

Independence Blue Cross & Highmark Blue Shield Caring Foundation

CHIP Benefits Update 1

(Please keep this update with your CHIP Benefits Handbook)

What Insurance is Available? (replaces the text under Introduction, page 10*) --- *effective March 1, 2007*

Free CHIP

A state and federally supported free health insurance program for uninsured children and teens up to 19. The family's size and income are used to determine a child's eligibility. The parent of an eligible child is not responsible for a monthly premium and/or copayments for covered services.

Low Cost CHIP

A state and federally supported health insurance program for uninsured children and teens up to 19. The family's size and income are used to determine a child's eligibility. The parent of an eligible child is responsible for a monthly premium, which is a portion of the full cost of the coverage, and the following copayments:

- \$5 for each visit to the child's primary care physician (except for well-child visits).
- \$10 for each visit to a referred specialist.
- \$25 for a visit to the emergency department of the closest hospital (waived if admitted).
- \$6 for each generic and \$9 for each brand name prescription drug.

At Cost CHIP

A health insurance program for uninsured children and teens up to 19. The family's size and income are used to determine a child's eligibility. The parent of an eligible child is responsible for a monthly premium, which is the full cost of the coverage, and the following copayments:

- \$15 for each visit to the child's primary care physician.
- \$25 for each visit to a referred specialist.
- \$50 for a visit to the emergency department of the closest hospital (waived if admitted).
- \$10 for each generic and \$18 for each brand name prescription drug.

Eligibility – Who is Eligible? (additional text under Section 1, Your Child's Eligibility, Coverage and Payments, page 11) --- *effective March 1, 2007*

- **For Low Cost and At Cost CHIP members ONLY:** Must be uninsured for at least six (6) months prior to the date of enrollment in CHIP, EXCEPT if uninsured as a direct result of a parent no longer working; if transferring from another public insurance program; or if the child is under age two; and
- **For At Cost CHIP members ONLY:** Must not have other affordable health insurance available, which means coverage is not more than 10% of the family's annual income OR the premium cost is not more than 150% of the CHIP premium, or must have been denied partial or full coverage due to a pre-existing condition.

Recommended Childhood Immunization Schedule (additions to the table on page 20) --- *effective March 1, 2005*

Hepatitis A: 1st dose, 12-23 months of age; 2nd dose, 6 months after 1st dose

Meningococcal: 1 dose (The Centers for Disease Control and Prevention recommends for all 11 to 12-year-olds, those entering high school, and college freshmen living in dorms if they have not previously received this vaccine.)

Emergency Care Copayment (additional text under Section 5, Emergency Care, Urgent Care and Follow-Up Care, page 34) --- *effective March 1, 2007*

If a Low Cost CHIP or At Cost CHIP member has been referred to the emergency department of the closest hospital by the child's primary care physician or Keystone Health Plan East, and if the services could have been provided in the primary care physician's office, the parent will be required to pay only the copayment for a visit to the primary care physician's office, not the copayment for an emergency department visit.

Durable Medical Equipment, Prosthetics, and Orthotics (clarification to the benefits listed under Section 10, Outpatient and Inpatient Services, pages 61-73) --- *effective January 1, 2007*

Durable medical equipment, prosthetics and orthotics with a purchase price of more than \$500 will require preapproval.

Ambulance Services (replaces the text on page 61) --- *effective January 1, 2007*

Benefits are provided for ambulance services that are medically necessary, as determined by Keystone Health Plan East, for transportation in a specially designed and equipped vehicle used only to transport sick or injured people, but only when:

- the vehicle is licensed as an ambulance where required by applicable law;
- the ambulance transport is appropriate for your child's clinical condition;
- the use of any other method of transport, such as taxi, private car, wheelchair van, or other type of private or public vehicle transport would be contraindicated (i.e., would endanger your child's medical condition); and
- the ambulance transport satisfies the destination and other requirements stated below.

Benefits are payable for air or sea transportation only if the child's condition, and the distance to the nearest facility able to treat your child's condition, justify the use of an alternative to land transport.

For emergency ambulance transport, the ambulance must be transporting the child from the child's home or the scene of an accident or medical emergency to the nearest hospital, or other facility that provides emergency care, that can provide the medically necessary covered services for the child's condition.

All non-emergency ambulance transports must be preapproved by Keystone Health Plan East to determine medical necessity, which includes specific origin and destination requirements specified in Keystone's policies. Also, non-emergency ambulance transports are not provided for the convenience of the child, the family, or the provider treating the child.

Contraceptives (additional text under Section 10, Outpatient and Inpatient Services, pages 61-73 and Section 11, Prescription Drug Benefits, pages 74-76) --- *effective March 1, 2007*

- Prescription contraceptive devices, obtained from the provider and implanted while in the provider's office, are covered benefits of this program.
- Oral contraceptives for birth control purposes are covered under the prescription drug benefits of this program.

Residential Treatment Center (additional text under Section 13, Mental Health, Serious Mental Illness and Substance Abuse Benefits, pages 80-84) --- *effective January 1, 2007*

A residential treatment facility, licensed and approved by the appropriate government agency and approved by Keystone Health Plan East, is an eligible provider not only for substance abuse treatment but also for treatment of mental illness or serious mental illness, to partial, outpatient, or live-in patients who do not require acute medical care.

Special Circumstances --- *effective January 1, 2007*

Independence Blue Cross and Keystone Health Plan East may waive certain contract requirements (e.g., referrals, preapproval, or use of participating providers) when faced with unforeseen events, such as natural disasters, pandemics, etc. These events are recognized in the community and by Keystone Health Plan East and appropriate regulatory authority as extraordinary circumstances not within the control of Keystone Health Plan East.

*All page listings refer to the CHIP Benefits Handbook (3/05).

CBU1b-2/07

Independence Blue Cross & Highmark Blue Shield Caring Foundation

CHIP Benefits Update 2

(Please keep this update with your CHIP Benefits Handbook)

What Happens if a Premium is Paid Late? (replaces the text under Section 1, Your Child's Eligibility, Coverage and Payments, page 13*) --- *effective September 1, 2007*

If your child is eligible for Low Cost CHIP or At Cost CHIP and you fail to pay your child's monthly premium by the due date listed on the bill, your child's CHIP coverage will be terminated at the end of the last month for which you did pay the premium. You will be responsible for any medical or dental costs incurred after the termination date.

If your child's CHIP coverage is terminated because you fail to pay the premium on time, your child may not be eligible again for CHIP until six months after the date the CHIP benefits end. Also, you will need to complete a new application.

Recommended Childhood Immunization Schedule (additions to the table in Section 2, Your Child's Primary and Preventive Health Services, page 20) --- *We cover your child's immunizations as recommended by the Centers for Disease Control and Prevention (CDC).*

- **Tetanus, Diphtheria, Pertussis (Tdap):** 1 dose, 11-12 years of age (if child did not receive a Td booster dose).
- **Varicella (chickenpox):** 1st dose, 12-15 months of age; 2nd dose, 4-6 years of age.
- **Influenza:** Annually, 6-59 months of age; annually, 5-18 years of age (if at high risk). Children under 9 who are receiving the influenza vaccine for the first time should receive two doses (separated by four or more weeks for TIV and six or more weeks for LAIV). If only one dose was received by a child in this age group during the first year of vaccination, two doses should be received the following year.
- **Rotavirus (Rota):** 1st dose, 2 months of age; 2nd dose, 4 months of age; 3rd dose, 6 months of age.
- **Human Papillomavirus (HPV):** for females only – 1st dose, 11-12 years of age; 2nd dose, 6 months after 1st dose; 3rd dose, 6 months after 2nd dose.
- **Hepatitis A (HepA):** 1st dose, 12-23 months; 2nd dose 6 months after 1st dose.
- **Meningococcal:** 1 dose, 11-18 years of age.

Diabetic Supplies (clarification to the benefit listed under Section 8, Summary of Benefits, page 56, and Section 10, Outpatient and Inpatient Services, Outpatient Services, page 62; and Inpatient Services, page 69) --- *effective March 1, 2005*

Diabetic supplies do not require preapproval.

(over)

Therapies (clarification to the benefits listed under Section 8, Summary of Benefits, pages 56-58, and Section 10, Outpatient and Inpatient Services, pages 61-73) --- *effective December 1, 2005*

- There is an annual maximum of 60 visits for each of the following Rehabilitation Therapy Services:
 - Speech
 - Occupational
 - Physical
- There is no maximum number of visits for Chemotherapy, Dialysis, Respiratory Therapy, or Radiation Therapy.

Nutritional Counseling (additional text under Section 10, Outpatient and Inpatient Services, Outpatient Services, pages 61-68) --- *effective July 1, 2007*

Benefits are provided for up to six *outpatient* nutritional counseling visits per year for the purpose of weight management when performed by a participating physician, including your primary care physician, or registered dietitian. When visits are with someone other than your child's primary care physician, a referral must be obtained from your child's primary care physician. If nutritional counseling visits are provided in addition to other covered services, a copayment may apply for Low Cost CHIP and At Cost CHIP members.

Private Duty Nursing (additional text under Section 10, Outpatient and Inpatient Services, Outpatient Services, pages 61-68) --- *effective March 1, 2005*

Benefits will be provided for *outpatient* Private Duty Nursing performed by a licensed Registered Nurse (RN) or a licensed Practical Nurse (PN) when ordered by your child's primary care physician or a referred specialist as part of a home health care treatment plan and that are medically necessary.

Substance Abuse (replaces the first paragraphs of the Outpatient Services – Substance Abuse and Inpatient Services – Substance Abuse, under Section 13, Mental Health, Serious Mental Illness, and Substance Abuse Benefits, page 83) --- *effective September 1, 2007*

- **Outpatient Services – Substance Abuse:** Your child is eligible for up to 90 substance abuse outpatient visits per calendar year. There is a lifetime limit of 360 outpatient visits. If needed, you can exchange one inpatient day for two outpatient visits for your child.
- **Inpatient Services – Substance Abuse:** Your child is eligible for a maximum of 90 substance abuse inpatient days per calendar year. There is a lifetime limit of 360 substance abuse inpatient days.

*All page listings refer to the CHIP Benefits Handbook (3/05).

CBU2-October 2007

Independence Blue Cross & Highmark Blue Shield Caring Foundation

CHIP Benefits Update 3

(Please keep this update with your CHIP Benefits Handbook)

Renewal of Coverage (additional text under Section 1; Your Child's Eligibility, Coverage and Payments; page 12*) – *effective September 1, 2008*

If by the end of the renewal period, you provide incomplete or no proof of income, the Caring Foundation will offer your child At Cost CHIP coverage.

Termination of Coverage (additional text under Section 1; Your Child's Eligibility, Coverage and Payments; page 13-14) – *effective January 1, 2008*

5. If you fail to pay your child's monthly premium for Low Cost CHIP or At Cost CHIP.
6. If you display a pattern of non-compliance with your child's physician's plan of treatment. You will receive written notice at least 30 days prior to termination. You have the right to use the Complaint Appeal and Grievance Appeal Process (see page 40).
7. If you do not cooperate with Keystone Health Plan East ("Keystone") in obtaining information necessary to determine Keystone's liability under this program.

Designated Providers (text added to How to Get Basic Health Care under Section 3, How to Use Your Child's Insurance – A Summary of Things to Remember About the Keystone Plan, page 21) – *effective January 1, 2008*

Your child's primary care physician will submit an electronic referral to his or her designated provider for the following outpatient specialist services: physical and occupational therapy, and diagnostic services for children 5 and older. Outpatient services are not covered when performed by any provider other than your child's primary care physician's designated provider. Before selecting your child's primary care physician, you may want to speak to the primary care physician regarding his or her designated providers.

How to See a Specialist (replaces text under Section 3, How to Use Your Child's Insurance – A Summary of Things to Remember About the Keystone Plan, page 21) – *effective January 1, 2008*

- Call your child's primary care physician for a referral. He or she will submit an electronic referral for specific care or will obtain a preapproval form from Keystone when required.
- A standing referral may be available to your child if he or she has a life-threatening, degenerative, or disabling disease or condition. For more information, see page 30.
- You may take your female child to any participating obstetrical/gynecological specialist without a referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care, or problem-related obstetrical/gynecological conditions. For more information, see page 29.
- Your child's primary care physician must obtain a preapproval for specialist services by nonparticipating providers.

Note: Any reference in the CHIP Benefits Handbook saying that your child's primary care physician will provide a written referral is deleted. The primary care physician will submit an electronic referral to the appropriate participating provider for your child's specialty care.

Designated Providers (replaces text in How Keystone Reimburses Providers under Section 3, How to Use Your Child's Insurance – A Summary of Things to Remember About the Keystone Plan, page 24) – *effective January 1, 2008*

For physical and occupational therapy and diagnostic services for children 5 and older, PCPs are required to select a designated provider to which they refer their patients for those particular services. Designated providers usually receive a set dollar amount per member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, a parent may want to speak to the child's PCP regarding the designated provider that PCP has chosen.

Your Child Has Direct Access to Certain Care (replaces item 2, Your Child Has Direct Access to Certain Care under Section 4, How to See a Specialist or Plan for Hospital Care, page 29) – *effective January 1, 2008*

2. Care from a participating obstetrical/gynecological specialist;

When You Don't Use the BlueCard® Program (change of address under Section 5; Emergency Care, Urgent Care, and Follow-up Care; page 38) – *effective January 1, 2008*

If direct billing to Keystone by the provider cannot be arranged, send a letter explaining the reason care was needed and an original itemized bill to:

Keystone Health Plan East
P.O. Box 69353
Harrisburg, PA 17106-9353

Internal Second Level Standard Grievance Appeals (change under Section 6, Your Child's Membership Rights/Filing a Complaint or Grievance for Your Child, page 50) – *effective January 1, 2008*

The sentence "The committee's review will include the matched specialist report prepared for the first level grievance committee" is replaced by "The committee's review will include the matched specialist report."

Claim Procedures (subsection is added to Section 7, Your Responsibilities as the Parent or Guardian of a Keystone CHIP Member, page 54) – *effective January 1, 2008*

Most claims are filed by providers in Keystone's network. The following applies if a claim must be submitted by the parent or the personal representative of the child.

Notice of claim – Keystone will not be liable for any claims under the CHIP Benefits Handbook unless proper notice is furnished to Keystone that covered services in the handbook have been rendered to your child. Written notice of a claim must be given to Keystone within 20 days, or as soon as reasonably possible after covered services have been rendered to your child. Notice given by or on behalf of your child to Keystone that includes information sufficient to identify your child who received covered services shall constitute sufficient notice of a claim to Keystone. You can give notice to Keystone by calling Member Services at 1-800-464-5437. A charge shall be considered incurred on the date your child receives the covered service for which the charge is made.

Proof of loss – Claims cannot be paid until a written proof of loss is submitted to Keystone. Written proof of loss must be provided to Keystone within 90 days after the charge for covered services is incurred. Proof of loss must include all data necessary for Keystone to determine benefits. Failure to submit a proof of loss to Keystone within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Keystone be required to accept a proof of loss later than 12 months after the charge for covered services is incurred.

Claim forms – If you (or if you are deceased, your child’s personal representative) are required to submit a proof of loss for benefits under this handbook, it must be submitted to Keystone on the appropriate claim form. Keystone, upon receipt of a notice of claim will, within 15 days following the date notice of claim is received, furnish to you (or your child’s personal representative) claim forms for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of such notice, you (or your child’s personal representative) shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. Itemized bills may be submitted to Keystone. Call Member Services at 1-800-464-5637 to request a claim form. Itemized bills cannot be returned.

Submission of claim forms – For claims submitted for a child, the completed claim form, with all itemized bills attached, must be forwarded to Keystone at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this handbook.

To avoid delay in handling member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

- A. Person or organization providing the service or supply;
- B. Type of service or supply;
- C. Date of service or supply;
- D. Amount charged; and
- E. Name of patient.

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. Keystone reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

Timely payment of claims – Claims payment for benefits payable under this handbook will be processed immediately upon receipt of proper proof of loss.

Diabetic Self-Management and Education (replaces text under Section 10, Outpatient and Inpatient Services, page 62) – *effective January 1, 2008*

Benefits are provided for self-management training and education relating to diet when prescribed by a primary care physician or referred specialist. Covered services may be provided by a participating provider who is a licensed health care professional approved by Keystone. Covered services may also be provided by a participating community-based program, which is approved by Keystone in accordance with criteria based on the certification programs for diabetic self-management training and education programs developed by the American Diabetes Association and the Pennsylvania Department of Health, as follows:

- A. Visits medically necessary upon the diagnosis of diabetes;
- B. Visits under circumstances whereby your child’s primary care physician or referred specialist identifies or diagnoses a significant change in your child’s symptoms or conditions that necessitates changes in his or her self-management;
- C. Where a new medication or therapeutic process relating to your child’s treatment and/or management of diabetes has been identified as medically necessary by your child’s primary care physician or referred specialist.

Note: The text “or at a participating hospital on an outpatient basis” is deleted.

Home Health Care (Preapproval) (additional text under Section 10, Outpatient and Inpatient Services, page 64) – *effective January 1, 2008*

Care within 48 hours following release from an inpatient admission when the discharge occurs within 48 hours following a mastectomy.

Rehabilitation Therapy Services (change under Section 10, Outpatient and Inpatient Services, page 67) – *effective January 1, 2008*

The first sentence, “Covered services for all covered therapies other than speech therapy must be performed by your child’s primary care physician’s designated provider” is replaced by “Covered services for all covered therapies other than hand therapy and speech therapy must be performed by your child’s primary care physician’s designated provider.”

Organ Transplants (replaces text under Section 10, Outpatient and Inpatient Services, page 71) – *effective January 1, 2008*

Eligibility for covered services related to human organ, bone, and tissue transplant are as follows:

When your child is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all covered services. Covered services for inpatient and outpatient care related to the transplant include procedures that are generally accepted as not experimental/investigational services by medical organizations of national reputation. These organizations are recognized by Keystone as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services that are directly and specifically related to your child’s covered transplant. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to your child.

The determination of medical necessity for transplants will take into account the proposed procedure's suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.

If a human organ or tissue transplant is provided by a donor to a human transplant recipient:

- A. when both the recipient and the donor are members, each is entitled to the benefits of this plan.
- B. when only the recipient is a member, both the donor and the recipient are entitled to the benefits in this Benefits Handbook. However, donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.
- C. when only the donor is a member, the donor is entitled to the benefits of this Benefits Handbook, subject to the following limitations:
 1. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Benefits Handbook;
 2. No benefits will be provided to the non-member transplant recipient.
- D. If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program.

Covered services of a donor include:

1. Removal of the organ;
2. Preparatory pathologic and medical examinations;
3. Post-surgical care.

Dental Services – What is Covered (replaces item A, Preventive Services under Section 12, Dental Benefits, page 77) – *effective December 1, 2007*

- A. Routine prophylaxis (including cleaning, scaling, and polishing of teeth), but limited to not more than once in any period of six consecutive months with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during the pregnancy.

Exclusions (replaces text under Section 15, Medical Exclusions – What is Not Covered, pages 88-93) – *effective January 1, 2008, unless noted otherwise*

17. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary. This exclusion does not apply to Keystone's weight reduction program or nutrition counseling visits/sessions as provided by Keystone through its Nutrition Counseling for weight management benefit. (*effective July 1, 2007*)
39. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational, and speech therapies in a multidisciplinary, goal-oriented, and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy).

45. The cost of home blood pressure machines except for members: a) with pregnancy-induced hypertension; b) with hypertension complicated by pregnancy; or c) with end-stage renal disease receiving home dialysis.
50. Treatment of obesity, except for surgical treatment of obesity when Keystone:
- A. Determines the surgery is medically necessary;
 - B. The surgery is not a revision, repeat, or reversal of any previous obesity surgery. The exclusion of coverage for a revision, repeat, or reversal of any previous obesity surgery does not apply when required for complications that, if left untreated, would result in endangering the health of the member.
- This exclusion does not apply to nutrition counseling visits/sessions provided by Keystone through its Nutrition Counseling for weight management benefit. (*effective July 1, 2007*)

Definitions (change under Section 16, Important Definitions, pages 94-107) – *effective January 1, 2008, unless noted otherwise*

- **Cognitive Rehabilitative Therapy** (replaces “Cognitive Therapy”) – medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g., trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities that mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a physician, neuropsychologist, or psychologist, as well as physical, occupational, or speech therapist using a team approach.
- **Participating Provider**
 - G. **Obstetricians and Gynecologists** – a participating provider selected by a female member who provides obstetrical and/or gynecological covered services without a referral. Participating obstetricians and gynecologists have the same responsibilities as referred specialists. For example, they must seek preapproval for certain services. Similarly, just as you have the right to designate a referred specialist as your child’s PCP, you may designate a participating obstetrician or gynecologist as your child’s PCP.
- **Physician** – a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery, and dispense drugs.
- **Professional Provider** (replaces “Provider”) – a person or practitioner who is certified, who is registered, or who is licensed and performing services within the scope of such licensure. The professional providers are: audiologist, certified registered nurse, certified nurse midwife, chiropractor, dentist, independent clinical laboratory, licensed clinical social worker (for Mental Health Care and Serious Mental Illness services only), masters-prepared therapist, optometrist, physical therapist, physician, podiatrist, psychologist, registered dietitian, speech-language pathologist, and teacher of the hearing impaired.

- **Registered Dietitian (R.D.)** – a dietitian registered by a nationally recognized professional association of dietitians. A Registered Dietitian (R.D.) is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential “R.D.”
(effective July 1, 2007)

*All page listings refer to the CHIP Benefits Handbook (3/05).

The Independence Blue Cross & Highmark Blue Shield Caring Foundation For Children, in agreement with Keystone Health Plan East, independent licensees of the Blue Cross and Blue Shield Association, is an administrator of the Children’s Health Insurance Program (CHIP). For additional information regarding CHIP, call 1-800-986-KIDS, or visit www.chipcoverspakids.com.

Independence Blue Cross & Highmark Blue Shield Caring Foundation

CHIP Benefits Update 4

(Please keep this update with your CHIP Benefits Handbook)

What Insurance is Available? (clarification for Low-Cost CHIP specialist copayments under Introduction, page 10*) --- *effective February 1, 2009*

Low-Cost CHIP

“\$10 for each visit to a referred specialist” should be deleted and replaced by
“\$10 for each visit to a referred specialist (except for mental health and substance abuse services).”

Complaint or Grievance (changes to Section 6, Your Child’s Membership Rights/Filing a Complaint or Grievance for Your Child, pages 40-53) --- *effective January 1, 2009*

How to Pursue a Member Complaint or Grievance Appeal

The sentence, “In order to authorize someone else to be your child’s appeal representative, you must complete *The Member/Enrollee Authorization to Appeal by Provider or Other Representative and the Authorization to Release form*” should be deleted and replaced by, “In order to authorize someone else to be your child’s appeal representative, you must complete the appropriate forms.”

The sentence, “If your provider files an appeal on your child’s behalf, Keystone will verify that the provider is acting as your child’s appeal representative with your permission by obtaining valid authorization forms” should be deleted and replaced by, “If your provider files an appeal on your child’s behalf, Keystone will verify that the provider is acting as your child’s appeal representative with your permission by obtaining a valid consent form.”

The sentence, “The decision letter will also state the qualifications and titles of the individual(s) who reviewed your child’s appeal – by title, a general description of experience, and the board certification of any Physician-reviewer – and indicate their understanding of the nature of the appeal” should be deleted and replaced by, “The decision letter will also state the qualifications and titles of the individuals who reviewed your child’s appeal and indicate their understanding of the nature of the appeal.”

The correct address for the Pennsylvania Department of Health is:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Toll-free: 1-888-466-2787
717-787-5193
Fax: 717-705-0947

External Standard and Expedited Complaint Appeals

The correct addresses for the Pennsylvania Insurance Department and the Department of Health are:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Toll-free: 1-877-881-6388
717-787-2317
Fax: 717-787-8585

Pennsylvania Department of Health
Bureau of Managed Care
Attn: Complaint Appeals
Room 912 Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Toll-free: 1-888-466-2787
717-787-5193
Fax: 717-705-0947

Internal First-Level Standard Grievance Appeals

The second and third paragraphs should be deleted and replaced with the following single paragraph:

Your child's first-level standard grievance appeal is decided by a licensed psychologist or a physician who holds an active unrestricted license to practice medicine. This individual has had no previous involvement with the case, is not a subordinate of anyone previously involved with the case, and is of the same profession and/or similar specialty that typically manages the care under review.

Internal Second-Level Standard Grievance Appeals

The third paragraph should be deleted and replaced with:

The second-level grievance committee for a standard grievance appeal is composed of at least three persons who have had no previous involvement with your child's case and who are not subordinate to the original reviewer. The second-level grievance committee members include Keystone employees familiar with managed care operations and benefits. At least one of these employees is a Keystone medical director who holds an active, unrestricted license to practice medicine. Additionally, one-third of the committee consists of other persons not employed by Keystone.

Internal Expedited Grievance Appeals

The third paragraph should be deleted and replaced with:

The expedited grievance committee has the same composition as a second-level grievance committee for a standard grievance appeal, which includes Keystone employees familiar with managed care operations and benefits. At least one of these employees is a Keystone medical director who holds an active, unrestricted license to practice medicine. Additionally, one-third of the committee consists of other persons not employed by Keystone. The committee members include Keystone staff.

Over-the-Counter Drugs (replaces item 2, Prescription Drug Exclusions – What is Not Covered under Section 11, Prescription Drug Benefits, page 75) --- *effective January 1, 2009*

2. Drugs that do not by federal or state law require a prescription order (i.e., over-the-counter) or drugs that require a prescription order but have an over-the counter equivalent, except insulin and drugs specifically designated by Keystone, whether or not prescribed by a physician.

Dental (changes to Section 12, Dental Benefits, pages 78) --- *effective February 1, 2009*

Dental Services – What is Covered

3. Minor Restorations
 - A. Amalgam (silver) and resin-based composite (white) restorations for all permanent and deciduous teeth.
4. General Services
 - H. Periodontics (nonsurgical and surgical treatment of diseases of the gums and bone supporting the teeth)
 - Scaling and root planing – one per 24 months per area of mouth;
 - Periodontal maintenance (prophylaxis) – two in 12 months;
 - Debridement (full mouth) to enable comprehensive evaluation and diagnosis – once per lifetime;
 - Gingivectomy and gingivoplasty – one per surgical area per 24 months;
 - Osseous surgery – one per surgical area per 24 months;
 - Guided tissue regeneration – once per site per lifetime;
 - Bone replacement graft – one per surgical area per 24 months;
 - Soft tissue grafts – one per surgical area per 24 months;
 - Gingival flap procedures – one per surgical area per 24 months;
 - Distal or proximal wedge – (when not performed in conjunction with surgical procedures in same anatomical region) – one per surgical area per 24 months;
 - Crown lengthening – one per tooth per lifetime.

Dental Exclusions – What is Not Covered

“Labial veneers and laminates done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered” should be deleted and replaced by “Labial veneers and laminates done for cosmetic purposes.”

Note: Periodontics is deleted under Dental Exclusions.

Substance Abuse (removes the lifetime limits for Outpatient Services – Substance Abuse and Inpatient Services – Substance Abuse, under Section 13, Mental Health, Serious Mental Illness, and Substance Abuse Benefits, page 83, and CHIP Benefits Update 2) --- *effective February 1, 2009*

- **Outpatient Services – Substance Abuse:** Your child is eligible for up to 90 substance abuse outpatient visits per calendar year. There is no lifetime limit. If needed, you may exchange one inpatient day for two outpatient visits for your child.

- **Inpatient Services – Substance Abuse:** Your child is eligible for a maximum of 90 substance abuse inpatient days per calendar year. There is no lifetime limit.
 - Your child is eligible for seven days of detoxification per admission. There is no lifetime limit.

Definitions (changes under Section 16, Important Definitions, pages 94-107)---*effective January 1, 2009*

Intensive Outpatient Program – planned, structured program comprised of coordinated and integrated multidisciplinary services designed to treat a patient, often in crisis, who suffers from mental illness, serious mental illness, or substance abuse/substance abuse dependency. Intensive outpatient treatment is an alternative to inpatient hospital treatment or partial hospitalization and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until he or she is able to transition to less intensive outpatient treatment, as required.

Medically Necessary (or Medical Necessity) – health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease; and (3) not primarily for the convenience of the patient, 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 that patient’s illness, injury, or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Partial Hospitalization – medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a hospital or facility provider, designed for a patient who would benefit from more intensive services than are offered in outpatient treatment (intensive outpatient session or outpatient office visit) but who does not require inpatient confinement.

***All page listings refer to the CHIP Benefits Handbook (3/05).**

The Independence Blue Cross & Highmark Blue Shield Caring Foundation For Children, in agreement with Keystone Health Plan East, independent licensees of the Blue Cross and Blue Shield Association, is an administrator of the Children’s Health Insurance Program (CHIP). For additional information regarding CHIP, call 1-800-986-KIDS, or visit www.chipcoverspakids.com.