Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Independence
1901 Market Street
Philadelphia, PA 19103-1480

Independence Blue Cross

Children's Health Insurance Program (CHIP) Benefits Update

(Please keep this update with your CHIP Benefits Handbook)

Member Complaint and Grievance Appeal Process (pages 38 – 46*) - effective August 1, 2022

Description of the member complaint and grievance appeal process has been updated to read as:

Informal Member Complaint Process

Keystone HMO CHIP will make every attempt to answer any questions or resolve any concerns you have related to your child's benefits or services.

If you have a concern you should:

- call our Keystone HMO CHIP Member Help Team at 1-800-464-5437; or
- write or fax to:
  Manager of Customer Service
  Independence Blue Cross
  P.O. Box 13449
  Philadelphia, PA 19101-3449
  Fax: 215-241-3679

Most concerns are resolved informally at this stage. If Keystone HMO CHIP cannot immediately resolve your concerns, we will acknowledge it in writing within five (5) business days of receiving it. If you are not satisfied with the response to your concern from Keystone HMO CHIP, you have the right to file a formal complaint within sixty (60) calendar days, through the formal member complaint process described below.

Appeals

There are two types of appeals: grievances (medical necessity) and complaints (administrative). Appeals are also classified as standard or expedited. An expedited appeal is available for "urgent care," an appeal for medical care or treatment on which the application of the time frames for a non-urgent appeal could seriously jeopardize the life, health, or ability to regain maximum function of the enrollee; or in the opinion of a physician with knowledge of the enrollee's medical condition, the application of the standard time frame would subject the enrollee to unmanageable pain.

To file an appeal:

- call Member Appeals at 800-464-5437; or
- write or fax to:
  Keystone Health Plan East
  Member Appeals Department
  P.O. Box 41820
  Philadelphia, PA 19101-1820
  Fax: 1-888-671-5274

Grievances (Medical Necessity)

Internal Grievance for a Standard or Expedited Appeal (Keystone Health Plan East [KHPE] makes the decision) – There is one level of internal grievance appeal for both standard and expedited requests. The enrollee or their designee may submit a standard appeal request within 60 calendar days of the receipt of the original determination. KHPE makes a determination and notifies the enrollee or the designee within 30 calendar days of receipt of a standard grievance request. For expedited requests, if the grievance request is submitted by a physician, KHPE makes a decision and notifies the service provider and or prescribing physician, the enrollee or designee, if applicable, within 48 hours of receipt of the request.

If the expedited request is submitted by the enrollee or designee, KHPE makes a determination and notifies the member or designee within 72 hours of receipt of the request. Additionally, a written determination must be sent within two business days of the decision. All expedited requests must be certified by a physician.

Committee - The grievance is decided by a committee of three individuals: a KHPE Medical Director, who is a physician holding an active unrestricted license to practice medicine; a KHPE employee familiar with Managed Care and benefits; and a nonemployee voter. In addition, either a KHPE Medical Director or an independent consultant, is in the same or similar specialty as the Physician managing the care. The committee participants have had no previous involvement with the case and are not the subordinates of anyone previously involved. The enrollee or designee may participate in person, via teleconference or videoconference.

External Grievance - Upon completion of the internal appeals process, an enrollee or designee may request a standard or expedited external review, within 15 calendar days of the mail date of the final internal decision letter. An Independent Review Organization (assigned by the Pennsylvania Bureau of Managed Care) makes a determination and notifies the enrollee or designee within 60 calendar days of a standard external review request and within 72 hours of an expedited request, certified by a physician. For more information, please refer to the final internal grievance decision letter.

Complaints (Administrative)

Internal Complaints (KHPE makes the decision) - There are two levels of internal complaint appeals: For first level complaints, the enrollee or designee must submit their request to the plan within 60 calendar days of the original decision. The complaint decision is made by a KHPE employee who has knowledge of Managed Care and benefits. This individual has no previous involvement with the case and is not the subordinate of anyone previously involved. KHPE makes a decision and notifies the enrollee or designee within 30 calendar days of receipt of the appeal request. The enrollee or designee may request an in person first level complaint review.

For the second level complaint, the enrollee or designee must submit a request to KHPE within 45 calendar days of receipt of the first level decision letter. The decision is made by the second level committee and notification is sent to the enrollee or designee within 45 calendar days of receipt of the complaint request.

For expedited complaints, if the request is submitted by a physician, the Plan makes a decision and notifies the physician and enrollee within 48 hours of receipt of the request. If the expedited request is submitted by the enrollee or designee, KHPE makes a determination and notifies the member or designee within 72 hours of receipt of the request. Expedited requests must include a physician's certificate.

Committee for Second Level and Expedited Complaints - The decision is made by a committee of three individuals: a KHPE Medical Director, who holds an active, unrestricted license to practice medicine; a KHPE employee familiar with Managed Care and benefits; and a non-employee voter. Additionally, the committee participants have had no previous involvement with the case and are not the subordinates of anyone previously involved. The enrollee or designee may attend the committee meeting in person, via teleconference or video conference.

External Complaints - The enrollee or designee may submit an external complaint within 15 calendar days of the mail date of a second level decision, or an expedited decision, by contacting the Pennsylvania Bureau of Managed Care directly. For more information, please refer to the final internal complaint decision letter.

Appeal Classification

Enrollees or their designees may contact the Pennsylvania Bureau of Managed Care regarding KHPE's classification of an appeal as either a grievance or complaint. For more information, please refer to the final internal decision letter.

Copies of Relevant Information

Upon request from the enrollee KHPE provides the enrollee or designee with copies of all relevant documents, including clinical criteria pertaining to the grievance or complaint, free of charge, sufficiently in advance of the decision time frames.

Definition of contraception (page 54*) – effective August 1, 2022

The definition of contraception has been updated to read as:

Contraception: The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of contraceptives to prevent unintended pregnancy and improve health outcomes. Contraceptive care includes screening, education, counseling, initiation of contraceptive use, and follow-up care. The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration (FDA) include (1) sterilization surgery for women; (2) surgical sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) the shot or injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (progestin only, and); (9) oral contraceptives (extended or continuous use); (10) the contraceptive patch; (11) vaginal contraceptive rings; (12) diaphragm; (13) contraceptive sponges; (14) cervical caps; (15) condoms; (16) spermicides; (17) emergency contraception (levonorgestrel); and (18) emergency contraception (ulipristal acetate). Although all Food and Drug Administration-approved contraceptive methods, and patient education and counseling, not including abortifacient drugs, are covered, only certain contraceptive drug options in each category are covered at no cost share to the Member when provided by a Participating Provider. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Independence
1901 Market Street
Philadelphia, PA 19103-1480

Clarification of pharmacy contraceptive coverage for generic drugs (page 80*) - effective August 1, 2022

Description of contraceptives drugs and devices updated to read as:

Contraceptives Drugs and Devices – Coverage includes benefits for Contraceptive Drugs and Devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordability Act for certain generic products and brand products approved by the Federal Food and Drug Administration are covered at no cost-share to the Member when obtained from a Participating Pharmacy or Participating Mail Service Pharmacy. Coverage includes oral and injectable contraceptives, diaphragms, cervical caps, vaginal contraceptive rings, transdermal patches, emergency contraceptives and certain over- the-counter contraceptive methods. Intrauterine devices (IUD) and implantable rods are covered under the medical benefit. Abortifacient drugs are not covered. The noted standard cost-sharing in the "Outpatient Prescription Drugs" subsection of the ***Benefits at a Glance*** applies for all other contraceptive products.

Dual Drug Coverage Cost-Share (page 80*) - effective August 1, 2022

Dual coverage language added to description of Specialty Drugs:

Dual Coverage

Coverage and costs: Keystone HMO CHIP will provide coverage for an injectable medication in accordance with medical policy coverage criteria and the terms and conditions of this benefit booklet. This is subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements:

- If the drug is covered under the Injectable Medication benefit of this Benefit Booklet and is administered by a healthcare Provider in a Hospital Outpatient facility, provider's office, ambulatory (or free-standing) infusion suite, home (through a home infusion vendor), inpatient Hospital, or any other health care facility, this drug is eligible for coverage under the medical benefit:
    - Injectable medications are subject to the cost-share specified in the Schedule of Covered Services.
- Certain injectable medications may have a different formulation that is deemed eligible for coverage under the prescription drug benefit, if the benefit exists for the drug and if the Member can safely self-administer the drug without the assistance of a healthcare Provider, in accordance with the drug's prescribing information:
    - Self-administered drugs are subject to the cost-sharing associated with the terms of the Member's prescription drug benefit.
- Cost-sharing amounts for a drug that may be eligible for coverage under the Member's medical benefit or prescription drug benefit may vary. Members should discuss these coverage options with their healthcare Provider. Member financial responsibilities (including Deductible, Copayment, and/or Coinsurance) depend on the terms and conditions of the Member's applicable benefit. These terms and conditions are subject to change.

*The page listing refers to the CHIP Benefits Handbook (12/15).