



Benefits Handbook for Keystone HMO Children's Health Insurance Program (CHIP)

Free or low-cost health coverage through
Keystone Health Plan East, Inc. (KHPE)



Multi-Language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: 1-800-464-5437 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-464-5437 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-464-5437 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-464-5437 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-464-5437 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-464-5437 (رقم هاتف الصم والبكم: (TTY: 711).

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주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-464-5437 (TTY: 711) 번으로 전화해 주십시오.

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-464-5437 (TTY: 711)។

ATTENTION :Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-464-5437 (ATS : 711).

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ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-464-5437 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-464-5437 (TTY: 711).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-464-5437 (TTY: 711)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-464-5437 (TTY: 711).

सुचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-464-5437 (TTY: 711).

Look inside for...

- Services covered
- Using your child's insurance
- Seeing a specialist
- Services not covered
- How to file a complaint or grievance

Keystone HMO CHIP

Please read this Benefits Handbook and other benefits materials carefully. You also have access to the IBX member website at ibx.com where you can register and take advantage of the resources available to you for your child's care. If you have any questions about your child's coverage, please contact our Keystone HMO CHIP Member Help Team:

1-800-464-5437

(TTY/TDD users, call 711).



Benefits underwritten by Keystone Health Plan East, Inc., a subsidiary of Independence Blue Cross, independent licensees of the Blue Cross and Blue Shield Association. For additional information regarding the Children's Health Insurance Program (CHIP), visit chipcoverspakids.com.

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Required Disclosure of Information

State law requires that Keystone HMO CHIP make the following information available to you when you make a request in writing to Keystone Health Plan East (KHPE):

- a list of names, business addresses and official positions of the membership of the Board of Directors or Officers of KHPE;
- the procedures adopted to protect the confidentiality of medical records and other Member information;
- a description of the credentialing process for health care providers;
- a list of the participating health care providers affiliated with participating hospitals;
- whether a specifically identified drug is included or excluded from coverage;
- a description of the process by which a health care provider can prescribe any of the following when either: (1) the drug formulary's equivalent has been ineffective in the treatment of the Member's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the Member:
 - specific drugs;
 - drugs used for an off-label purpose; and
 - biologicals and medications not included in the drug formulary for prescription drugs or biologicals;
- a description of the procedures followed by KHPE to make decisions about the experimental nature of individual drugs, medical devices or treatments;
- a summary of the methodologies used by KHPE to reimburse for health care services (This does not mean that KHPE is required to disclose individual contracts or the specific details of financial arrangements with health care providers.);
- a description of the procedures used in KHPE's quality assurance program;
- other information that the Pennsylvania Department of Health or the Pennsylvania Insurance Department may require.

Policy Year

For purposes of the provisions of the Patient Protection and Affordable Care Act, with respect to the Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions, the policy year for this contract will be a calendar year.

Introduction

Welcome

On behalf of Independence Blue Cross (Independence), welcome to Keystone HMO CHIP.

Independence Blue Cross

- Independence is a leading health insurance organization in Southeastern Pennsylvania, which includes Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. Since 1939, we have been enhancing the health and wellness of the people and communities we serve by delivering innovative and competitively priced health care products and services; pioneering new ways to reward doctors, hospitals, and other health care professionals for coordinated, quality care; and supporting programs and events that promote wellness.
- Independence distributes Keystone HMO CHIP applications directly to families and through its vast network of community partners.
- Independence receives the completed applications and processes the information on behalf of the Commonwealth of Pennsylvania.
- Independence, through Keystone Health Plan East, Inc., provides health insurance to children enrolled in Keystone HMO CHIP.

CHIP

- This program has been offered by the Commonwealth of Pennsylvania since 1993.
- This program is funded by the state and federal governments for children and teens up to age 19.
- This program provides health insurance to children who fall within CHIP income guidelines and are not eligible for, or enrolled in, Medical Assistance (Medicaid), or covered by private insurance.
- There are three main tiers of coverage, which are based on a child's age, and family size and income.
 - **Free CHIP** – The parent of an enrolled child is not responsible for a monthly premium and there are no copayments for covered services.
 - **Low-Cost CHIP** – The parent of an enrolled child is responsible for paying a monthly premium, which is a portion of the total cost of the health insurance coverage. The monthly premium is based on family size and income. In addition, there are copayments for some covered services.
 - **Full-Cost CHIP** – The parent of an enrolled child is responsible for paying a monthly premium, which is the total cost of the health insurance coverage. The monthly premium is based on family size and income. In addition, there are copayments for some covered services.

Find a Doctor

Our *Find a Doctor* tool makes it easy to find the right doctor for your child's care. Go to www.ibx.com and search by providers, hospitals, or other care facilities.

We also provide informative doctor and hospital profiles and nationally recognized quality measurements to help you select the provider who is right for your child. Our provider profiles include:

- Credentials
- Hospital affiliations
- Reviews from other Members
- Office hours
- Status of accepting new patients

Keystone HMO CHIP coverage provides medical benefits through a large network of participating doctors and hospitals. You will be required to select a primary care physician (PCP) from the Keystone HMO CHIP network to provide your child's routine health care. United Concordia Companies, Inc., an independent company, provides dental benefits through a large network of participating dentists. Vision care benefits are administered by Davis Vision, an independent company.

Referrals are Needed to See a Specialist

This plan will pay some or all of the costs to see a specialist for covered services, but only if you obtain a referral before your child sees the specialist.

Your child does not need a referral from his or her PCP for the following covered services:

- Emergency services
- Nutrition counseling for weight management
- Inpatient hospital services that require preapproval (this does not include a maternity hospital stay)
- Behavioral health care and substance use treatment
- Diabetic education
- Mammograms
- Dialysis services performed in a participating provider facility
- Care from a participating obstetrical/gynecological specialist

Section 1

Eligibility, Coverage, and Payments

Eligibility

Who is Eligible?

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

- a resident of Pennsylvania for at least **thirty (30) days** prior to the date of enrollment (except newborns);
- a U.S. citizen, permanent/resident alien, temporary alien (under specific circumstances), or refugee;
- not covered by any other health insurance plan, self-insured plan, or self-funded plan;
- not eligible for, or covered by, Medical Assistance (Medicaid) offered through the Pennsylvania Department of Human Services (DHS);
- within guidelines based on family size and income;
- under the age of 19; and
- For Full-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.

Proof of Eligibility

You must provide proof of eligibility (for example, documentation of income or citizenship status) to DHS whenever you are asked to do so. If you refuse to provide the requested documentation, your child's coverage will be terminated.

Coverage

Who is Covered?

The child enrolled in the program and named on the KHPE ID card and the United Concordia* ID card is covered by Keystone HMO CHIP. Only the child named on these cards is eligible to receive benefits.

How Long is My Child Covered?

Your child is covered if your child continues to meet all of the CHIP eligibility guidelines. Eligibility will be renewed at least once a year on the anniversary date of your family's enrollment (see "Renewal of Coverage" below).

*Independence dental plans are administered by United Concordia Companies, Inc., an independent company.

Renewal of Coverage

DHS will check your child's eligibility at least once each year. This is called renewal. It is very important that you provide all the information requested on the renewal form that is sent to you by the due date listed. Renewals that are incomplete or received after the due date may result in the termination of your child's Keystone HMO CHIP coverage.

To complete the renewal, you can:

1. Visit dhs.pa.gov/COMPASS and follow the prompts
2. Call **1-800-986-5437** to complete the renewal over the phone
3. Mail, fax, or drop off documents to your local County Assistance Office (CAO)

DHS will notify you of your child's eligibility status. This will be based on the the information you provide during the renewal.

DHS may terminate your child's coverage if false or inaccurate information is provided or if information is omitted at the time of renewal.

Your Child's ID Cards

By the time you review this Benefits Handbook you should have received ID cards. Each enrolled child in your family will receive two ID cards: one from KHPE for medical, prescription drug, behavioral health, and vision services; and one from United Concordia for dental services.

Here are some important things to do and remember:

- **Make sure that you receive one KHPE ID card and one United Concordia ID card for each child you have enrolled.** These cards will allow the child named to get all the covered services that are detailed in this Benefits Handbook.
- **Check the information on each of your child's ID cards.** Make sure everything is correct, especially the spelling of your child's name. If you find any mistakes, contact the Keystone HMO CHIP Member Help Team at **1-800-464-5437** and United Concordia at **1-800-332-0366**.
- **Check the name of the primary care physician on the KHPE ID card.** Make sure the name of the doctor or group practice that you chose for your child is correct. If you find a mistake, contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- **Carry your child's ID cards with you at all times.** You must show one of these cards anytime your child receives covered services.
- **There is important information on the back of the KHPE ID card.** For example, there is:
 - information about services that will help you in a medical emergency;
 - a toll-free number that you can tell a hospital to call if they have questions about your child's medical coverage; and
 - a toll-free number that you must call for behavioral health and substance use services.
- If you lose the medical ID card, contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- If you lose the dental ID card, contact United Concordia at **1-800-332-0366**.

Premium Payment

Depending on your child's age, and family size and income, your child may be eligible for one of the three tiers of Keystone HMO CHIP coverage. If your child is eligible for Low-Cost CHIP or Full-Cost CHIP, you will be required to pay a monthly premium. You can make your payment by check, money order, credit card, debit card, or electronically. To get more information on your options, please contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

Monthly premiums effective July 1, 2023

Free CHIP	\$0
Low-cost CHIP 1	\$45 per child*
Low-cost CHIP 2	\$91.11 per child*
Low-cost CHIP 3	\$104.13 per child*
Full-cost CHIP	\$304.92 per child*

*The premium for three or more children is capped at three times (3x) the per-child monthly premium.

Note: Before your child can be enrolled, you will be required to pay for the first month's premium in advance. After that time, you will be billed directly by KHPE.

What Happens if a Premium is Paid Late?

If you fail to pay your child's monthly premium by the due date listed on the bill, your child's Keystone HMO 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 Keystone HMO CHIP coverage is terminated because you fail to pay the premium on time, you will have 90 days to pay all past due premiums to reinstate coverage without a lapse. If payment is not made within 90 days, you will need to complete a new application.

Potential Eligibility for Medical Assistance

Besides a decrease in your family's income, your child could be eligible for Medical Assistance due to a disabling condition. As required by its contract with the Commonwealth of Pennsylvania, KHPE will regularly review the health status of Keystone HMO CHIP Members. If a child has a condition that may be disabling, you and your child's primary care physician and/or specialist providers will be contacted for additional information. It is important that you cooperate fully by completing the form that you receive and promptly returning it. If the information indicates that your child has a disabling condition, we will initiate a smooth transfer of your child's enrollment in Medical Assistance with no lapse in coverage.

Termination of Coverage

Your child's Keystone HMO CHIP coverage may be canceled under the following conditions:

- If you commit willful misrepresentation or fraud in applying for or obtaining coverage for your child from KHPE (subject to your rights under the complaint procedure);
- If you misuse either of your child's ID cards, or allow someone other than your enrolled child to use the ID cards to receive care or benefits;
- If your child no longer meets all the eligibility requirements;
- If you fail to respond to the renewal request or return incomplete information with the renewal (see page 8);
- If you fail to pay your child's monthly premium for Low-Cost CHIP or Full-Cost CHIP; or;
- If you do not cooperate with KHPE in obtaining information necessary to determine KHPE's liability under this program.

Inpatient Provision

If your child is receiving inpatient care in a hospital or skilled nursing facility on the day Keystone HMO CHIP coverage is terminated, except for termination due to fraud or material misrepresentation, the benefits shall be provided until the earliest of:

- the expiration of such benefits according to the limitations included with this contract;
- determination of the primary care physician and KHPE that inpatient care is no longer medically necessary; or
- your child's discharge from the facility.

Note: Your child's coverage will not be terminated because of your child's health status or need for medically necessary covered services, unless your child is eligible for Medical Assistance coverage as discussed above, or because you exercised your rights under the complaint and grievance process.

Hearings and Appeals

If you do not agree with your CHIP eligibility decision, you will be able to appeal the decision and request a fair hearing that will be held by phone or, in some cases, face to face. The fair hearing form is included with your eligibility notice.

Section 2

How to Use Your Child's Insurance

How to Get Basic Health Care

All medical treatment begins with your child's primary care physician. You may often hear this referred to as your child's "PCP."

- **Always call your child's primary care physician first before you go for medical care** (except for conditions requiring emergency services as described on page 13).
- Your child's primary care physician provides coverage 24 hours a day, 7 days a week.
- Whenever possible, please schedule routine visits well in advance. Always call to cancel an appointment if you cannot make it.

Select a Primary Care Physician Before Receiving Services

- Prior to the time your child's coverage becomes effective in accordance with the provisions of this contract, you must choose a primary care physician (PCP) from whom you wish your child to receive covered services under this contract.
- At your option and subject to the nonparticipating provider's agreement to certain terms and conditions, your child may continue an ongoing course of treatment with a nonparticipating provider for a period of up to **sixty (60) days** from your child's effective date of coverage (see Continuity of Care on page 27).
- You can select a PCP as part of your CHIP application process, or call the Keystone HMO CHIP Member Help Team at 1-800-464-5437 (TTY/TDD: 711) to tell us the PCP you want. If we do not have your PCP selection, we will try to contact you. Ten days after your child's effective date, if you have not yet chosen a PCP, we will select one for you. We do this to ensure that a doctor is ready to help when your child needs care. If we assign a PCP, you can still choose another provider. See "How to Change Your Child's Primary Care Physician" on page 14 for more details.

How to See a Specialist

- Call your child's primary care physician for a referral. The physician will submit an electronic referral for specific care or will obtain preapproval from KHPE when required.
- A standing referral may be available to your child if your child has a life-threatening, degenerative, or disabling disease or condition. For more information, see page 25.
- You may take your 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 25.
- Your child's primary care physician must obtain a preapproval for specialist services by nonparticipating providers.

Designated Provider

Your child's primary care physician is required to select a designated provider for certain specialist services. The primary care physician will submit an electronic referral to their designated provider for these outpatient specialist services:

- Physical and occupational therapy;
- Diagnostic services for children age five (5) and older; and
- Laboratory and pathology tests.

Designated providers usually receive a set dollar amount per Member per month (capitation) for their services based on the primary care physicians that have selected them. These outpatient services are **not covered** when performed by a 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 their designated providers.

How to Obtain Emergency Medical Care

If you believe your child needs emergency services, call 911 or go immediately to the emergency department of the closest hospital. For more information, see page 85.

How to Get Continuing Care After Emergency Medical Care

Call your child's primary care physician if your child needs more care after getting emergency medical care. All continuing care as a result of emergency medical services must be provided, or referred, by your child's primary care physician or coordinated through our Keystone HMO CHIP Member Help Team **(1-800-464-5437)**.

What Medical Services Need Preapproval

Certain covered services need to be authorized by your child's primary care physician and preapproved by KHPE prior to your child receiving them. The primary care physician or referred specialist will obtain this approval from Keystone HMO CHIP prior to providing services to your child. Services in this category include, but are not limited to: hospitalization, certain outpatient services, skilled nursing facility services and home health care. You have the right to appeal any decision through the Grievance Appeal Process. Instructions for the appeal will be described in the denial notification you receive in the mail.

To be Covered, Services Must be Received from Keystone HMO CHIP Participating Providers

Except in cases requiring emergency services or urgent care while outside the service area, medical services must be received from Keystone HMO CHIP participating providers unless preapproved by KHPE. See "Preapproval for Nonparticipating Providers" on page 27 for procedures for obtaining preapproval for use of a nonparticipating provider. If your child receives services from a nonparticipating provider without obtaining preapproval, the services will not be covered.

Please visit ibx.com to find out more about individual providers, including hospitals, and primary care physicians and referred specialists and their affiliated hospitals. You can also obtain other information, such as whether the provider is accepting new patients, gender, hospital admitting privileges, professional qualifications, medical school attended, residency completion, board certification status, and languages spoken.

If you cannot access this website or you need assistance, please contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

How to Change Your Child's Primary Care Physician

You may change your child's primary care physician by calling our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. If you call before the end of the month, the change will be effective the first day of the following month. However, changes will take effect on the first of the current month:

- when you did not make a primary care physician selection at the time of enrollment, or
- if your child's primary care physician is no longer a participating provider.

If the participating status of your child's primary care physician changes, you will be notified so you can select another primary care physician.

When you change your child's primary care physician, your child will receive a new KHPE ID card. Remember to have your child's medical records transferred to the new physician.

How to Change Your Child's Referred Specialist

You may change the referred specialist to whom your child has been referred by your child's primary care physician or for whom you have a standing referral. To do so, ask your child's primary care physician to recommend another referred specialist before services are performed. Remember that only services authorized on the referral form will be covered.

If the participating status of a referred specialist your child regularly visits changes, you will be notified to select another referred specialist.

Interpreter Services

KHPE's interpreter services can help if you need assistance communicating with your child's health care provider because you are unable to speak or understand English, or have a hearing impairment.

KHPE offers interpreter services for Keystone HMO CHIP Members covering over sixty (60) different languages and dialects, as well as Certified Deaf Interpreters who translate American Sign Language. All interpreter services are provided at no cost to Members and patient confidentiality is assured.

There are two ways to request an interpreter:

1. Primary care providers or family physicians may call KHPE's Care Management and Coordination department to make arrangements to provide interpreter services for a Keystone HMO CHIP Member.
2. A parent of a Keystone HMO CHIP Member may call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** to schedule interpreter services for their child's doctor visit.

All requests should be made at least two weeks before the doctor's appointment.

To offer quality service, KHPE also has:

- multilingual staff members;
- telephone language services; and
- TTY/TDD for the deaf or hearing-impaired.

If you have questions about how KHPE can assist with language barriers in communication with your child's health care provider, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437 (TTY/TDD: 711)**.

Prescription Drugs are Covered Under Keystone HMO CHIP

Under Keystone HMO CHIP, prescription drugs, including medications and biologicals, are covered services or supplies when ordered during your child's inpatient hospital stay. Your child also has prescription drug coverage for outpatient prescription drugs. (For more information, see page 76).

Prescription drug benefits do not cover over-the-counter drugs except insulin or over-the counter drugs that are prescribed by a physician in accordance with applicable law. (For more information, see page 76).

Additionally, prescription drug benefits are subject to quantity level limits as conveyed by the U.S. Food and Drug Administration ("FDA") or KHPE's Pharmacy and Therapeutics Committee.

KHPE, for all prescription drug benefits, requires preapproval of a small number of drugs approved by the FDA for use in specific medical conditions. Where preapproval or quantity limits are imposed, your child's physician may request an exception for coverage by providing documentation of medical necessity. You may obtain information about how to request an exception by calling our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

You, or your child's physician acting on your child's behalf, may appeal any denial of benefits or application of higher copayments, if applicable, through the Complaint and Grievance Appeal Process described beginning on page 37.

Disease Management and Decision Support Programs

Disease management and decision support programs help parents and children to be effective partners in their health care by providing information and support for children with certain chronic conditions and those with everyday health concerns. Disease management is a systematic, population-based approach that involves identifying children with certain chronic diseases, intervening with specific information or support to follow primary care physicians' and treating physicians' treatment plans, and measuring clinical and other outcomes. Decision support involves identifying children who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their primary care physicians and treating physicians.

Decision support also includes the availability of general health information, personal health coaching, primary care physician's and treating physician's information, or other programs to assist in health care decisions.

Disease management interventions are designed to help children manage their chronic condition in partnership with their primary care physicians and treating physicians. Disease management programs, when successful, can help such children avoid long-term complications, and relapses that would otherwise result in hospital or emergency room care. Disease management programs also include outreach to parents and children to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the form of telephonic health coaching, print, audio library or videotape, or internet formats.

KHPE will use medical information such as claims data to operate the disease management or decision support programs, e.g., to identify children with chronic disease, predict which children would most likely benefit from these services, and communicate results to a child's treating primary care physician and treating physicians. KHPE will decide what chronic conditions are included in the disease management or decision support programs. A parent may call the Pediatric Case Management team directly at any time at 1-833-444-6428 to request enrollment into a disease management program. Additionally, parents with questions or concerns about their child's health may call a Nurse Health Coach, available 24 hours a day, at 1-833-444-6428.

Participation by a child in disease management or decision support programs is voluntary. A child may continue in the disease management or decision support program until any of the following occurs: (1) the parent or child notifies KHPE that they decline participation; or (2) KHPE determines that the program, or aspects of the program, will not continue.

Other Important Information About KHPE

How KHPE Reimburses Providers

KHPE's reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for their Members. Provided below is a general description of KHPE's reimbursement programs, by type of participating health care provider. These programs vary by state. Please note, these programs may change from time to time and arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your health care provider is compensated, please speak with them directly or contact us.

Professional Providers

Primary Care Physicians

Most primary care physicians are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a "capitation" payment and it covers most of the care delivered by the PCP. Covered services not included under capitation are paid fee-for-service according to the KHPE fee schedule. Many PCPs are also eligible to receive additional payments for meeting certain medical quality, patient service and other performance standards. By far the largest incentive component is related to quality and is based on compliance with preventive and chronic care guidelines. Other incentive payments are available for practices that have extended office hours or submit encounter and referral data electronically. There is also an incentive that is based on the extent to which a PCP prescribes generic drugs (when available and appropriate, relative to similar PCPs).

Referred Specialists

Most specialists are paid on a fee-for-service basis, meaning that payment is made according to KHPE's fee schedule for the specific medical services that the referred specialist performs. Some referred specialists are paid a global fee covering all of the related services delivered during an encounter and, therefore, may be at risk for the cost of these services. Obstetricians are paid global fees that cover most of their professional services for prenatal care and delivery.

Designated Providers

For a few specialty services, primary care physicians are required to select a designated provider to which they refer all of their KHPE patients for those services. The specialist services for which primary care physicians must select a designated provider vary by state and could include, but are not limited to, radiology, laboratory and pathology tests, and physical therapy. Designated providers usually receive a set dollar amount per Member per month (capitation) for their services based on the primary care physicians that have selected them. Before selecting a primary care physician, you may want to speak to the primary care physician regarding the designated provider that primary care physician has chosen.

Hospital-Based Provider

When your child receives covered services from a hospital-based provider while your child is an inpatient at a participating hospital or other participating facility provider and is being treated by a participating professional provider, your child will receive benefits for the covered services provided by a nonparticipating hospital-based provider.

A hospital-based provider can bill you directly for their services, for either the provider's charges or amounts in excess of KHPE's payment to the hospital-based providers (i.e., "balance billing"). You are not liable for any balance billing charges for covered services provided by a hospital-based provider. Your out-of-pocket costs are limited to applicable copayments. If you receive any bills from the provider, you need to contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. When you notify KHPE about these bills, KHPE will resolve the balance billing.

Institutional Providers

Hospitals

For most inpatient medical and surgical covered services, hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the hospital. These rates usually vary according to the intensity of services provided. Some hospitals are also paid case rates, which are set dollar amounts paid for a complete hospital stay related to a specific procedure or diagnosis, e.g., transplants.

For most outpatient and emergency covered services and procedures, most hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient services (e.g., lab and radiology) that includes both the facility and physician payment. For a few covered services, hospitals are paid based on a percentage of billed charges. Most hospitals are paid through a combination of the above payment mechanisms for various covered services.

Skilled Nursing Homes, Rehabilitation Hospitals, and other care facilities

Most skilled nursing facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Member is in the facility. These amounts may vary according to the intensity of services provided.

Ambulatory Surgical Centers (ASCs)

Most ASCs are paid specific rates based on the type of service performed. For a few covered services, some ASCs are paid based on a percentage of billed charges.

Integrated Delivery Systems

In a few instances, global payment arrangements are in place with integrated hospitals/physician organizations called Integrated Delivery Systems (IDS). The IDS may provide or arrange for some of the hospital, physicians, and ancillary covered services provided to some Members who select PCPs that are employed by or otherwise participate with the IDS. An IDS is paid a global fee to cover all such covered services, whether provided by the IDS or other providers. The IDS is, therefore, "at risk" for the cost of these covered services. An IDS may provide incentives to their IDS-affiliated professional providers for meeting certain quality, service or other standards.

Physician Group Practices and Physician Associations

Certain physician group practices and Independent Physician Associations (IPA) employ or contract with individual physicians to provide medical covered services. These groups are paid as outlined above. These groups may pay these affiliated physicians a salary and/or provide incentives based on quality, production, service or other performance standards. In addition, KHPE has entered into a joint venture with an IPA. This IPA is paid a global fee to cover the cost of all covered services, including hospital, professional and ancillary covered services provided to Members who choose a PCP in this IPA. This IPA provides incentives to its affiliated physicians for meeting certain quality, service and other performance standards.

Ancillary Service Providers

Some ancillary service providers, such as durable medical equipment and home health care providers, are paid fee-for-service payments according to KHPE's fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory services, receive a set dollar amount per Member per month (capitation). Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Mental Health/Alcohol or Drug Use and Dependency

A Mental Health/Alcohol or Drug Use and Dependency ("behavioral health") management company administers most of the behavioral health benefits and provides a network of participating behavior specialists. The behavioral health management company is paid a set dollar amount per Member per month (administrative service fee) for each Member and is responsible for providing the behavioral health network and performing utilization review to determine that medical necessity criteria are being met. (See "Utilization Review Process" on page 19). The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters.

Pharmacy

A pharmacy benefits management company (PBM), which is affiliated with KHPE, administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. KHPE anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of prescription drug benefits.

Participating Dentist

When treatments are performed by a participating dentist, in accordance with the participating dentist's contract, covered benefits will be paid directly to the participating dentist. Both the Member and the dentist will be notified of benefits covered and the payment the participating dentist received. Payment will be based on the maximum allowable charge the treating participating dentist has contracted to accept. Maximum allowable charges may vary depending on the geographical area of the dental office and in accordance with the participating dentist's contract and the particular participating dentist rendering the service. Participating dentists agree by contract to accept maximum allowable charges as payment in full for covered services rendered to Members. The Member shall be held harmless if, after receiving services from a participating dentist, such services are determined not dentally necessary.

Benefits for any services started prior to a child's effective date of coverage are not covered. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the child's effective date are the liability of the parent.

When an overpayment for benefits is made, KHPE has the right to recover the overpayment either from the parent or from the person or dentist to whom it was paid. The overpayment will be recovered either by requesting a refund or offsetting the amount overpaid from future claim payments. This recovery will follow any applicable state laws or regulations. The parent must provide any assistance necessary, including furnishing information and signing necessary documents, for KHPE to be reimbursed.

This contract does not coordinate benefits with other dental plans.

Utilization Review Process

Two conditions of KHPE's and its affiliates' benefit plan are that in order for a health care service to be covered or payable, the service must be: (1) eligible for coverage under the benefit plan, and: (2) medically necessary. To assist KHPE in making coverage determinations for certain requested health care services, KHPE uses established medical policies and medical guidelines based on clinically credible evidence to determine the medical necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the medical necessity of requested health care services for coverage determinations based on the benefits available under a Member's benefit plan is called utilization review.

It is not practical to verify medical necessity on all procedures on all occasions; therefore, certain procedures may be determined by KHPE to be medically necessary and automatically approved based on the accepted medical necessity of the procedure itself, the diagnosis reported or an agreement with the performing provider. An example of such automatically approved services is an established list of services, received in an emergency room, which have been approved by KHPE based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g., rule out myocardial infarction, or major trauma). Other requested services, such as certain elective inpatient or outpatient procedures, may be reviewed on a procedure-specific or setting basis.

Utilization review generally includes several components based on when the review is performed. When the review is required before a service is performed (pre-service review) it is called "pre-certification" or "preapproval." Reviews occurring during a hospital stay are called "concurrent reviews." Those reviews occurring after services have been performed (post-service reviews) are called "retrospective reviews." KHPE follows applicable state and federally required standards for the timeframes in which such reviews are performed.

Generally, where a requested service is not automatically approved and must undergo medical necessity review, nurses perform the initial case review and evaluation for plan coverage approval using KHPE's medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director may deny coverage for a procedure based on medical necessity. The evidence-based clinical protocols evaluate the medical necessity of specific procedures and the majority is computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration the individual Member's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of medical necessity, a letter is sent to the requesting provider and Member in accordance with applicable law.

KHPE's utilization review program encourages peer dialogue regarding coverage decisions based on medical necessity by providing physicians with direct access to KHPE medical directors to discuss coverage of a case. The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination. KHPE does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals, which would encourage utilization review decisions that result in underutilization.

Prior Authorization

Sometimes, there are services or items that your PCP must ask KHPE to approve for you. This is known as "Prior Authorization." These services include, but are not limited to:

- All scheduled (non-emergency) hospital admissions
- Ambulance services (non-emergency)
- Ambulatory Surgical Center/Short Procedure Unit procedures
- Certain durable medical equipment, such as wheelchairs and repairs
- Chemotherapy
- CT scans/PET scans/MRI
- Echocardiography
- Medicines not included in the KHPE formulary
- Occupational/Physical/Speech Therapy

When KHPE receives a complete request for prior authorization, a written decision notice will be mailed to you within two business days from the date of our decision. If KHPE believes that we do not have all the information needed to make a decision, we will ask for the additional information needed from your child's provider. If your provider does not send the additional information within the requested timeframes, then we will base our decision on the information available.

You have the right to appeal any prior authorization request that is denied. The written notice will tell you what you have to do to appeal. KHPE follows set standards when making a decision about prior authorization or whether a procedure is medically necessary. These standards are called "clinical criteria." Your provider can get a copy of these criteria by calling the provider helpline. You may get a copy of the clinical criteria used in making a medical necessity decision by calling the Keystone HMO CHIP Member Help Team at 1-800-464-5437 (TTY/TDD: 711).

If your children's provider calls for an authorization for a service and it is not approved, KHPE will not pay for that service. However, you may still receive the service if you are willing to pay out of pocket. Your provider will have you sign a form saying you are aware you are responsible for paying for this unauthorized service. Before your child receives any service requiring prior authorization, you have the right to check that authorization has been approved by calling the Keystone HMO CHIP Member Help Team at 1-800-464-5437 (TTY/TDD: 711).

Discharge Planning

Discharge planning is performed during an inpatient admission and is used to identify and coordinate a Member's needs and benefit plan coverage following the inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or skilled nursing facility placement. Discharge planning involves KHPE's authorization of post-hospital covered services and identifying and referring Members to disease management or case management benefits.

Selective Medical Review

In addition to the foregoing requirements, KHPE reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain covered services ("selective medical review") that are otherwise not subject to review as described above. In addition, KHPE reserves the right to waive medical review for certain covered services for certain providers, if KHPE determines that those providers have an established record of meeting the utilization and/or quality management standards for those covered services. Regardless of the outcome of KHPE's selective medical review, there are no coverage penalties applied to the Member.

Clinical Criteria, Guidelines and Resources

The following guidelines, clinical criteria and other resources are used to help make medical necessity coverage decisions:

Clinical Decision Support Criteria: An externally validated and computer-based system used to assist KHPE in determining medical necessity. These evidence-based, clinical decision support criteria are nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist KHPE's clinical staff in evaluating the medical necessity and appropriateness of coverage based on a Member's specific clinical needs. Clinical decision support criteria help promote consistency in KHPE's plan determinations for similar medical issues and requests, and reduce practice variation among KHPE's clinical staff to minimize subjective decision-making.

Clinical decision support criteria may be applied for covered services including, but not limited to the following:

- Some elective surgeries — settings for inpatient and outpatient procedures (e.g., tonsillectomy and sinus surgery)
- Inpatient hospital services
- Inpatient rehabilitation care
- Home health care
- Durable Medical Equipment (DME)
- Skilled nursing facility services

Centers for Medicare and Medicaid Services (CMS) Guidelines: A set of guidelines adopted and published by CMS for coverage of services by Medicare for persons who are eligible and have health coverage through Medicare or Medicaid.

HMO Medical Policies: Our internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services. Certain medical policies are available on our website.

Covered services for which KHPE's medical policies are applied include, but are not limited to:

- Ambulance
- Durable Medical Equipment (DME)
- Infusion therapy
- Occupational therapy
- Physical therapy
- Review of potential cosmetic procedures
- Speech therapy

Internally Developed Guidelines: A set of guidelines developed specifically for KHPE by clinical experts based on accepted practice guidelines within the specific fields and reflecting KHPE's medical policies for coverage.

Delegation of Utilization Review Activities and Criteria

In certain instances, KHPE has delegated certain utilization review activities, which may include preapproval, pre-certification, concurrent review, and case management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, neonates/premature infants) or a type of benefit or service (such as radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with KHPE's approval.

Utilization Review and Criteria for Mental Health/Substance Use Services

Utilization review activities for mental health/substance use ("behavioral health") services have been delegated by KHPE to a behavioral health management company, which administers the behavioral health benefits for KHPE's Members. The behavioral health management company's utilization review criteria are available through a link on our website.

Medical Technology Assessment is Performed by KHPE

- Technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These expert sources include, and are not limited to, articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature.
- KHPE uses the technology assessment process to find out whether new drugs, procedures or devices are considered to be safe and effective before approving them as a covered service.
- When new technology becomes available or when a practitioner or Member requests, KHPE researches scientific information available from expert sources. Following this analysis, KHPE decides when a new drug, procedure, or device has been proven to be safe and effective and uses this information to decide if an item becomes a covered service.
- A Member or their Provider should contact KHPE to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. KHPE maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

Special Circumstances

If special circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for covered services under this contract (e.g., obtaining referrals, use of participating providers), or to the administration of this contract by KHPE, KHPE may, on a selective basis, waive certain procedural requirements or cost-sharing of this contract. Such waiver shall be specific as to the requirements that are waived and shall last for such period of time as is required by the special circumstances as defined below.

KHPE shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, KHPE shall provide access to covered services in so far as practical, and according to its best judgment. Neither KHPE nor providers in Keystone HMO CHIP's network shall incur liability or obligation for delay, or failure to provide or arrange for covered services if such failure or delay is caused by special circumstances.

Special circumstances, as recognized in the community and by KHPE and appropriate regulatory authority, are extraordinary circumstances not within the control of KHPE, including but not limited to:

- a major disaster;
- an epidemic;
- a pandemic;
- the complete or partial destruction of facilities;
- riot;
- civil insurrection; or
- similar causes.

Section 3

How to See a Specialist or Plan for Hospital Care

Your Child Has Direct Access to Certain Care

Your child does not need a referral from your child's primary care physician for the following covered services:

- Emergency services;
- Care from a participating obstetrical/gynecological specialist;
- Mammograms;
- Behavioral health care and substance use treatment;
- Inpatient hospital services that require preapproval. This does not include a maternity hospital stay.
- Dialysis services performed in a participating facility provider or by a participating professional provider;
- Nutrition counseling for weight management; and
- Diabetic education program.

How to Get a Specialist Referral

If, except for services listed under the "Your Child Has Direct Access to Certain Care" provision above, your child's primary care physician refers your child to a specialist or facility, just follow these steps:

- Your child's primary care physician will supply an electronic form that indicates the services authorized.
- You can give this form to the referred specialist or facility or it can be sent electronically to the referred specialist or facility before the services are performed.
- Take your child to see the specialist within **ninety (90) days**. Your child's referral is valid for only **ninety (90) days** from the date you get it. Your child must still be enrolled in Keystone HMO CHIP when the specialist sees your child.
- Only services authorized on the referral form and provided within **ninety (90) days** from the date of referral will be covered.
- You must request another electronic referral form from your child's primary care physician if the specialist recommends additional treatment beyond the **ninety (90) days** from the date of issue of the initial referral.
- Your child must be an enrolled Member at the time your child receives services from a referred specialist or nonparticipating provider in order for services to be covered.

Services by nonparticipating providers require preapproval by KHPE in addition to the electronic referral from your child's primary care physician. See "Preapproval for Nonparticipating Providers" on page 27 for procedures for obtaining preapproval for use of a nonparticipating provider.

How to Obtain a Standing Referral

If your child has a life-threatening, degenerative or disabling disease or condition, your child may receive a standing referral to a specialist to treat that disease or condition. The referred specialist will have clinical expertise in treating the disease or condition. A standing referral is granted upon review of a treatment plan by KHPE and in consultation with your child's primary care physician.

Follow these steps to start your child's standing referral request:

- Call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. (Or, you may ask your child's primary care physician to call the Provider Services or the Care Management and Coordination department to obtain a standing referral request form.)
- A standing referral request form will be mailed or faxed to you.
- You must complete a part of the form and your child's primary care physician will complete the medical part. Your child's primary care physician will send the form to KHPE's Care Management and Coordination department.
- The Care Management and Coordination department will either approve or deny the request for the standing referral. You, your child's primary care physician and the referred specialist will receive notice of the approval or denial in writing. The notice will include the time period for the standing referral.

If the Standing Referral is Approved

If the request for the standing referral to a specialist is approved, the referred specialist, your child's primary care physician and you will be informed in writing by the Care Management and Coordination department. The referred specialist must agree to abide by all the terms and conditions that KHPE has established with regard to standing referrals. This includes, but is not limited to, the need for the referred specialist to keep your child's primary care physician informed of your child's condition. When the standing referral expires, you or your child's primary care physician will need to contact the Care Management and Coordination department and follow the steps outlined above to see if another standing referral will be approved.

If the Standing Referral is Denied

If the request for a standing referral is denied, you and your child's primary care physician will be informed in writing. You will be given information on how to file a formal complaint if you want to do so.

How to Have a Referred Specialist Designated as Your Child's Primary Care Physician

If your child has a life-threatening, degenerative or disabling disease or condition, your child may have a referred specialist named to provide and coordinate both your child's primary and specialty care. The referred specialist will be a physician with clinical expertise in treating your child's disease or condition. It is required that the referred specialist agrees to meet KHPE's requirements to function as a primary care physician.

Follow these steps to initiate your request for your child's referred specialist to be your child's primary care physician:

- Call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. Or, you may ask your child's primary care physician to call the Provider Services or Care Management and Coordination department to initiate the request.

- A “Request for Specialist to Coordinate All Care” form will be mailed or faxed to you.
- You must complete a part of the form and your child’s primary care physician will complete the medical part. Your child’s primary care physician will then send the form to KHPE’s Care Management and Coordination department.
- A medical director will speak directly with the primary care physician and the selected referred specialist to inform all parties of the primary services that the referred specialist must be able to provide in order to be designated as your child’s primary care physician. If the Care Management and Coordination department approves the request, it will be sent to the Provider Services area. That area will confirm that the referred specialist meets the same credentialing standards that apply to primary care physicians. (At the same time, your child will be given a standing referral to see the referred specialist.)

If the Referred Specialist as Primary Care Physician Request is Approved

If the request for the referred specialist to be your child’s primary care physician is approved, the referred specialist, your child’s primary care physician and you will be informed in writing by the Care Management and Coordination department.

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a referred specialist designated to provide and coordinate your child’s primary and specialty care is denied, you and your child’s primary care physician will be informed in writing. You will be given information on how to file a formal complaint if you want to do so.

How to Plan for Hospital Care

If your child needs hospitalization or outpatient surgery, here are some things you should be aware of:

- Your child’s primary care physician is the one who will arrange for your child to be admitted to the hospital or to have outpatient surgery.
- Your child’s primary care physician will talk with KHPE to make sure the admission or surgery will be covered. This is called preapproval.
- If the referred specialist feels that your child needs hospitalization or outpatient surgery, the referred specialist will talk with your child’s primary care physician. If they agree, they will work together to arrange for your child’s care to be preapproved by KHPE.
- You do not need to get an electronic referral from your child’s primary care physician.
- When KHPE’s Care Management and Coordination department receives the information from your child’s primary care physician or referred specialist, they will evaluate the request for hospitalization or outpatient surgery based on clinical criteria guidelines. A KHPE medical director will evaluate the request. If the request is denied, you, your child’s primary care physician or referred specialist has a right to appeal this decision through the grievance process.
- While your child is in the hospital, the Care Management and Coordination department will be monitoring your child’s hospital stay to assure that a plan for your child’s discharge is in place. This is to make sure your child has a smooth transition from the hospital to home, or to another setting like a skilled nursing or rehabilitation facility. A KHPE case manager will work closely with your child’s primary care physician or referred specialist to help with your child’s discharge and if necessary, arrange for other medical services.

- You will receive written notification if your child's primary care physician or referred specialist agrees with KHPE that inpatient hospitalization services are no longer required. If your child remains in the hospital after this notification, the hospital may have the right to bill you after the date of the notification. You may appeal this decision through the grievance process.

Continuity of Care

If your child is in an ongoing course of treatment and:

- your child's physician is no longer a participating provider because KHPE terminates its contract with that physician, for reasons other than cause; or
- your child is newly enrolled in the plan and is already in an ongoing course of treatment with a nonparticipating provider.

You have the option, if your child's physician agrees to be bound by certain terms and conditions required by KHPE, to continue your child's ongoing course of treatment with that physician for up to **sixty (60) calendar days** from:

- receipt of notice that the status of your child's physician has changed; or
- your child's effective date of coverage.

If your child is in the second or third trimester of pregnancy at the time of enrollment or the termination of a participating provider's contract, the continuity of care with that physician will extend through post-partum care related to the delivery.

Follow these steps to initiate your child's continuity of care:

- Call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** and ask for a "Request for Continuation of Treatment" form.
- The "Request for Continuation of Treatment" form will be mailed or faxed to you.
- You must complete the form for your child and send it to the Care Management and Coordination department at the address that appears on the form.

If your child's physician agrees to continue to provide your child's ongoing care, the physician must also agree to be bound by the same terms and conditions that apply to participating providers.

You will be notified when the participating status of your primary care physician changes so that you can select another primary care provider.

Preapproval for Nonparticipating Providers

KHPE may approve payment for covered services provided by a nonparticipating provider if you have:

- First sought and received care from a participating provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the nonparticipating provider that you have requested for your child (your child's primary care physician is required to obtain preapproval from KHPE for services provided by a nonparticipating provider);
- Been advised by the participating provider that there are no participating providers that can provide the requested covered services; and

- Obtained authorization from KHPE prior to receiving care. KHPE reserves the right to make the final determination whether there is a participating provider that can provide the covered services.

If KHPE approves the use of a nonparticipating provider, you will not be responsible for the difference between the provider's billed charges and KHPE's payment to the provider, but you will be responsible for applicable cost-sharing amounts, if any. If you receive any bills from the provider, please contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. When you notify KHPE about these bills, KHPE will resolve the balance billing. Applicable program terms including medical necessity, referrals and preapproval by KHPE, when required, will apply.

Section 4

Emergency Care, Urgent Care, and Follow-up Care

What is Emergency Care?

Emergency care is any health care service provided to a child after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the child or, with respect to a pregnant adolescent, the health of the adolescent or unborn child in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service.

Note: It is your responsibility to contact KHPE for any bill you receive for emergency services provided by a nonparticipating provider. If you receive any bills from the provider, you need to contact our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. When you notify KHPE about these bills, KHPE will resolve the balance billing.

Emergency Care Copayment

If a Low-Cost CHIP or Full-Cost CHIP Member has been referred to the emergency department of the closest hospital by the child's primary care physician or KHPE, 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.

Medical Screening Evaluation Determines Whether or Not an Emergency Exists

Medical screening evaluation services are covered services when performed in a hospital emergency department to determine whether or not an emergency exists.

What is Urgent Care?

Urgent care needs are for sudden illness or accidental injury that require prompt medical attention, but are not life-threatening and are not emergency medical conditions, when your primary care physician is unavailable. Examples of urgent care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, and X-rays that are not preventive care or follow-up care.

Please visit ibx.com/chipemergencyurgent to learn more about the differences between emergency care and urgent care.

Urgent Care and Follow-Up Care Outside KHPE's Service Area — The BlueCard® Program's Urgent and Follow-Up Care Benefits

Keystone HMO CHIP Members have access to health care services when traveling outside KHPE's service area. These services are available through the Blue Cross and Blue Shield Association's BlueCard® Program. The length of time that your child will be outside the service area may affect:

- the benefits your child receives;
- your portion of cost-sharing, if any; or
- the procedures you must follow to obtain care for your child. Visit ibx.com/chipbluecard to learn more about the BlueCard® Program.

What is Follow-up Care?

Follow-up care is medically necessary follow-up visits that occur while your child is outside KHPE's service area. Follow-up care:

- is provided only for urgent ongoing treatment of an illness or injury that originates while your child is in KHPE's service area. An example is dialysis.
- must be preapproved by your child's primary care physician prior to traveling.

Through the BlueCard® Program, your child has access to medically necessary urgent care needed while traveling outside KHPE's service area during a temporary absence (less than **ninety (90) consecutive days**). Covered services will be provided by participating providers with affiliated Blue Cross and/or Blue Shield plans ("BlueCard® Providers"). This contract describes the steps to follow to obtain the needed urgent care.

Under the BlueCard® Program, coverage is provided only for the specified, preapproved service(s) authorized by your child's primary care physician in KHPE's service area and KHPE's Care Management and Coordination department. Follow-up care benefits under the BlueCard® Program are available during your child's temporary absence (less than ninety (90) consecutive days) from KHPE's service area. Covered services will be provided by a contracted Blue Cross and Blue Shield Association traditional participating provider ("BlueCard® Provider"). Follow the steps described below to receive covered services for follow-up care.

Out-of-pocket costs are limited to applicable copayments. A claim form is not required to be submitted in order for a Keystone HMO CHIP Member to receive benefits, provided the Member meets the requirements identified below.

Emergency Care Services: If your child experiences a medical emergency while traveling outside the KHPE service area, go to the nearest emergency or urgent care facility.

Urgent Care Benefits When Traveling Outside KHPE's Service Area

Urgent care benefits cover medically necessary treatment for any unforeseen illness or injury that requires treatment prior to when your child returns to KHPE's service area.

- Covered services for urgent care are provided by a contracted Blue Cross and Blue Shield Association traditional participating provider ("BlueCard[®] Provider").
- Coverage is for medically necessary services required to prevent serious deterioration of the Member's health while traveling outside KHPE's service area during a temporary absence (less than ninety (90) consecutive days). After that time, your child must return to KHPE's service area or be disenrolled automatically from Keystone HMO CHIP.

Urgent care required during a temporary absence will be covered when:

- You call 1-800-810-BLUE (TTY/TDD: 711) for your child. This number is available 24 hours a day, 7 days a week. You will be given the names, addresses and phone numbers of three BlueCard[®] Providers. The BlueCard[®] Program has some international locations. When you call, you will be asked whether you are inside or outside of the United States.
- You decide which provider to use.
- You call 1-800-227-3116 (TTY/TDD: 711) to get prior authorization (approval) for the service from KHPE.
- After receiving KHPE's approval, you call the provider to schedule an appointment for your child. The BlueCard[®] Provider confirms your child's eligibility.
- You show your child's KHPE ID card when seeking services from the BlueCard[®] Provider.
- You pay any applicable copayment at the time of your child's visit.

Follow-up Care Benefits When Traveling Outside KHPE's Service Area

Follow-up care benefits under the BlueCard[®] Program cover medically necessary follow-up care required while your child is traveling outside of KHPE's service area. The care must be needed for urgent ongoing treatment of an injury, illness, or condition that occurred while your child was in KHPE's service area.

- Follow-up care must be pre-arranged and preapproved by your child's primary care physician in KHPE's service area prior to leaving the service area.
- Under the BlueCard[®] Program, coverage is provided only for those specified, preapproved services authorized by your child's primary care physician in KHPE's service area and KHPE's Care Management and Coordination department.
- Follow-up care benefits under the BlueCard[®] Program are available during your child's temporary absence (less than **ninety (90) consecutive days**) from KHPE's service area.

Follow-up care required during a temporary absence (less than **ninety (90) consecutive days**) from KHPE's service area will be covered when these steps are followed:

- Your child is currently receiving urgent ongoing treatment for a condition.
- You plan to go out of KHPE's service area with your child temporarily, and your child's primary care physician recommends that your child continues treatment.
- Your child's primary care physician must call 1-800-227-3116 (TTY/TDD: 711) to get prior authorization for the service from KHPE. If a BlueCard[®] Provider has not been preselected for the follow-up care, your child's primary care physician or you will be told to call 1-800-810-BLUE (TTY/TDD: 711).
- You or your child's primary care physician will be given the names, addresses and phone numbers of three BlueCard[®] Providers.

When you decide which BlueCard[®] Provider to use:

- You or your child's primary care physician must inform KHPE by calling 1-800-227-3116 (TTY/TDD: 711).
- You should call the BlueCard[®] Provider to schedule an appointment for your child.
- The BlueCard[®] Provider confirms your child's eligibility.
- You show your child's KHPE ID card when seeking services from the BlueCard[®] Provider.
- You pay any applicable copayment at the time of your child's visit.

Additional Information about the BlueCard® Program

Whenever your child accesses covered health care services outside KHPE's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lesser of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to KHPE.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Subsequent estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price KHPE uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

When You Don't Use the BlueCard® Program

If you have out-of-area urgent care or emergency services, not provided as described above and provided by a nonparticipating provider, ask the provider to submit the bill to KHPE. Show the provider your child's KHPE ID card for necessary information about your child's coverage. For direct billing, the provider should mail the bill to the address listed below. If direct billing to KHPE 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, Inc.
P.O. Box 69353
Harrisburg, PA 17106-9353

Note: It is your responsibility to forward to KHPE any bill you receive for emergency services or out-of-area urgent care provided by a nonparticipating provider.

Auto- or Work-Related Accidents

Motor Vehicle Accident

If your child is injured in a motor vehicle accident, contact your child's primary care physician as soon as possible.

Note: KHPE will always be secondary to your auto insurance coverage. However, in order for services to be covered by KHPE as secondary, your child's care must be provided or referred by your child's primary care physician.

Tell your child's primary care physician that your child was involved in a motor vehicle accident and the name and address of your auto insurance company. Give this same information to any provider to whom your child's primary care physician refers your child for treatment.

Call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** as soon as possible and advise us that your child has been involved in a motor vehicle accident. This information helps KHPE coordinate your child's KHPE benefits with coverage provided through your auto insurance company. Only services provided, or referred, by your child's primary care physician will be covered by KHPE.

Work-Related Accident

If your adolescent child is employed, report any work-related injury to your child's employer and contact your child's primary care physician as soon as possible.

Note: KHPE will always be secondary to your child's workers' compensation coverage. However, in order for services to be covered by KHPE as secondary, your child's care must be provided or referred by your child's primary care physician.

Tell your child's primary care physician that your child was involved in a work-related accident and the name and address of your child's employer and any applicable information related to your child's employer's workers' compensation coverage. Give this same information to any provider to whom your child's primary care provider refers your child for treatment.

Call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** as soon as possible and advise us that your child has been involved in a work-related accident. This information helps KHPE to coordinate your child's KHPE benefits with coverage provided through your child's employer's workers' compensation coverage. Only services provided, or referred, by your child's primary care physician will be covered by KHPE.

Section 5

Membership Rights and Filing a Complaint or Grievance

If you have questions, suggestions, problems, or concerns regarding benefits or services rendered, KHPE is ready to assist you. Don't hesitate to call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. Our representatives will respond to any inquiry.

Your Child's Membership Rights

We at Keystone Health Plan East respect the rights of our Members and are dedicated to keeping our Members healthy and informed. Please visit www.ibx.com/chiprights to view a full list of your child's rights and responsibilities.

Advance Directives

For Members age 18 years and older – You may specify what actions you wish to be taken for your health if you are not able to make decisions for yourself due to illness or incapacity. This legal document is called an Advance Directive and considers the following questions:

- How important is it for you to die without a long period of pain and suffering?
- How important is it for you to follow your religious beliefs?
- How important is it to have your choices respected and followed?

There are two types of Advance Directives in Pennsylvania: Living Wills and Health Care Power of Attorney documents (these are also called Durable Power of Attorney documents).

Living Wills

A Living Will is a document containing your wishes on how you would like to be treated if you have a terminal illness (illness resulting in death) or a very serious operation. If you are ill and cannot speak for yourself and/or make decisions for yourself, your Living Will document will tell your doctor what life-sustaining treatments (treatments to help keep you alive) you may want and which treatments you do not want.

Examples of life-sustaining treatments are:

- Cardiopulmonary resuscitation (CPR) — a way to get your heart beating again
- Intravenous therapy (IV) — a way to keep you medicated when you can't take medicine by mouth
- Feeding tubes — a way to feed you if you can no longer feed yourself
- Respirators — a way to help you breathe if you can't breathe for yourself
- Dialysis — a way to purify your blood if your kidneys can't do it
- Pain relief — either requesting or refusing it

In order for your wishes to be carried out, your Living Will must be written before you become ill or have an operation; your doctor must have a copy of it; and your doctor must determine, at the time the life-sustaining treatment decision is being made, that you are incompetent (in no condition to speak your wishes) and that your condition is either terminal (you will die) or that you are permanently unconscious (in a coma).

Health Care Power of Attorney or Durable Power of Attorney

A Health Care or Durable Power of Attorney is a written statement that gives the name of a person (called a “proxy” or a “health care agent”) who can make certain medical decisions for you if you are not able to express yourself physically or mentally (if you cannot think, make decisions, or speak). This written list of instructions is compiled before medical services are needed. Your doctor will follow these instructions if you cannot communicate these wishes for yourself. Your proxy/health care agent can be an adult friend or family member and does not need to be a lawyer or medical professional. Some examples of the decisions or authority given to your proxy/health care agent through a Health Care/Durable Power of Attorney are:

- Admitting you to a hospital, residential or nursing facility
- Signing health care contracts for your medical services
- Authorizing medical or surgical procedures

Just like with the Living Will, you must write down your wishes in a Health Care/Durable Power of Attorney ahead of time and give them to your doctor and others who need to know your wishes, such as your proxy/health care agent. Under Pennsylvania law, you can change or end (“revoke”) your Living Will or Health Care/Durable Power of Attorney at any time as long as you are competent. Just be sure to let your doctor know if you are revoking it. If you make changes to your Living Will or Health Care/Durable Power of Attorney, be sure your doctor has a copy of the new document with your changes. You can combine your Health Care Power of Attorney document with your Living Will and have just one document which covers both topics (the Living Will and the Health Care Power of Attorney), or you can keep both documents separate.

To get help writing an Advance Directive, just call a lawyer, social worker, your doctor’s office, or the State Attorney General’s office. You can also call the Keystone HMO Member Help Team at **1-800-464-5437 (TTY/TDD: 711)**.

Will My Wishes Always be Followed?

The law does not ensure that a provider must follow your wishes in every case. However, it does say that if the doctor cannot in good conscience carry out your wishes, or if there are other policies that prevent the doctor from following your wishes, that the doctor must inform you. Your doctor must also help you locate another provider who is able to follow your wishes, if your wishes are permitted under Pennsylvania law. This is another reason why it is so important that you give your Advance Directive decisions to your doctor in writing ahead of time, so that, if they are unable to carry out your wishes, you can be transferred to a doctor who can. If you believe that your doctor or KHPE did not follow your Advance Directive, you have the right to file a complaint or a grievance.

You Can File a Complaint or Grievance for Your Child

General Information About the Member Appeal Processes

KHPE maintains a complaint appeal process and a grievance appeal process for its Members. Each of these appeal processes provides formal review for a parent's dissatisfaction with a denial of coverage or other issues related to their child's health plan underwritten by KHPE.

What is the Difference Between a Member Complaint and a Member Grievance Appeal?

The complaint appeal process and the grievance appeal process focus on different issues and have other differences. For example:

- You file a complaint appeal when you have questions or concerns related to your child's benefits or services, provider status, exclusions, KHPE operations and management policies, or other issues related to coverage.
- You file a grievance appeal when you disagree with a decision by KHPE about the provision of a covered health care service that was based solely on medical necessity or appropriateness. (See Medical Necessity, page 108).

Please refer to the separate sections below entitled "The Complaint Appeal Process" and "The Grievance Appeal Process" for specific information on each process.

Note: Complaints or issues regarding the determination of your child's Keystone HMO CHIP eligibility are not handled through the complaint appeal or grievance appeal processes. Please refer to the "Eligibility Review Process" on page 11 for details.

How to Pursue a Member Complaint or Grievance Appeal

The complaint appeal process and grievance appeal process have some common features. To understand how to pursue a Member complaint or grievance appeal for your child, you should review the background information outlined here that applies to both the complaint appeal process and the grievance appeal process.

- **Authorizing Someone to Represent Your Child.** At any time, you may choose a third party to be your child's representative in your child's Member appeal such as a provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that your written authorization or consent is required in order for this third party—called an "appeal representative" or "authorized representative"—to pursue an appeal on your child's behalf. An appeal representative may make all decisions regarding your child's appeal, provides and obtains correspondence, and authorizes the release of medical records and any other information related to your child's appeal. In addition, if you choose to authorize an appeal representative, you have the right to limit their authority to release and receive your child's medical records or in any other way you identify.

In order to authorize someone else to be your child's appeal representative, you must complete the appropriate forms. The required forms are sent to adult Members or the parents, guardians or other legal representatives of minor or incompetent Members who appeal and indicate that they want an appeal representative. Authorization forms can be obtained by calling or writing to the address listed below:

Keystone Health Plan East, Inc.
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll-free: 1-800-464-5437 Fax: 1-888-671-5274

Except in the case of an expedited appeal, KHPE must receive completed, valid authorization forms before your child's appeal can be processed. (For information on expedited appeals, see the definition below and the references in the "Member Complaint Process" and "Member Grievance Appeal Process" sections below.) You have the right to withdraw or rescind authorization of your child's appeal representative at any time during the process.

If your provider files an appeal on your child's behalf, KHPE will verify that the provider is acting as your child's appeal representative with your permission by obtaining valid authorization forms. A parent who authorizes the filing of their child's appeal by a provider cannot file a separate appeal.

- **How to File and Get Assistance.** Appeals may be submitted either verbally or in writing by you or your child's appeal representative, with your authorization, by following the steps outlined below in the descriptions of the "Member Complaint Appeal Process" and "Member Grievance Appeal Process." At any time during these appeal processes, you may request the help of a KHPE employee in preparing or presenting your child's appeal; this assistance will be available at no charge. Please note that a KHPE employee designated to assist you will not have participated in any previous level of review or decision-making and will not be a subordinate of the original reviewer.
- **Providing and Obtaining Information.** At all appeal levels, you or your child's appeal representative may submit additional information pertaining to your child's case. You may also specify the remedy or corrective action being sought. At any time during the appeal process, KHPE will provide access to, and copies of, all documents, records, and other information reviewed by the Committee deciding the appeal that is not confidential, proprietary or privileged, as well as the resulting decision.
- **Appeal Decision Letters.** If your child's appeal request is not granted in full, the decision letter will state the reasons for the determination and describe how to pursue any available options for further appeal review. If a benefit provision, internal rule, guideline, protocol, or other similar criterion was used in making the determination, it will either be stated or there will be instructions on how to receive this information at no charge. 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.
- **Appeal Classifications.** The two classifications of appeals — Complaints and Grievances — established by Pennsylvania state laws and regulations are described in detail in separate sections below.
 - A complaint appeal may be filed to challenge a denial based on a contract limitation or to complain about other aspects of health plan policies or operations.
 - A grievance appeal may be filed when the denial of a covered service is based primarily on medical necessity.

You may question the classification of your child's appeal as a complaint or grievance by contacting KHPE's Member Appeals Department, your child's assigned Appeals Specialist at the address and telephone number on page 37, or the Pennsylvania Department of Health as follows:

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
1-717-787-5193
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

For more information about the complaint appeal and grievance appeal processes, please visit www.ibx.com/chipappeals.

You Can Accept or Refuse Treatment for Your Child

- When your child joins Keystone HMO CHIP, you agree that your child will receive care according to the recommendation of your child's primary care physician.
- You have the right to give your informed consent before the start of any procedure or treatment for your child.
- You have the right to refuse any drugs, treatment, or other procedures offered to your child by Keystone HMO CHIP providers and to be informed by the physician of the medical consequences to your child if you refuse any drugs, treatment or procedure.
- KHPE and your child's primary care physician will make every effort to arrange a professionally acceptable alternative treatment for your child.
- However, if you still refuse the recommended treatment plan for your child, KHPE will not be responsible for the costs of further treatment for your child's condition and you will be so notified.
- You may use the grievance procedure to have your child's case reviewed, if you so desire.

Confidentiality and Disclosure of Medical Information

KHPE's privacy practices, as they apply to Members enrolled in Keystone HMO CHIP, as well as a description of Members' rights to access their personal health information that may be maintained by KHPE, are set forth in KHPE's HIPAA Notice of Privacy Practices (the "Notice"). The Notice is sent to each new Member upon initial enrollment in Keystone HMO CHIP, and subsequently, to all Keystone HMO CHIP Members if and when the Notice is revised.

By enrolling your child in Keystone HMO CHIP, you give consent to KHPE to receive, use, maintain, and/or release your child's medical records, claims-related information, health and related information for the purposes identified in the Notice to the extent permitted by applicable law. However, in certain circumstances, which are more fully described in the Notice, a specific Member authorization may be required prior to KHPE's use or disclosure of your child's personal health information. You should consult the Notice for detailed information regarding your child's privacy rights.

Member Liability

Except when certain limitations are specified in this Benefits Handbook, you are not responsible for any charges for covered services when these services have been provided or referred by your child's primary care physician and your child is eligible for such benefits on the date of service.

Section 6

Responsibilities

Membership Responsibilities

We, at Keystone Health Plan East, are dedicated to keeping our Members healthy and informed. We not only respect your rights, we also encourage you to exercise your responsibilities. The information in the following link describes rights and obligations for KHPE and our Members. For a full list of your or your child's rights and responsibilities, please visit www.ibx.com/chiprights.

Subrogation and Reimbursement Rights

By accepting benefits for covered services, you agree that KHPE has the right to enforce subrogation and reimbursement rights in accordance with applicable state and federal law. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to you for an injury or illness. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

Subrogation Rights

Subrogation rights arise when KHPE pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. KHPE is subrogated to the Member's right to recover from the Responsible Third Party. This means that KHPE "stands in your shoes" – and assumes your right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that KHPE has reimbursed you for medical expenses or paid medical expenses on your behalf. The right to pursue a subrogation claim is not contingent upon whether or not you pursue the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery — regardless of how it's described or structured — from a Responsible Third Party, the Member must fully reimburse KHPE for all medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party, to the extent permitted by law. KHPE has the right to pursue recovery of the full reimbursement amount.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- KHPE will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless KHPE agrees to do so in writing.

- In addition to any Coordination of Benefits rules described in this contract, the benefits paid by KHPE will be secondary to any no-fault auto insurance benefits and to any workers' compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- KHPE has the right to pursue recovery of the full reimbursement amount of the medical benefits paid without regard to any claim of fault on your part.

Obligations of the Parent of a Member

- Immediately notify KHPE or its designee in writing if you assert a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify KHPE or its designee in writing whenever a Responsible Third Party contacts you or your representative — or you or your representative contact a Responsible Third Party — to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until you receive written authorization from KHPE or its delegated representative.
- Fully cooperate with KHPE and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm KHPE's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse KHPE or its designated representative promptly, if appropriate, out of the amounts recovered from the Responsible Third Party whether the funds are received by court judgment, settlement or otherwise from a Responsible Third Party.

All of these obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

Claim Procedures

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

Notice of claim – KHPE will not be liable for any claims under this contract unless proper notice is furnished to KHPE that covered services in the contract have been rendered to your child. Written notice of a claim must be given to KHPE within twenty (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 KHPE that includes information sufficient to identify your child who received covered services shall constitute sufficient notice of a claim to KHPE. You can give notice to KHPE by calling our Keystone HMO CHIP Member Help Team 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 KHPE. Written proof of loss must be provided to KHPE within **ninety (90) days** after the charge for covered services is incurred. Proof of loss must include all data necessary for KHPE to determine benefits. Failure to submit a proof of loss to KHPE 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 KHPE be required to accept a proof of loss later than **twelve (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 contract, it must be submitted to KHPE on the appropriate claim form. KHPE, upon receipt of a notice of claim will, within **fifteen (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 **fifteen (15) days** after giving 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 KHPE. Call our Keystone HMO CHIP Member Help Team 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 KHPE 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 contract.

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:

- Person or organization providing the service or supply;
- Type of service or supply;
- Date of service or supply;
- Amount charged; and
- 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. KHPE 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 contract will be processed immediately upon receipt of proper proof of loss.

Physical examinations and autopsy – KHPE at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under the contract; and KHPE shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

Payment of claims – If any indemnity of the contract shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, KHPE may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by KHPE to be equitably entitled thereto. Any payment made by KHPE in good faith pursuant to this provision shall fully discharge KHPE to the extent of such payment.

Time Limit on Certain Defenses – After **three (3) years** from the date of issue of the contract, no misstatements, except fraudulent misstatements made by the applicant in the application for such contract, shall be used to void said contract or to deny benefits for a claim incurred commencing after the expiration of such **three (3) year** period.

How to Report Suspected Fraud and Abuse

Please choose any one of the three options listed below.

- Telephone: Call our confidential Fraud Hotline at 1-866-282-2707 (TTY: 888-789-0429), 24 hours a day, 7 days a week.
- Online: Complete and submit our Online Fraud Report Form.
- Mail or Fax: Write a description of your complaint, enclose copies of any supporting documentation, and mail it to:

Independence Blue Cross
Corporate and Financial Investigations Department
1901 Market Street, 42nd Floor
Philadelphia, PA 19103
215-238-2287

We will make every effort to keep all information that we receive confidential.

What is Health Care Fraud and Abuse?

Health care fraud and abuse is a national problem that affects all of us either directly or indirectly. National estimates project that tens of billions of dollars are lost to health care fraud and abuse on an annual basis. These losses lead to increased health care costs and potential increased costs for coverage.

Specifically, health care fraud is an intentional misrepresentation, deception, or intentional act of deceit for the purpose of receiving greater reimbursement. Health care abuse is reckless disregard or conduct that goes against and is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement.

While Independence believes that most providers, Members, groups, and brokers are honest, there are a small number of people who try to take advantage of Independence and our Members by engaging in health care fraud and abuse.

Types of Health Care Fraud and Abuse

Health care fraud and abuse takes many forms. The most common of these forms include:

Providers

- Billing for services that were not provided
- Duplicate submission of a claim for the same service
- Misrepresenting the service provided
- “Upcoding” — charging for a more complex or expensive service than was actually provided
- Billing for a covered service when the service actually provided was not covered

Members

- Using a Member ID card that does not belong to that person
- Adding someone to a policy that is not eligible for coverage (e.g., grandchildren)
- Failing to remove someone from a policy when that person is no longer eligible (e.g., a former spouse)
- “Doctor shopping” — visiting several doctors to obtain multiple prescriptions

Help Us Prevent Health Care Fraud and Abuse

Independence takes the fight against health care fraud and abuse very seriously. That is why we have a department dedicated to preventing fraud and abuse: The Corporate & Financial Investigations Department (CFID). CFID includes a staff of trained professionals who carefully review all allegations of suspected fraud and abuse.

CFID's mission is to detect, investigate, prevent, prosecute, and recover the loss of corporate and customer assets resulting from fraudulent and abusive actions committed by providers, Members, groups, brokers, and others.

If you suspect that Independence and/or our Members are victims of health care fraud and abuse, please report the matter to CFID immediately via any of the options listed on page 43. Your assistance will help Independence in its continued efforts to combat the rising costs of health care.

Health Care Fraud and Abuse Prevention Tips

Health care fraud and abuse is a national problem, and your assistance is vital in helping us prevent the problem. Simple tips that you can take to help prevent fraud and abuse include:

- Review your Explanations of Benefits to ensure accurate dates of service, name of providers, and types of services reported
- Protect your insurance card and personal information at all times
- Count your pills each time that you pick up a prescription
- Research your providers with your state's medical boards
- Report suspected fraud and abuse as soon as possible

Section 7

Keystone HMO CHIP Benefits At A Glance

As noted elsewhere in this Benefits Handbook, some services below may require Prior Authorization

Keystone HMO CHIP Benefit	Coverage using network providers	Copays or Limits
PCP office visits and retail health clinic visits		
Free CHIP	100%	\$0 per office visit
Low-cost CHIP	100%	\$5 per office visit*
Full-cost CHIP	100%	\$15 per office visit*
* No copay for certain well-child visits		
Specialist office visits (referrals required)		
Free CHIP	100%	\$0 per office visit
Low-cost CHIP	100%	\$10 per office visit*
Full-cost CHIP	100%	\$25 per office visit*
* No copay for behavioral health and substance use services		
Preventive care		
Routine annual physical exams	100%	—
Immunizations	100%	—
Routine gynecological exams, including a Pap test	100%	—
Mammograms	100%	—
Nutrition counseling for weight management	100%	6 visits per benefit period
Outpatient laboratory/pathology	100%	—
Outpatient X-ray/radiology	100%	—
- Routine radiology/diagnostic		
- MRI/MRA, CT/CTA Scan, PET Scan		
Inpatient hospital services		
Facility services	100%	—
Physician/Surgeon	100%	—
Outpatient surgery		
Ambulatory surgical facility	100%	—
Hospital-based	100%	—
Physician/surgeon	100%	—
Urgent care center		
Free CHIP	100%	\$0 per office visit
Low-cost CHIP	100%	\$10 per office visit
Full-cost CHIP	100%	\$25 per office visit

Keystone HMO CHIP benefit	Coverage using network providers	Copays or Limits
Emergency care		
Free CHIP	100%	\$0 per visit
Low-cost CHIP	100%	\$25 per visit*
Full-cost CHIP	100%	\$50 per visit*
* Does <u>not</u> apply if child is admitted		
Emergency Ambulance	100%	
Autism spectrum disorder treatment	100%	
Dental care		Covered through United Concordia Dental providers
Preventive: cleanings, fluoride treatments, sealants	100%	–
Diagnostic: routine exams, X-rays	100%	–
Restorative: fillings, crowns	100%	–
Oral surgery: extractions	100%	–
Orthodontic services	100%	Must meet medical necessity criteria
Dental services as a result of accidental injury	100%	–
<i>Refer to Section 12, Dental Benefits, for more details.</i>		
Diabetes education, equipment & supplies	100%	
Diagnostic services (imaging, medical, and laboratory)	100%	
DME & prosthetics	100%	
Family planning (for prescription contraceptives, devices, and counseling)	100%	
Habilitative services – outpatient		
Occupational, physical, speech therapies	100%	30 visits per calendar year for each therapy for a total of 90 visits.
Hearing care		
Hearing and audiometric exam	100%	One exam per calendar year
Hearing aid and device	100%	Reimbursement for one hearing aid or device, per ear, every two calendar years
Home health care	100%	
Hospice care	100%	
Hospital services	100%	

Keystone HMO CHIP benefit	Coverage using network providers	Copays or Limits
Infusion therapy		
Injectable medications <ul style="list-style-type: none"> - Standard injectable drugs - Biotech/specialty injectables 	100%	—
Maternity and obstetrical care		
Physician services relating to antepartum, intrapartum & postpartum care	100%	—
Hospital	100%	—
Medical foods	100%	
Medical therapy services – outpatient (cardiac, chemotherapy, dialysis, infusion, radiation, respiratory)	100%	
Behavioral health		
Inpatient behavioral health	100%	—
Outpatient behavioral health	100%	—
Newborn care	100%	Limited to first 31 days following birth
Outpatient Prescription drugs		
Free CHIP	100%	\$0
Low-cost CHIP	100%	Retail (31-day supply): \$6 generic, \$9 brand Mail-order (90-day supply): \$12 generic, \$18 brand
Full-cost CHIP	100%	Retail (31-day supply): \$10 generic, \$18 brand Mail-order (90-day supply): \$20 generic, \$36 brand
Specialty drugs: Use Specialty Pharmacy Program; charge is the same as “Retail” brand charge listed above. Non-formulary drug: Same as “Retail” brand charge listed above. Nonparticipating pharmacy: Pay the full charge and submit a claim form for reimbursement consideration.		
Private duty nursing	100%	
Rehabilitation services – outpatient	100%	
Therapy services <ul style="list-style-type: none"> - Physical Therapy - Speech Therapy - Occupational Therapy 	100%	60 visits per calendar year for each therapy
Skilled nursing facility	100%	
Spinal manipulation / chiropractic care	100%	20 visits per calendar year
Substance use		
Inpatient detoxification	100%	—
Inpatient rehabilitation	100%	—
Outpatient	100%	—

Keystone HMO CHIP benefit	Coverage using network providers	Copays or Limits
Transplant services	100%	
Routine Vision care		Covered through Davis Vision providers
Routine eye exam and refractions	100%	—
Frames and lenses	100%	One pair of frames and lenses per calendar year that may be plastic or glass, single vision, bifocal, trifocal, lenticular and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, and polycarbonate prescription lenses. Covered when selected from Davis Vision Collection of frames; Allowance of \$130 for other frames
Scratch-resistant coating for lenses		Additional copayment applies for premium lenses or coatings (beyond scratch-resistance).
Optional lens types and treatments:		
Ultraviolet protective coating	100%	—
Blended segment lenses	—	\$20
Intermediate vision lenses	—	\$30
Progressive lenses (standard)	—	\$50
Progressive lenses (premium)	—	\$90
Progressive lenses (ultra)	—	\$140
Progressive lenses (unlimited)	—	\$175
Glass photochromic lenses	—	Single - \$20; Multifocal - \$20
Plastic photosensitive single lenses	—	\$65
Plastic photosensitive multi lenses	—	\$70
Polarized lenses	—	\$75
Anti-reflective (ar) coating (standard)	—	\$35
Anti-reflective (ar) coating (premium)	—	\$48
Anti-reflective (ar) coating (ultra)	—	\$60
Hi-index lenses	—	\$55
Scratch protection plan (single vision)	—	\$20
Scratch protection plan (multifocal)	—	\$40
Contact lenses (in lieu of eyeglasses or when medically necessary)	100%	Covered if on formulary; or allowance of \$130
Replacement pair of eyeglasses		One replacement pair available due to loss or breakage per calendar year

Section 8

Primary and Preventive Health Care

Keeping Your Child Healthy

Regular checkups and immunizations are a key part of preventive care because they help to keep your child from getting sick in the first place. KHPE wants your child to grow up healthy. One of the ways we help your child to do this is to provide health care coverage, not just when your child is sick, but also when your child is well.

KHPE periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics/Bright Futures; the U.S. Preventive Services Task Force (USPSTF), all items or services with a rate of A or B in the current recommendations; Centers for Disease Control and Prevention (CDC), Advisory Committee for Immunization Practices (ACIP), Adult and Pediatric Immunization Schedules; U.S. Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; U.S. Department of Health and Human Services, Women's Preventive Services: Required Health Plan Coverage Guidelines Supported by the Health Resources and Services Administration; and the Health Resources and Services Administration (HRSA). Examples of covered "USPSTF A" recommendations are folic acid supplementation, and tobacco use counseling and interventions. Examples of covered "USPSTF B" recommendations are dental cavities prevention for preschool children, healthy diet counseling, oral fluoride supplementation/rinses and vitamins, BRCA risk assessment and genetic counseling and testing, chlamydial infection screening for pregnant and non-pregnant individuals, and sexually transmitted infections counseling. Examples of covered HRSA required benefits include all Food and Drug Administration-approved contraceptive methods, sterilization procedures, breast feeding equipment, and patient education and counseling for all those with reproductive capacity. All services required by HRSA are covered. Accordingly, the Preventive Services are provided at no cost to the Member. KHPE reserves the right to modify coverage for these covered services at any time after written notice of the change has been given to you.

Your Child's Primary Care Physician

Prior to enrolling in Keystone HMO CHIP, you should have selected a primary care physician in the Keystone HMO CHIP network for your child. Always call the primary care physician, listed on your child's KHPE ID card, before you go for medical care (except for conditions requiring emergency services as described on page 29). Your child's primary care physician will provide the services or refer your child to an appropriate specialist when medically necessary. A Member with a life-threatening, degenerative, or disabling disease or condition shall have access to a specialist as a PCP or medical home, consistent with procedures developed by KHPE.

Pediatric Preventive Care

Pediatric Preventive Care includes the following, with no cost-sharing or copayments:

- Physical Examination, Routine History, Routine Diagnostic Tests.
- Well baby care, which generally includes a medical history, height and weight measurement, physical examination, and counseling.
- Lead Screening and Blood Lead Level Testing. This blood test detects elevated lead levels in the blood.

- Oral Health Risk Assessment, Fluoride varnish for children 5 years of age and younger, beginning with first tooth eruption (as a U.S. Preventive Task Force recommendation).
- Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.
- Routine preventive and diagnostic dental and vision services.
- Immunizations, except those required for travel or work, including the immunizing agents that conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Pediatric and adult immunization schedules may be found by accessing the following link: www.cdc.gov/vaccines/schedules/parents.

Influenza vaccines can be administered by a participating pharmacy for Members starting at the age of nine (9) years old, with parental consent, according to PA Act 8 of 2015.

Well Woman Preventive Care

There is no cost-sharing for preventive services under the services of family planning, women's health, and contraceptives.

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Affordable Care Act. Covered services and supplies include, but are not limited to, the following:

- **Routine gynecological exam, Pap smear:** Members are covered for one (1) routine gynecological exam each calendar year. This includes a pelvic exam and clinical breast exam; and routine Pap smear in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Members have direct access to care by an obstetrician or gynecologist. This means that no referral is needed from the Member's primary care physician.
- **Mammograms:** Coverage will be provided for screening mammograms without referral. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.
- **Breastfeeding:** Comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under Durable Medical Equipment with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing individuals at no cost-sharing to the Member.
- **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); (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.

Please refer to the “Make Your Child’s Health a Priority” document for further information on regular checkups, health, and wellness.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration-approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items under law.

Section 9

Outpatient Services

Please refer to the “Keystone HMO CHIP Benefits At A Glance” overview for copayment information.

Unless otherwise specified in this Benefits Handbook, the following benefits are provided on an outpatient basis when:

- medically necessary;
- provided or referred by your primary care physician; and
- preapproved by KHPE, where specified.

Ambulance Services/Transport

Benefits are provided for ambulance services that are medically necessary, as determined by KHPE, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured, 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; and
- 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 endanger the Member’s health or be inappropriate for the Member’s medical condition;
- the ambulance transport satisfies the destination and other requirements stated below in either ‘For Emergency Ambulance transport’ or ‘For Non-Emergency Ambulance transport.’

In addition, KHPE will provide coverage for services provided by a licensed emergency services provider who initiates necessary intervention to evaluate and, if necessary, stabilize the condition of the Member and subsequently determines the Member does not require transport or the Member refuses to be transported. These services must be Medically Necessary as determined by KHPE.

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.

For Non-Emergency Ambulance transport:

- Non-emergency air or ground facility-to-facility transport may be covered when Medically Necessary as determined by KHPE (e.g., sending facility does not have the required services to effectively treat the Member, such as trauma or burn care).
- Non-emergency air or ground transport may be covered to transport the Member back to a Participating Facility Provider in the Member’s Service Area as determined by KHPE, when:
- The transfer is Medically Necessary (as determined by KHPE’s definition of Medical Necessity); and
- The Member’s medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance; and
- Non-emergency ambulance transports are not provided for family members or companions, or for the convenience of the Member, the family, or the provider treating the Member.

Autism Spectrum Disorders (ASD)

KHPE will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Keystone HMO CHIP Members when provided or referred by your child's primary care physician for the development of an ASD Treatment Plan. Treatment of Autism Spectrum Disorders must be:

- Prescribed, ordered or provided by a participating professional provider, including your child's primary care physician, referred specialist, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner;
- Provided by an autism service provider, including a behavior specialist; or
- Provided by a person, entity or group that works under the direction of an autism service provider.

Treatment of Autism Spectrum Disorders is defined as any of the following medically necessary services that are listed in an ASD Treatment Plan developed by a licensed physician or licensed psychologist who is a participating professional provider:

- **Applied Behavioral Analysis ("ABA")** – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- **Pharmacy Care** – means the following when prescribed and/or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner who is a participating professional provider:
 - Medications; and
 - Any assessment, evaluation or test to determine the need or effectiveness of such medications. The ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable under the Prescription Drug benefit.
- **Psychiatric Care** – Direct or consultative services provided by a physician specializing in psychiatry who is a participating professional provider.
- **Psychological Care** – Direct or consultative services provided by a psychologist who is a participating professional provider.
- **Rehabilitative Care** – Professional services and treatment programs, including applied behavioral analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- **Therapeutic Care** – Services provided by a speech language pathologist, occupational therapist or physical therapist who is a participating professional provider.

An ASD Treatment Plan shall be developed by a licensed physician or licensed psychologist who is a participating professional provider pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The ASD Treatment Plan may be reviewed by KHPE once every six months. A more or less frequent review can be agreed upon by KHPE and the licensed physician or licensed psychologist developing the ASD Treatment Plan.

A diagnostic assessment is defined as medically necessary assessments, evaluations or tests performed by a participating professional provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than **twelve (12) months**, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

Autologous Blood Drawing/Storage/Transfusion

Covered services include the administration of blood and blood processing from donors. In addition, autologous blood drawing, storage or transfusion, i.e., an individual having their own blood drawn and stored for personal use, such as self-donation in advance of planned surgery, are covered services.

Covered services also include whole blood, blood plasma and blood derivatives, which are not classified as prescription drugs in the official formularies and which have not been replaced by a donor.

Consumable Medical Supplies

KHPE will provide coverage for the purchase of Consumable Medical Supplies when:

- they are used in the Member's home; and
- they are obtained through a Participating Durable Medical Equipment Provider.

Dental Benefits (See page 80)

Dental Services as a Result of Accidental Injury

Covered services are only provided for:

- The initial treatment of accidental injury or trauma (i.e., fractured facial bones and fractured jaws) in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of sound natural teeth, consisting of the first caps, crowns, bridges and dentures required for the initial treatment for the accidental injury or trauma.
- The preparation of the jaws and gums required for initial replacement of sound natural teeth.

Diabetic Education Program

Benefits are provided for diabetes outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a participating professional provider legally authorized to prescribe such items under law. A referral from your child's primary care physician is not required to obtain services for the Diabetic Education Program benefits.

The attending physician must certify that your child requires diabetic education on an outpatient basis under the following circumstances:

- Upon the initial diagnosis of diabetes;
- A significant change in the patient's symptoms or condition; or
- The introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services are covered services when provided by a participating provider. The Diabetic Education Program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of KHPE. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include outpatient sessions that include, but may not be limited to, the following information:

- Initial assessment of your child's needs;
- Family involvement and/or social support;
- Psychological adjustment for the patient;
- General facts/overview on diabetes;
- Nutrition, including its impact on blood glucose levels;
- Exercise and activity;
- Medications;
- Monitoring and use of the monitoring results;
- Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
- Use of community resources; and
- Pregnancy and gestational diabetes, if applicable.

Diabetic Equipment and Supplies

Benefits shall be provided for diabetic equipment and supplies purchased from a Durable Medical Equipment provider, subject to any precertification requirements applicable to Durable Medical Equipment benefits. Certain diabetic equipment and supplies, including insulin and oral agents, must be purchased at a pharmacy, subject to any cost-sharing arrangements applicable to the Prescription Drug benefit. Certain diabetic equipment and supplies are not available at a pharmacy. In these instances, the diabetic equipment and supplies will be provided under the Durable Medical Equipment benefit.

Diabetic Equipment

- Blood glucose monitors;
- Insulin pumps;
- Insulin infusion devices; and
- Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

Diabetic Supplies

- Blood testing strips;
- Visual reading and urine test strips;
- Insulin and insulin analogs;
- Injection aids;
- Insulin syringes;
- Lancets and lancet devices;
- Monitor supplies;
- Pharmacological agents for controlling blood sugar levels; and
- Glucagon emergency kits.

Diagnostic Services

The following diagnostic services when ordered by a participating professional provider and billed by a referred specialist, and/or a facility provider:

- Routine diagnostic services, including routine radiology (consisting of X-rays, mammograms, ultrasound, and nuclear medicine), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), Nuclear Cardiology Imaging, and other diagnostic medical procedures approved by KHPE) and allergy testing (consisting of percutaneous, intracutaneous and patch tests);

- Non-routine diagnostic services, including Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan), sleep studies, and Computed Tomography (CT Scan); and
- Genetic testing and counseling, including those services provided to a child at risk for a specific disease due to family history or because of exposure to environmental factors that are known to cause physical or behavioral health disorders. When clinical usefulness of specific genetic tests has been established by KHPE, these services are covered for the purpose of diagnosis, screening, predicting the course of a disease, judging the response to a therapy, examining risk for a disease, or reproductive decision-making.

Durable Medical Equipment

Benefits are provided for the rental (but not to exceed the total allowance of purchase) or, at the discretion of KHPE, the purchase of standard Durable Medical Equipment (DME) when:

- it is used in the patient's home; and
- it is obtained through a participating DME provider.

Replacement and repair: Benefits are provided for the repair and replacement of DME when the equipment does not function properly and is no longer useful for its intended purpose when:

- there is a change in your child's condition that requires a repair or replacement of the DME; or
- the DME is broken due to significant damage, defect, or wear, KHPE will provide repair or replacement only if the DME's warranty has expired and it has exceeded its reasonable useful life as determined by KHPE.

If the DME breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are:

- KHPE's responsibility in the case of rented equipment; and,
- Your responsibility in the case of purchased equipment.

KHPE is not responsible if the DME breaks during its reasonable useful lifetime for any reason not covered by warranty. For example, no benefits are provided for repairs and replacements needed because the equipment was abused or misplaced.

Benefits are provided to repair DME when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of DME, replacement means the removal and substitution of DME or one of its components necessary for proper functioning. A repair is a restoration of the DME or one of its components to correct problems due to wear or damage or defect.

Habilitative Services

Benefits offer health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings. Covered services are limited to 30 visits per calendar year for physical therapy; 30 visits per calendar year for occupational therapy; and 30 visits per calendar year for speech therapy, for a combined visit limit of 90 days per calendar year. Visit limits under this benefit are combined with visit limits described under Outpatient Rehabilitation Therapy or Therapy Services.

Hearing Care Services

Hearing aids and devices, and the fitting and adjustment of such devices, are covered when determined to be medically necessary.

One (1) routine hearing examination and one (1) audiometric examination are covered per calendar year. Benefits are provided for 100% reimbursement for one (1) hearing aid or device, per ear, every two (2) calendar years. A reimbursement form may be obtained by calling our Keystone HMO CHIP Member Help Team at **1-800-464-5437**. Batteries for hearing aids and devices are not covered.

Home Health Care

Benefits will be provided for the following services when performed by a licensed home health care agency:

- A. Professional services of appropriately licensed and certified individuals;
- B. Intermittent skilled nursing care;
- C. Physical therapy;
- D. Speech therapy;
- E. Well-mother/well-baby care following release from an inpatient maternity stay; and
- F. Care within **forty-eight (48) hours** following release from an inpatient admission when the discharge occurs within **forty-eight (48) hours** following a mastectomy.

Home health care does not include special care. With respect to Item E above, home health care services will be provided within **forty-eight (48) hours** if discharge occurs earlier than **forty-eight (48) hours** of a vaginal delivery or **ninety-six (96) hours** of a cesarean delivery. No copayment, if any, shall apply to these benefits when they are provided after an early discharge from the inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include occupational therapy, medical social services, home health aides in conjunction with skilled services and other services that may be approved by KHPE.

Home health care benefits will be provided only when prescribed in a written plan of treatment and approved by KHPE.

There is no requirement that your child be previously confined in a hospital or skilled nursing facility prior to receiving home health care.

With the exception of home health care provided to your child immediately following an inpatient release for maternity care, your child must be homebound in order to be eligible to receive home health care benefits by a home health care provider. This benefit is offered with no copayments and no limitations.

Hospice Care

Covered services include palliative and supportive services provided to a terminally ill child through a hospice program by a participating hospice provider. This also includes respite care. Two conditions apply for hospice benefit eligibility: (1) your child's primary care physician or a participating specialist must certify for KHPE that your child has a terminal illness; and (2) you must elect to have your child receive care primarily to relieve pain. Hospice care is primarily comfort care, including pain relief, physical care, counseling and other services that will help your child cope with a terminal illness rather than cure it. Hospice care provides services to make your child as comfortable and pain-free as possible. When you elect to have your child receive hospice care, benefits for treatment provided to cure the terminal illness are no longer provided. However, you may elect to revoke the election of hospice care at any time.

Respite Care: When hospice care is provided primarily in the home, such as care on a short-term inpatient basis in a Medicare-certified skilled nursing facility, will also be covered when the hospice considers such care necessary to relieve primary caregivers in the patient's home.

Benefits for covered hospice services are provided until the earlier date of your child's death or discharge from hospice care.

Injectable Medications

Benefits will be provided for injectable medications required in the treatment of an injury or illness administered by a participating professional provider.

Specialty Drug - Refers to a medication that meets certain criteria including, but is not limited to, the drug is used in the treatment of a rare, complex, or chronic disease; a high level of involvement is required by a health care provider to administer the drug; complex storage and/or shipping requirements are necessary to maintain the drug's stability; the drug requires comprehensive patient monitoring and education by a health care provider regarding safety, side effects, and compliance; and access to the drug may be limited.

Some Generic Drugs are included in this category and are subject to the Specialty Drug cost-sharing.

Preapproval is required for those specialty drugs noted in the preapproval list, which is available online at ibx.com/chip, or by calling our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

Standard Injectable Drug - Refers to a medication that is either injectable or infusible but is not defined by the company to be a self-administered prescription drug or a specialty drug. Standard injectable drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a participating professional provider.

Self-Administered Prescription Drugs - Are generally not covered except as covered under a Prescription Drug benefit. For more information on self-administered prescription drugs, please refer to the Exclusions – What Is Not Covered section of this Benefits Handbook.

Laboratory and Pathology Tests

Benefits are provided for medically necessary laboratory and pathology services. Your child is required to have these services performed by your child's primary care physician's designated provider.

Mastectomy and Breast Reconstruction

Benefits are provided for a mastectomy performed on an outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy; and
- Physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one home health care visit, as determined by the child's physician, received within **forty-eight (48) hours** after discharge.

Maternity and Obstetrical Care Services

A Member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Physician services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the Member's pregnancy or delivery, are covered.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than **forty-eight (48) hours** following a vaginal delivery, or less than **ninety-six (96) hours** following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the Keystone HMO CHIP Member is released prior to **forty-eight (48) hours** for a vaginal delivery and **ninety-six (96) hours** for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an inpatient stay for maternity services are not subject to copayments.

Maternity/Obstetrical Care

Services rendered in the care and management of your child's pregnancy are covered services under this contract. Your child's participating obstetrician or gynecologist will notify KHPE of your child's maternity care within one (1) month of the first prenatal visit to that provider. Covered services include: (1) facility services provided by a participating facility provider that is a hospital or birth center; and (2) professional services performed by a participating obstetrician or gynecologist that is a physician or a certified nurse midwife. Benefits are also payable for certain services provided by a participating obstetrician or gynecologist for elective home births.

Benefits payable for a delivery shall include prenatal and postnatal.

In case of early postpartum discharge from an inpatient stay, benefits are provided for home health care as described in the Home Health Care item listed earlier in this section.

Abortion Services

Covered services include services provided in a participating facility provider that is a hospital or birth center and services performed by a participating obstetrician or gynecologist for the termination of your child's pregnancy to prevent the death of your child, or to terminate a pregnancy caused by rape or incest, are covered services under this contract. Services are also provided to treat a child who has complications from an abortion performed elsewhere.

Newborn Care

The newborn child of a Member shall be entitled to benefits provided by this contract from the date of birth up to a maximum of **thirty-one (31) days**. Such coverage within the **thirty-one (31) days** shall include care that is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond **thirty-one (31) days** under conditions specified in the Eligibility section of this Benefits Handbook. It is the Member's responsibility to call KHPE, to assure newborn coverage, and determine future coverage, as soon as the child is born.

Medical Care

Medical care rendered by a participating professional provider, including a physician or surgeon, who provides services to your child while an outpatient in a participating facility provider for services related to surgery or other ambulatory patient services.

Medical Foods and Nutritional Formulas

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of inborn errors of metabolism (IEMs) such as:

- phenylketonuria,
- branched-chain ketonuria,
- galactosemia and
- homocystinuria.

Coverage is provided when administered on an outpatient basis either orally or through a tube.

Benefits are also payable for Nutritional Formulas when the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Participating Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this plan.

An estimated basal caloric requirement for Medical Foods and Nutritional Formula is not required for those with IEMs, or for when administered through a tube.

Behavioral Health Care (See page 84)

Methadone Treatment Counseling

Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

Nutritional Counseling

Benefits are provided for up to six (6) outpatient nutritional counseling visits per year for the purpose of weight management when performed by a participating physician, including your child's primary care physician, or registered dietitian.

This benefit is in addition to any other nutrition counseling covered services described in this contract. A referral from your child's primary care physician is not required to obtain services for nutritional counseling for weight management.

If nutritional counseling visits are provided in addition to other covered services, a copayment may apply for Low-Cost CHIP and Full-Cost CHIP Members.

Office Visits

Benefits are provided for medical care visits for the exam, diagnosis, and treatment of an illness or injury by your child's primary care physician. This also includes physical exams and routine child care, including well-baby visits.

For the purpose of this benefit, office visits include medical care visits to your child's primary care physician's office, during and after regular office hours, emergency visits and medical care visits by the provider to your child's residence, if within the service area.

In addition to office visits, your child may receive medical care at a Retail Health Clinic. Retail Health Clinics are staffed by certified family nurse practitioners who are trained to diagnose, treat, and write prescriptions when clinically appropriate. Nurse practitioners are supported by a local physician who is on-call during clinic hours to provide guidance and direction when necessary. Examples of treatment and services that are provided at a Retail Health Clinic include, but are not limited to: sore throat; ear, eye, or sinus infection; allergies; minor burns; skin infections or rashes and pregnancy testing.

Orthotics

Benefits are provided for:

- the initial purchase and fitting (per medical episode) of orthotic devices, except foot orthotics, unless the covered child requires foot orthotics as a result of diabetes; or
- the replacement of covered orthotics for a covered child when required due to natural growth.

Podiatric Care

Covered services include capsular or surgical treatment of bunions; ingrown toenail surgery; and other non-routine medically necessary foot care. In addition, for patients with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, routine foot care services are covered.

Prescription Drugs (See page 76)

Private Duty Nursing

Benefits will be provided for outpatient private duty nursing performed by a licensed registered nurse (RN) or a licensed practical nurse (LPN) 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.

Prosthetic Devices

Benefits will be provided for prosthetic devices required as a result of illness or injury. Benefits include, but are not limited to:

- the purchase and fitting, and the necessary adjustments and repairs, of prosthetic devices and supplies (except dental prosthesis);
- supplies and replacement of parts necessary for the proper functioning of the prosthetic device, except coverage is not available for enhancements or deluxe supplies or convenience features that do not serve or contribute towards any clinically established physiological and/or functional improvements; or
- with respect to visual prosthetics when medically necessary and prescribed for one of the following conditions:
 - initial contact lenses prescribed for the treatment of infantile glaucoma;
 - initial pinhole glasses prescribed for use after surgery for detached retina;
 - initial corneal or scleral lenses prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity (other than astigmatism);
 - initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 - an initial pair of basic eyeglasses when prescribed to perform the function of a human lens lost (aphakia) as a result of:
 - accidental injury;
 - trauma; or
 - ocular surgery

The “Repair and Replacement” paragraphs set forth below do not apply to this provision for visual prosthetics.

Benefits are provided for the replacement of a previously approved prosthetic device with an equivalent prosthetic device when:

- there is significant change in your child’s condition that requires a replacement;
- the prosthetic device breaks because it is defective;
- the prosthetic device breaks because it has exceeded its life duration as determined by the manufacturer; or
- the prosthetic device needs to be replaced for your child due to the normal growth process when medically necessary.

Benefits will be provided for the repair of a prosthetic device when the cost to repair is less than the cost to replace it. Repair means the restoration of the prosthetic device or one of its components to correct problems due to wear or damage. Replacement means the removal and substitution of the prosthetic device or one of its components necessary for proper functioning.

If an item breaks and is under warranty, it is a parent’s responsibility to work with the manufacturer to replace or repair it.

We will neither replace nor repair the prosthetic device due to abuse or loss of the item.

Rehabilitation Services

Benefits are provided for the following forms of therapy:

- **Occupational Therapy** (limit of 60 visits per year)
Coverage will also include services rendered by a registered, licensed occupational therapist. Your child is required to have these services performed by your child's primary care physician's designated provider.
- **Physical Therapy** (limit of 60 visits per year)
Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part. Your child is required to have these services performed by your child's primary care physician's designated provider.
- **Speech Therapy** (limit of 60 visits per year)
Includes treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Routine Patient Costs Associated With Qualifying Clinical Trials

Benefits are provided for routine patient costs associated with participation in a Qualifying Clinical Trial (see Important Definitions section). To ensure coverage and appropriate claims processing, KHPE must be notified in advance of the Member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a participating professional provider, and conducted in a participating facility provider. If there is no comparable Qualifying Clinical Trial being performed by a participating professional provider, and in a participating facility provider, then KHPE will consider the services by a nonparticipating provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by KHPE.

Specialist Services

Benefits will be provided for specialist services medical care provided in the office by a participating specialist. For the purpose of this benefit, "in the office" includes medical care visits to the provider's office, medical care visits by the provider to your child's residence, or medical care consultations by the provider on an outpatient basis.

Spinal Manipulation / Chiropractic Services

Benefits are provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column. This benefit also includes the consultation, X-rays, and other necessary tests for proper chiropractic care. A limit of 20 visits per year applies.

Substance Use Treatment (See page 114)

Surgical Services

Covered services for surgery include services provided by a participating provider, professional or facility, for the treatment of disease or injury. Separate payment will not be made for inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Covered services also include:

- **Congenital Cleft Palate**

The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

- **Mastectomy Care**

Coverage for the following when performed subsequent to mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas; and
- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Coverage is also provided for:

- The surgical procedure performed in connection with the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and
- The treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- **Routine neonatal circumcisions and any voluntary surgical procedure for sterilization**

- **Oral Surgery**

Oral surgery is subject to special conditions as described below:

- Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
 - The initial treatment of accidental injury or trauma (i.e., fractured facial bones and fractured jaws), in order to restore proper function.
 - In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
 - In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.
- Other oral surgery – defined as surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered service will only be provided for:
 - Surgical removal of impacted teeth that are partially or completely covered by bone;
 - Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
 - Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

KHPE has the right to decide which facts are needed. KHPE may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which KHPE deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to KHPE such information as may be necessary to implement this provision.

- **Assistant at Surgery**

Benefits are provided for an assistant surgeon's services if:

- The assistant surgeon actively assists the operating surgeon in the performance of covered surgery;
- An intern, resident, or house staff member is not available; and
- Your child's condition or the type of surgery must require the active assistance of an assistant surgeon as determined by KHPE.

- **Anesthesia**

Administration of anesthesia in connection with the performance of covered services when rendered by, or under the direct supervision of, a participating specialist other than the surgeon, assistant surgeon, or attending participating specialist.

General anesthesia, along with hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia, when rendered in conjunction with dental care provided to children age seven (7) or under and for developmentally disabled children when determined by KHPE to be medically necessary and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

- **Second Surgical Opinion (Voluntary)**

Consultations for surgery to determine the medical necessity of an elective surgical procedure. Elective surgery is surgery that is not of an emergency or life-threatening nature.

Such covered services must be performed and billed by a participating specialist other than the one who initially recommended performing the surgery.

Telemedicine Services

Telemedicine services are covered, when provided by a Participating Professional Provider who is licensed in the state where the telemedicine service is being offered, and subject to the relevant cost share applicable to that provider. The provider's eligibility will be determined by KHPE in accordance with KHPE's Medical Policies. Telemedicine services are covered when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA)-compliant interactive audio and video telecommunications system as specified in KHPE's Medical Policies.

Therapy Services

Benefits are provided for the following forms of therapy:

- **Cardiac Rehabilitation Therapy**

Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

- **Chemotherapy**

The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided it meets all of the criteria listed below:

- The drugs/biologics are approved by the FDA as antineoplastic agents.

- The FDA-approved use is based on reliable evidence demonstrating positive effect on health outcomes and/or the use is supported by the established referenced Compendia identified in the Company's policies.
- Drugs/biologics are eligible for coverage when they are injected or infused into the body by a professional provider.

- **Dialysis**

Benefits are provided for dialysis treatment when provided in the outpatient facility of a hospital, a freestanding renal dialysis facility or in the home. In the case of home dialysis, covered services will include equipment, training, and medical supplies. The decision to provide covered services for the purchase or rental of necessary equipment for home dialysis will be made by KHPE. The covered services performed in a participating facility provider or by a participating professional provider for dialysis are available without a referral.

- **Infusion Therapy**

This therapy involves the infusion of a drug, hydration, or nutrition (parenteral or enteral) into the body by a health care provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the child. The type of health care provider who can administer the infusion depends on whether the drug is considered to be a specialty drug infusion or a standard injectable drug infusion, as determined by KHPE.

- **Orthoptic/Pleoptic Therapy** (limit of 8 visits per lifetime)

Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from:

- vision disorder;
- eye surgery; or
- injury.

Treatment involves a program that includes evaluation and training sessions.

- **Pulmonary Rehabilitation Therapy**

This includes treatment through a multidisciplinary program that combines physical therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status. Benefits are limited to treatment received within a sixty (60) consecutive-day period.

- **Radiation Therapy**

Benefits are provided for the treatment of disease by X-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the provider.

- **Respiratory Therapy**

Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

- **Speech Therapy** (limit of 60 visits per year)

Includes treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Transplant Services

When your child is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all covered services. Covered services for outpatient care related to the transplant include procedures that are generally accepted as not experimental/investigative services by medical organizations of national reputation. These organizations are recognized by KHPE 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 covered transplant. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to you.

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.

Eligibility for covered services related to human organ, bone and tissue transplant are as follows. If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

- When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under 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.
- When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding, as no benefits are provided to the donor under this Benefits Handbook.
- When only the donor is a Member, the donor is entitled to the benefits of this Benefits Handbook for all related donor expenses, subject to the following additional limitations:
 - The benefits are limited to only those not provided or available to the donor from any other source of funding or coverage in accordance with the terms of the Benefits Handbook; and
 - No benefits will be provided to the non-Member transplant recipient.
- 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:

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

Urgent Care Center

Benefits are provided for Urgent Care Centers, when medically necessary as determined by KHPE. Urgent Care Centers are designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-emergency situation that cannot wait to be addressed by your child's primary care physician or Retail Health Clinic.

Vision Care (See page 88)

Section 10

Inpatient Services

Unless otherwise specified in this Benefits Handbook, the following benefits are provided on an inpatient basis when:

- medically necessary;
- provided or referred by your primary care physician; and
- preapproved by KHPE, where specified.

Note: All inpatient stays must be preapproved by KHPE at least five (5) working days before admission, except for an emergency admission.

Autologous Blood Drawing/Storage/Transfusion

Covered services include the administration of blood and blood processing from donors. In addition, autologous blood drawing, storage or transfusion, i.e., an individual having their own blood drawn and stored for personal use, such as self-donation in advance of planned surgery, are covered services.

Covered services also include whole blood, blood plasma and blood derivatives, which are not classified as Prescription Drugs in the official formularies and which have not been replaced by a donor.

Behavioral Health Care (See page 84)

Habilitative Services

This involves health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient settings.

Hospice Care

Covered services include palliative and supportive services provided to a terminally ill child through a hospice program by a participating hospice provider. This also includes Respite Care. Two conditions apply for hospice benefit eligibility: (1) your child's primary care physician or a participating specialist must certify for KHPE that your child has a terminal illness; and (2) you must elect to have your child receive care primarily to relieve pain. Hospice care is primarily comfort care, including pain relief, physical care, counseling and other services that will help your child cope with a terminal illness rather than cure it. Hospice care provides services to make your child as comfortable and pain-free as possible. When you elect to have your child receive hospice care, benefits for treatment provided to cure the terminal illness are no longer provided. However, you may elect to revoke the election of hospice care at any time.

Respite Care: When hospice care is provided primarily in the home, such as care on a short-term inpatient basis in a Medicare-certified skilled nursing facility, will also be covered when the hospice considers such care necessary to relieve primary caregivers in the patient's home.

Benefits for covered hospice services are provided until the earlier date of your child's death or discharge from hospice care.

Hospital Services

• **Ancillary Services**

Benefits are payable for all ancillary services usually provided and billed for by hospitals (except for personal convenience items) including, but not limited to, the following:

- Meals, including special meals or dietary services as required by your child's condition;
- Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- Oxygen and oxygen therapy;
- Anesthesia when administered by a hospital employee, and the supplies and use of anesthetic equipment;
- Therapy services when administered by a person who is appropriately licensed and authorized to perform such services. Covered services include inpatient therapy up to 45 visits per calendar year for treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery;
- All prescription drugs and medications (including intravenous injections and solutions) for use while in the hospital and which are released for general use and are commercially available to hospitals. (KHPE reserves the right to apply quantity level limits as conveyed by the FDA or KHPE's Pharmacy and Therapeutics Committee for certain prescription drugs);
- Use of special care units, including, but not limited to, intensive or coronary care and related services; and
- Pre-admission testing.

• **Room and Board**

Benefits are payable for general nursing care and such other services as are covered by the hospital's regular charges for accommodations in the following:

- An average semi-private room, as designated by the hospital; or a private room, when designated by KHPE as semi-private for the purposes of this contract in hospitals having primarily private rooms;
- A private room, when medically necessary;
- A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
- A bed in a general ward; and
- Nursery facilities.

Maternity and Obstetrical Care Services

A Member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the Member's pregnancy or delivery, are covered.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than **forty-eight (48) hours** following a vaginal delivery, or less than **ninety-six (96) hours** following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the Keystone HMO CHIP Member is released prior to **forty-eight (48) hours** for a vaginal delivery and **ninety-six (96) hours** for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care Provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an inpatient stay for maternity services are not subject to copayments.

Maternity/Obstetrical Care

Services rendered in the care and management of your child's pregnancy are covered services under this contract. Your child's participating obstetrician or gynecologist will notify KHPE of your child's maternity care within one (1) month of the first prenatal visit to that provider. Covered services include: (1) facility services provided by a participating facility provider that is a hospital or birth center; and (2) professional services performed by a participating obstetrician or gynecologist that is a physician or a certified nurse midwife. Benefits are also payable for certain services provided by a participating obstetrician or gynecologist for elective home births.

Benefits payable for a delivery shall include prenatal and postnatal care. Maternity care inpatient benefits will be provided for **forty-eight (48) hours** for vaginal deliveries and **ninety-six (96) hours** for cesarean deliveries.

In case of early postpartum discharge from an inpatient stay, benefits are provided for home health care as described in the Home Health Care item under the Outpatient Services section of this Benefits Handbook.

Abortion Services

Covered services include services provided in a participating facility provider that is a hospital or birth center and services performed by a participating obstetrician or gynecologist for the termination of your child's pregnancy to prevent the death of the child, or to terminate a pregnancy caused by rape or incest, are covered services under this contract. Care is also provided if a Member needs services as a result of an abortion performed elsewhere.

Newborn Care

The newborn child of a Member shall be entitled to benefits provided by this contract from the date of birth up to a maximum of **thirty-one (31) days**. Such coverage within the **thirty-one (31) days** shall include care that is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond **thirty-one (31) days** under conditions specified in the Eligibility section of this Benefits Handbook.

Medical Care

Medical care rendered by a participating professional provider in charge of your child's case while an inpatient in a participating facility provider that is a hospital, rehabilitation hospital or skilled nursing facility for a condition not related to surgery, pregnancy, mental illness or except as specifically provided. Such care includes inpatient intensive medical care rendered to your child while your child's condition requires a referred specialist's constant attendance and treatment for a prolonged period of time.

Concurrent Care

Services rendered to your child while an inpatient in a participating facility provider that is a hospital, rehabilitation hospital or skilled nursing facility by a referred specialist who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of your child, standby services, routine preoperative physical exams or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal or medical care required by the participating facility provider's rules and regulations.

Consultations

Consultation services when rendered to your child during an inpatient stay in a participating facility provider that is a hospital, rehabilitation hospital or skilled nursing facility by a referred specialist at the request of the attending professional provider. Consultations do not include staff consultations that are required by the participating facility provider's rules and regulations.

Private Duty Nursing

Benefits will be provided for inpatient private duty nursing performed by a licensed registered nurse (RN) or a licensed practical nurse (LPN) when ordered by your child's primary care physician.

Reconstructive Surgery

Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology that causes functional impairment; or breast reconstruction following a mastectomy.

Routine Patient Costs Associated With Qualifying Clinical Trials

Benefits are provided for routine patient costs associated with participation in a Qualifying Clinical Trial. To ensure coverage and appropriate claims processing, KHPE must be notified in advance of the Member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a participating professional provider, and conducted in a participating facility provider. If there is no comparable Qualifying Clinical Trial being performed by a participating professional provider, and in a participating facility provider, then KHPE will consider the services by a nonparticipating provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by KHPE.

Skilled Nursing Facility Services

Benefits are provided for a participating skilled nursing care facility, when medically necessary as determined by KHPE.

Your child must require treatment by skilled nursing personnel that can be provided only on an inpatient basis in a skilled nursing care facility.

During your child's admission, members of KHPE's Care Management and Coordination team are monitoring your child's stay to assure that a plan for your child's discharge is in place. This is to ensure that your child has a smooth transition from the facility to home or other setting. A KHPE case manager will work closely with your child's primary care physician or the participating specialist to help with your child's discharge and, if necessary, arrange for other medical services.

Should your child's primary care physician or participating specialist agree with KHPE that continued stay in a skilled nursing facility is no longer required, you will be notified in writing of this decision. Should you decide to have your child remain in the facility after its notification, the facility has the right to bill you after the date of the notification. You may appeal this decision through the Grievance Appeal Process.

Substance Use Treatment (See page 114)

Surgical Services

Covered services for surgery include services provided by a participating provider, professional or facility, for the treatment of disease or injury. Separate payment will not be made for inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Covered services also include:

- **Congenital Cleft Palate**

The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

- **Mastectomy Care**

Coverage for the following when performed subsequent to mastectomy:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas; and
- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Coverage is also provided for:

- The surgical procedure performed in connection with the initial and subsequent, insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and
 - The treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- **Routine Neonatal Circumcisions and Any Voluntary Surgical Procedure for Sterilization**
 - **Hospital Admission for Dental Procedures or Dental Surgery**

Benefits will be payable for a hospital admission in connection with dental procedures or surgery only when your child has an existing non-dental physical disorder or condition and hospitalization is medically necessary to ensure your child's health. Dental procedures or surgery performed during such a confinement will only be covered for the services described in the Oral Surgery and Assistant at Surgery provisions.

- **Oral Surgery**

Oral surgery is subject to special conditions as described below:

- Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
 - The initial treatment of accidental injury or trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.
 - In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
 - In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.
- Other oral surgery – defined as surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered service will only be provided for:
 - Surgical removal of impacted teeth that are partially or completely covered by bone;
 - Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
 - Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

KHPE has the right to decide which facts are needed. KHPE may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which KHPE deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to KHPE such information as may be necessary to implement this provision.

- **Assistant at Surgery**

Benefits are provided for an assistant surgeon's services if:

- The assistant surgeon actively assists the operating surgeon in the performance of covered surgery;
- An intern, resident, or house staff member is not available; and
- Your child's condition or the type of surgery must require the active assistance of an assistant surgeon as determined by KHPE.

- **Anesthesia**

Administration of anesthesia in connection with the performance of covered services when rendered by or under the direct supervision of a participating specialist other than the surgeon, assistant surgeon or attending participating specialist.

General anesthesia, along with hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia, when rendered in conjunction with dental care provided to children age seven (7) or under and for developmentally disabled children when determined by KHPE to be medically necessary and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

- **Second Surgical Opinion (Voluntary)**

Consultations for surgery to determine the medical necessity of an elective surgical procedure. Elective surgery is surgery that is not of an emergency or life-threatening nature.

Such covered services must be performed and billed by a participating specialist other than the one who initially recommended performing the surgery.

Transplant Services

When your child is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all covered services. Covered services for inpatient care related to the transplant include procedures that are generally accepted as not experimental/investigative services by medical organizations of national reputation. These organizations are recognized by KHPE 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 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.

Eligibility for covered services related to human organ, bone and tissue transplant are as follows. If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

- When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under the terms of this booklet. 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.
- When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under this Benefits Handbook.
- When only the donor is a Member, the donor is entitled to the benefits of this Benefits Handbook for all related donor expenses, subject to the following additional limitations:
 - The benefits are limited to only those benefits not provided or available to the donor from any other source of funding or coverage in accordance with the terms of this booklet; and
 - No benefits will be provided to the non-Member transplant recipient.

- 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:

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

Section 11

Prescription Drug Benefits

Please refer to the “Keystone HMO CHIP Benefits At A Glance” overview for copayment information.

Prescription drug benefits provided under this program are available for covered drugs and supplies dispensed because of a prescription order for the out-of-hospital use by the Member.

Prescription Drug Benefits – What is Covered

A description of benefits for your child’s covered drugs or supplies is described below:

- **Prescribing Physician** – Prescription drugs and maintenance prescription drugs prescribed by your child’s primary care physician or referred specialist and furnished by a participating pharmacy. Generically equivalent pharmaceuticals will be dispensed whenever applicable. Prescription drugs contained in the drug formulary will be prescribed and dispensed whenever appropriate, pursuant to the professional judgment of the primary care physician, referred specialist and/or the pharmacist. Covered drugs or supplies not listed in the drug formulary shall be subject to the non-preferred drug copay. Members will be given a copy of the formulary and the coverage may exclude, or require, the Member to pay higher cost-share for certain prescription drugs. To obtain a copy of the formulary, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- **Drugs From a Participating Pharmacy** – Covered drugs or supplies will be furnished by a participating pharmacy subject to the prescription drug cost-share, if any, for each prescription drug order or refill. Cost-sharing and limitations are listed in the “Benefits At A Glance” document.
- **Participating Mail Service Pharmacy** – Covered drugs or supplies will be furnished by a participating mail service pharmacy subject to the prescription drug cost-share, if any, for each prescription drug order or refill.
- **Drugs from Retail Participating Pharmacy Same Cost Share as Participating Mail Service Pharmacy** – Benefits shall also be provided for covered prescription drugs prescribed by a physician for covered maintenance prescription drugs or supplies and dispensed by an Act 207 retail participating pharmacy. The cost-sharing indicated in the “Benefits At A Glance” document will apply. Benefits are available for up to a 90-day supply. To verify that a retail pharmacy is a participating Act 207 pharmacy, access ibx.com.
- **Vitamins** that require a prescription drug order or refill.
- **Self-Administered Medications** – Benefits are provided for self-administered covered drugs or supplies.
- **Insulin**, only by prescription drug order or refill. Coverage includes oral agents, insulin, disposable insulin needles and syringes, diabetic blood testing strips, lancets and glucometers. There is no prescription drug cost-share requirement for lancets and glucometers obtained through a participating pharmacy or a participating mail service pharmacy.

- **Specialty Drugs** – KHPE will only provide benefits for covered specialty drugs through the PBM's Specialty Pharmacy Program for the appropriate cost-sharing indicated in the "Benefits At A Glance" document. Benefits are available for up to a thirty (30) day supply. No benefits shall be provided for prescription drugs obtained from a Specialty Pharmacy Program other than the PBM's Specialty Pharmacy Program. It is the Member's responsibility to initiate the Specialty Pharmacy process.
- **Dual Coverage**
 - **Coverage and costs** – KHPE will provide coverage for an injectable medication in accordance with medical policy coverage criteria and the terms and conditions of this Benefits Handbook. 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 Benefits Handbook and is administered by a health care provider in a hospital outpatient facility, provider's office, ambulatory (or freestanding) 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 or Member's parent can safely self-administer the drug without the assistance of a health care 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 or their parent should discuss these coverage options with their health care 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.
- **Prescription drug benefits** are subject to dispensing level limits as conveyed by the FDA or KHPE's Pharmacy and Therapeutics Committee.
- **KHPE requires preapproval** by the Member's physician for certain drugs to ensure that the prescribed drug is medically appropriate. Where preapproval or dispensing level limits are imposed, the Member's physician may request an exception for coverage by providing documentation of medical necessity. The Member may obtain information about:
 - whether a particular Prescription Drug appears on the Drug Formulary; or
 - how to request an exception by calling our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

Information about criteria and how cost share will be determined for tier and formulary exceptions can be found in the Formulary Exception Policy. Tier exceptions can only be requested for coverage of Non-Preferred Drugs at the Preferred Brand Drug tier for Brand-Name Drugs or at the generic tier for Generic Drug products. The policy is available at www.ibx.com/formularyexceptionspolicy. The Member may request a hard copy of the policy or obtain information about how to request an exception by calling our Keystone HMO Member Help Team at the phone number on the Member's ID card.

The Member, or the Member's physician acting on their behalf, may appeal any denial of benefits through the Member Complaint Appeal and Grievance Appeal Process described in this Benefits Handbook.

- **Contraceptive 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.
- **Select medications** such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and covered at no Member cost when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- **Select over-the-counter products** may be covered if mandated by the Affordable Care Act. If the Member has a prescription for the over-the-counter medication; the medication is listed in the formulary, if one applies; and the Member has been diagnosed with certain medical conditions, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.

Prescription Drug Limitations

A description of limitations for your child's covered drugs or supplies is described below:

- A Member shall pay to a non-participating pharmacy one hundred percent (100%) of the cost for a prescription drug. A Member can submit a Prescription Reimbursement Request Form for reimbursement consideration. The Member must submit to KHPE acceptable proof of payment with a the form. All reimbursement requests must be received by KHPE or an agent of KHPE within ninety (90) days of the date of purchase. Prescription Reimbursement Request Forms may be obtained through ibx.com or by contacting our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- Drugs that do not appear on the Drug Formulary are not covered, except where an exception has been granted pursuant to the Formulary Exception Policy.
- A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.

- The quantity of a prescription drug dispensed from a pharmacy is limited to a **thirty-four (34) day** supply or 120 dosage units, whichever is less. Up to a **ninety (90) day** supply of a maintenance prescription drug may be obtained through the mail service pharmacy. For information on the mail service pharmacy, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- Members must present their KHPE ID card, and the existence of prescription drug coverage must be indicated on the card.
- A Member shall pay to a participating pharmacy:
 - One hundred percent (100%) of the cost for a prescription drug dispensed when the Member fails to show the Member's KHPE ID card. A claim for reimbursement for covered drugs or supplies may be submitted to KHPE;
 - One hundred percent (100%) of a non-covered drug or supply;
 - The applicable prescription drug cost-sharing; or
 - When a prescription drug is available as a generic, KHPE will only provide benefits for that prescription drug at the generic drug level. If the prescribing physician indicates that the brand-name drug is medically necessary and should be dispensed, the Member shall be responsible for paying the dispensing pharmacy the generic drug copayment, if applicable. To address any questions regarding the Member's pharmacy benefit, call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**.
- In certain cases, KHPE may determine that the use of certain covered prescription drugs for a Member's medical condition requires preapproval for medical necessity.
- KHPE reserves the right to apply dispensing limits for certain covered drugs or supplies as conveyed by the FDA or KHPE's Pharmacy and Therapeutics Committee.
- In certain cases where KHPE determines there may be prescription drug use by a Member that exceeds what is generally considered appropriate under the circumstances, KHPE shall have the right to direct that Member to one pharmacy for all future covered prescription drugs.
- When clinically appropriate drugs are requested by the Member, but are not covered by KHPE, the Member or Member's parent may call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** to obtain information for the process required to obtain the prescription drugs.
- The dollar amount paid by a third party will not accumulate toward any applicable Deductible or Out-of-Pocket Maximum to the extent permitted by law.
- Please visit www.ibx.com/chiprxguidelines to learn more about the prior authorization process, age and quantity limits, and other ways we support the safe prescribing practice of covered medications.

Section 12

Dental Benefits

Keystone HMO CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. There are no copayments for dental services, and no referrals are needed from your child's primary care physician to make an appointment, so making sure your child gets high-quality dental care couldn't be easier. Your child's Keystone HMO CHIP dental benefits are administered by United Concordia Companies, Inc., an independent company.

Tooth decay is the most common chronic childhood disease. Help prevent your child from suffering the effects of tooth decay by encouraging them to practice good oral hygiene daily and taking them to see the dentist for regularly scheduled checkups even if their teeth appear to be healthy.

Who can my child see for dental care?

You may make an appointment with any participating United Concordia dentist. You'll find a list of United Concordia providers on the United Concordia website at ucci.com/PACHIP or by calling United Concordia at **1-800-332-0366** or our Keystone HMO CHIP Member Help Team.

If you need help finding a dental provider or getting an appointment, please call United Concordia at **1-800-332-0366** or our Keystone HMO CHIP Member Help Team and someone will assist you.

Can my child receive services from a nonparticipating dental provider?

Yes, except for orthodontic treatment. Orthodontic treatment must be provided by a participating United Concordia orthodontist. If you take your child to a nonparticipating dentist for services other than orthodontic treatment, you will be responsible for paying the difference between the nonparticipating dentist's charge and the allowance for covered services.

How much does dental care cost?

Except in the case of an emergency, in order for the dental benefit to be completely covered by Keystone HMO CHIP, dental care must be provided by a dentist who is a participating United Concordia provider. Covered dental benefits provided by a participating provider and approved as required by United Concordia will result in no out-of-pocket costs.

Some nonparticipating dental providers will expect payment in full for services at the time of the visit. In this case, it will be your responsibility to pay the bill, and then submit the bill to United Concordia and request reimbursement. You will be sent a check for the allowed amount of the covered services your child received. This check may be for less than the amount you paid the nonparticipating dentist.

In a case involving a covered service in which the Member or the Member's parent selects a more expensive course of treatment than is customarily provided for the dental condition, payment under this benefit will be based on the charge allowance for the lesser procedure. In this case, the dentist may choose to balance-bill you for the difference between the charge of the actual service rendered and the amount received from United Concordia.

What dental services are not covered by Keystone HMO CHIP?

- Dental services performed for cosmetic purposes rather than medical necessity; and
- Additional treatment that is needed due to noncompliance with prescribed dental care.

Please refer to Dental Specific Exclusions below for additional information.

What dental services are covered by Keystone HMO CHIP?

As long as services are provided within the dental benefits limits, your child is eligible to have a routine examination and cleaning once per six months completely free of charge when provided by a participating dentist.

Your child is eligible for a number of other dental benefits, as well. Some dental benefits are restricted to certain age groups, may be limited by how often your child may receive them, may be restricted to a particular facility setting, or may require prior authorization to determine whether the service is medically necessary for your child. You should contact United Concordia at **1-800-332-0366** our Keystone HMO CHIP Member Help Team for detailed information regarding specific benefits limitations that may apply to non-routine services.

Dental-related services that your child may be eligible to receive are listed below. Certain services require prior authorization and may be available only if they are determined to be medically necessary and age-appropriate for your child.

Diagnostic services

- Routine examinations – once per six months, including consultations
- X-rays, including full-mouth X-rays – 1 in any 3 consecutive years
- Bitewing X-rays – 1 set per six months
- Intraoral/periapical X-rays

Preventive services

- Routine cleanings – once per six months, with the exception of a Member under care for a pregnancy for whom 1 additional cleaning is available in the calendar year
- Topical application of fluoride (under age 19) – 3 per calendar year with the exception of a Member under care for a pregnancy or who is considered high risk by the American Dental Association (ADA) caries risk assessment for whom 1 additional fluoride is available in the benefit period
- Topical fluoride varnish (under age 19) – 3 applications per calendar year; high-risk Members may receive 4 applications per calendar year
- Sealants (under age 19)– limited to permanent molars free from caries and/or restorations; 1 treatment per tooth every 3 years except when visible evidence of clinical failure is evident
- Fixed space maintainers
- Recementation of space maintainers

Restorative Care

- Amalgam (silver) restorations – all permanent and deciduous teeth
- Resin-based (white) composite restorations – permanent and deciduous anterior teeth only; other restorations are not covered unless there is special need

Endodontic Services (prior authorization mandatory, except where indicated)

- Pulpotomies – deciduous teeth only – prior authorization not required
- Pulpal Therapy (incisors up to age 6 and cuspids and molars up to age 11) – 1 per tooth per 2 years; prior authorization not required
- Root canals (permanent teeth only)
- Apicoectomy

Periodontal Services

- Periodontal surgery and soft tissue grafts – 1 per 3 years
- Periodontal scaling and root planing – 1 per quadrant per 24 months
- Periodontal maintenance – 4 per 12 months combined with adult prophylaxis after the completion of active periodontal therapy
- Gingivectomy or gingivoplasty – 1 service per quadrant or site limit every 36 months
- Full-mouth debridement – 1 per lifetime

Prosthodontic (prior authorization mandatory)

- Full and partial removable dentures (limited) – 1 every 5 years
- Fixed partials (covered only in cases where medically necessary as a result of an accident or injury) – limited
- Repairs/relines/adjustments
- Crowns (resin, porcelain, and full cast) – Permanent teeth only if the tooth cannot be restored with another material (i.e., amalgam); porcelain to predominantly base metal on anterior teeth only – 1 in 5 years; preoperative X-ray required
- Crowns (stainless steel) – 1 per tooth every 5 years
- Crown lengthening or repairs
- Implantology and related services – 1 per tooth in 5 years
- Occlusal guards – 1 per year for a child 13 years old or older

Oral Surgery

- Simple extractions
- Surgical extractions

Oral and Maxillofacial Surgery (prior authorization mandatory)

Surgical extractions not covered by the Member's medical oral surgery benefit, including those involving wisdom teeth:

- Soft tissue wisdom teeth
- Brush biopsies
- Alveoloplasties
- Removal of tooth-related/non-tooth-related cysts
- Incision and drainage of abscesses
- Oroantral fistula closure
- Surgical exposure and placement of device for eruption facilitation
- Tooth reimplantation and/or stabilization of an accidentally evulsed tooth
- Frenulectomy/Frenotomy
- Removal of exostosis; mandibular or palatal tori; reduction of osseous tuberosities
- Osseous surgery – 1 every 36 months

Orthodontic Services (prior authorization mandatory and must be provided by a participating orthodontist)

- Evaluation for braces – limited to once per benefit period
- Comprehensive orthodontic treatment – limited to once per lifetime
- Orthodontic retention
- Covered only if your child is diagnosed with a significant handicapping malocclusion or other severe condition (such as cleft palate) and orthodontic treatment is determined to be the only method capable of restoring your child's oral structure to health and function
- Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services

Adjunctive General Services

- General anesthesia in conjunction with a covered service
- Intravenous conscious sedation

Emergency Services

- Temporary crown for treatment of a fractured tooth
- Apicoectomy/periradicular surgery
- Palliative treatment of dental pain

Section 13

Behavioral Health and Substance Use Benefits

Your child is eligible for behavioral health and substance use benefits with Keystone HMO CHIP. All inpatient services and certain outpatient services must be coordinated and authorized by an in-network behavioral health provider to determine that medical necessity criteria are met for the services. (See “Utilization Review Process” on page 19. Once medical necessity criteria are not met any longer, the authorization will be updated to reflect only those days of service that are covered. Unauthorized services rendered at a participating provider are not covered and are not the Member’s responsibility to pay. For out-of-network behavioral health and substance use services, see “Preapproval for Nonparticipating Providers” on page 27 for obtaining preapproval for use of a nonparticipating provider.

How to Access Behavioral Health and Substance Use Benefits

Need someone to talk to? Call a Customer Care Advocate at 1-800-294-0800 for assistance in finding a behavioral health provider.

1-800-294-0800

TTY/TDD service for hearing- and speech-impaired: 1-800-409-8640

Call this number when you need help or information on any of the following:

- to access or receive a list of behavioral health network providers;
- to determine if medical necessity criteria are met for inpatient, Partial Hospitalization Programs (“PHP”) and Intensive Outpatient Programs (“IOP”) for behavioral health or substance use care, or for Repetitive Transcranial Magnetic Stimulation (“rTMS”) for severe major depressive disorders;
- emergency assistance 24 hours a day, every day of the year; or
- general information about your child’s behavioral health and substance use benefits.

Your Child’s Behavioral Health Benefits — What is Covered

Outpatient Services

Your child is eligible for benefits for covered services during a behavioral health outpatient visit/session for the treatment of a mental illness, when provided by a participating behavioral health/substance use provider.

The following behavioral health benefits are provided in an outpatient setting:

- Electroconvulsive therapy
- Family counseling
- Group counseling
- Individual counseling
- Masters-prepared therapist visits
- Medication management
- Participating licensed clinical social worker visits
- Psychiatric consultations
- Psychological testing
- Psychiatric visits
- Repetitive Transcranial Magnetic Stimulation
- Telebehavioral Health services

Emergency Care

If your child is in a crisis or emergency situation, call the toll-free hotline number, **1-800-294-0800**.

A behavioral health professional will help you assess the seriousness of the situation. If it is an emergency, the behavioral health professional will assist you in getting the treatment needed as quickly as possible.

A psychiatric emergency is the sudden onset of a potentially life-threatening condition where you believe, with a prudent layperson's judgement, that your child is at risk of injury to themselves or others if immediate medical attention is not given. A child as young as 14 years old can self-refer.

The initial treatment for psychiatric emergencies is covered even when provided by nonparticipating behavioral health providers or hospitals if the symptoms are severe enough to need immediate attention.

If the condition is not a life-threatening one that requires inpatient admission, we will help schedule your child for an urgent behavioral health care appointment.

When there is need for immediate medical treatment, you need to first seek appropriate medical care. To do this, follow the steps for emergency services on page 30.

Inpatient Services

Your child is eligible for benefits for covered services during a behavioral health inpatient admission for the treatment of a behavioral illness, when provided by a participating behavioral health/substance use provider.

During a behavioral health admission your child will be eligible for:

- Concurrent care
- Electroconvulsive therapy
- Group counseling
- Individual counseling
- Medication management
- Psychiatric consultations
- Psychiatric visits
- Psychological testing

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP)

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) is care that is more intensive than outpatient care, but does not require an inpatient hospital stay. It is a day or evening treatment program which is:

- **a minimum of three (3) visits per week; and**
- **a maximum of five (5) visits per week lasting three (3) hours each.**

PHP and IOP include medical, nursing, counseling or therapeutic services. These services are provided on a planned and regularly scheduled basis in a network behavioral health facility or hospital.

All PHP and IOP services must be reviewed to determine that medical necessity criteria are being met. See "Utilization Review Process" on page 19. Once medical necessity criteria are not met any longer, the authorization will be updated to reflect only those days of service that are covered. Unauthorized services rendered at a participating provider are not covered and are not the Member's responsibility to pay. For out-of-network behavioral health and substance use services, see "Preapproval for Nonparticipating Providers" on page 27 for obtaining preapproval for use of a nonparticipating provider.

The criteria for medical necessity determinations made by the participating behavioral health/substance use provider with respect to behavioral health care benefits will be made available to the Member upon request.

Your Child's Substance Use Benefits — What is Covered

Outpatient Services

Benefits are provided for covered services during an outpatient substance use treatment visit/session for the diagnosis and medical treatment of substance use, including detoxification in an acute care hospital or a substance use treatment facility that is a behavioral health/substance use provider.

Benefits are also provided for covered services for non-medical treatment, such as vocational rehabilitation or employment counseling during an outpatient substance use treatment visit/session in a substance use treatment facility that is a behavioral health/substance use provider.

A referral from your child's primary care physician is **not** required. Call us at **1-800-294-0800** (TTY/TDD: 1-800-409-8640). A child as young as age 14 can self-refer.

Outpatient substance use treatment covered services include:

- Diagnostic services, including psychiatric, psychological and medical laboratory tests;
- Services provided by the behavioral health/substance use providers on staff;
- Rehabilitation therapy and counseling;
- Family counseling and intervention; and
- Medication management and use of equipment provided by the substance use treatment facility or a residential treatment facility that is a behavioral health/substance use provider.

Inpatient Services

Your child is eligible for benefits for covered services during a substance use inpatient admission for the diagnosis and medical treatment of substance use, including detoxification, when provided at a participating facility provider that is a participating behavioral health/substance use provider.

Benefits are also provided for covered services for non-medical treatment, such as vocational rehabilitation or employment counseling, during an inpatient substance use treatment admission in a substance use treatment facility or a residential treatment facility that is a behavioral health/substance use provider.

During a substance use admission your child will be eligible for:

- Lodging and dietary services;
- Diagnostic services, including psychiatric, psychological and medical laboratory tests;
- Services provided by a staff physician, psychologist, registered or licensed practical nurse, and/or certified addictions counselor;
- Rehabilitation therapy and counseling;
- Family counseling and intervention; and
- Prescription drugs, medicines, supplies and use of equipment provided by the substance use treatment facility or a residential treatment facility that is a behavioral health/substance use provider.

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP)

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) is care that is more intensive than outpatient care, but does not require an inpatient stay. PHP and IOP services are a day or evening treatment program that lasts:

- **a minimum of two (2) hours per session; and**
- **three (3) to five (5) sessions weekly.**

IOP includes counseling or therapeutic services. These services are provided on a planned and regularly scheduled basis in a network substance use health facility or network outpatient provider group. All PHP and IOP services must be reviewed to determine that medical necessity criteria are being met. See "Utilization Review Process" on page 19. Once medical necessity criteria are not met any longer, the authorization will be updated to reflect only those days of service that are covered. Unauthorized services rendered at a participating provider are not covered and are not the Member's responsibility to pay. For out of network behavioral health and substance use services, see "Preapproval for Nonparticipating Providers" on page 27 for obtaining preapproval for use of a nonparticipating provider.

The criteria for medical necessity determinations made by the participating behavioral health/substance use provider with respect to substance use disorder benefits will be made available to the Member upon request.

Complaints and Grievances

If you have a concern about your child's behavioral health or substance use services, call Keystone HMO CHIP at **1-800-464-5437**. If a Keystone HMO CHIP Member Help Team representative is not able to resolve your problem, you may file a formal complaint or grievance with KHPE. See "You Can File a Complaint or Grievance for Your Child" on page 37.

Section 14

Routine Vision Care Benefits

Please refer to the “Keystone HMO CHIP Benefits At A Glance” overview for copayment information.

Routine vision care benefits are administered by Davis Vision.[†] No referrals are necessary to use vision benefits. Only examinations performed by a Davis Vision participating provider are covered.

How to Access Vision Care Benefits

To locate a Davis Vision participating provider near you, call:

1-888-393-2583

TTY/TDD service for hearing- and speech-impaired: 1-800-523-2847

Call this number when you need to locate a provider for your child. No referral is necessary. Once you select a participating provider, tell the provider’s office:

- that your child is enrolled in KHPE; and
- your child’s ID number located on your child’s KHPE ID card.

The provider will obtain the necessary authorization for your child.

Your child’s frames and lenses will be covered 100%, if:

- purchased through a Davis Vision participating provider; and
- chosen from a large selection of quality frames in the Davis Collection of Frames.

You may purchase contact lenses, in place of eyeglasses, for your child. (Please refer to the information below.)

Vision Care – What is Covered

Eye Examinations

- All routine eye examinations must be performed by a Davis Vision participating provider. There is no coverage when performed by a nonparticipating provider.*
- A routine eye examination and refraction, including dilation if professionally indicated, is **covered 100%, once (1) every calendar year.**

Frames and Lenses

- **One (1) pair of frames every calendar year** at no additional cost, when purchased from a Davis Vision participating provider and selected from the Davis Collection of Frames.
- For frames that are not part of the Davis Collection of Frames, expenses over \$130 are your responsibility. Additionally, a 20% discount applies to any amount over \$130.

[†] KHPE vision benefits are administered by Davis Vision, an independent company.

***A Davis Vision participating provider must be used for these services when in the Southeastern Pennsylvania service area.**

- **One (1) set of eyeglass lenses every calendar year** that may be plastic or glass*, single vision, bifocal, trifocal, lenticular and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, and polycarbonate prescription lenses.
- All lenses include scratch-resistant coating.
- There is no copayment for covered standard eyeglass lenses. However, most optional lens types and treatments have applicable copayments.
- Replacement of lost, stolen, or broken frames and lenses, when deemed medically necessary, once every calendar year.*

Contact Lenses

- **One (1) contact lens benefit every calendar year**, in place of eyeglasses or when medically necessary, must be purchased from a Davis Vision participating provider.
- Expenses over \$130, which may be applied toward the cost of evaluation, materials, fitting and follow-up care, are the Member's responsibility. Additionally, a 15% discount applies to any amount over \$130.
- In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care related to contact lenses. Should this occur, and the value of the contact lenses received is less than the allowance, the remaining balance can be applied to the total \$130 allowance.
- Expenses in excess of \$600 for medically necessary contact lenses, and with preapproval, may be obtained for conditions including:
 - aphakia;
 - pseudophakia;
 - keratoconus;
 - if the patient has had cataract surgery or implant, or corneal transplant surgery; or
 - if visual activity is not correctable to 20/40 in the worse eye by use of eyeglass lenses, but can be improved to 20/40 in the worse eye by use of contact lenses.
- Replacement of lost, stolen, or broken contact lenses, when deemed medically necessary, once every calendar year.*

Low Vision Benefits

One (1) comprehensive low vision evaluation every five (5) years, with a maximum charge of \$300; maximum low vision aid allowance of \$600, with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care—four (4) visits in any five (5)-year period, with a maximum charge of \$100 per visit. Providers will obtain the necessary pre-authorization for these services.

***A Davis Vision participating provider must be used for these services when in the Southeastern Pennsylvania service area.**

Participating Provider Exclusion for Replacements

If your child is unexpectedly out of the Southeastern Pennsylvania service area (for example, on vacation) and your child needs replacement eyeglasses or contact lenses, you may purchase the eyewear from a nonparticipating provider. However, you will be required to pay the costs. To be reimbursed:

- Call Davis Vision at **1-888-393-2583** for a reimbursement form.
- Submit your receipt of purchase to Davis Vision for a reimbursement up to your child's benefit amount.
- Balances in excess of the benefit amount are your responsibility.

Section 15

Exclusions – What is Not Covered

The following are excluded from your child's coverage:

1. Services or supplies that are:
 - not provided by or referred by your child's primary care physician except in an emergency or as specified elsewhere in this Benefits Handbook;
 - not medically necessary, as determined by your child's primary care physician or referred specialist or KHPE, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive covered services specifically provided under this contract and described in this Benefits Handbook; or
 - provided by family members, relatives, and friends.
2. Services for any occupational illness or bodily injury that occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers' compensation law or any similar occupational disease law or act. This exclusion applies whether or not the Member claims the benefits or compensation.
3. Services, charges or supplies for which a Member would have no legal obligation to pay, or another party has primary responsibility.
4. For any loss sustained or expenses incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared.
5. Care related to military service disabilities and conditions that your child is legally entitled to receive at government facilities which are not KHPE providers, and which are reasonably accessible to your child.
6. Any charges for services, supplies or treatment while a Member is incarcerated in any adult or juvenile penal or correctional facility of institution.
7. Care for conditions that federal, state or local law requires to be treated in a public facility.
8. Services, supplies or charges paid or payable by Medicare when Medicare is primary. For purposes of this Benefits Handbook, a service, supply or charge is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premiums for, maintains, claims or receives Medicare benefits.
9. For injuries resulting from the maintenance or use of a motor vehicle if the treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.
10. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a prescribed plan of treatment.

11. Services or supplies that are experimental/investigative in nature, except Routine Patient Costs Associated With Qualifying Clinical Trials that meet the definition of a Qualifying Clinical Trial under this Benefits Handbook, and which have been preapproved by KHPE.

Routine patient costs do not include any of the following:

- the investigational item, device, or service itself;
 - items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
 - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
12. Routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for camp, college or travel, and examinations for insurance, licensing and employment.
 13. For care in a long-term care facility, including a nursing home, home for the aged, convalescent home, school, camp, or institution for intellectually disabled children, custodial care in a skilled nursing facility.
 14. Cosmetic surgery, including cosmetic dental surgery. Cosmetic surgery is defined as any surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected.

This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including but not limited to the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

This exclusion does not include those services performed when the patient is a Member of KHPE and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process.

This exclusion does not apply to otherwise covered services necessary to correct medically diagnosed congenital defects and birth abnormalities for children.

15. Any therapy service provided for:
 - work hardening activities/programs;
 - evaluations not associated with therapy.
16. All surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to, radial keratotomy and refractive keratoplasty.
17. Immunizations required for employment purposes or travel.
18. Custodial and domiciliary care, residential care, protective and supportive care, including educational services, rest cures and convalescent care.
19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary. This exclusion does not apply to KHPE's weight reduction program or nutrition counseling visits/sessions as provided by KHPE through its nutrition counseling for weight management benefit. This exclusion does not include weight reduction services that are required to be covered under the Affordable Care Act.

20. For Medical Foods and Nutritional Formulas:

- For appetite suppressants.
- For oral non-elemental nutritional supplements (e.g. Boost, Ensure, NeoSure, PediaSure, Scandishake), casein hydrolyzed formulas (e.g. Nutramigen, Alimentum, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, soy-based products. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the Description of Covered Services;
- For elemental semi-solid foods (e.g. Neocate Nutra);
- For products that replace fluids and electrolytes (e.g. Electrolyte Gastro, Pedialyte)
- For oral additives (e.g. Duocal, fiber, probiotics, or vitamins) and food thickeners (e.g. Thick-It, Resource ThickenUp);
- For supplies associated with the oral administration of formula (e.g. bottles, nipples).

21. Customized wheelchairs.

22. Personal or comfort items such as television, telephone, air conditioning, humidifiers, barber or beauty service, guest service and similar incidental services and supplies that are not medically necessary.

23. Sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist.

24. For routine foot care, as defined in the carrier's medical policy, unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

25. Marriage or religious counseling.

26. In vitro fertilization; embryo transplant; ovum retrieval, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any services required in connection with these procedures.

27. Services for repairs or replacements of prosthetic devices or Durable Medical Equipment needed because the item was abused, lost or misplaced.

28. Reversal of voluntary sterilization and services required in connection with such procedures.

29. Wigs and other items intended to replace hair loss due to androgenetic alopecia; or due to illness or injury including, but not limited to, injury due to traumatic or surgical scalp avulsion, burns or chemotherapy.

30. Ambulance Services/Transport, unless medically necessary, and as provided in the subsection entitled "Ambulance Services/Transport" specified in Outpatient Services of this Benefits Handbook.

31. Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as described in this Benefits Handbook and provided under the contract. No payment will be made for human organs that are sold rather than donated.

32. Charges for completion of any insurance form.

33. For self-administered prescription drugs under medical benefits, regardless of whether the drugs are provided or administered by a provider. Drugs are considered self-administered prescription drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. Self-administered drugs will not be covered unless they are:
 - mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes; or
 - required for treatment of an emergency condition that requires a self-administered prescription drug.
34. Foot orthotic devices except as described in this Benefits Handbook and provided under the contract. This exclusion does not apply to foot orthotic devices used for the treatment of diabetes.
35. Any services, supplies or treatments not specifically listed in this Benefits Handbook or provided under the contract as covered benefits, unless the unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. KHPE reserves the right to specify providers of, or means of delivery of covered services, supplies or treatments under this plan, and to substitute such providers or sources where medically appropriate.
36. For prescription drugs and medications, except as provided under the Prescription Drug Benefit described in this Benefits Handbook.
37. For contraceptives, except as covered under the Prescription Drug Benefit described in this Benefits Handbook.
38. The following outpatient services that are not performed by your child's primary care physician's designated provider, when required under the plan, unless preapproved by KHPE:
 - rehabilitation therapy services (other than speech therapy and services for Autism Spectrum Disorders);
 - diagnostic radiology services for children age five (5) or older; and
 - laboratory and pathology tests.
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 KHPE following neurological damage to the central nervous system caused by illness or trauma (e.g., stroke, acute brain insult, encephalopathy).
40. Medication furnished by any other medical service for which no charge is made to the Member.
41. Charges in excess of benefit maximums.
42. For over-the-counter drugs, or any other medications that may be dispensed without a doctor's prescription, except for medications administered during an inpatient stay.
43. Equipment costs related to services performed on high cost technological equipment unless the acquisition of such equipment was approved through a Certificate of Need process and/or KHPE.
44. Services incurred prior to the effective date of coverage.
45. Services that were or are incurred after the date of termination of the Member's coverage, except as provided in this Benefits Handbook.
46. Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trust or similar person.

47. Counseling with patient's relatives except as may be specifically provided in the subsection titled "Your Child's Substance Use Benefits - What is Covered" or "Transplant Services" specified in the Inpatient and Outpatient sections of this Benefits Handbook.
48. With regard to Durable Medical Equipment (DME), items for which any of the following statements are true is not DME and will not be covered.

Any item:

- **That is for comfort or convenience.** Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps; telephone alert systems; bed-wetting alarms; and ramps;
- **That is for environmental control.** Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; and ambient heating and cooling equipment;
- **That is inappropriate for home use.** This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes;
- **That is a non-reusable supply** or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME.
- **That is not primarily medical in nature.** Equipment that is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: exercise equipment; speech teaching machines; strollers; toileting systems; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief;
- **That has features of a medical nature which are not required by the patient's condition, such as a gait trainer.** The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a medically necessary and realistically feasible alternative item that serves essentially the same purpose;
- **That duplicates or supplements existing equipment for use when traveling or for an additional residence.** For example, a patient who lives in the Northeast for six (6) months of the year, and in the Southeast for the other six (6) would not be eligible for two (2) identical items, or one (1) for each living space;
- **That is not customarily billed for by the provider.** Items not covered include, but are not limited to: delivery; setup and service activities (such as routine maintenance, service, or cleaning); and installation and labor of rented or purchased equipment;
- **That modifies vehicles, dwellings, and other structures.** This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair; or
- **Equipment for safety.** Items that are not primarily used for the diagnosis, care or treatment of disease or injury but are primarily used to prevent injury or provide a safe surrounding. Examples include: restraints, safety straps, safety enclosures, car seats.

We will neither replace nor repair the DME due to abuse or loss of the item.

49. With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:

- The item is for comfort or convenience.
- The item is not primarily medical in nature. Items not covered include, but are not limited to: earplugs; ice packs; silverware/utensils; feeding chairs; toilet seats.
- The item has features of a medical nature which are not required by the patient's condition.
- The item is generally not prescribed by an eligible provider.

Some examples of not-covered consumable medical supplies are incontinence pads; lamb's wool pads; face masks (surgical); disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations.

50. For skilled nursing facility benefits:

- When confinement is intended solely to assist a Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
- For the treatment of substance use and behavioral health care; or
- After the Member has reached the maximum level of recovery possible for the Member's particular condition and no longer requires definitive treatment other than routine custodial care.

51. The cost of home blood pressure machines except for Members: a) with pregnancy-induced hypertension; b) with hypertension complicated by pregnancy; c) with end-stage renal disease receiving home dialysis; or (d) who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates.

52. In regard to hospice care:

- research studies directed to life-lengthening methods of treatment;
- expenses incurred in regard to the Member's personal, legal, and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property); or
- treatment to cure the Member's illness.

53. Alternative Therapies/Complementary Medicine, including but not limited to: acupuncture; music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements and therapy, except as required to be covered under the Affordable Care Act; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy.

54. For health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.

55. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

56. Charges not billed/performed by provider.

57. Services performed by a professional provider enrolled in an educational or training program when such services are related to the educational or training program and are provided through a hospital or university.

58. Home health care services and supplies in connection with home health services for the following:
- custodial services, food, housing, homemaker services, home-delivered meals and supplementary dietary assistance;
 - rental or purchase of Durable Medical Equipment;
 - rental or purchase of medical appliances (e.g., braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
 - prescription drugs, except as covered under the Prescription Drug Benefit;
 - provided by family members, relatives and friends;
 - a Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
 - emergency or non-emergency ambulance services;
 - visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy and/or social services;
 - services provided to individuals (other than a Member released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and
 - visits by any provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for home health care services and will or will not be provided services by the provider.
59. Treatment of obesity, including, but not limited to: (a) weight management programs; (b) dietary aids, supplements, injections, and medications; (c) weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician; and (d) group nutrition counseling.
- Surgical procedures specifically intended to result in weight loss (including bariatric surgery).
60. Coverage is not provided for the services or treatment related to an elective abortion, an abortion that is the voluntary termination of pregnancy other than one which is necessary to prevent the death of the woman, or to terminate a pregnancy that was caused by rape or incest.
61. For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
62. For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.
63. The following are not covered under the Prescription Drug benefits of this program:
- Devices of any type, even though such devices may require a prescription order. This includes, but is not limited to, therapeutic devices or appliances, hypodermic needles, syringes or similar devices, support garments or other devices, regardless of their intended use, except as specified as a benefit in this contract. This exclusion does not apply to: (a) devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; or (c) contraceptive devices as mandated by the Women's Preventive Services provision of the Affordable Care Act;

- 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 KHPE, whether or not prescribed by a physician (This exclusion does not include over-the-counter drugs that are required to be covered under the Affordable Care Act.);
- Any drugs covered under another provision of this contract;
- Prescription drugs covered without charge under federal, state, or local programs, including workers' compensation and occupational disease laws;
- Prescription refills resulting from loss or theft, or any unauthorized refills;
- Experimental drugs or investigational drugs or drugs prescribed for experimental (non-FDA-approved) indications;
- Drugs used for cosmetic purposes, including, but not limited to, anabolic steroids, minoxidil lotion, or Retin A (tretinoin) when used for non-acne related conditions. However, this exclusion does not include drugs prescribed to treat medically diagnosed congenital defects and birth abnormalities;
- Pharmacological therapy for weight reduction or diet agents unless preapproved by KHPE (This exclusion does not include pharmacological therapy for weight reduction or diet agents that are required to be covered under the Affordable Care Act.);
- Injectable drugs, including injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization. This exclusion does not include injectable contraceptive drugs;
- Drugs prescribed and administered in the physician's office;
- Medication for a Member confined to a rest home, skilled nursing facility, sanitarium, extended care facility, hospital or similar entity;
- Medication furnished by any other medical service for which no charge is made to the Member;
- Any covered drug that is administered at the time and place of the prescription order;
- Any charges for the administration of prescription legend drugs or injectable insulin;
- Prescription drugs provided by nonparticipating pharmacies, except as specified in "Prescription Drug Benefits – What is Covered" provision above
- Immunization agents (except those covered on the Drug Formulary), biological sera, blood or plasma, or allergy serum;
- Prescription drugs not approved by KHPE or prescribed drug amounts exceeding the quantity level limits as conveyed by the FDA or KHPE's Pharmacy and Therapeutics Committee;
- Specialty drugs that are not purchased through the PBM's Specialty Pharmacy Program. This exclusion does not apply to insulin;
- Any charge where the usual and customary charge is less than the Member's applicable cost-sharing amount;
- For Convenience Pack drugs, which combine two or more individual drug products into a single package with a unique national drug code;
- Drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy.

64. The following are not covered under the Dental Care benefits of this program:

- Claims involving covered services in which the dentist and the Member select a more expensive course of treatment than is customarily provided by the dental profession and consistent with sound professional standards of dental practice for the dental condition concerned
- Dentures and other prosthodontics, unless medically necessary, as a result of surgery for trauma or a disease process that renders the dental condition untreatable by a less intensive restorative procedure
- Duplicate and temporary devices, appliances, and services
- Gold foil restorations and restorations or prosthodontics using high noble or noble metals unless the use of such materials is determined to be medically necessary
- Labial veneers
- Laminates done for cosmetic purposes
- Local anesthesia when billed for separately by a dentist
- Oral surgery that is covered under the medical portion of the benefits
- Plaque-control programs, oral hygiene education, and dietary instruction
- Retainer replacement
- Periodontics not otherwise listed
- Orthodontics (braces) that do not meet the criteria required. Braces are not covered for cosmetic purposes.
- Procedures to alter vertical dimension and/or restore or maintain the occlusion, attrition, and restoration for malalignment of teeth
- Any treatment that is necessitated by lack of cooperation by the Member or the eligible Member's family with the dentist or noncompliance with prescribed dental care
- A contract between the Member or Member's family and dentist prior to the effective date of coverage

65. The following are not covered under the Vision Care benefits of this program:*

- Vision therapy
- Special lens designs or coatings, other than those previously described
- Non-prescription (plano) lenses

Section 16

Important Definitions

For the purposes of this Benefits Handbook, the terms below have the following meanings:

ACCIDENTAL INJURY — bodily injury that results from an accident directly and independently of all other causes.

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE — complementary and alternative medicine is defined as a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine based on recognition by the National Institutes of Health.

AMBULATORY SURGICAL FACILITY — a facility operated, licensed, or approved as an Ambulatory Surgery Facility by the responsible state agency, which provides a specialty or multispecialty outpatient surgical treatment or procedure that is not located on the premises of a Hospital.

AUTHORIZED GENERICS — Brand-Name Drugs that are marketed without the brand name on their labels. An authorized generic may be marketed by the brand-name drug company, or another company with the brand company's permission. Unlike a standard Generic Drug, the authorized generic is not approved by the FDA abbreviated new drug application process (ANDA). For cost-sharing purposes, authorized generics are treated as Brand-Name Drugs.

AUTISM SERVICE PROVIDER — a person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either:

- Licensed or certified in this Commonwealth; or
- Enrolled in the Commonwealth's Medical Assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavioral Specialist.

AUTISM SPECTRUM DISORDER (ASD) — any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

AUTISM SPECTRUM DISORDER TREATMENT PLAN (ASD TREATMENT PLAN) — a plan for the treatment of Autism Spectrum Disorders:

- Developed by a licensed physician or licensed psychologist who is a participating professional provider; and
- Based on a comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

BEHAVIORAL HEALTH CONDITION — any of various conditions categorized as behavioral health disorders by the most recent edition of the International Classification of Diseases (ICD), wherein behavioral health treatment is provided by a qualified behavioral health provider.

BENEFITS — see COVERED SERVICE.

*KHPE vision benefits are administered by Davis Vision, an independent company.

BLUECARD® PROGRAM — a program that enables Members obtaining health care services while traveling outside KHPE’s service area to receive all the same benefits of their plan and access to BlueCard® providers and savings. The program links participating health care providers and the independent Blue Cross and Blue Shield licensees across the country and also to some international locations through a single electronic network for claims processing and reimbursement.

BRAND-NAME DRUG — a Prescription Drug approved by the FDA through the new drug application (NDA) process and in compliance with applicable state laws and regulations. For purposes of this Program, the term “Brand-Name Drug” shall also include Authorized Generics and, if applicable, devices such as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) — the program providing free and low-cost health insurance to low-income, uninsured children in Pennsylvania, established by Act 113 of 1992, and expanded by PA Act 68 of 1998.

COMPLAINT — a dispute or objection regarding a participating provider or the coverage, operations, or management policies of KHPE, which has been filed with KHPE or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department. The term does not include a Grievance.

CONDITIONS FOR DEPARTMENTS (for Qualifying Clinical Trials) — the conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
- Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

CONSUMABLE MEDICAL SUPPLY — Non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

CONTRACEPTIVE DRUGS — FDA-approved drugs requiring a prescription order to be dispensed for the use of contraception. These include oral contraceptives, such as birth control pills, as well as injectable contraceptive drugs. This does not include implants.

COORDINATION OF BENEFITS (COB) — a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two (2) or more group plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims, and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, that plan does not have to pay benefits first. This provision does not apply to student accident or group hospital indemnity plans paying one hundred dollars (\$100) per day or less.

COPAYMENT — a fixed amount paid by Member or Member’s parent to the provider for a covered health care service, usually when the Member receives the service. The amount can vary by the type of covered health care service.

COVERED DRUGS OR SUPPLIES — drugs, including self-administered prescription drugs, or supplies approved under Federal Law by the Food and Drug Administration for general use, and limited to the following:

- Prescription drugs that appear on the Drug Formulary, or where an exception has been granted pursuant to the Formulary Exception Policy;
- Prescription drugs prescribed by a primary care physician or referred specialist subject to the Prescription Drug Exclusions, and other exclusions listed in this contract;
- Compounded prescription drugs containing at least one legend drug or controlled substance in an amount requiring a prescription drug order or refill;
- Insulin (by prescription order only); or
- Spacers for metered dose inhalers (by prescription order only).

COVERED SERVICE — a service or supply specified in the contract and detailed in this Benefits Handbook, for which benefits will be provided.

CUSTODIAL CARE (DOMICILIARY CARE) — care provided primarily for maintenance of the patient, or care which is designed essentially to assist the patient in meeting the patient's activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DECISION SUPPORT — describes a variety of services that help Members make educated decisions about health care and support their ability to follow their primary care physician's and participating specialist's treatment plans. Some examples of decision support services include support for major treatment decisions and information about everyday health concerns.

DENTALLY NECESSARY — services or supplies provided by a dentist, except for dental emergency care, that are:

- Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- In accordance with accepted standards of good dental practice;
- Not primarily for the convenience of the patient or the provider; and
- The most appropriate supply or level of service that can be safely provided to the Member.

DENTIST — a licensed doctor of dental surgery, doctor of dental medicine, doctor of medicine or doctor of osteopathy.

DESIGNATED PROVIDER — a participating provider with whom KHPE has contracted the following outpatient services: (a) certain rehabilitation therapy services (other than speech therapy); (b) diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests. The Member's primary care physician will provide a referral to the designated provider for these services.

DETOXIFICATION — the process whereby an alcohol or drug intoxicated, or alcohol- or drug-dependent person is assisted, in a facility licensed by the Department of Health, or in case of opiates, by an appropriately licensed behavioral health provider in an ambulatory setting. This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

DIABETIC EDUCATION PROGRAM — an outpatient diabetic education program provided by a participating facility provider that has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

DISEASE MANAGEMENT — an approved program designed to identify and help people who have a particular chronic disease to stay as healthy as possible. Disease Management programs use a population-based approach to:

- identify Members who have or are at risk for a particular chronic medical condition;
- intervene with specific programs of care; and
- measure and improve outcomes.

Disease Management programs use evidence-based guidelines to:

- educate and support Members, PCPs, and Participating Professional Providers;
- match interventions to Members with greatest opportunity for improved clinical or functional outcomes;

To assist Members with chronic disease(s), Disease Management programs may employ:

- education;
- provider feedback and support statistics;
- compliance monitoring and reporting; and/or
- preventive medicine.

Disease Management interventions are intended to both:

- improve delivery of services in various active stages of the disease process;
- reduce/prevent relapse or acute exacerbation of the condition.

DRUG FORMULARY — a list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other practitioners to prescribe all medically necessary treatment of a Member's condition.

DURABLE MEDICAL EQUIPMENT (DME) — is equipment that meets all of these tests:

- It is durable. This means it can withstand repeated use;
- It is medical equipment. This is equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury;
- It is generally not useful to a person without an illness or injury; or
- Is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to, the following: diabetic supplies; hospital beds, crutches, canes, wheelchairs, walkers, traction equipment, home oxygen equipment and commode chairs.

EFFECTIVE DATE OF COVERAGE — the date CHIP coverage begins, as shown on the records of KHPE.

ELECTIVE ABORTION — a voluntary termination of pregnancy other than a termination that is necessary to avert the death of the woman, or other than the termination of a pregnancy caused by rape or incest.

ELIGIBLE CHILD — a child who has been determined as meeting all of the eligibility requirements for Keystone HMO CHIP.

EMERGENCY CARE (EMERGENCY) — any health care services provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member or with respect to a pregnant Member, the health of the pregnant Member or the Member's unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

EXPERIMENTAL/INVESTIGATIVE — a drug, biological product, device, medical treatment, procedure, or diagnostic test which meets any of the following criteria:

- Is the subject of ongoing Clinical Trials;
- Is the research, experimental, study or investigational arm of an ongoing Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by reliable evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on reliable evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

Any drug, biological product, device, medical treatment or procedure, or diagnostic procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

- A. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- B. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
- C. Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the paragraph above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- E. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure, or diagnostic test is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Any approval granted as an interim step in the FDA regulatory process (for example: An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of a drug or biological product (e.g., infusable agent) for another diagnosis, condition, or in a manner that does not align with the FDA approval shall require that one or more of the established reference Compendia identified in the Company's policies recognize the use as appropriate medical treatment.

FACILITY PROVIDER — an institution or entity licensed, where required, to provide care. Such facilities include:

- | | |
|-----------------------------------|-----------------------------|
| A. Birth center | E. Hospital |
| B. Freestanding dialysis facility | F. Rehabilitation hospital |
| C. Home health care agency | G. Short procedure unit |
| D. Hospice | H. Skilled nursing facility |

FOLLOW-UP CARE — care scheduled for medically necessary follow-up visits that occur while the Member is away from home. Follow-up care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is dialysis. Follow-up care must be preapproved by the Member's primary care physician prior to traveling. This service is available through the BlueCard[®] Program for temporary absences (less than ninety 90 consecutive days) from KHPE's service area.

FULL-COST CHIP — health insurance for eligible children of families with incomes above 314% of the Federal Poverty Level guidelines. The Member, or the Member's parent or legal guardian, is responsible for full cost of the premium.

GENERIC DRUG — any form of a particular drug that is: (a) sold by a manufacturer other than the original patent holder; (b) approved by the Federal Food and Drug Administration as generically equivalent through the FDA abbreviated new drug application (ANDA) process; and (c) in compliance with applicable state laws and regulations.

GRIEVANCE — a request to have KHPE or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. The term does not include a Complaint. A Grievance may be filed regarding KHPE's decision to:

1. deny, in whole or in part, payment for a service or item;
2. deny or issue a limited authorization of a requested service or item, including the type or level of service or item;
3. reduce, suspend, or terminate a previously authorized service or item;
4. deny the requested service or item but approve an alternative service or item; and
5. deny a request for a Benefit Limit Exemption (BLE). This term does not include a complaint.

HABILITATION THERAPY (HABILITATIVE SERVICES) — health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEARING AID — a prosthetic device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A hearing aid is comprised of: (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound, and; (d) a battery for power. A hearing aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a hearing aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a hearing aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely in-the-canal, or (e) implanted (can be partial or complete). A hearing aid is not a cochlear implant.

HOME — for purposes of the home health care and homebound covered services only, this is the place where the Member lives. This may be a private residence/domicile, an assisted living facility, a long-term care facility or a skilled nursing facility at a custodial level of care.

HOME HEALTH CARE PROVIDER — a licensed provider that has entered into an agreement with KHPE to provide home health care covered services to Members on an intermittent basis in the Member's home in accordance with an approved home health care plan of treatment.

HOMEBOUND — when there exists a normal inability to leave home due to severe restrictions on the Member's mobility and when leaving the home: (a) would involve a considerable and taxing effort by the Member; and (b) the Member is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered homebound but must meet both requirements (a) and (b).

HOSPICE PROVIDER — a facility provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The hospice must be: (1) certified by Medicare to provide hospice services, or accredited as a hospice by the appropriate regulatory agency, and: (2) appropriately licensed in the state where it is located.

HOSPITAL — a short-term, acute care, general hospital that has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by KHPE and which:

- Is a duly licensed institution;
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians;
- Has organized departments of medicine;
- Provides 24-hour nursing service by or under the supervision of registered nurses;
- Is not, other than incidentally, a skilled nursing facility; nursing home; custodial care home; health resort, spa or sanitarium; place for rest; place for aged; place for treatment of behavioral health conditions; place for treatment of substance use; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of hospice care.

HOSPITAL SERVICES — except as limited or excluded herein, acute-care covered services furnished by a hospital which are referred by your child's primary care physician, and preapproved by KHPE.

HOSPITAL-BASED PROVIDER — a physician who provides medically necessary services in a hospital or other participating facility provider supplemental to the primary care being provided in the hospital or participating facility provider, for which the subscriber has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by KHPE. When these physicians provide services other than in the hospital or other participating facility, they are not considered hospital-based providers.

IDENTIFICATION CARDS (ID CARDS) — the currently effective cards issued to an enrolled Keystone HMO CHIP Member by KHPE and United Concordia, which must be presented when a covered service is requested.

IMMUNIZATIONS — pediatric and medically necessary immunizations (except those required for work or travel). Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

INPATIENT CARE — treatment received as a bed patient in a hospital, a rehabilitation hospital, a skilled nursing facility or a participating facility provider that is a behavioral health/substance use provider.

INPATIENT STAY (INPATIENT) — the actual entry into a hospital, extended care facility or facility provider of a Member who is to receive inpatient services as a registered bed patient in such hospital, extended care facility or facility provider and for whom a room and board charge is made. The inpatient admission shall continue until such time as the Member is actually discharged from the facility.

INTENSIVE OUTPATIENT PROGRAM — planned, structured program comprised of coordinated and integrated multidisciplinary services designed to treat a patient, often in crisis, who suffers from behavioral health illness or substance use/substance use 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.

KEYSTONE HMO CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) — a health maintenance organization providing access to comprehensive health care to Members.

LEGEND DRUG — any medicinal substance that is required by the Federal Food, Drug and Cosmetic Act to be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription".

LICENSED CLINICAL SOCIAL WORKER — a social worker who has graduated from an accredited educational institution with a Master's or Doctoral degree and is licensed by the appropriate state authority.

LICENSED PRACTICAL NURSE (LPN) — a nurse who had graduated from a practical or nursing education program and is licensed by the appropriate state authority.

LIMITATIONS — the maximum number of covered services, measured in number of visits or days, or the maximum dollar amount of covered services that are eligible for coverage. Limitations may vary depending on the type of program and covered services provided. Limitations, if any, are identified in this Benefits Handbook.

LOW-COST CHIP — medical coverage provided to an eligible child whose family income is greater than 208% and less than or equal to 314% of the FPL, and for which the family must pay a cost-sharing premium established by the Pennsylvania Department of Human Services.

MAINTENANCE — continuation of care and management of the Member when:

- The maximum therapeutic value of a medically necessary treatment plan has been achieved;
- No additional functional improvement is apparent or expected to occur;
- The provision of covered services ceases to be of therapeutic value; and
- It is no longer medically necessary.

This includes maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

MAINTENANCE PRESCRIPTION DRUG — a covered drug or supply, as determined by KHPE, used for the treatment of chronic or long-term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

MEDICAID — the program of Medical Assistance established by Title XIX of the Social Security Act of 1965, as amended, and Pennsylvania Statute, 62 P.S. Section 441.1 et seq., as amended.

MEDICAL DIRECTOR — a physician designated by KHPE to design and implement quality assurance programs and continuing education requirements, and to monitor utilization of health services by Members.

MEDICAL FOODS — liquid nutritional products that are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

MEDICAL POLICY (MEDICAL POLICIES) — a medical policy is used to determine whether covered services are medically necessary. Medical policy is developed based on various sources including, but not limited to, peer-reviewed scientific literature published in journals and textbooks, guidelines promulgated by governmental agencies and respected professional organizations and recommendations of experts in the relevant medical specialty.

MEDICAL SCREENING EVALUATION — an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel.

MEDICAL TECHNOLOGY ASSESSMENT — Technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include and are not limited to articles published by governmental agencies, national peer-review journals, national experts, clinical trials, and manufacturers' literature. KHPE uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a covered service.

When new technology becomes available or at the request of a practitioner or Member, KHPE researches all scientific information available from these expert sources. Following this analysis, KHPE makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a covered service.

A Member or their Provider should contact KHPE to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. KHPE maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

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.

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, Physician, or other health care provider;
- Not more costly than an alternative service or sequence of services that are 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; and
- Furnished in the most appropriate and cost-effective setting (site of care) that is appropriate to the Member's medical needs and condition, based on the Member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.

For these purposes, “generally accepted standards of medical practice” means standards that are based on:

- Credible scientific evidence, published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations;
- The views of physicians practicing in relevant clinical areas; and
- Any other relevant factors.

MEDICARE — a federally-financed health insurance program administered by the CMS pursuant to 42 U.S.C. §§1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five years (65) of age who are disabled or have chronic kidney disease.

MEMBER — a subscriber who meets the eligibility requirements and is enrolled in the Children’s Health Insurance Program (CHIP).

NONPARTICIPATING PHARMACY— a pharmacy (whether a retail or mail service pharmacy) that has not entered into a written agreement with KHPE or an agent of KHPE to provide covered drugs or supplies to Members.

NONPARTICIPATING PROVIDER — a facility provider, professional provider, ancillary service provider that is not a member of the KHPE’s network.

NON-PREFERRED DRUG — these drugs generally have one or more generic alternatives or preferred brand options within the same drug class.

NUTRITIONAL FORMULA — liquid nutritional products, which are formulated to supplement or replace normal food products.

OCCUPATIONAL THERAPY — medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the Member’s ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

OFFICE VISITS — covered services provided in the physician’s office and performed by or under the direction of your child’s primary care physician or a referred specialist.

OTHER PROFESSIONAL PROVIDER — with respect to dental care benefits, a certified registered nurse anesthetist. This does not include any certified registered nurse anesthetist employed by a health care facility or by an anesthesiology group.

OUT-OF-POCKET MAXIMUM — the maximum dollar amount that a Member pays for covered services under this contract in each benefit period. The out-of-pocket maximum includes copayments and coinsurance amounts; it does not include any amounts above the allowed amount for a specific provider, or the amount for any services not covered under this contract.

OUTPATIENT BEHAVIORAL HEALTH CARE/OUTPATIENT SUBSTANCE USE TREATMENT (OUTPATIENT TREATMENT) — the provision of medical, nursing, counseling, or therapeutic covered services on a planned and regularly scheduled basis in an acute care hospital or a facility licensed by the Department of Health as a substance use treatment program or any other behavioral health therapeutic modality designed for a patient or client who does not require care as an inpatient. Outpatient treatment includes care provided under a partial hospitalization program or an intensive outpatient program.

OUTPATIENT CARE — medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a hospital or other inpatient facility.

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.

PARTICIPATING FACILITY PROVIDER — a facility provider that is a Member of Keystone HMO CHIP's network.

PARTICIPATING MAIL SERVICE PHARMACY — a registered, licensed pharmacy with whom KHPE or an agent of KHPE has contracted to provide covered drugs or supplies through the mail and to accept as payment in full the KHPE payment plus any applicable prescription drug copayments for covered drugs or supplies and is in the Keystone HMO CHIP network.

PARTICIPATING PHARMACY — any registered, licensed pharmacy, other than a participating mail service pharmacy, with whom KHPE or an agent of KHPE has contracted to dispense covered drugs or supplies to Members and to accept as payment in full the KHPE payment plus any applicable prescription drug cost-sharing for the covered drugs or supplies and is in the Keystone HMO CHIP network.

PARTICIPATING PROFESSIONAL PROVIDER — a professional provider who is a member of KHPE network.

PARTICIPATING PROVIDER — a provider with whom KHPE has contracted, directly or indirectly, who is in the Keystone HMO CHIP network, and, where applicable, is medically certified to render covered services. This includes, but is not limited to:

- **Primary Care Physician (PCP)** — a participating provider selected by a Member who is responsible for providing all primary care covered services and for authorizing and coordinating all covered medical care, including referrals for specialist services.
- **Participating Specialist** — a professional provider who provides specialist services with a referral or, for direct access care, without a referral. A participating specialist is in one of the following categories:
- **Referred Specialist** — a professional provider who provides covered specialist services within that provider's specialty and upon referral from a primary care physician. If there is no participating provider to provide these services, referral to a nonparticipating provider will be arranged by your child's primary care physician with preapproval by KHPE. See "Preapproval for Nonparticipating Providers" on page 27 for obtaining preapproval for use of a nonparticipating provider.

For the following outpatient services, the referred specialist is your child's primary care physician's designated provider: (a) certain rehabilitation therapy services (other than speech therapy); (b) certain diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests. Your child's primary care physician will provide a referral to the designated provider for these services.

- **Participating Hospital** — a hospital that has contracted with KHPE to provide covered services to Members and is in the Keystone HMO CHIP network.
- **Behavioral Health/Substance Use Provider** — A provider in a network made up of professionals and facilities contracted directly or indirectly with KHPE and is in the Keystone HMO CHIP network to provide behavioral health/substance use covered services for the treatment of mental illness and substance use (including detoxification) to Keystone HMO CHIP's Members. Licensed clinical social workers and masters-prepared therapists are contracted to provide covered services for treatment of mental health care only.

- **Hospice Provider** — a licensed participating provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six (6) months or less. Covered services to be provided by the hospice provider include home hospice and/or inpatient hospice services that have been referred by your child's primary care physician and preapproved by KHPE.

PHARMACIST — an individual, duly licensed as a pharmacist by the State Board of Pharmacy or other governing body having jurisdiction, who is employed by or associated with a pharmacy.

PHARMACY AND THERAPEUTICS COMMITTEE — a group composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee consists of at least two-thirds licensed and actively practicing physicians and pharmacists and shall consist of at least one pharmacist.

PHYSICAL THERAPY — medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

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.

PLAN OF TREATMENT — a plan of care which is developed or approved by your child's primary care physician for the treatment of an injury or illness. The plan of treatment should be limited in scope and extent to that care which is medically necessary for the Member's diagnosis and condition.

PREAPPROVED (PREAPPROVAL) — the approval which your child's primary care physician or referred specialist must obtain from KHPE to confirm KHPE coverage for certain covered services or medical necessity for certain covered drugs or supplies for a Member's medical condition.

With regard to your child's medical services, such approval must be obtained prior to providing your child with covered services or referrals. If your child's primary care physician or referred specialist is required to obtain a preapproval, and provides covered services or referrals without obtaining such preapproval, you will not be responsible for payment. Preapproval is not required for a maternity inpatient stay.

With regard to prescription drug benefits, such preapproval must be obtained prior to providing the covered drug or supply. KHPE also reserves the right to apply dispensing limits for certain covered drugs or supplies as conveyed by the FDA or KHPE's Pharmacy and Therapeutics Committee. The parent may call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** to find out if the covered drug or supply has been approved by KHPE, or may ask the child's primary care physician to call Provider Services.

Approval will be given by the appropriate KHPE staff, under the supervision of a medical director.

PREFERRED BRAND DRUG — These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

PRENOTIFICATION — the requirement that a Member provide prior notice to KHPE that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Member and the category of service are covered under this plan.

PRESCRIBE or PRESCRIBED — to write or give a prescription order.

PRESCRIPTION DRUG — a legend drug or controlled substance, which has been approved by the Food and Drug Administration for a specific use and which can, under federal or state law, be dispensed only pursuant to a prescription order. You may call our Keystone HMO CHIP Member Help Team at **1-800-464-5437** to find out if your prescription drug has been approved by KHPE or you may ask your child's primary care physician to call Provider Services.

This definition includes insulin and spacers for metered dose inhalers obtained with a prescription drug order or refill.

PRESCRIPTION DRUG ORDER or REFILL (PRESCRIPTION DRUG ORDER) — the authorization for a prescription drug issued by a primary care physician or referred specialist who is duly licensed to make such an authorization in the ordinary course of their professional practice.

PRESCRIPTION ORDER — the authorization for: 1) a prescription drug, or 2) services or supplies prescribed for the diagnosis or treatment of an illness, which are issued by a primary care physician or participating specialist who is duly licensed to make such an authorization in the ordinary course of professional practice.

PRIOR AUTHORIZATION — a determination made by KHPE to approve or deny payment for a provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the provider's initiation or continuation of the requested service.

PRIVATE DUTY NURSING — medically necessary continuous skilled nursing services provided to a Member by a registered nurse or a licensed practical nurse.

PROFESSIONAL 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, autism service provider, behavioral specialist, certified registered nurse, certified nurse midwife, chiropractor, dentist, independent clinical laboratory, licensed clinical social worker (for mental health care only), masters-prepared therapist, optometrist, physical therapist, physician, physician assistant, podiatrist, psychologist, registered dietitian, speech-language pathologist, and teacher of the hearing-impaired.

PROSTHETIC DEVICE — devices (except dental prosthetic devices) that replace all or part of: 1) an absent body organ, including contiguous tissue or 2) the function of a permanently inoperative or malfunctioning body organ.

PROVIDER(S) — any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a physician, a group of physicians, allied health professional, certified nurse midwife, hospital, skilled nursing facility, rehabilitation hospital, birthing facility, or home health care provider. In addition, for behavioral health care services only, a licensed clinical social worker and a masters-prepared therapist will also be considered a provider.

QUALIFIED INDIVIDUAL (for Clinical Trials) — a Member who meets the following conditions:

- The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- Either:
 - The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
 - The Member provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Member meeting the conditions described above.

QUALIFYING CLINICAL TRIAL — a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 1. The National Institutes of Health (NIH);
 2. The Centers for Disease Control and Prevention (CDC);
 3. The Agency for Healthcare Research and Quality (AHRQ);
 4. The Centers for Medicare and Medicaid Services (CMS);
 5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 6. Any of the following, if the Conditions For Departments are met:
 - The Department of Veterans Affairs (VA);
 - The Department of Defense (DOD); or
 - The Department of Energy (DOE), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The citation for reference is 42 U.S.C. § 300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer “may not deny the individual participation in the clinical trial.”

In the absence of meeting the criteria listed above, the clinical trial must be approved by KHPE as a Qualifying Clinical Trial.

REFERRED (REFERRAL) — written or electronic documentation from the Keystone HMO CHIP Member’s primary care physician that authorizes covered services to be rendered by a Keystone HMO CHIP participating provider or provider specifically named on the referral. Referred care includes all services provided by a referred specialist. Referrals to nonparticipating providers must be preapproved by KHPE. See “Preapproval for Nonparticipating Providers” on page 27 for procedures for obtaining preapproval for use of a nonparticipating provider. A referral must be issued to the Keystone HMO CHIP Member prior to receiving covered services and is valid for **ninety (90) days** from the date of issue for an enrolled Member.

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.”

REGISTERED NURSE (R.N.) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION HOSPITAL — a facility licensed by the Pennsylvania Department of Health that is primarily engaged in providing rehabilitation care on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

REHABILITATION THERAPY (REHABILITATIVE SERVICES) — includes treatments designed to improve, maintain, and prevent the deterioration of skills and functioning for daily living that have been lost or impaired. Rehabilitation therapy includes occupational therapy, physical therapy, and speech therapy.

RELIABLE EVIDENCE — peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered reliable evidence if generally accepted by the relevant medical community.

RESPITE CARE — hospice services necessary to relieve primary caregivers, provided on a short-term basis in a Medicare-certified skilled nursing facility to a Member for whom hospice care is provided primarily in the home.

RETAIL HEALTH CLINIC — Retail Health Clinics are staffed by certified nurse practitioners trained to diagnose, treat and write prescriptions when clinically appropriate. Services are available to treat basic medical needs for urgent care. Examples of needs are sore throat; ear, eye or sinus infection; allergies; minor burns; skin infections or rashes; and pregnancy testing.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS — routine patient costs include all items and services consistent with the coverage provided under this contract that is typically covered for a qualified individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

- The investigational item, device, or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SERVICE AREA — the geographical area within which KHPE is approved to provide access to covered services.

SEVERE SYSTEMIC PROTEIN ALLERGY — means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT — a unit which is approved by KHPE and which is designed to handle either lengthy diagnostic or minor surgical procedures on an outpatient basis which would otherwise have resulted in an inpatient stay in the absence of a short procedure unit.

SKILLED NURSING FACILITY — an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental illness, tuberculosis, or substance use and has contracted with KHPE and is in the Keystone HMO CHIP network, to provide covered services to Members, which:

- Is accredited as a skilled nursing facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations;
- Is certified as a skilled nursing facility or extended care facility under the Medicare Law; or
- Is otherwise acceptable to KHPE.

SLEEP STUDIES — refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to diagnose sleep disorders (e.g., narcolepsy, sleep apnea, parasomnias), initiate treatment for a sleep disorder and/or evaluate an individual's response to therapies such as continuous positive airway pressure (CPAP) or bi-level positive airway pressure device (BPAP).

SOUND NATURAL TEETH — teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the accidental injury or trauma, and are not man-made.

SPECIALIST SERVICES — all physician services providing medical care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALTY DRUG — a medication that meets certain criteria including, but not limited to:

- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a healthcare provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a health care provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.
- Some generic drugs are included in this category and are subject to the Specialty Drug cost-sharing.

KHPE reserves the right to determine which specialty drug vendors and/or health care providers can dispense or administer certain specialty drugs.

STANDARD INJECTABLE DRUG — a medication that is either injectable or infusible but is not defined by the company to be a self-administered prescription drug or a specialty drug. Standard injectable drugs include, but are not limited to allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a participating professional provider.

STANDING REFERRAL (STANDING REFERRED) — written documentation from KHPE that authorizes covered services for a life-threatening, degenerative or disabling disease or condition. The covered services will be rendered by the referred specialist named on the standing referral form. The referred specialist will have clinical expertise in treating the disease or condition. A standing referral must be issued to the Member prior to receiving covered services. The Member, the primary care physician and the referred specialist will be notified in writing of the length of time that the standing referral is valid. Standing referred care includes all primary and specialist services provided by that referred specialist.

SUBSCRIBER — the person who is eligible and is enrolled for coverage in the Children's Health Insurance Program (CHIP).

SUBSTANCE USE — any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE USE TREATMENT FACILITY — a facility which is licensed by the Pennsylvania Department of Health and has contracted with the behavioral health management company to provide covered services to Members and that is primarily engaged in providing detoxification and rehabilitation treatment for substance use.

SURGERY — the performance of generally accepted operative and cutting procedures, including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for surgery includes an allowance for related inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY SERVICES — the following services or supplies prescribed by a physician and used for the treatment of an illness or injury to promote the recovery of the Member:

- **Cardiac Rehabilitation Therapy**

Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

- **Chemotherapy**

The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells.

- **Dialysis**

Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

- **Infusion Therapy**

The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a health care provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of health care provider who can administer the infusion depends on whether the drug is considered to be a specialty drug infusion or a standard injectable drug infusion, as determined by KHPE.

- **Orthoptic/Pleoptic Therapy**

Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye surgery, or injury. Treatment involves a program that includes evaluation and training sessions.

- **Pulmonary Rehabilitation Therapy**

Multidisciplinary treatment that combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

- **Radiation Therapy**

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, or other radioactive substances regardless of the method of delivery.

- **Respiratory Therapy**

Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

URGENT CARE — urgent care needs are for sudden illness or accidental injury that require prompt medical attention, but are not life-threatening and are not emergency medical conditions, when your child's primary care physician is unavailable. Examples of urgent care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not preventive care or follow-up care.

URGENT CARE CENTER — a participating facility provider designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-emergency situation that cannot wait to be addressed by your child's primary care physician's office or Retail Health Clinic. Urgent care is not the same as emergency services (see definition of **URGENT CARE** above).

IMPORTANT NOTICES

Regarding Nondiscrimination Rights

The Member has the right to receive health care services without discrimination:

- based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity;
- for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Nondiscrimination Notice

Independence Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Blue Cross provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats).

Independence Blue Cross provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact Independence Blue Cross at 1-888-377-3933 (TTY: 711).

If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY (800) 654-5484, Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone with the U.S. Department of Health and Human Services, Office for Civil Rights at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Questions about your child's health insurance?

Contact us:

By phone:

1-800-464-5437 (TTY/TDD: 711)

By mail:

Keystone Health Plan East, Inc.:

c/o Independence Blue Cross

P.O. Box 13449

Philadelphia, PA 19101-3449

More information is also available online at www.ibx.com/chip.

