you know you won’t make it to an appointment.
• follow the rules in this Handbook.
• treat health care staff with the respect you expect yourself.
• notify Affinity Health Plan if . . .
Health Care Fraud Notice
Health care fraud affects us all and causes an increase in health care costs. If you suspect any person or company of defrauding or attempting to defraud Affinity Health Plan, please call us.

All calls are confidential and you may report your suspicions anonymously via our toll-free hotline at 1-888-528-1505, 24 hours a day, 7 days a week.

How does Affinity Health Plan pay providers? If your child’s PCP works in a Health Center, Affinity Health Plan pays that Health Center a fixed fee every month to take care of your child. The fee is the same whether your child uses the Health Center that month or not. The Center pays the PCP a salary. If your child’s PCP works in a private office, we pay the PCP a fixed fee every month to take care of your child. The fee is the same whether your child sees the PCP that month or not. We pay specialists for each visit your child makes. We pay hospitals a fee that is set by the State or that the hospital and Affinity Health Plan have agreed on.

Information You Can Request From Our Plan
By calling toll-free at 1-866-247-5678, you can ask us for the following written information.

• The people who run Affinity Health Plan, including a list of names, addresses, and titles of our Board of Directors and Officers.
• Affinity Health Plan money matters, including a copy of the most recent certified financial statements, balance sheets, and summary of income and expenses.
• Information from the State Insurance Department about consumer complaints filed against Affinity Health Plan.
• Information on how we protect your child’s privacy.
• How Affinity Health Plan is set up, and how we check on the quality of care your child receives from our providers.
• How we decide about coverage for experimental or investigational drugs, medical devices, or treatments in clinical trials.
• A directory of Affinity Health Plan participating providers and which hospitals Affinity Health Plan doctors work with.
• The professional guidelines we use to review conditions or diseases.
• Application procedures and minimum qualification requirements for health care providers who participate in our provider network.
• If you ask us, we will tell you:
  a) if our contracts or subcontracts include physician incentives that may affect the use of referral services; and, if so,
  b) the types of arrangements we use; and
  c) if stop-loss insurance protection is provided for physicians and physician groups.
How You Can Help with Affinity Health Plan Policies

We at Affinity Health Plan value your ideas. Please tell us if you have any ideas about how we could improve our services.

We also have a Member Advisory Board that gives us advice and helps us develop new policies. Call Customer Service toll-free at 1-866-247-5678 if you would like to work with the Member Advisory Board.
Child Health Plus
SUBSCRIBER CONTRACT
CHILD HEALTH PLUS
MODEL SUBSCRIBER CONTRACT

This is your Child Health Plus Contract with Affinity Health Plan. It entitles you to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

Notice of 10-Day Right to Examine Contract

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

IMPORTANT NOTICE

Except as stated in this Contract, all services must be provided, arranged or authorized by your Primary Care Physician (PCP). You must contact your PCP in advance in order to receive benefits, except for emergency care described in Section Five, for certain obstetric and gynecological care described in Section Four, vision care described in Section Eight, and except for dental care described in Section Nine of this Contract.
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1. **Child Health Plus Program** This Contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. We will enroll you in the Child Health Plus Program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. You and/or the responsible adult, as listed on the application, must report to us any change in residency or health care coverage that may make you ineligible for participation in Child Health Plus, within thirty (30) days of the change.

2. **Health Care Through an HMO** This contract provides coverage through an HMO. In an HMO, all care must be medically necessary and provided, arranged or authorized in advance by your PCP. Except for emergency care, for certain obstetric and gynecological services, and for vision and dental services there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when your PCP refers you to a non-participating provider.

   It is your responsibility to select a PCP from the list of PCPs when you enroll for this coverage. You may change your PCP for any reason by contacting us. The PCP you have chosen is referred to as “your PCP” throughout this Contract.

3. **Words We Use** Throughout this Contract, Affinity Health Plan will be referred to as “we”, “us” or “our”. The words “you”, “your” or “yours” refer to you, the child to whom this Contract is issued and who is named on the identification card.

4. **Definitions** The following definitions apply to this Contract:

   A. **Contract** means this document. It forms the legal agreement between you and us. Keep this Contract with your important papers so that it is available for your reference.

   B. **Emergency Condition** means 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 person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment of such person’s bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.

   C. **Emergency Services** means those physician and outpatient Hospital services necessary for treatment of an Emergency Condition.
D. **Hospital** means a facility defined in ARTICLE 28 of the Public Health Law which:

- is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USC 1395x[k]);
- is duly licensed by the agency responsible for licensing such hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education or rehabilitatory care.

E. **Medically Necessary** means health care and services that we determine are necessary to prevent, diagnose, manage or treat conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee’s capacity for normal activity, or threaten some significant handicap.

F. **Participating Hospital** means a hospital that has an agreement with us to provide covered services to our members.

G. **Participating Pharmacy** means a pharmacy that has an agreement with us to provide covered services to our members.

H. **Participating Physician** means a physician who has an agreement with us to provide covered services to our members.

I. **Participating Provider** means any participating physician, hospital, home health care agency, laboratory, pharmacy, or other entity that has an agreement with us to provide covered services to our members. We will not pay for health services from a non-participating provider except in an emergency or when your PCP sends you to that non-participating provider [with our approval].

J. **Primary Care Physician (PCP)** means the Participating Physician you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.

K. **Service Area** means the following counties: Bronx, Kings, Manhattan, Nassau, Queens, Richmond, Rockland, Suffolk, and Westchester.
SECTION TWO – WHO IS COVERED

1. **Who is Covered Under this Contract** You are covered under this Contract if you meet all of the following requirements:

   - You are younger than age 19.
   - You do not have other health care coverage.
   - You are not eligible for Medicaid.
   - You are a New York State resident and a resident of our Service Area.
   - Your parent or guardian is not a public employee with access to family health insurance coverage by a state health benefits plan and the state or public agency pays all or part of the cost of family coverage.
   - You are not an inmate of a public institution or a patient of an institution for mental diseases.

2. **Recertification** We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. Annually, you must resubmit an application to us so that we can determine whether you still meet the eligibility requirements. This process is called “recertification”. If more than one child in your family is currently covered by us, then the recertification date for all the children in your family covered by us will be the same. You must recertify once each year unless another child in your family applies for coverage with us after you are covered. If another child in your family applies for coverage with us, then all other children will be recertified when that child’s coverage is effective. Thereafter, all the children in your family covered by us will recertify once each year on the same date.

3. **Change in Circumstances** You must notify us of any changes to your residency or health care coverage that might make you ineligible for this contract. You must give us this notice within thirty (30) days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.
SECTION THREE – HOSPITAL BENEFITS

1. **Care In a Hospital** You are covered for medically necessary care as an inpatient in a Hospital if all the following conditions are met:

   A. Except if you are admitted to the Hospital in an Emergency or your PCP has arranged for your admission to a non-Participating Hospital, the Hospital must be a Participating Hospital.

   B. Except in an emergency, your admission is authorized in advance by your PCP.

   C. You must be a registered bed patient for the proper treatment of an illness, injury or condition that cannot be treated on an outpatient basis.

2. **Covered Inpatient Services** Covered inpatient services under this Contract include the following:

   A. Daily bed and board, including special diet and nutritional therapy;

   B. General, special and critical care nursing service, but not private duty nursing service;

   C. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;

   D. Oxygen and other inhalation therapeutic services and supplies;

   E. Drugs and medications that are not experimental;

   F. Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;

   G. Blood products, except when participation in a volunteer blood replacement program is available;

   H. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations;

   I. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;

   J. Facilities, services and supplies and equipment related to radiation and nuclear therapy;
K. Facilities, services, supplies and equipment related to emergency medical care;

L. Facilities, services, supplies and equipment related to mental health, substance abuse and alcohol abuse services;

M. Chemotherapy;

N. Radiation therapy; and

O. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.

3. **Maternity Care** Other than for perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a Caesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Caesarean Section. Maternity care coverage includes parent education, assistance and training in breast or bottle feeding and performance of necessary maternal and newborn clinical assessments.

You have the option to be discharged earlier than 48 hours (96 hours for Caesarean Section). If you choose an early discharge, we will pay for one home care visit if you ask us to within 48 hours of delivery (96 hours for a delivery by Caesarean Section). The home care visit will be delivered within 24 hours of the later of your discharge from the Hospital or your request for home care. The home care visit will be in addition to the home care visits covered under Section Seven of this Contract.

4. **Limitations and Exclusions**

A. We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not medically necessary.

B. Benefits are paid in full for a semi-private room. If you are in a private room at a Hospital, the difference between the cost of a private room and a semi-private room must be paid by you unless the private room is medically necessary and ordered by your physician.

C. We will not pay for non-medical items such as television rental or telephone charges.
SECTION FOUR – MEDICAL SERVICES

1. Your PCP Must Provide, Arrange or Authorize all Medical Services

Except in an emergency or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:

- Your PCP’s office.
- Another provider’s office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition.
- The outpatient department of a Hospital.
- As an inpatient in a Hospital, you are entitled to medical, surgical and anesthesia services.

2. Covered Medical Services. We will pay for the following medical services:

   A. General medical and specialist care, including consultations. Medically necessary curative services will continue to be covered while a child receives hospice care.

   B. Preventive health services and physical examinations. We will pay for preventive health services including:

   - Well child visits in accordance with the visitation schedule established by the American Academy of Pediatrics,
   - Nutrition education and counseling,
   - Hearing testing,
   - Medical social services,
   - Eye screening,
   - Routine immunizations in accordance with the Advisory Committee on Immunization Practices recommended immunization schedule,
   - Tuberculin testing,
   - Dental and developmental screening,
   - Clinical laboratory and radiological testing; and
   - Lead screening.

   C. Diagnosis and treatment of illness, injury or other conditions. We will pay for the diagnosis and treatment of illness or injury including:

   - Outpatient surgery performed in a provider’s office or at an ambulatory surgery center, including anesthesia services,
   - Laboratory tests, X-rays and other diagnostic procedures,
   - Renal dialysis,
   - Radiation therapy,
   - Chemotherapy,
   - Injections and medications administered in a physician’s office,
• Second surgical opinion from a board certified specialist,
• Second medical opinion provided by an appropriate specialist, including one affiliated with a specialty care center, where there has been a positive or negative diagnosis of cancer, or a recommendation of a course of treatment of cancer, and
• Medically necessary audiometric testing.

D. **Physical and Occupational Therapy** We will pay for physical and occupational therapy services likely to improve the underlying condition significantly after a relatively short-term. The therapy must be skilled therapy.

E. **Radiation Therapy, Chemotherapy and Hemodialysis** We will pay for radiation therapy and chemotherapy, including injections and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

F. **Obstetrical and Gynecological Services** including prenatal, labor and delivery and postpartum services are covered with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from a qualified Participating Provider of obstetric and gynecologic services. You may also receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:

• Up to two annual examinations for primary and preventive obstetric and gynecologic care; and
• Care required as a result of the annual examinations or as a result of an acute gynecological condition.

G. **Cervical Cancer Screening** If you are a female who is eighteen years old, we will pay for an annual cervical cancer screening, an annual pelvic examination, pap smear and evaluation of the pap smear. If you are a female under the age of eighteen years and are sexually active, we will pay for an annual pelvic examination, pap smear and evaluation of the pap smear. We will also pay for screening for sexually transmitted diseases.
SECTION FIVE – EMERGENCY CARE

1. **Hospital Emergency Room Visits** We will pay for Emergency Services provided in a Hospital emergency room. You may go directly to any emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval.

   If you go to the emergency room, you or someone on your behalf should notify us within 48 hours of your visit or as soon as it is reasonably possible. If the emergency room services rendered were not in treatment of an Emergency Condition as defined in Section One, the visit to the emergency room will not be covered.

2. **Emergency Hospital Admissions** If you are admitted to the Hospital you or someone on your behalf must notify us within 48 hours of your admission, or as soon as it is reasonably possible. If you are admitted to a non-Participating Hospital, we may require that you be moved to a Participating Hospital as soon as your condition permits.

3. **Prehospital Emergency Medical Services** We will pay for prehospital emergency medical services, including prompt evaluation and treatment for an emergency condition, and/or non-air-borne transportation of you to a hospital. Coverage for such transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.
SECTION SIX – MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE SERVICES

1. **Inpatient Mental Health and Substance Use Disorder Services** We will pay for inpatient mental health services and inpatient substance use disorder services when such services are provided in a facility that is:

   - Operated by the Office of Mental Health under section 7.17 of the Mental Hygiene Law;
   - Issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law; or
   - A general hospital as defined in Article 28 of the Public Health Law.

2. **Outpatient Visits for Treatment of Mental Health Conditions and for Treatment of Substance Use Disorder** We will pay for the outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if such visits are related to your mental health or substance use disorder treatment.

3. **Autism Spectrum Disorder** We will provide coverage for the following services when such services are prescribed or ordered by a participating network licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder (“autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS)):

   - Screening and Diagnosis. We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
   - Assistive Communication Devices. We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech generating devices. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will determine whether the device should be purchased or rented. We will not cover items, such as, but not limited to, laptops, desktops, or tablet computers. We will, however, cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member’s...
current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance. Prior approval of assistive communication devices is required. Refer to the prior approval procedures in this Contract.

- Behavioral health treatment. We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms. Our coverage of applied behavior analysis services is limited to six hundred eighty (680) hours of treatment per Member per Calendar Year.

- Psychiatric and Psychological care. We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

- Therapeutic care. We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.

- Pharmacy care. We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under this Contract. We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.
1. **Diabetic Equipment and Supplies** We will pay for the following equipment and supplies for the treatment of diabetes which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title 8 of the New York State Education Law:

- Blood glucose monitors
- Blood glucose monitors for visually impaired
- Data management systems
- Test strips for monitors and visual reading
- Urine test strips
- Injection aids
- Cartridges for visually impaired
- Insulin
- Syringes
- Insulin pumps and appurtenances thereto
- Insulin infusion devices
- Oral agents; and
- Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

2. **Diabetes Self Management Education** We will pay for diabetes self management education provided by your PCP or another Participating Provider.

   Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education is medically necessary as determined by us. We will also pay for home visits if medically necessary.

3. **Durable Medical Equipment, Prosthetic Appliances, and Orthotic Devices**

   A. **Durable Medical Equipment** We will pay for devices and equipment ordered by a participating provider, including equipment servicing, for the treatment of a specific medical condition. Covered durable medical equipment includes:

   - Canes
   - Crutches
   - Hospital beds and accessories
   - Oxygen and oxygen supplies
   - Pressure pads
   - Volume ventilators
   - Therapeutic ventilators
   - Nebulizers and other equipment for respiratory care
   - Traction equipment
   - Walkers, wheelchairs and accessories
   - Commode chairs and toilet rails
   - Apnea monitors
• Nutrition infusion pumps; and
• Ambulatory infusion pumps.

B. **Prosthetic Appliances** We will pay for appliances and devices ordered by a qualified practitioner which replace any missing part of the body, except that there is no coverage for cranial prostheses (i.e. wigs). Further, dental prostheses are excluded from coverage under this section, except those: (1) made necessary due to an accidental injury to sound, natural teeth and provided within twelve months of the accident and/or (2) needed in the treatment of a congenital abnormality or as part of reconstructive surgery.

C. **Orthotic Devices** We will pay for devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. There is no coverage for orthotic devices that are prescribed solely for use during sports.

4. **Prescription and Non-prescription Drugs**

A. **Scope of Coverage** We will pay for those FDA approved drugs which require a prescription and which are listed in our Child Health Plus formulary. We will pay for those non-prescription drugs which are authorized by a professional licensed to write prescriptions and which appear in the Medicaid drug formulary. We will also pay for medically necessary enteral formulas for the treatment of specific diseases and for modified solid food products used in the treatment of certain inherited diseases of amino acid and organic acid metabolism.

B. **Participating Pharmacy** We will only pay for prescription drugs and non-prescription drugs for use outside of a Hospital. Except in an emergency, the prescription must be issued by a Participating Provider and filled at a Participating Pharmacy.

C. **Exclusions and Limitations** Under this Section we will not pay for the following:

• Administration or injection of any drugs.
• Replacement of lost or stolen prescriptions.
• Prescribed drugs used for cosmetic purposes only, unless medically necessary.
• Experimental or investigational drugs, unless recommended by an external appeal agent.
• Nutritional supplements taken electively.
• Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications:
  - The American Hospital Formulary Service-Drug Information
  - National Comprehensive Cancer Networks Drugs and Biologics Compendium
  - Thompson Micromedex Drug Dex
- Elsevier Gold Standard’s Clinical Pharmacology
- Authoritative compendia identified by the Federal Secretary of Health and Human Services or by the Centers for Medicare and Medicaid Services (CMS) or recommended by a review article or editorial comment in a major peer reviewed professional journal.
  - Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.
  - Prescribed drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
  - Prescribed drugs used for the purpose of treating erectile dysfunction.

5. **Home Health Care** We will pay for up to forty (40) visits per calendar year for home health care provided by a licensed or certified home health agency that is a Participating Provider. We will pay for home health care only if you would have to be admitted to a Hospital if home care was not provided.

Home care includes one or more of the following services:

  - part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;
  - part-time or intermittent home health aide services which consist primarily of caring for the patient;
  - physical, occupational or speech therapy if provided by the home health agency; and
  - medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered if the covered person had been in a Hospital.

6. **Preadmission Testing** We will pay for preadmission testing when performed at the Hospital where surgery is scheduled to take place, if:

  - reservations for a Hospital bed and for an operating room at that Hospital have been made, prior to performance of tests;
  - your physician has ordered the tests; and
  - surgery actually takes place within seven days of such preadmission tests.

If surgery is canceled because of the preadmission test findings, we will still cover the cost of these tests.

7. **Speech and Hearing** We will pay for speech and hearing services, including hearing aids, hearing aid batteries, and repairs. These services include one hearing examination per year to determine the need for corrective action. Speech therapy required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy, will be covered when performed by an audiologist, language pathologist, a speech therapist, and/or otolaryngologist.
SECTION EIGHT – VISION CARE

1. **Emergency, Preventive and Routine Vision Care** We will pay for emergency, preventive, and routine vision care. You do not need your PCP’s authorization for covered vision care if you seek such care from a qualified Participating Provider of vision care services.

2. **Vision Examinations** We will pay for vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to:

   - Case history;
   - External examination of the eye or internal examination of the eye
   - Ophthalmoscopic exam
   - Determination of refractive status
   - Binocular distance
   - Tonometry tests for glaucoma
   - Gross visual fields and color vision testing
   - Summary findings and recommendation for corrective lenses

3. **Prescribed Lenses** We will pay for quality standard prescription lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

4. **Frames** We will pay for standard frames adequate to hold lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation.

   If medically warranted, more than one pair of glasses will be covered.

5. **Contact Lenses** We will pay for contact lenses only when deemed medically necessary.
1. **Dental Care**  We will pay for the dental care services set forth in this contract when you seek care from a qualified Participating Provider of dental services.

2. **Emergency Dental Care**  We will pay for emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

3. **Preventive Dental Care**  We will pay for preventive dental care, which includes procedures which help to prevent oral disease from occurring, including:

   - Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
   - Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
   - Sealants on unrestored permanent molar teeth.

4. **Routine Dental Care**  We will pay for routine dental care, including:

   - Dental examinations, visits and consultations covered once within a six (6) month consecutive period (when primary teeth erupt);
   - X-ray, full mouth X-rays at thirty-six (36) month intervals if necessary, bitewing X-rays at six (6) to twelve (12) month intervals, or panoramic X-rays at thirty-six (36) month intervals if necessary, and other X-rays as required (once primary teeth erupt);
   - All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care;
   - In-office conscious sedation;
   - Amalgam, composite restorations and stainless steel crowns; and
   - Other restorative materials appropriate for children.

5. **Endodontics**  We will pay for endodontic services, including all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

6. **Periodontics**  We will pay for periodontal services, except for those services in anticipation of, or leading to, orthodontia.

7. **Prosthodontics**  We will pay for prosthodontic services as follows:

   - Removable complete or partial dentures, including six (6) months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate;
   - Fixed bridges are not covered unless they are required:
     - For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth;
     - For cleft-palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

- Unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
SECTION TEN – ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When a Specialist Can be Your PCP** If you have a life threatening condition or disease or a degenerative and disabling condition or disease, you may ask that a specialist who is a Participating Provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.

2. **Standing Referral to a Network Specialist** If you need ongoing specialty care, you may receive a “standing referral”, to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether a “standing referral” would be appropriate in your situation.

3. **Standing Referral to a Specialty Care Center** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease you may request a standing referral to a specialty care center that is a Participating Provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.

4. **When Your Provider Leaves the Network** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to ninety (90) days after you are notified by us of the provider’s leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former provider through delivery and postpartum care directly related to the delivery.

   However, in order for you to continue care for up to ninety (90) days or through a pregnancy with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.

5. **When New Members Are In a Course of Treatment** If you are in a course of treatment with a non-Participating Provider when you enroll with us, you may be able to receive care from the non-Participating Provider for up to sixty (60) days from the date you become covered under this Contract. The course of treatment must be for a life threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract.

   You may continue care through delivery and any post-partum services directly related to the delivery.

   However, in order for you to continue care for up to sixty (60) days or through pregnancy, the non-Participating Provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.
In addition to the limitations and exclusions already described, we will not pay for the following:

1. **Care That is Not Medically Necessary** You are not entitled to benefits for any service, supply, test or treatment which is not Medically Necessary or appropriate for the diagnosis or treatment of your illness, injury or condition (See Sections Fifteen and Sixteen).

2. **Accepted Medical Practice** You are not entitled to services which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.

3. **Care Which Is Not Provided, Authorized or Arranged by Your PCP** Except as otherwise set forth in this Contract, you are entitled to benefits for services only when provided, authorized, or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.

4. **Inpatient services in a nursing home, rehabilitation facility, or any other facility not expressly covered by this Contract.**

5. **Physician services while an inpatient of a nursing home, rehabilitation facility or any other facility not expressly covered by this Contract.**

6. **Experimental or investigitional services, unless recommended by an external appeal agent.** (See Section Sixteen.)

7. **Cosmetic Surgery** We will not pay for cosmetic surgery, unless medically necessary, except that we will pay for reconstructive surgery:
   - When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or
   - When required to correct a functional defect resulting from congenital disease or anomaly.

8. **In vitro fertilization, artificial insemination or other assisted means of conception.**

9. **Private duty nursing**

10. **Orthodontia**

11. **Autologous blood donation**

12. **Physical Manipulation Services** We will not pay for any services in connection with
the detection and correction (by manual or mechanical means) of any of the following in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

- Structural imbalance; or
- Distortion; or
- Subluxation

13. **Routine Foot Care**

14. **Other Health Insurance, Health Benefits and Governmental Programs** We will reduce our payments under this Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children’s Program and the Early Intervention Program.

15. **No-Fault Automobile Insurance** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.

16. **Other Exclusions** We will not pay for:

   A. Sex transformation procedures, unless medically necessary; or

   B. Custodial care.

17. **Workers’ Compensation** We will not provide coverage for any service or care for an injury, condition or disease if benefits are provided to you under a Workers’ Compensation Law or similar legislation.

18. **Non-emergency Transportation**
SECTION TWELVE – PREMIUMS FOR THIS CONTRACT

1. **Amount of Premiums** The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.

2. **Your Contribution Toward the Premium** Under New York State Law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any.

3. **Grace Period** All premiums for this Contract are due one month in advance. However, we will allow a grace period for the payment of all premiums, except the first month’s. This means that, except for the first month’s premium for each child, if we receive payment within the grace period, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the grace period, the coverage under this Contract will terminate as of the last day of the month of the grace period.

4. **Agreement to Pay For Services if Premium is Not Paid** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.

5. **Change in Premiums** If there is to be an increase or decrease in the premium or your contribution toward the premium for this Contract, we will give you at least thirty days (30) written notice of the change.

6. **Changes in Your Income or Household Size** You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at **1-866-247-5678** or by calling the Child Health Plus Hotline at 1-800-698-4543. At that time, we will provide you with the form and documentation necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within ten (10) business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than forty (40) days from receipt of the review request and supporting documentation.
SECTION THIRTEEN – TERMINATION OF COVERAGE

1. **For Non-Payment of Premium** If you are required to pay a premium for this Contract, this Contract will terminate at the end of the grace period if we do not receive your payment.

2. **When You Move Outside the Service Area** This Contract shall terminate when you cease to reside in the Service Area.

3. **When You No Longer Meet Eligibility Requirements** This Contract shall terminate as follows:
   
   A. On the last day of the month in which you reach the age of 19; or
   
   B. The date on which you are enrolled in the Medicaid program; or
   
   C. The date on which you become covered under other health care coverage or gain access to a state health benefits plan.
   
   D. The date you become an inmate of a public institution or a patient in an institution for mental disease.

4. **Termination of the Child Health Plus Program** This Contract shall automatically terminate on the date when the New York State law which establishes the Child Health Plus program is terminated or the State terminates this Contract or when funding from New York State for this Child Health Plus program is no longer available to us.

5. **Our Option To Terminate This Contract** We may terminate this Contract at any time for one or more of the following reasons:

   A. Fraud in applying for enrollment under this Contract or in receiving any services.

   B. Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than thirty (30) days prior written notice of such termination.

   C. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five (5) months prior written notice of such termination.

   D. You do not provide the documentation we request within sixty (60) days of your enrollment or recertification date.

   E. You do not provide the application we request for recertification.

   F. If you appear Medicaid eligible at recertification and do not complete the Medicaid application process within the sixty (60) day temporary enrollment period.
6. **Your Option to Terminate This Contract** You may terminate this Contract at any time by giving us at least one month's prior notice. We will refund any portion of the premium for this Contract that has been prepaid by you.

7. **On Your Death** This Contract will automatically terminate on the date of your death.

8. **Benefits After Termination** If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:

- A date on which you are no longer totally disabled; or
- A date twelve months from the date this Contract terminates.

We will not pay for more care than you would have received if your coverage under this Contract had not terminated.
SECTION FOURTEEN – RIGHT TO A NEW CONTRACT AFTER TERMINATION

1. **When You Reach Age 19** If this contract terminates because you reach age 19, then you may purchase a new contract as a direct payment subscriber.

2. **If Child Health Plus Ends** If this Contract terminates because the Child Health Plus program ends, you may purchase a new contract as a direct payment subscriber.

3. **How to Apply** You must apply to us within thirty (31) days of termination of this Contract and pay the first premium for the new contract.

4. **The New Contract** The new contract which we will make available to you will be the direct payment contract we offer to persons not covered by Child Health Plus.
SECTION FIFTEEN – GRIEVANCE PROCEDURE AND UTILIZATION REVIEW APPEALS

1. Grievance Procedure You are entitled to seek a review in the event we deny access to a referral or determine that a requested benefit is not covered. To do so, a “grievance” must be submitted. You, or a representative you designate, may submit a grievance by calling us or writing to us. Should a grievance be submitted orally (i.e., over the phone as opposed to in writing), we may require that you sign a written acknowledgment of the grievance prepared for us.

All grievances will be resolved as quickly as possible, and in no event more than:

- forty-eight (48) hours after the receipt of all necessary information when a delay would significantly increase the risk to your health;
- thirty (30) days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and
- forty-five (45) days after the receipt of all necessary information in all other instances.

We will designate one or more qualified personnel to review the grievance. Notice of a determination of the grievance shall be made in writing to you or your designee. When time is of the essence due to a potential risk to your health, the notice will be made by telephone with written notice to follow within three (3) business days. Among other information, the notice of determination will include our reasoning (clinical rationale if applicable) along with further appeal rights and procedures. You will have sixty (60) business days after receipt of notice of the grievance determination to file a written appeal.

We seek to resolve all appeals in the most expeditious manner possible and will make an appeal determination and provide notice no more than:

- two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to your health; and
- thirty (30) business days after the receipt of all necessary information in all other instances.

We will not retaliate or take any discriminatory action against you because you filed a grievance or appeal.

2. Utilization Review You are also entitled to seek a review in the event we deny a service on the basis that it is not medically necessary. We will make a determination involving any of the following and provide notice within one (1) business day of receipt of the necessary information (except, with respect to home health care services following an inpatient hospital admission, within seventy-two (72) hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday):

- continued or extended health care services;
- additional services when you are undergoing a course of continued treatment
Otherwise, we will make a determination within three (3) business days of receipt of necessary information if the service requires pre-authorization, and within thirty (30) days of receipt of necessary information if the service has already been provided.

You will have forty-five (45) days to appeal. Expedited appeals will be determined within two (2) business days of receipt of necessary information, and standard appeals will be determined within sixty (60) days of receipt of necessary information. All decisions related to medical necessity will be made by clinical peer reviewers.
SECTION SIXTEEN – EXTERNAL APPEAL

1. **Unnecessary Care**

In general, we will not cover any health care service that we 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 had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Subscriber Contract. (For further information on external appeals, consult your Member Handbook.)

2. **Experimental/Investigational Treatments**

In general, we do 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 the External Appeal Agent approves coverage of 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-health care services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments provided in such clinical trial. (For further information on external appeals, consult your Member Handbook.)

3. **Other External Appeal Rights**

New York law also establishes rights to an external appeal associated with denials of coverage:

- of a service on the grounds that a service is out-of-network and an alternate recommended health service is available in-network; and
- of a service or procedure likely to benefit in the treatment of a rare disease when the benefit outweighs the risks involved.
1. **No Assignment** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.

2. **Legal Action** You must bring any legal action against us under this Contract within three (3) years from the date we refused to pay for a service under this Contract. Before you bring a lawsuit against us, however, we request that you submit a claim to us and allow us at least 60 days to review and attempt to resolve that claim.

3. **Amendment of Contract** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least thirty (30) days written notice of any change.

4. **Medical Records** We agree to preserve the confidentiality of your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.

5. **Who Receives Payment Under This Contract** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.

6. **Notice** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

   If to us:

   **Affinity Health Plan**  
   **Metro Center Atrium**  
   **1776 Eastchester Road**  
   **Bronx, New York 10461**

   If to you: To the latest address provided by you on enrollment or official change-of-address form.

You must notify Affinity Health Plan within sixty (60) days of any changes in income, family size, availability of other health insurance or residency which may affect eligibility for the Child Health Plus program.
Dental Care

**Affinity Health Plan** believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with DentaQuest, an expert in providing quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

**How to Access Dental Services:**

- If you need to find a dentist or change your dentist, please call DentaQuest at 1-866-731-8004 (TTY: 1-800-662-1220). Customer Services Representatives are there to help you. Many speak your language or have a contract with language Line Services.
- You can also go to a dental clinic that is run by an academic dental center without a referral. Please call DentaQuest at 1-866-731-8004 (TTY: 1-800-662-1220) for more information.
This Rider amends your Contract and provides coverage for the following:

Section 7 - Other Covered Services: We will pay for the following medical supplies:

8. **Ostomy Equipment and Supplies:** We will pay for ostomy equipment and supplies prescribed by a licensed health care provider legally authorized to prescribe under title eight of the education law.
Section Nine – Dental Care

Orthodontia is a dental specialty dedicated to diagnosing, preventing and treating malocclusion (improper alignment of biting or chewing surfaces of upper and lower teeth) through corrective procedures to straighten teeth and correct jaw alignment.

Prior approval for orthodontia coverage is required. Orthodontia coverage includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Orthodontia coverage is not covered if the child does not meet the criteria described above.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE)
- Placement of component parts (e.g. brackets, bands)
- Interceptive orthodontic treatment
- Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)
- Removable appliance therapy
- Orthodontic retention (removal of appliances, construction and placement of retainers)
SECTION FOUR - MEDICAL SERVICES

This Rider amends your Contract and provides coverage for the following:

2. Covered Medical Services: We will pay for the following medical services:

   (H) Blood Clotting Factor: We will pay for blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies on an outpatient basis. We will pay for blood clotting factor products and services when infusion occurs in an outpatient setting or in the home by a home health care agency, a properly trained parent or legal guardian of a child, or a child that is physically and developmentally capable of self-administering such products.
NOTICE OF PRIVACY PRACTICES

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

This Notice is Effective August 1, 2015

YOUR INFORMATION. YOUR RIGHTS. OUR DUTIES.
Affinity Health Plan is required by law to protect the privacy of your health information, and to provide you with this Notice that outlines your rights and our duties with respect to your information.

- This notice describes the privacy practices of Affinity Health Plan with respect to your medical information. It explains how we use your medical information and when we can share that information with others.

- This notice informs you of your rights with respect to your medical information, and how you can exercise these rights.

- This notice also describes the duties of Affinity Health Plan with respect to your information. We are required to maintain the privacy of your medical information, to provide you with notice of our privacy practices, and to notify you in the event that your medical information is breached.

YOUR HEALTH INFORMATION.

Why We Collect Your Information
Protected Health Information (PHI) is information in any form (including oral, written, or electronic) that relates to payment for providing health care to you and that can be used to identify you. Affinity collects, creates and maintains your protected health information in order to provide you with health coverage and related services.

Affinity may collect other types of personal information about you, your spouse and dependents that we obtain from your application or through administering your coverage, claims, or account. This information includes: Name, address, telephone number and email address; Social security number, birth date, age, gender and marital status; Income and asset information used to make eligibility and enrollment determinations. To the extent this personal information is or may become part of your medical records, claims history or other health information, it will be treated like the protected health information described in this notice.

How We May Use or Share Your Information without Authorization
Affinity is generally prohibited from using or sharing (disclosing) your health information without your written authorization. In order to provide you with access to quality care, important public benefits, and to comply with government programs and priorities, Affinity may use or share your health information without obtaining your authorization, for purposes of treatment, payment or healthcare operations, with our business associates, and in other limited circumstances as listed in the sections below.
Treatment, Payment, and Healthcare Operations:

- **Treatment:** We may share your medical information with your doctors, hospitals, other providers or insurers to help to provide, coordinate or manage health care and related services for you. For example, if you request a recommendation to a specialist, we may share your medical information with that specialist.

- **Payment:** We may use and share your information to process and pay claims in connection with medical services provided to you, to obtain premium payments, and to determine your eligibility for a plan or program.

- **Health Care Operations:** We may use and share your information in connection with certain administrative, financial, legal, and quality improvement activities that are necessary to support treatment and payment activities. These activities include, but are not limited to: Conducting medical review, utilization review, case management and care coordination activities; Providing customer service and resolving internal grievances; Performing quality assessment and improvement activities; Fraud and abuse detection and compliance programs; and Business planning and development activities.

**Business Associates:** We may share your information with persons or entities that perform certain functions or activities for us such as claims and data processing, administration and analysis; utilization review; quality assurance; billing; and benefit management, as well as legal, actuarial, accounting; consulting, data aggregation management, administrative, accreditation, and financial services. We may permit a business associate to create, receive, maintain, or transmit health information on our behalf if we obtain written assurances that the business associate will appropriately protect the confidentiality of this information.

**De-Identified Information:** We may use your protected health information to create information that is not individually identifiable health information. We may also disclose protected health information to a business associate for the purpose of de-identifying it, whether or not the information is to be used by Affinity.

**Limited Data Sets:** We may use or disclose a “limited data set” of protected health information from which certain specified identifiers have been removed, for purposes of research, health care operations and public health purposes, provided that the recipient signs a data use agreement promising to safeguard the protected health information within the limited data set.

Other Ways We May Use or Share Your Information
Affinity may use or disclose your protected health information without first receiving your authorization in certain public policy circumstances outlined below. Affinity must comply with federal and state laws that provide special protections to sensitive and highly confidential information concerning HIV or AIDS, mental health, alcohol and substance use, pregnancy, sexually transmitted infections, and genetics when making these disclosures:

- **As Required by Law.** We may share your information when required by a court order, a warrant, subpoena or summons issued by a court, grand jury, government investigative agency, or an administrative body authorized to require the production of information. We may also share your
information pursuant to statutes or regulations that require the information when payment is made under a program that provides public benefits such as Medicaid or Medicare.

- **For law enforcement purposes.** We may share your health information with a law enforcement official for legitimate law enforcement purposes such as: Identifying or locating a suspect, fugitive, witness or missing person; If you are believed to be the victim of a crime or to alert law enforcement in the event of your death as a result of criminal conduct; If your information is evidence of a crime that occurred on Affinity’s premises.

- **Victims of abuse, neglect or domestic violence.** We may disclose your health information to an appropriate government authority if we believe that you, your spouse or dependent are a victim of abuse, neglect or domestic violence. We will obtain your agreement to make the disclosure unless the law requires the disclosure. We will notify you of the disclosure unless we believe that doing so would place you at risk of serious harm, or that the person who usually receives information from us on your behalf is responsible for the abuse, neglect or domestic violence.

- **For judicial and administrative proceedings.** We may share your health information in response to an appropriate order of a court or administrative body, including a subpoena, summons or order issued in the course of any judicial or administrative proceeding.

- **For public health activities.** We may share your health information with a public health authority or other agency or organization that makes a written request for information related to preventing or controlling disease, injury or disability; reporting vital events statistics such as births or deaths; reporting child abuse or neglect; or reviewing the quality, safety or effectiveness of an FDA-regulated product or activity.

- **For health oversight activities.** We may share your health information with a state or federal health oversight agency that requests the information for the purpose of performing activities authorized by law such as audits, investigations, inspections and licensing surveys, for which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

- **To avert a serious threat to health or safety.** We may share your health information to prevent or lessen a serious and immediate threat to the health or safety of you, another person or the general public. We will disclose your health information for this purpose only to persons who may be reasonably able to prevent or lessen the threat, consistent with applicable law and standards of ethical conduct.

- **For specialized government functions.** We may share your health information to assist with certain government functions, such as assuring the proper execution of a military mission, conducting special intelligence and counter-intelligence investigations, providing protective services to the President and foreign heads of state, and the administration and maintenance of correctional institutions. We will not release health information of Members who are no longer inmates when released on parole, probation, supervised release, or otherwise no longer in lawful custody.

- **To coroners or funeral directors, or for organ, eye or tissue donation.** We may disclose your health information to a coroner or medical examiner for purposes such as identifying a deceased person or determining a cause of death; to a funeral director in reasonable anticipation of your death or as
necessary to assist in carrying out duties with respect to a decedent; to organ procurement organizations and similar entities for the purpose of assisting in organ, eye or tissue donation or transplantation activities.

- **For school administration.** We may share your information with schools at which you are a student or prospective student if the information is limited to proof of immunization and the school is required by law to have such proof of immunization prior to admitting you. We may also share your information with applicable city and state immunization registries as required by law.

- **For workers' compensation.** We may use or disclose your health information as authorized by and to the extent necessary to comply with laws governing the workers' compensation program or other similar programs that provide benefits for work-related injuries or illnesses without regard to fault.

**When We are Required to Obtain Your Authorization.**
We will not use or disclose your health information for any purpose not specified in this Notice unless we first obtain your express written authorization. If you give us your authorization, you may revoke (cancel) it at any time, in which case we will no longer disclose your health information to the party or for the purpose that you authorized, but we cannot make any changes with respect to information we disclosed prior to your revocation.

**Fundraising:** We may use or disclose to a business associate or to an institutionally-related foundation certain information for the purposes of our own fundraising, so long as you are provided with a clear and conspicuous mechanism to opt-out of further communications.

**Marketing:** Your authorization is required before we use or disclose your information to communicate with you about a product or service where the communication encourages you to purchase or use the product or service.

**Psychotherapy notes.** We will not disclose psychotherapy notes without your authorization unless we created the notes and are going to use them for treatment; or the psychotherapy notes will be used for our own training, to defend ourselves in legal proceedings brought by you, to investigate or determine our compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner, or as otherwise required by law.

**Research.** We will not use or disclose your health information for research purposes, such as studies comparing the benefits of alternative treatments received by our members, without your authorization.

**Sale of Health Information:** We will not make a disclosure of your health information in exchange for direct or indirect payment, made to us or to our Business Associates, by the entity that would receive the information.

**Sensitive and Highly Confidential Information:** State and federal law give special privacy protections to certain types of health information that are deemed highly confidential. Sensitive and Highly Confidential Information Includes information about: HIV or AIDS testing and diagnosis, mental health treatment, alcohol and substance use, pregnancy, sexually transmitted infections, and genetics. We will only disclose highly confidential information with your prior express written authorization or when specifically permitted or required by law.
How We May Use or Share Information with Your Friends and Family
We may disclose your health information to a family member, other relative, or close personal friend who assists you in receiving or obtaining payment for health care services. We will disclose your health information to these individuals only if the disclosure is consistent with any prior preference that you have expressed to us (including a personal representative designation or health care proxy), or if the information is relevant to the individual’s involvement in your care. We may also disclose your health information to disaster relief organizations such as the Red Cross to assist your family members or friends in locating you or learning about your general condition in the event of a disaster.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect or Obtain a Copy of Your Information
You have the right to inspect and to obtain a copy of your health information that we maintain. Your request should describe the information you want to review and the format in which you want to review it. For example, if you want to inspect your records at our offices, receive paper copies, or have them copied onto a flash drive. We will honor your request if the information can be readily produced in that format, but may charge a fee for the costs of production. If we deny your request to inspect or obtain your information, you may appeal the denial. You can make a request to inspect or obtain copies of your information by writing to our Director of Customer Service.

Right to Request an Amendment of Your Information
You have the right to request an amendment (change) to any health information we maintain in your designated record set if you state a reason why this information is incorrect or incomplete. We do not have to agree to make the changes you request. If we determine the requested changes are not appropriate, we will advise you in writing. You can choose to have your objection to our decision included in your health records. You may request an amendment by writing to our Director of Customer Service.

Right to Obtain a List of Disclosures of Your Information
You have the right to obtain a list of certain disclosures of your health information that we have made for purposes other than treatment, payment or health care operations during the six (6) years prior to your request. You can request one free list every twelve (12) months, but we will charge a fee for additional requests you make during a 12-month period to cover our costs in providing the additional lists. You may request a list of disclosures by writing to our Director of Customer Service.

Right to Request Limits on the Use and Sharing of Your Information
You have the right to request limits (restrictions) on how we use and disclose your health information for treatment, payment and health care operations. You also have the right to ask us to limit the information we share with your family members or others who are involved in your health care or payment for your health care. While we will try to honor your request, we are not required to agree to the limits. You may request a restriction by contacting our Director of Customer Service.

Right to Request Confidential Communications
You have the right to request that we use a different method to contact you if you believe that us contacting you using your current information would endanger you (for example, if you are hiding from an abusive spouse). If you are a minor who has received reproductive or other health care services based on your own consent, you may also have the right to request confidential communications. You
can request that we send information to an alternative address, different phone number, or by alternative means, such as by fax. Your request should be in writing and specify the alternative method or location and state that you are endangered (you need not explain why). We will accommodate reasonable requests.

Right to Obtain a Copy of this Notice
You have the right to receive a paper copy of this Notice at any time. You may receive a paper copy even if you have previously requested to receive this Notice electronically. You may also obtain a copy of this Notice by going to our website at http://www.affinityplan.org. You may obtain a paper copy of this Notice, by writing to our Director of Customer Service.

Right to File a Complaint
You have the right to file a complaint about the privacy policies, procedures and practices of Affinity Health Plan. You can:

- Call our Customer Service Department at (866) 247-5678/TDD: (888) 447-4833 during normal business hours.
- Make an anonymous complaint by calling our Ethics Line at (866) 528-1505.
- Make a written complaint by email or postal mail at the addresses listed below.

You also have the right complain to the US Department of Health and Human Services, Office for Civil Rights at OCRComplaint@hhs.gov or call (800) 368-1019/ TDD (800) 537-7697

Right to Ask Questions
You can contact us at any time if you have questions with respect to this Privacy Notice or our privacy policies. You can call our Customer Service Department at (866) 247-5678/TDD: (888) 447-4833 during normal business hours. You can send us written questions as follows:

- E-mail Affinity Customer Service at Member@affinityplan.org or complete an inquiry form on our website at https://www.affinityplan.org/Contact_Us.aspx
- E-mail Affinity’s Chief Privacy Officer at Privacy@affinityplan.org
- Mail a letter to the attention of our Customer Service Director or Chief Privacy Officer at: Affinity Health Plan, Metro Center Atrium, 1776 Eastchester Road Bronx, New York 10461

OUR DUTIES WITH RESPECT TO YOUR INFORMATION

To Maintain the Privacy of Your Health Information
We are required to maintain the privacy and security of your health information, whether in paper, electronic or other form. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. We enter into agreements with business associates, contractors and vendors to ensure that they protect your health information. We do not sell information about our customers or former customers.
To Limit the Amount of Information Disclosed
When we use or disclose your health information, or we request your information from another covered entity or business associate, we will make reasonable efforts to limit the health information shared to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

To Notify You if Your Information is Breached
We are required to notify you in the event that your information is improperly accessed, used, acquired or disclosed in violation federal or state privacy laws, and that results in potential harm. If we determine that Affinity or one of our business associates has experienced a breach of your information, we will take action in accordance with applicable laws and regulations to notify you, certain government agencies, and in some cases the media, about the breach.

To Provide You With Copies of this Notice
We are required by law to provide you with a copy of this Privacy Notice, including any paper copies you request, and to comply with the terms of this Notice when we use or disclose your health information. If we make any material changes to this Notice, we must provide you with a copy of the updated notice. A copy of this Privacy Notice can be found on our website at http://www.affinityplan.org.

To Notify You of Changes to this Notice
We are required to abide by the terms of this Notice of Privacy Practices as currently in effect. We reserve the right to change the terms of the notice and to make the new notice effective for all the protected health information that we maintain. In addition, for the convenience of our members, the revised Privacy Notice will also be posted on our web site: http://www.affinityplan.org.
Customer Service:
866.247.5678
Monday - Friday, 8AM – 6PM
TTY/TDD:
800.662.1220
Fax:
718.794.7800
Visit our web site:
AffinityPlan.org