

## Important Child Health Plus Disclosure Information

### General information

Your plan of benefits is determined by New York State requirements for Child Health Plus coverage. Your plan is underwritten and administered by Affinity Health Plan – Metro Center Atrium, 1776 Eastchester Road, Bronx, New York 10461. You may contact us at this address or by contacting our Customer Services at 1-866-247-5678. In the event of any inconsistency between this disclosure document and the Child Health Plus subscriber contract the terms and conditions of the subscriber contract shall be controlling.

### Customer Services and Affinity member website

When you require assistance from an Affinity customer service representative, call us during regular business hours, Monday through Friday from 8:30 am to 6:00pm, toll free, at 1-866-247-5678. TTY users may call us at 1-800-662-1220. **If you do not speak English**, we can help. We want to make sure you know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.

If you call these numbers after hours and leave a message, we will get back to you the next business day.

For people with disabilities: If you use a wheelchair, are blind, have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or if it is equipped with special communications devices. Also, we have services like:

- TTY machine (our TTY phone number is 1-800-662-1220)
- New York Relay Inquiry Line: 1-800-664-6349 (voice)  
1-800-835-5515 (TTY)
- Information in Large Print
- Case Management
- Help in Making or Getting to Appointments
- Names and Addresses of Providers Who Specialize in Your Disability

**At the Affinity website** you can

- View your plan benefits and claims.
- Answer benefits questions.
- Search network providers.
- Get advice on how to file a claim
- Get advice on how to file complaints and appeals.
- Connect to behavioral health services.
- Find information on various health related topics.
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services.
- Visit [www.Affinityplan.org](http://www.Affinityplan.org) and click on the Member tab.

### Plan of benefits

Covered services include most types of treatment provided by primary care physicians (PCP), specialists and hospitals. In order to be covered, all services, including the location (type of facility), duration and costs of service must be "medically necessary and appropriate" as defined below and as determined by Affinity. The information that follows provides general information regarding Affinity's Child Health Plus plan. For a complete description of the benefits available to you, including procedures, exclusions and limitations, please refer to your Child Health Plus subscriber contract.

## General conditions for coverage

The service or supply must be covered by your Child Health Plus plan. For a service or supply to be covered, it must: be included as a covered expense in your plan documents and not be an excluded expense and not exceed the maximums and limitations stated in your plan documents; and be obtained in accordance with all the terms, conditions policies and procedures stated in your plan documents. Affinity will pay for covered medical expenses, up to the maximums shown in your subscriber contract. Affinity will not pay for any expenses you incur that exceed the maximum limits or any non-covered health care procedures, treatments or services.

## Medically necessary and appropriate

“Medically necessary and appropriate” means services or supplies furnished by a physician or other health care provider that are necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

Provision of a medically necessary and appropriate the service or supply is:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and
- Not primarily for the convenience of you, or for the physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

**Important note:** Not every service, supply or prescription drug that fits the definition for medical necessity and appropriate is covered by your plan. Exclusions and limitations apply to certain medical and hospital services, supplies and other expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum.

Refer to your plan documents for the plan limits and maximums.

## Member cost sharing

You are responsible for any copayments for covered services. Copayment obligations are paid directly to the provider or facility at the time the service is rendered.

## Primary care physician (“PCP”)

### Role of PCP

Selecting a primary care physician (PCP) is an important first step toward managing your healthcare. You are required to select a PCP who participates in the Affinity network. If you do not select one, we will assign you a PCP in your area, based on your ZIP Code. If for any reason you are not happy with your PCP and you wish to choose a different PCP, you may do so at any time. To find a new doctor in your area, call Customer Services at our toll-free 1-866-247-5678. Before selecting a PCP, you should either call Customer Services, or call the doctor’s office directly to verify that he/she is accepting new patients. A PCP may be a general practitioner, family physician, internist, or a pediatrician. Each covered family member may select his or her own PCP. Your PCP will provide primary care as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed. You do not need a written referral from a PCP before receiving Specialist care from a Participating Provider. However, we strongly suggest that you inform your PCP of any care you receive from a Specialist.

### Find a doctor

You can search Affinity’s online Provider directory, by logging on to Affinity’s website at [www.Affinity.org](http://www.Affinity.org). You can search for names and locations of physicians and other health care providers and facilities. You can look for a doctor by

specialty and location. You can even look for doctors who are board certified and speak your language. If you need a printed directory, call Customer Services. If you are not an Affinity member yet, or if you have not received your ID card call Customer Service at 1-866-247-5678. If you use the printed directory, you should call Customer Services or the provider to verify the provider is accepting new patients. Affinity cannot guarantee the availability or continued participation of a particular provider. Either Affinity or any network provider may terminate the provider contract or limit the number of people accepted in a practice. If the physician initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

If your provider leaves Affinity Health Plan, we will inform you within fifteen (15) days from when we know about his or her departure. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time.

If any of these conditions apply to you, check with your PCP or call Customer Service at 1-866-247-5678.

### **How to change your PCP or specialist**

You may change your PCP or specialist at any time by calling 1-866-247-5678 the Customer Services toll-free number. The change will become effective the first of the following month upon Affinity's approval of the request.

### **Standing authorizations**

If you have a condition that requires ongoing care from a specialist, you may request a standing authorization from Affinity.

### **Specialist as PCP**

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating your primary and specialty care.

This referral will be issued based on a treatment plan that is approved by Affinity, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative. Please call Customer Services at the toll-free number in order to request these services.

### **Direct specialist care for life-threatening conditions**

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center, or a specialist responsible for providing or coordinating your medical care. In order to request these services, please call Customer Services at the toll-free number.

### **Direct Access Ob/Gyn program**

Your plan allows female members to visit any participating obstetrician or gynecologist for an annual routine well-woman exam, including a Pap smear, and for obstetric or gynecologic problems. Care required as a result from an annual exam and treatment for acute gynecological conditions are also covered. .Obstetricians and gynecologists may also refer a woman directly to other participating providers for covered obstetric or gynecologic services. All health plan preauthorization and coordination requirements continue to apply.

## **Transition of care**

If a participating provider leaves the Affinity network, members who are under an ongoing course of treatment on the day the provider's agreement terminates may continue to receive treatment from the provider during a transitional period of up to ninety (90) days. Female members who have entered the second trimester of pregnancy may continue to receive treatment from the provider for a transitional period that includes the provision of postpartum care directly related to the delivery.

A new member whose health care provider is not a participating provider at the time of enrollment may request to continue an ongoing course of treatment with that provider for a period of up to sixty (60) days from the effective date of enrollment if the member has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include postpartum care directly related to the delivery.

Whether you are a new or existing member, for such a request for transitional coverage to be approved, the health care provider must:

- Agree to accept reimbursement from Affinity at established rates prior to the start of the transitional period as payment in full
- Adhere to Affinity's quality assurance requirements
- Provide Affinity with necessary medical information related to this care
- Adhere Affinity's policies and procedures

The provider must agree to these conditions before Affinity will approve transitional care. In accordance with New York law, transitional care is not permitted if the provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

## **Transplants and other complex conditions**

Our specialty programs help you access covered treatment for transplants and certain other complex medical conditions at participating facilities experienced in performing these services. Depending on the terms of your plan of benefits, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

## **Emergency care**

An emergency medical condition means a medical or behavioral condition 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:

1. Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or
2. Serious impairment of such person's bodily functions; or
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

If you need emergency care, you are covered 24 hours a day, seven (7) days a week. If you travel outside of the United States, you can get urgent and emergency care only in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

## **Urgent care**

Care for certain conditions (such as sprains, severe vomiting, earaches, sore throats or fever) is considered “urgent care.” Urgent care may be obtained from your PCP or an urgent care facility. You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night you are covered for any urgently needed care rendered by any licensed physician or facility.

## **Follow-up care after emergencies**

All follow-up care must be coordinated by your PCP. Follow-up care with nonparticipating providers is only covered with prior authorization from Affinity. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

## **Utilization reviews**

This is a review to determine whether services are or were medically necessary or experimental or investigational (including treatment for a rare disease or a clinical trial). Affinity reviews health services to determine whether the services are or were medically necessary or experimental or investigational (“medically necessary”). This process is called utilization review (UR). Utilization review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call Customer Service at 1-866-247-5678. All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review. Affinity does not compensate or provide financial incentives to its employees or reviewers for determining that services are not or were not medically necessary. Affinity has developed guidelines and protocols to assist in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can contact Affinity or visit our website at [www.Affinityplan.org](http://www.Affinityplan.org). To contact the Utilization Review Agent, call Customer Services at 1-866-247-5678. The Utilization Review Agent is available during regular business hours (9 a.m. - 5 p.m. EST) Monday through Friday. For calls made after business hours or during the weekend, the Member can leave a message.

## **Prior Authorization:**

Some treatments and services require a prior approval for before you receive them or in order to be able to continue receiving them. This is called prior authorization. The following treatments and services must be approved before you get them:

- out-of-network referrals
- elective inpatient admissions (non-emergency admissions)
- non-emergency use of ambulance or ambulette
- home health visits
- organ transplants and pre-transplant evaluations
- durable medical equipment (limited to wheelchairs, beds, motorized scooters, patient lifts, pneumatic compressors, insulin pumps)
- prosthetics
- physical, occupational, and speech therapies
- cardiac rehabilitation services
- contact lenses (call Block Vision at 1-800-243-1401)
- hemodialysis
- cardiac catheterization
- Experimental or investigational treatments

Asking for approval of a treatment or service is called a prior authorization request. To get approval for these treatments or services:

- Your PCP or specialist must give us information explaining why you need the requested service. The PCP or specialist can call our Medical Management 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 three workdays after we get that information. We will let you or your designee and your doctor know our decision by telephone and in writing.
- If you are getting care or treatment that your doctor thinks should continue, or if your doctor thinks you need more services, we will review the request and make our decision within three (3) business days but not more than fourteen (14) business days for a standard request and within three (3) business days for an expedited request after we get the information we need. We will let you or your designee and your doctor know whether or not we approve the request by telephone and in writing.
- If we are checking on care that you have already received, we will decide whether or not to approve payment within thirty (30) days of the request.
- Your doctor may ask to speak to our Medical Director about the requested service and our decision. The Medical Director will talk to your doctor within one 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 doctor how to appeal our decision. We will explain your options for asking for an appeal from us or from the State.

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called concurrent review.

### **What happens after we get your prior authorization request?**

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

Any decision to deny a prior authorization request or to approve it for an amount that is less than requested is called an action. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

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

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

## **Preauthorization reviews**

This is a decision by Affinity prior to your receipt of a covered service, procedure, treatment plan, device, or prescription drug that the covered service, treatment plan, device or prescription drug is medically necessary. Affinity will indicate which of the covered services requires preauthorization. If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the request. If we need additional information, we will request it within three (3) business days.

You or your provider will then have fourteen (14) additional business days to submit the information. If we receive the requested information within fourteen (14) business days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of our receipt of the information.

## **Expedited preauthorization reviews**

With respect to expedited preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within one (1) calendar day of the decision.

If we need additional information, we will request it within twenty-four (24) hours. You or your provider will then have forty-eight (48) hours to submit the information. Affinity will make a determination and provide notice to you and your provider by telephone and in writing within forty-eight (48) hours of the earlier of Affinity's receipt of the information or the end of the forty-eight (48)-hour time period.

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your provider within seventy-two (72) hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission. We will not deny coverage for home care services while our decision on the request is pending.

## **Concurrent reviews**

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your provider will then have fourteen (14) business days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business of our receipt of the information.

## **Expedited concurrent reviews**

For concurrent reviews that involve an extension of expedited care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, Affinity will make a determination and provide notice to you and your provider by telephone within twenty-four (24) hours of receipt of the request.

Written notice will be provided within one (1) business day of receipt of the request for coverage if all necessary information was included or three (3) calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, the expedited preauthorization review timeframes apply.

## **Retrospective reviews**

If Affinity has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your provider within thirty (30) calendar days of the receipt of the request. If we need additional information, we will request it within thirty (30) calendar days. You or your provider will then have forty-five (45) calendar days to provide the information. Affinity will make a determination and provide notice to you and your provider in writing within fifteen (15) calendar days of the earlier of Affinity's receipt of the information or the end of the forty-five (45) day period. Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

## **Retrospective review of preauthorized services**

Affinity may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

## **Reconsideration**

If Affinity did not attempt to consult with your provider before making an adverse determination, your provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

## **How Affinity compensates your health care provider and other providers**

All the physicians are independent practicing physicians that are neither employed nor exclusively contracted with Affinity. Individual physicians and other providers are in the network by either directly contracting with Affinity and/or affiliating with a group or organization that contract with us. Participating providers in our network are compensated in various ways for the services covered under your plan:

- Per individual service or case (fee for service at contracted rates)
- Inpatient hospital services are payable at a percentage of published Medicaid per diem rates
- Outpatient hospital services are payable at ambulatory patient groups or negotiated case rates
- Capitation (a prepaid amount per member, per month)
- Through integrated delivery systems (IDS), independent practice associations (IPA), physician hospital organizations (PHO), physician medical groups (PMG), behavioral health organizations and similar provider organizations or groups; Affinity pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

## **Technology review**

Affinity reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which one should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.

- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health Care Research and Quality.
- Seek input from relevant specialists and experts in the technology
- Determine whether the technologies are experimental or investigational. You can find out more on new tests and treatments in our Clinical policy guidelines.

## Prescription drugs

Your plan covers outpatient prescription drugs and includes a preferred drug list (also known as a “drug formulary”). The preferred drug list includes a list of prescription drugs that covered on a preferred basis. Your benefit plans may include Affinity’s precertification or step-therapy programs. Under the step-therapy program, members must first try certain prerequisite medication(s) before a step-therapy drug will be covered. The prescribing physician can submit a request for prior authorization to CVS Health (Caremark) Prior Authorization Department in writing, by phone, or online.

Information provided must include member identification, medical history, and laboratory data necessary to review the request. The request for medical exception will be reviewed along with Affinity’s Pharmacy clinical policy guideline applicable to the medication. If the medical exception meets the criteria established in the clinical policy guideline, CVS Health Affinity will notify the physician and member of the authorization.

If an Affinity medical director determines the drug is not approved for coverage, an adverse determination letter will be sent to the member and provider. The notice will explain the reason for the denial of coverage and the appeal process. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Affinity’s website at **[www.Affinityplan.org](http://www.Affinityplan.org)**. Printed preferred drug guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Customer Services at 1-866-247-5678. Certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification which requires a trial of one or more “prerequisite therapy” medications before a “step therapy” medication will be covered. If it is medically necessary for you to use a medication subject to these requirements, your physician can request coverage of such drug as a medical exception. You may determine which medications are included in the Step Therapy Program and require trial of prerequisite drugs through any of the following methods:

- Contacting CVS Health (Caremark) toll free at the phone number on your ID card
- Via the public website **[www.Affinityplan.org/formulary](http://www.Affinityplan.org/formulary)**

## Updates to the drug formulary

You can obtain formulary information from the Internet at **[www.Affinityplan.org/formulary](http://www.Affinityplan.org/formulary)**, or by calling our Customer Services toll-free number.

## Behavioral health information

Behavioral health care services are managed by Beacon, who is responsible for making initial coverage determinations and coordinating referrals to Affinity’s provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

Your health plan includes behavioral health services for covered for mental health conditions and/or drug and alcohol abuse services, including inpatient and outpatient services, partial hospitalizations and other behavioral health services. You can determine the type of behavioral health coverage available under the terms of your plan and how to access services by calling Customer Services number at 1-866-247-5678.

If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by calling the toll-free behavioral health number (where applicable) listed on your ID card or if no number is listed, call the Customer Services at 1-866-247-5678.

## **Dental health services information**

Dental Services are covered through DentaQuest Affinity's dental plan administrator. Regular and routine dental services, supplies and devices are covered. Members do not need a referral or authorization from their PCP for dental services. Members can choose their own DentaQuest dental provider, or, if they do not have a preference, a dental provider is assigned. Members may contact DentaQuest at any time to change their primary dentist or get assistance in making a dental appointment. DentaQuest assistance is available at 1-866-731-8004 (TTY: 1-800-662-1220) or [www.dentaquest.com](http://www.dentaquest.com).

## **Vision health information**

Vision, Optometry, Glasses – Superior Vision is a national vision benefits manager. Superior Vision's network of optometrists provides routine vision care for all Affinity Members. Members can visit their Web site at [www.blockvision.com](http://www.blockvision.com) or contact them at 1-800-879-6901.

## **Clinical policy guidelines**

Affinity's clinical policy guidelines describe Affinity's policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by case basis consistent with applicable policies. Affinity's clinical policy guidelines do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment.

While Affinity's clinical policy guidelines are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to any treatment limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. Affinity's clinical policy guidelines are available upon request.

## **Claim determinations**

Affinity's claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. If you disagree with our claim determination you may submit a grievance. For a description procedures and appeal process for medical necessity or experimental or investigational determinations, see Utilization Review. A pre-service claim is a request that a service or treatment be approved before it can be received. A post-service claim is a request for a service or treatment that you have already received.

## **Pre-service claim determinations**

Pre-service claims review is the review for approval of a claim before the service has taken place. If Affinity has all the information necessary to make a determination regarding a pre-service claim (for example a referral or a covered benefit determination), Affinity will make a determination and provide notice to you (or your designee) within fifteen (15) days from receipt of the claim. If Affinity needs additional information, Affinity will request it within fifteen (15) days from receipt of the claim. You will have forty-five (45) calendar days to submit the information. If Affinity receives the information within forty-five (45) days, Affinity will make a determination and provide notice to you (or your designee) in writing, within fifteen (15) days of Affinity's receipt of the information. If all necessary information is not received by Affinity within forty-five (45) days, Affinity will make a determination within fifteen (15) calendar days of the end of the forty-five (45) day period.

## **Urgent pre-service reviews**

With respect to urgent pre-service requests, if Affinity has all information necessary to make a determination, Affinity will make a determination and provide notice to you (or your designee) by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within three calendar days of the decision. If Affinity needs additional information, Affinity will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. Affinity will make a determination and provide notice to you (or your designee) by telephone within forty-eight (48) hours of the earlier of Affinity's receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

## **Post-service claim determinations**

The purpose of post-service claim review is to review initial requests for certification received after discharge or after the provision of services, retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage of health care services.

If Affinity has all information necessary to make a determination regarding a post-service claim, Affinity will make a determination and notify you (or your designee) within thirty (30) calendar days of the receipt of the claim. If Affinity needs additional information, Affinity will request it within thirty (30) calendar days. You will then have forty-five (45) calendar days to provide the information. Affinity will make a determination and provide notice to you (or your designee) in writing within fifteen (15) calendar days of the earlier of Affinity's receipt of the information or the end of the forty-five (45) day period.

Whether a utilization review determination is made before, during or after services are provided, any adverse determination, including a claim denial, will be made by a clinical peer reviewer and all notices of adverse determinations will include the specific reasons for the denial as well as information about your rights to appeal, including your right to appeal a final adverse determination to the New York State External Review Program. All final adverse determinations will be made by a clinical peer reviewer other than the clinical peer reviewer who made the initial adverse determination.

The notice of adverse determination will include:

- The reasons for the adverse determination, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any
- A description of Affinity's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions how to start the appeals, expedited appeals and external appeals process
- Notice of the availability, upon request, of the clinical review criteria used to make the adverse determination. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Affinity in order to render a decision on appeal.

## **Discharge planning**

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits for the member after s/he is released from the inpatient facility.

## **Grievances**

A grievance is a complaint that you communicate to us that does not involve a Utilization Review determination. Affinity's grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding Affinity's administrative policies or access to providers.

## **Filing a grievance**

You can contact us by phone by calling Customer Services at 1-866-247-5678, in person, or in writing to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. You or your designee has up to one hundred eighty (180) calendar days from when you received the decision you are asking us to review to file the grievance. When Affinity receives your grievance, it will mail an acknowledgment letter within fifteen (15) business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and will take no discriminatory action because of your issue. Affinity has a process for both standard and expedited grievances, depending on the nature of your inquiry.

## **Grievance determination**

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. Affinity will decide the grievance and notify you within the following timeframes:

### **Expedited/Urgent grievances**

By phone within the earlier of forty-eight (48) hours of the necessary information or seventy-two (72) hours of receipt of your grievance. Written notice will be provided within seventy-two (72) hours of receipt of your grievance.

### **Pre-service grievances**

(A request for a service or treatment that has not yet been provided) in writing, within fifteen (15) calendar days of receipt of your grievance.

### **Post-service grievances**

(A claim for a service or a treatment that has already been provided) in writing, within thirty (30) calendar days of receipt of your grievance.

**All other grievances** (That are not in relation to a claim) in writing, within thirty (30) calendar days of receipt of your grievance.

## **Grievance appeals**

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by telephone, in person, or in writing. However, urgent appeals may be filed by telephone. You have up to sixty (60) business days from receipt of the grievance determination to file an appeal. When we receive your appeal, we will mail an acknowledgment letter within fifteen (15) business days.

The acknowledgement letter will include the name, address, and telephone number of the person handling your appeal and indicate what additional information, if any, must be provided. One or more qualified personnel at a higher level than the personnel that rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the appeal and notify you in writing within the following timeframes:

### **Expedited/Urgent grievances**

The earlier of two (2) business days of receipt of the necessary information or seventy-two (72) hours of receipt of your appeal.

### **Pre-service grievances**

(A request for a service or treatment that has not yet been provided) within fifteen (15) calendar days of receipt of your appeal.

### **Post-service grievances**

(A claim for a service or a treatment that has already been provided) within thirty (30) calendar days of receipt of your appeal .

### **All other grievances**

(That are not in relation to a claim or request for service) within thirty (30) business days of receipt of all necessary information to make a determination. If you remain dissatisfied with Affinity's appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Health at

**1-800-206-8125** or write them at:

New York State Department of Health

Corning Tower

Empire State Plaza

Albany, New York 12237

**[www.health.ny.gov](http://www.health.ny.gov)**

If you need assistance filing a grievance or appeal you may also contact the state independent Consumer Assistance Program at:

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: **1-888-614-5400**

Or e-mail: **[cha@cssny.org](mailto:cha@cssny.org)**

### **Utilization reviews**

This is a review to determine whether services are or were medically necessary or experimental or investigational (including treatment for a rare disease or a clinical trial). Affinity reviews health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called utilization review (UR). Utilization review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call Customer Service at 1-866-247-5678. All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review. Affinity does not compensate or provide financial incentives to its employees or reviewers for determining that services are not or were not medically necessary. Affinity has developed guidelines and protocols to assist in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can contact Affinity or visit our website at [www.Affinityplan.org](http://www.Affinityplan.org). To contact the Utilization Review Agent, call Customer Services at 1-866-247-5678. The Utilization Review Agent is available during regular business hours (9 a.m. - 5 p.m. EST) Monday through Friday. For calls made after business hours or during the weekend, the Member can leave a message.

### **Preauthorization reviews**

This is a decision by Affinity prior to your receipt of a covered service, procedure, treatment plan, device, or prescription drug that the covered service, treatment plan, device or prescription drug is medically necessary. Affinity will indicate which of the covered services requires preauthorization. If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three (3) business days. You or your provider will then have forty-five (45) calendar days to submit the information. If we receive the requested information within forty-five (45) days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing,

within three business days of our receipt of the information. If all necessary information is not received within forty-five (45) days, we will make a determination within fifteen (15) calendar days of the end of the forty-five (45) day period.

### **Expedited preauthorization reviews**

With respect to expedited preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within one calendar day of the decision. If we need additional information, we will request it within twenty-four (24) hours. You or your provider will then have forty-eight (48) hours to submit the information. Affinity will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of Affinity's receipt of the information or the end of the forty-eight (48) hour time period. After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your provider within seventy-two (72) hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission. We will not deny coverage for home care services while our decision on the request is pending.

### **Concurrent reviews**

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the 45-day time period.

### **Expedited concurrent reviews**

For concurrent reviews that involve an extension of expedited care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, Affinity will make a determination and provide notice to you and your provider by telephone within twenty-four (24) hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three (3) calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, the expedited preauthorization review timeframes apply.

### **Retrospective reviews**

If Affinity has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your provider within thirty (30) calendar days of the receipt of the request. If we need additional information, we will request it within thirty (30) calendar days. You or your provider will then have forty-five (45) calendar days to provide the information. Affinity will make a determination and provide notice to you and your provider in writing within fifteen (15) calendar days of the earlier of Affinity's receipt of the information or the end of the forty-five (45) day period. Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

### **Retrospective review of preauthorized services**

Affinity may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

## **Reconsideration**

If Affinity did not attempt to consult with your provider before making an adverse determination, your provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

## **Utilization review internal appeals**

You, your designee, and, in retrospective review cases, your provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a nonparticipating provider, but only when the service is not available from a participating provider. You are not eligible for a utilization review appeal if the service you request is available from a participating provider, even if the nonparticipating provider has more experience in diagnosing or treating your condition. (Such an appeal will be treated as a grievance.) For a utilization review appeal of denial of an out-of-network health service, you, or your designee, must submit:

- A statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition; and
- Two documents from the available medical and scientific evidence that the out-of-network service:
  - ✓ Is likely to be more clinically beneficial to you than the alternate in-network service; and
  - ✓ That the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

You have up to one hundred eighty (180) calendar days after you receive notice of the adverse determination to file an appeal. Affinity will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

## **First level appeal**

If your appeal relates to a preauthorization request, Affinity will decide the appeal within fifteen (15) calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your provider within two business days after the determination is made, but no later than fifteen (15) calendar days after receipt of the appeal request. If your appeal relates to a retrospective claim, Affinity will decide the appeal within thirty (30) calendar days of receipt of the appeal request. Written notice of the determination will be

provided to you (or your designee) and where appropriate your provider within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the appeal request.

### **Expedited appeals**

Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of seventy (72) hours from receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal. If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal. Affinity's failure to render a determination of your appeal within sixty (60) calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

### **External appeal**

#### **Your right to an external appeal**

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if Affinity has denied coverage on the basis that a service does not meet our requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the state to conduct these appeals. An external appeal application may be obtained from Customer Services by calling 1-866-247-5678.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered service under the plan, and
- In general, you must have received a final adverse determination through the first level of Affinity's internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the first level of our internal appeal process if:
  - ✓ We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
  - ✓ You file an external appeal at the same time as you apply for an expedited internal appeal; or
  - ✓ Affinity fails to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and Affinity).

#### **Your right to appeal a determination that a service is not medically necessary**

If Affinity has denied coverage on the basis that the service does not meet its requirements for medical necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal in the External Appeal section above.

#### **Your right to appeal a determination that a service is experimental or investigational**

If Affinity has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal as stated above and your attending physician must certify that:

- Your condition or disease is one for which standard health services are ineffective or medically inappropriate; or
- One for which there does not exist a more beneficial standard service or procedure covered by Affinity; or
- One for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (Only certain documents will be considered in support of this recommendation. Your attending physician should contact the state for current information as to what documents will be considered or acceptable.); or
- A clinical trial for which you are eligible (Only certain clinical trials can be considered.); or
- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year. For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

### **Your right to appeal a determination that a service is out of network**

If Affinity has denied coverage of an out-of-network treatment because it is not materially different than the health service available in network, you may appeal to an external appeal agent if you meet the two (2) requirements for an external appeal stated above, and you have requested preauthorization for the out-of-network treatment. In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. For purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service. You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a healthcare provider is available in network to provide the particular health service requested by you.

### **The external appeal process**

Affinity will provide you with a copy of the standard description of the external appeal process. Requests for an external appeal shall be submitted to:

The Department of Financial Services  
Consumer Assistance Unit  
1 Commerce Plaza  
Albany, New York 12257

Upon receipt of such request, the Department of Financial Services will screen the request for eligibility. The member and/or member's provider must release all pertinent medical information concerning the member's medical condition, and request for services. All external appeals will be conducted by clinical peer reviewers. All requests, after they have been determined they are eligible, shall be randomly assigned to an external appeals agent.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. Affinity will provide an external appeal application with the final adverse determination issued through the first level of its internal appeal process or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at **1-800-400-8882**. Submit the completed

application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the state will forward the request to a certified external appeal agent. You can submit additional documentation with your external appeal request. If the external appeal agent determines that the information you submit represents a material change from the information on which Affinity based its denial, the External Appeal Agent will share this information with Affinity in order for Affinity to exercise its right to reconsider its decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below); we do not have a right to reconsider our decision. In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or Affinity. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and Affinity by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision. If the external appeal agent overturns Affinity's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of the plan. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Affinity will only cover the costs of services required to provide treatment to you according to the design of the trial. We will 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 that would not be covered under this plan for non-experimental or non-investigational treatments provided in the clinical trial. The external appeal agent's decision is binding on both you and Affinity. The external appeal agent's decision is admissible in any court proceeding. A physician requesting an external appeal of an adverse determination involving a concurrent care claim, including when such physician requests the external appeals as the member's designee, shall not pursue reimbursement from any member for services determined not medically necessary by the external appeals agent, except where applicable, to collect a copayment. Affinity will charge you a fee of \$25 for each external appeal, not to exceed \$75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

**Your responsibilities - It is your responsibility to start the external appeal process.**

You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

**Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or Affinity's failure to adhere to claim processing requirements. Affinity has no authority to extend this deadline.**

**Your responsibilities**

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative. **Under New York State law, your completed request for**

**external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or Affinity's failure to adhere to claim processing requirements. Affinity has no authority to extend this deadline.**

## You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members.

If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Customer Service at 1-866-247-5678 to find out how you can help.

## **Member rights and responsibilities**

### **Information – you have the right to:**

- Know the names and qualifications of the health care professionals involved in your medical treatment.
- Obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms you can be reasonably expected to understand. When it is not advisable for such information to be given to the member, it shall be made available to an appropriate person on the member's behalf.
- Get up-to-date information about the services covered or not covered by your plan and any applicable limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Be advised how to file a complaint, grievance or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to give informed consent or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or nontreatment and the risks involved in each, and the name of the health care professionals who will carry out the procedure or treatment. When it is not advisable to give such information to you, your doctor may give such information to a person acting on your behalf.
- Be informed by participating providers about continuing health care requirements following discharge from inpatient or outpatient facilities.
- Be advised if a health care professional proposes to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation regarding noncovered services.
- Receive a prompt reply when you ask questions about the plan or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

### **Access to care – you have the right to:**

- Obtain primary and preventive care from the PCP you chose from the plan's network.
- Change your PCP to another available PCP who participates in the plan.
- Obtain a second opinion about your care and treatment.
- Obtain necessary care from participating network specialists, hospitals and other providers.
- Be referred to participating network specialists who are experienced in treating your chronic illness.

- Be advised by your health care professionals how to schedule appointments and get health care during and after office hours, including continuity of care.
- Be advised how to get in touch with your PCP or a backup physician 24 hours a day, every day.
- Call 911 (or the local emergency hotline) or go to the nearest emergency facility when you have an emergency medical condition as defined in your plan documents.
- Receive urgently needed medically necessary care.
- Receive thoughtful and respectful care in a clean and safe setting.

**Freedom to make decisions – you have the right to:**

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Complete an advance directive, living will or other directive and give it to your health care professionals.
- Know that you or your health care professionals cannot be penalized for filing a complaint or appeal.

**Personal rights – you have the right to:**

- Have your medical records kept private, except when permitted by law or with your approval.
- Be treated with respect for your privacy and dignity.
- Help your health care professionals make decisions about your health care.

**Input – you have the right to:**

- Have your health care professionals help you to make decisions about the need for services and with the complaint process.
- Suggest changes in the plan’s policies and services. To submit suggestions on the plan’s policies, please write to us at the below address:  
Affinity Health Inc.  
Metro Center Atrium  
1776 Eastchester Road,  
Bronx New York 10461

**Exercise your rights – you have the right to:**

- Choose a PCP from the plan’s network and form an ongoing patient-physician relationship.
- Help your health care professionals make decisions about your health care.

**Follow instructions – you have the right to:**

- Read and understand your plan and benefits. Know the copayments. If any, and what services are covered and what services are not covered.
- Follow the directions and advice on which you and your health care professionals have agreed.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including prior authorization for inpatient hospitalization and out-of-network treatment.
- Show your membership card to health care professionals before getting care from them.
- Pay the copayments required by your plan.
- Promptly follow your plan’s complaint processes if you believe you need to submit a complaint.
- Treat all providers, their staff members and the staff of the plan with respect.
- Not be involved in dishonest activity directed at the plan or at any provider.

**Communicate – you have the right to:**

- Tell your health care professionals if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.

- Tell your health care professionals promptly when you have unexpected problems or symptoms.
- Consult with your PCP for referrals to nonemergency covered specialist or hospital care.
- Understand that network physicians and other health care professionals who care for you are not employees of Affinity and that Affinity does not control them.
- Contact Customer Services if you do not understand how to use your benefits.
- Give correct and complete information to physicians and other health care professionals who care for you.
- Advise Affinity about other medical insurance coverage you or plan members in your family may have.
- Ask your treating physician about all treatment options.
- Ask about the physician's compensation arrangement with Affinity.

**As an Affinity Health Plan Member you have the responsibility to:**

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Customer Service.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

**Advance directives**

An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself. There are three types of advance directives:

- Living will – Spells out the type and extent of care you want to receive.
- Durable power of attorney – Appoints someone you trust to make medical decisions for you.
- Do-not-resuscitate order – States that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

**Privacy notice**

Affinity considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you. When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors

(health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans.

To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent. To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please contact Customer Service at 1-866-247-5678. You can also visit our Internet site at [www.Affinityplan.org](http://www.Affinityplan.org). You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.