SPECIAL CARE SM

Special Care SM*

Low-cost Blue Cross® and Blue Shield® Coverage for eligible individuals and families

APPLICATION

A low-cost, limited benefit policy from Independence Blue Cross and Highmark Blue Shield—names you can trust!

- ✓ No physical exam needed!
- ✓ No annual Deductibles!
- ✓ No claim forms to fill out!

and

No wait list—eligible individuals are enrolled on a monthly basis!

Independence Blue Cross
Highmark Blue Shield

*Special Care is not affiliated with SPECIAL CARE, Inc., a home care company.
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.

If you have any questions
about this application, please call:

1-866-282-2702
(TDD 215-241-2622)

www.caringfoundation.com

Important Information:

This is an application for Special Care. Please note that if, in addition to you and/or your spouse, you are applying for a child on this application, your child will be screened automatically for the Children's Health Insurance Program (CHIP) and Medical Assistance.

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Special Care℠

The Special Care Program

For over 60 years, Independence Blue Cross (IBC) has provided health insurance to residents of the Greater Philadelphia region. IBC and Highmark Blue Shield share a mission to make health care coverage available and affordable to more of our community residents, and therefore the Special Care Program was created. Special Care is a low-cost product designed for people who are uninsured and cannot afford to purchase private insurance.

Eligibility

Special Care coverage is available to single individuals and families who are uninsured and do not qualify for any government programs including the Children's Health Insurance Program (CHIP), Medical Assistance, or Medicare, and cannot afford to purchase private health insurance. Applicants must reside within the five-county area served by Independence Blue Cross (unless they are found eligible for CHIP, Medical Assistance, or Medicare) and must meet family-size and income guidelines (income documentation is required).

Before you buy Special Care insurance, check the coverage in all health policies you already have.

Annual Renewal

Members will be required to renew their eligibility once each year on the anniversary of their original enrollment date by providing us with updated information and income documentation.

Special Care Benefits

Special Care is a traditional fee-for-service, limited benefit policy. Benefits include:

- Inpatient hospital care (up to 21 days per benefit period)
- Maternity and newborn care
- Surgery and anesthesia
- Four office visits per year for illness or injury ($10 copay)
- Preventive care including:
  - Pediatric preventive care
  - Annual mammograms for women age 40 and over
  - Annual GYN exams for all female subscribers
- Emergency accident and medical care
- Chemotherapy and radiation therapy
- Diagnostic tests and services

Special Care Providers

Medical/Surgical benefits are provided by all Highmark Blue Shield participating doctors.

Non-emergency hospital care services are provided by all Independence Blue Cross participating hospitals in the five-county area including Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, as well as those participating hospitals in Berks, Lancaster, Lehigh, and Northampton counties. Non-emergency admissions to a hospital that does not participate with Special Care are not covered.

Pre-Existing Conditions

Special Care includes a "pre-existing" rule. This means that for the first 12 months of coverage, Special Care will not pay for expenses related to a condition for which medical advice or treatment was recommended by a physician or received from a physician during the 12 months prior to the effective date of the policy.

This "pre-existing" rule does not apply to a person who transfers coverage from another Blue Cross/Blue Shield plan within 30 days or to a person who qualifies for CHIP, Medical Assistance, or Medicare.

Information For Medicare Recipients

Special Care is not Medicare Supplemental Insurance

Special Care insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplemental insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them including:

- **hospitalization**
- **physician services**
- **hospice care**
- **other approved items and services**

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The Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a state and federally funded health insurance program that provides health insurance coverage to uninsured children and teens up to age 19 who are Pennsylvania residents and are not eligible for Medical Assistance or Medicare and are not covered by private insurance. CHIP benefits are more comprehensive than Special Care benefits, and include prescriptions, as well as eye and dental care.

For many families CHIP is free. The cost of CHIP coverage is based on your family's income. (See income guidelines on page 3.)

Free CHIP: Provides free, comprehensive health care coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. **There is no wait list.**

Low Cost CHIP ($35.00, $56.21, or $64.24 per month per child): Provides low-cost health care coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. **There is no wait list.**

At Cost CHIP ($160.60 per month per child): Provides full-cost health care coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. **There is no wait list.**

If you are applying for a child on this application, your child will be screened automatically for CHIP or Medical Assistance.

Eligibility

Income and eligibility guidelines are similar for CHIP and Special Care. This application provides you the opportunity to fill out one form that works for both programs. If you meet the Special Care income guidelines and your child is not eligible for CHIP or Medical Assistance, he or she may be enrolled in Special Care.

Note: This is a Special Care application and will be considered an application for CHIP only if you are applying for Special Care. For child-only coverage, please use the enclosed CHIP/adultBasic application.

Annual Renewal

You will be required to renew your child's eligibility once every year on the anniversary date of his/her enrollment by providing us with updated information and current income documentation.

CHIP Benefits

CHIP coverage is provided through Keystone Health Plan East HMO. Coverage is available immediately upon enrollment, even for a pre-existing condition. Benefits include:

- Prescription drugs
- Doctor office visits
- Pediatric preventive care
- Immunizations
- Dental (cosmetic/orthodontia not included)
- Eye exams and eyeglasses
- Hearing exams and hearing aids
- Chemotherapy and radiation therapy
- Emergency care
- Diagnostic tests
- Hospitalization
- Surgery
- Substance abuse treatment
- Mental health care
- Durable medical equipment
- Maternity and newborn care

Copays are required for some services for Low Cost and At Cost CHIP members only. There are no copays for Free CHIP members.

Service	Free CHIP	Low Cost CHIP	At Cost CHIP
Primary Care Physician (PCP) visit	$0	$5*	$15
Specialist visit	$0	$10	$25
Emergency care visit (waived if admitted)	$0	$25	$50
Prescription drugs	$0	$6 generic $9 brand name	$10 generic $18 brand name

*Except for well-child visits

CHIP Providers

CHIP benefits are provided through Keystone Health Plan East HMO. All Keystone doctors and hospitals participate in CHIP.

Pre-Existing Condition

CHIP does not have a pre-existing condition rule. Treatment is available immediately on the child's effective date for any existing condition.

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What Are The Eligibility Guidelines?

Special Care Eligibility Requirements

To be eligible for Special Care you must:

- reside in one of the five counties served by Independence Blue Cross: Bucks, Chester, Delaware, Montgomery, or Philadelphia;
- not be covered by any other health insurance plan, self-insured plan, or self-funded plan;
- not be eligible for or covered by any government program, including CHIP, Medical Assistance, or Medicare; and
- meet the family size and income guidelines listed below.

CHIP Eligibility Requirements

A child must meet the following requirements to be enrolled in CHIP:

- Must be under age 19;
- Must be a resident of Pennsylvania;
- Must be a U.S. citizen, permanent/resident alien, or refugee;
- Must not be covered by any other health insurance plan, self-insured plan, or self-funded plan;
- For Low Cost or At Cost CHIP only: Must be uninsured for six 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 2; and
- Must not be eligible for or covered by Medical Assistance or Medicare.

Income Guidelines for Special Care and CHIP

Special Care	
Family size	Maximum allowable income limit
1	$20,420
2	$27,380
3	$34,340
4	$41,300
5	$48,260
6	$55,220
7	$62,180
8	$69,140

FREE CHIP			
Family size	Ages 0 to 1	Ages 1 through 5	Ages 6 through 18
1	$18,889 - $20,420	$13,580 - $20,420	$10,210 - $20,420
2	$25,327 - $27,380	$18,208 - $27,380	$13,690 - $27,380
3	$31,765 - $34,340	$22,837 - $34,340	$17,170 - $34,340
4	$38,203 - $41,300	$27,465 - $41,300	$20,650 - $41,300
5	$44,641 - $48,260	$32,093 - $48,260	$24,130 - $48,260
6	$51,079 - $55,220	$36,722 - $55,220	$27,610 - $55,220
7	$57,517 - $62,180	$41,350 - $62,180	$31,090 - $62,180
8	$63,955 - $69,140	$45,979 - $69,140	$34,570 - $69,140

Low Cost CHIP				At Cost CHIP
Family size	Ages 0 through 18 $35.00 per child per month	Ages 0 through 18 $56.21 per child per month	Ages 0 through 18 $64.24 per child per month	Ages 0 through 18 $160.60 per child per month
1	$20,421 - $25,525	$25,526 - $28,078	$28,079 - $30,630	over $30,630
2	$27,381 - $34,225	$34,226 - $37,648	$37,649 - $41,070	over $41,070
3	$34,341 - $42,925	$42,926 - $47,218	$47,219 - $51,510	over $51,510
4	$41,301 - $51,625	$51,626 - $56,788	$56,789 - $61,950	over $61,950
5	$48,261 - $60,325	$60,326 - $66,358	$66,359 - $72,390	over $72,390
6	$55,221 - $69,025	$69,026 - $75,928	$75,929 - $82,830	over $82,830
7	$62,181 - $77,725	$77,726 - $85,498	$85,499 - $93,270	over $93,270
8	$69,141 - $86,425	$86,426 - $95,068	$95,069 - $103,710	over $103,710

FPL 2/07

Income Documentation

Income documentation is required for both Special Care and CHIP.

Annual Renewal

Special Care and CHIP members will be required to renew their eligibility once a year by providing us with updated information and income documentation.

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How Do I Apply?

1. Read the application carefully.
2. Fill out the form. Please print clearly.
3. Answer all questions, including information requested about yourself, your spouse, and/or all dependents.
4. Attach proof of household income received during the last 60 days. See the section below for details.
5. Be sure to sign the application in Section 20 on page 11. This application cannot be processed if this section is not signed.
6. When you have completed the form, detach, fold, and insert the form and all income documentation into the included postage-paid envelope. Mail to:

Caring Foundation
PO Box 13449
Philadelphia, PA 19101-9552.

If you need help with this application, call 1-866-282-2702 or, if you are hearing impaired, call TDD 215-241-2622.
Si usted necesita ayuda con esta solicitud, llame al 1-866-282-2702 o, si es impedido de audición, llame al 215-241-2622.

Important Information: This is an application for Special Care. Please note that if, in addition to you and/or your spouse, you are applying for a child on this application, your child will be screened automatically for the Children's Health Insurance Program (CHIP) and Medical Assistance.

What Is Required As Income Documentation?

NOTE: You must attach proof of *all* household income received:
- During the last 60 days, and
- Before taxes and deductions. (Gross Pay)

If you receive wages, provide at least one pay stub that shows the following:
1. Gross income, and
2. Pay period dates.

If you do not receive a pay stub, your employer can write a letter that states your gross income per pay period.
NOTE: A tax return is not acceptable for wages.

If self-employed, provide both:
1. A complete copy of your most recent tax return form, and
2. If you receive a draw, copies of one month's worth of checks drawn within the last 60 days.

If you recently began your business, a Profit and Loss statement or other records may count as proof of income.

If unemployed, provide both:
1. Copy of the award letter, and
2. Copies of recent check stubs or a bank statement that shows direct deposit.

If you receive Social Security, pension, or Workers' Compensation, provide:
1. A copy of the most recent check, award letter, or a bank statement that shows direct deposit.

If you receive child support or alimony, provide both:
1. Recent check stubs, printout from Domestic Relations (can be found at www.childsupport.state.pa.us), printout for EPPI payments, or a bank statement that shows direct deposit, and
2. The amount of the award and frequency of payments.

A signed letter explaining your situation may be included to support any of the documentation you provide.

PLEASE SEND COPIES ONLY. ORIGINALS WILL NOT BE RETURNED.

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1. SUBSCRIBER INFORMATION

Social Security #	Last Name	First Name	M.I.	Gender	Date of Birth

Address	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #	Best time to call:

Race (circle one) *Optional*
- African American
- Asian
- Caucasian
- Native Alaskan/American Indian
- Native Hawaiian/Pacific Islander
- Asian (Indian Subcontinent)

Ethnicity (circle one) *Optional*
- Hispanic
- Non-Hispanic

2. FAMILY SIZE INFORMATION

Are you applying for any dependents?	Y N	How many people are in your household, including yourself, spouse, dependent children (under age 19), and eligible handicapped children? Total should include all household members, not just those you wish to cover.	

3. INCOME INFORMATION

Please list all sources of household income and provide documentation.

Source	Subscriber		Spouse/Dependent	
Employer's Name				
Wages from employment	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Self-Employment Net Business Income (before taxes)	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Social Security/Supplemental Security Income	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Pension/Retirement/Workers' Compensation	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Unemployment Compensation	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Dividends, Interest	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Child Support	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
Other Income (List)	weekly semi-monthly bi-weekly monthly other	$	weekly semi-monthly bi-weekly monthly other	$
	Total Income Subscriber	$	**Total Income Spouse/Dependent**	$
			Total Combined Household Income	$

4. DAYCARE AND TRANSPORTATION EXPENSES

Some of your expenses can help make your children or you eligible. Please tell us what you pay for child care and adult care, and what you pay for transportation to go to work.

Daycare Expenses

List each child or disabled adult's monthly daycare expense amount.

Name of child or disabled adult	Monthly daycare amount
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
Total monthly daycare expenses	$

Transportation Expenses

How much does it cost you to get to work each week if you ride with another person or take a bus, subway, or trolley?
If you drive to work, how many miles do you drive each week?
If you have a car, how much is your monthly payment?

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5. OTHER INSURANCE

A. Do you have any other health insurance? (if yes, see Section 8)	Y	N
B. If yes, do you wish to replace this coverage with Independence Blue Cross and Highmark Blue Shield Special Care? (see Section 16)	Y	N
C. If you answered yes to question A above, do you understand that unless you are transferring from another Blue Cross and Blue Shield plan, Independence Blue Cross and Highmark Blue Shield will not pay benefits during the first 12 months of the policy for any medical condition or illness for which medical advice or treatment was recommended or received within the 12-month period preceding the effective date of coverage? (see Section 16)	Y	N

6. OTHER INDIVIDUALS TO BE COVERED

Social Security#	Name	Gender	Date of Birth MM/DD/YYYY	How is this person related to the subscriber?	Does this person have any other insurance? *(If yes, see Section 5)*	What is this person's citizenship status?	Race: African American, Asian, Caucasian, Native Alaskan/American Indian, Native Hawaiian/Pacific Islander, Asian (Indian Subcontinent)	Ethnicity (circle one)
/ /		M F	/ /	SPOUSE	Y N	N/A		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic
/ /		M F	/ /	☐ Child ☐ Stepchild ☐ Other	Y N	☐ Citizen ☐ Permanent/Legal Alien ☐ Temporary Alien ☐ Refugee ☐ Illegal		Hispanic Non-Hispanic

Are you, or is anyone who lives with you a stepparent? Yes ☐ No ☐ (If the answer is no, skip to Section 7)	Do the stepchildren live with you? Yes ☐ No ☐
If you answered yes to the above questions, tell us:	
Stepparent's Name:	Stepparent for which children?
Stepparent's Name:	Stepparent for which children?

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7. YOUR CHILD'S DOCTOR NAME

If you are applying for a child on this application, please provide the name of his or her physician. To locate a Keystone provider, call 1-800-464-5437 or go to www.ibx.com and click on Find a Provider.

Child/Children name		Current patient Yes ☐ No ☐
Physician/Practice name	Physician/Practice telephone #	Keystone provider #
Physician/Practice address		

Child/Children name		Current patient? Yes ☐ No ☐
Physician/Practice name	Physician/Practice telephone #	Keystone provider #
Physician/Practice address		

8. HEALTH INSURANCE INFORMATION

This section must be completed in order to determine eligibility for enrollment. Even if you currently have health insurance, Medical Assistance can sometimes pay bills that your health insurer does not cover.

1. Does anyone you are applying for have private health insurance now? Yes ☐ No ☐
2. Has anyone you are applying for had private health insurance within the last six months? Yes ☐ No ☐
3. Have you, your spouse, or your children lost health insurance coverage because either you or your spouse are no longer employed? Yes ☐ No ☐
   – If yes, who lost coverage? _____

If you answered yes to any of the questions above, please fill in one or more of the boxes below and tell us all you can about the insurance.* If you have more than one kind of insurance, please fill in a box for each policy.

Insurance Company	Who holds this policy?
List each person covered	What is covered? ☐ Hospital care ☐ Prescriptions ☐ Vision ☐ Doctors' visits ☐ Dental
Policy number	Group number/name
When did this insurance start?	When did/will this insurance stop? (Leave blank if still covered)

Insurance Company	Who holds this policy?
List each person covered	What is covered? ☐ Hospital care ☐ Prescriptions ☐ Vision ☐ Doctors' visits ☐ Dental
Policy number	Group number/name
When did this insurance start?	When did/will this insurance stop? (Leave blank if still covered)

*If you need more space, please attach a separate sheet of paper.

4. Has anyone you are applying for been denied full or partial private health insurance coverage due to a pre-existing medical condition (such as asthma, diabetes, or past injuries)? Yes ☐ No ☐
5. If yes, please list the name(s) of the person(s) denied coverage due to a pre-existing medical condition (this will not affect eligibilty for CHIP, adultBasic, or Medical Assistance): _____

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9. CAR INSURANCE

Car insurance will often pay for injuries that occur in an accident. Medical Assistance will pay for only what the car insurance doesn't cover.

Do you have car insurance? If yes, please fill in the next section. If no, leave blank.	Yes ☐ No ☐

Insurance company:	Who holds this policy?	Policy number:	Policy expiration date:

10. HEALTH INSURANCE FROM YOUR EMPLOYER

Medical Assistance can sometimes buy health insurance for your children or you from your employer. Please help them decide if this is possible by completing this section.

Can you get health insurance for yourself through your work?	Yes ☐ No ☐	If yes, would you have to pay for it?	Yes ☐ No ☐
Can you or anyone in your household get health insurance for your children through work?	Yes ☐ No ☐	If yes, would you have to pay for it?	Yes ☐ No ☐

In the last 30 days, did anyone in your family lose a job where they had health insurance? Yes ☐ No ☐

11. SPECIAL QUALIFYING INFORMATION

If someone you are applying for is pregnant or has a disability or a special health care need, a higher income limit can be used when the household is eligible for Medical Assistance. Additional services are available for these individuals. Please help us find out if anyone you are applying for is eligible for these additional services.

Are you or anyone who lives with you pregnant? Yes* ☐ No ☐ *If yes, please tell us who.

Name:	Due date:	Name:	Due date:

Do you, or anyone who lives with you have a disability, chronic condition, ongoing special health care need, or a need for health-sustaining medication? Yes* ☐ No ☐

* If yes, tell us who, and about their needs.

Name:	What is their disability or condition? (optional)
Name:	What is their disability or condition? (optional)

Has this person applied for disability benefits (for example, Social Security Disability, Supplemental Security Income (SSI), Workers' Compensation, Private Disability Insurance), or special assistance with medical bills because of this condition?	Yes ☐ No ☐

Name:	What is their disability or condition? (optional)
Name:	What is their disability or condition? (optional)

Did anyone receive Social Security in the past?	Yes* ☐ No ☐	Did anyone receive Supplemental Security Income (SSI) in the past?	Yes* ☐ No ☐
*If yes, who?		When did it stop?	
If SSI was stopped, was it because he or she began to get Social Security?			Yes ☐ No ☐
If SSI was stopped, was it because he or she got an increase in Social Security?			Yes ☐ No ☐

12. HELP WITH UNPAID MEDICAL BILLS

You may be able to get help from Medical Assistance for unpaid medical bills from the last three months.

Do you have any unpaid medical bills for anyone you are applying for? Yes ☐ No ☐

If yes, at this time do *not* send copies of medical bills. The Department of Public Welfare will contact you.

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13. HELP WITH CHILD SUPPORT AND HEALTH INSURANCE – OPTIONAL INFORMATION

These answers will not affect your application for health care coverage.

If you are eligible for Medical Assistance, you may be able to get help with child support payments and with health insurance for your child if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Name of Absent Parent: ☐ Check if deceased			
Absent Parent's Street Address:	City:	State:	Zip:
Date of Birth: Social Security #: Which child(ren) is/was this parent responsible for?			
Name of Absent Parent: ☐ Check if deceased			
Absent Parent's Street Address:	City:	State:	Zip:
Date of Birth: Social Security #: Which child(ren) is/was this parent responsible for?			

14. NOTICE TO APPLICANTS

This is to inform you that, as part of our procedure for processing your eligibility application, an investigative report to verify the information on this application may be made. Such information may be obtained through personal interviews with employers, family members, business associates, financial sources, friends, neighbors, or other third parties with whom you are acquainted. You have the right to make written requests, within a reasonable period of time, for complete disclosure of additional information concerning the nature and scope of investigation. If you become eligible for Medicare, Medical Assistance, or other government insurance or enroll in an employer plan or private insurance, you should notify us about your coverage.

15. DECLARATION

I elect coverage under the Special Care plan for the adults listed on this form and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. I elect coverage for my child/children under the Children's Health Insurance Program (CHIP) and agree to abide by the conditions of the agreement. If my child/children is not eligible for CHIP or Medical Assistance then I elect coverage for the child/children under Special Care. Applicant and any listed dependents authorize any hospital, physician, or other health care provider to furnish Independence Blue Cross and Highmark Blue Shield, its assignee or designee, with such medical information about the applicant and dependents listed on the application as Independence Blue Cross and Highmark Blue Shield may require for claims payments, utilization review, quality assurance or in fulfillment of obligations imposed by applicable state or federal law. I understand and agree that: (1) the agreements may contain certain waiting periods; and (2) the agreements shall be binding on Independence Blue Cross and Highmark Blue Shield only if all of my statements are true.

16. NOTICE OF SPECIAL CARE PRE-EXISTING CONDITION(S) EXCLUSION

Independence Blue Cross and Highmark Blue Shield will not pay benefits, except for newborn children, during the first 12 months of the policy for charges related to any medical condition or illness for which medical advice or treatment was recommended by a physician or received from a physician within the 12-month period preceding the effective date of coverage, unless you and your dependents have been enrolled in a Blue Cross and Blue Shield Plan, or an affiliate of Independence Blue Cross for a period of 12 months and are transferring directly without a break in coverage.

THIS DOES NOT APPLY TO CHIP. CHIP HAS NO PRE-EXISTING CONDITION EXCLUSION POLICY.

17. NOTICE REGARDING FRAUDULENT INFORMATION

Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

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18. CHIP – RIGHTS AND RESPONSIBILITIES

- I have read and fully understand this application. The information I have given is true and correct.
- I understand that there may be penalties for knowingly giving false information.
- I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medical Assistance. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.
- I understand that I can request an impartial review of an eligibility determination if I do not agree with a CHIP eligibility decision made on this application.
- I agree to help in the review of the CHIP program. I understand this may include interviews, and a review of my child's health records and application form.

19. MEDICAL ASSISTANCE – RIGHTS AND RESPONSIBILITIES

- I understand that the information on this form will be kept confidential.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medical Assistance programs.
- I understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.
- I understand I will receive a written notice explaining benefits.
- I understand that I can request a hearing if I do not agree with a decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that Medical Assistance applicants must provide their Social Security Number. This number may be used to check the information on this application.
- I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the children applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, then I will allow the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I certify that all information on this application is true under penalty of perjury.
- I certify to the best of my knowledge that I understand my rights and responsibilities.
- I certify that the person(s) that I am applying for Medical Assistance for are U.S. Citizens or aliens in satisfactory immigration status. (I understand this certification does not apply to an alien who is applying for Medical Assistance Emergency Health Care benefits.)

SPECIAL CARE℠

Independence Blue Cross Highmark Blue Shield

chip Pennsylvania's Children's Health Insurance Program
We Cover All Kids.
Commonwealth of Pennsylvania
Edward G. Rendell, Governor

20. SIGNATURE FOR SPECIAL CARE OR CHIP (REQUIRED)

I/we represent that I/we have responded to this form truthfully and to the best of my/our knowledge, and that any attempts to become eligible for Special Care or CHIP through fraud or other material misrepresentations by me/us may result in termination of such contracts and possible criminal prosecution. I/we hereby authorize Independence Blue Cross and Highmark Blue Shield to make reasonable investigation and to obtain any document necessary to verify the information provided. I/we understand that if my/our income should change in such a way as to no longer meet the guidelines set forth for the application program, I/we will immediately notify Independence Blue Cross and Highmark Blue Shield. I/we have read and agree to the terms set forth above and below.

By signing below, I/we have read and understand the statements on this application.

Your signature: _____ Date signed: _____

Spouse's signature: _____ Date signed: _____

THIS SECTION OF THE APPLICATION MUST BE SIGNED IN ORDER FOR US TO PROCESS YOUR APPLICATION.
REMEMBER TO INCLUDE INCOME DOCUMENTATION.

Return this application in the enclosed postage-paid envelope! ***Send no money now—we will bill you later.***

1-866-282-2702

Monday – Friday, 8 a.m. to 6 p.m.

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.

Special Care℠ is not affiliated with SPECIAL CARE, Inc., a home care company

2007-0186 (10/07)

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SPECIAL CARE℠

Independence Blue Cross Highmark Blue Shield

chip Pennsylvania's Children's Health Insurance Program
We Cover All Kids.
Commonwealth of Pennsylvania
Edward G. Rendell, Governor

What Happens Next?

1. **After we receive your application, we will review you and/or your family's eligibility and contact you with a letter.**
2. **After we verify your income and other information, if you and/or your spouse are:**

   Eligible for Special Care:

   – we will send you a bill that must be paid before coverage can begin;
   – we will notify you of the enrollment date; and
   – upon enrollment, you will receive a Special Care ID card.

   Not eligible for Special Care:

   – we will notify you in writing to let you know why you are not eligible.

3. **After we verify your income and other information and you are applying for a child on this application, and your child is:**

   Eligible for FREE CHIP:

   – we will notify you of the enrollment date; and
   – we will send you a CHIP ID card for each child enrolled.

   Eligible for Low Cost or At Cost CHIP:

   – we will send you a bill that must be paid before coverage can begin;
   – we will notify you of the enrollment date; and
   – upon enrollment, you will receive a CHIP ID card for each child enrolled.

   Not eligible for CHIP:

   – we will notify you in writing to let you know why your child is not eligible; and
   – if your child appears eligible for Medical Assistance, his or her information will be sent to the County Assistance Office.

Monthly Premium Costs	
One adult	$118.30
One adult with one or more children	$168.75
Two adults	$236.55
Two adults with one or more children	$287.05

Note: Special Care eligibility is based on family size and income; premium costs are based on those family members you actually enroll.

Independent licensees of the Blue Cross and Blue Shield Association.

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CHIP and Special Care[SM*] Premium Changes

Effective December 1, 2007, the premiums for Low-Cost CHIP health insurance coverage are $25.00, $40.00, or $50.00 per month per child.

Effective December 1, 2010, the premium for At-Cost CHIP health insurance coverage is $236.53 per month per child.

Effective January 1, 2011, the monthly premiums for Special Care are as follows.

- One adult -------$148.70
- One adult with one or more children ------$211.70
- Two adults ------$297.35
- Two adults with one or more children -----$360.50

Please refer to reverse side for Income Guidelines for CHIP and Special Care programs.

*Special Care is not affiliated with SPECIAL CARE, Inc. a home care company.

2011 Income Guidelines for CHIP and Special Care

FREE CHIP			
Family Size	Ages 0 to 1	Ages 1 thru 5	Ages 6 thru 18
1	$20,036 - $21,660	$14,404 - $21,660	$10,830 - $21,660
2	$26,955 - $29,140	$19,379 - $29,140	$14,570 - $29,140
3	$33,874 - $36,620	$24,353 - $36,620	$18,310 - $36,620
4	$40,793 - $44,100	$29,327 - $44,100	$22,050 - $44,100
5	$47,712 - $51,580	$34,301 - $51,580	$25,790 - $51,580
6	$54,631 - $59,060	$39,275 - $59,060	$29,530 - $59,060
7	$61,550 - $66,540	$44,250 - $66,540	$33,270 - $66,540
8	$68,469 - $74,020	$49,224 - $74,020	$37,010 - $74,020

	Low Cost CHIP			At Cost CHIP
Family Size	Ages 0 thru 18 $25.00 per child per month	Ages 0 thru 18 $40.00 per child per month	Ages 0 thru 18 $50.00 per child per month	Ages 0 thru 18 $236.53 per child per month
1	$21,661 - $27,075	$27,076 - $29,783	$29,784 - $32,490	over $32,490
2	$29,141 - $36,425	$36,426 - $40,068	$40,069 - $43,710	over $43,710
3	$36,621 - $45,775	$45,776 - $50,353	$50,354 - $54,930	over $54,930
4	$44,101 - $55,125	$55,126 - $60,638	$60,639 - $66,150	over $66,150
5	$51,581 - $64,475	$64,476 - $70,923	$70,924 - $77,370	over $77,370
6	$59,061 - $73,825	$73,826 - $81,208	$81,209 - $88,590	over $88,590
7	$66,541 - $83,175	$83,176 - $91,493	$91,494 - $99,810	over $99,810
8	$74,021 - $92,525	$92,526 - $101,778	$101,779 - $111,030	over $111,030

Special Care	
Family Size	Maximum allowable income limit
1	$21,660
2	$29,140
3	$36,620
4	$44,100
5	$51,580
6	$59,060
7	$66,540
8	$74,020

Income Guidelines according to January 23, 2009 Federal Register

FPL 3/09