



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

Commonwealth of Pennsylvania
chipcoverspakids.com



Look inside for...

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

Benefits Handbook CHIP of Pennsylvania

Free or low-cost health coverage through
Keystone Health Plan East HMO

Independence 

Benefits underwritten and/or administered by Keystone Health Plan East, 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.

Children's Health Insurance Program (CHIP)



Please read this handbook and other benefits materials carefully.
If you have any questions about your child's coverage, please contact our CHIP Customer Service at

1-800-464-5437
(TTY/TDD users, call 711).

Table of Contents

Required Disclosure of Information	4
Introduction	5
Section 1	
Eligibility, Coverage and Payments	6
Section 2	
How to Use Your Child’s Insurance	11
Section 3	
How to See a Specialist or Plan for Hospital Care	23
Section 4	
Emergency Care, Urgent Care and Follow-up Care	28
Section 5	
Membership Rights and Filing a Complaint or Grievance.....	35
Section 6	
Responsibilities	48
Section 7	
Primary and Preventive Health Care.....	53
Section 8	
Outpatient Services	55
Section 9	
Inpatient Services	71

Section 10

Prescription Drug Benefits 79

Section 11

Dental Benefits 84

Section 12

Mental Health and Substance Abuse Benefits 89

Section 13

Routine Vision Care Benefits 95

Section 14

Medical Exclusions --- What is Not Covered 98

Section 15

Important Definitions 106

Required Disclosure of Information

State law requires that Keystone Health Plan East, Inc. (Keystone) make the following information available to you when you make a request in writing to Keystone.

- a list of names, business addresses and official positions of the membership of the Board of Directors or Officers of Keystone;
- the procedures adopted to protect the confidentiality of medical records and other enrollee 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 enrollee's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee:
 - 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 Keystone to make decisions about the experimental nature of individual drugs, medical devices or treatments;
- a summary of the methodologies used by Keystone to reimburse for health care services (This does not mean that Keystone is required to disclose individual contracts or the specific details of financial arrangements with health care providers.);
- a description of the procedures used in Keystone'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 the Children's Health Insurance Program (CHIP).

Independence Blue Cross

- Independence is the 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 CHIP applications directly to low-income, uninsured 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 HMO, provides health insurance to children enrolled in CHIP.

CHIP

- This program has been offered by the Commonwealth of Pennsylvania since 1993.
- This is a program 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, the family size and the family's 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 a family's 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 a family's income. In addition, there are copayments for some covered services.

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;
- meet 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, or must have been denied partial or full coverage due to a pre-existing condition.

Proof of Eligibility

You must provide proof of eligibility (for example, documentation of income or citizenship status) to Independence 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 Keystone Health Plan East ID Card and the United Concordia ID Card is covered by CHIP. Only the child named on these cards is eligible to receive benefits.

How Long is My Child Covered?

Your child is covered as long as he or she 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).

Renewal of Coverage

Independence will check your child's eligibility at least once each year. This is called renewal. It is very important that we receive all the information requested on the renewal form that we send you by the due date listed. A form that is incomplete or received after the due date may result in the termination of your child's CHIP coverage.

You have two options for completing the renewal process:

1. Completely fill out and sign the form that you receive in the mail. You can return the form by mail or fax. Be sure to include any additional documentation that may be requested.
2. Go to **compass.state.pa.us** and fill out and submit the renewal information online. Then, print the signature page and sign it. You can return the signature page by mail or fax. Be sure to include any additional documentation that may be requested.

Our mailing address is:

Independence Blue Cross
P.O. Box 13449
Philadelphia, PA 19101-9552

Our fax number is:

215-241-3679

Independence will notify you of your child's eligibility status. This will be based on the information you give on your renewal form.

Independence reserves the right to cancel your child's coverage at renewal if you give incorrect or misleading information about your child's eligibility, or try to obtain benefits through misrepresentation or fraud.

Your Child's ID Cards

By the time you receive this Benefits Handbook you should have received ID cards. Each enrolled child in your family will receive two ID Cards: one from Keystone Health Plan East 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 Keystone 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 Keystone at **1-800-464-5437** and United Concordia at **1-800-332-0366**.
- **Check the name of the primary care physician on the Keystone 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 Keystone at **1-800-464-5437**.

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

- **Carry your child's ID Cards with you at all times.** You must show one of these cards any time your child receives covered services.
- **There is important information on the back of the Keystone 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 mental health and substance abuse services.
- If you lose the medical ID Card, contact Keystone 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, the family size and the family's income, your child may be eligible for one of the three tiers of 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, or electronically. To get more information on your options, please contact Customer Service at **1-800-464-5437**.

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 Keystone.

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 CHIP coverage will be terminated at the end of the last month for which you did pay the premium. You will be responsible for any medical or dental costs incurred after the termination date.

If your child's CHIP coverage is terminated because you fail to pay the premium on time, your child may not be eligible again for CHIP until **three (3) months** after the date the CHIP benefits end. Also, 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, Keystone will regularly review the health status of 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 suffers from 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

Independence may cancel your child's CHIP coverage under the following conditions:

- If you commit willful misrepresentation or fraud in applying for or obtaining coverage for your child from Independence (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 7);
- If you fail to pay your child's monthly premium for Low-Cost CHIP or Full-Cost CHIP.
- If you display a pattern of non-compliance with your child's physician's plan of treatment. You will receive written notice at least **thirty (30) days** prior to termination. You have the right to use the Complaint Appeal and Grievance Appeal Process (see page 35).
- If you do not cooperate with Independence in obtaining information necessary to determine Independence's liability under this program.

Inpatient Provision

If your child is receiving inpatient care in a hospital or skilled nursing facility on the day 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 Keystone that inpatient care is no longer medically necessary; or
- your child's discharge from the facility.

Note: Independence will not terminate your child's coverage because of his or her 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.

Eligibility Review Process

You may request an eligibility review for the following reasons:

- Your child's application for CHIP coverage is denied, except if referred to Medical Assistance;
- Your child's CHIP coverage is to be terminated, except if referred to Medical Assistance or if terminated for non-payment; or
- Your child's monthly premium increases due to a change in coverage from Free CHIP to Low-Cost CHIP or Full-Cost CHIP, or from Low-Cost CHIP to Full-Cost CHIP.

If you do not agree with this decision, you may submit a written request for an impartial review. However, we encourage you to call us first so that we can discuss our decision with you. In most cases, we can answer your questions about how we reached this eligibility decision. Please call Customer Service at **1-800-464-5437**, Monday through Friday from 8 a.m. to 6 p.m. (TTY/TDD users, please call 711).

In the event that you still do not agree with our decision, or if you choose not to call us to discuss the decision, you may submit a written request to us for an impartial review within **thirty (30) days** from the date of the eligibility letter you received. Please send:

- a written, dated request stating why you disagree with our decision;
- a copy of the eligibility letter;
- any additional documentation to support your case; and
- a phone number where you can be reached during the day.

Mail or fax this information to:

Independence Blue Cross
Attention: CHIP Eligibility Review
PO Box 13449
Philadelphia, PA 19101-9552
Fax: 215-241-3679

We may contact you for more information. If we cannot resolve your issue, we will forward your written request and any additional information to the Pennsylvania Department of Human Services. You may also receive more detailed information from the Pennsylvania Department of Human Services, including the time and date that a phone interview will be held, if needed.

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 28).
- 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.

Selection of a Primary Care Physician

- 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 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 his or her effective date of coverage (see Continuity of Care provision on page 26).
- If you fail either to select a primary care physician or complete a Continuity of Care form within **thirty (30) days** of your child's membership, Keystone reserves the right to assign your child to a primary care physician subject to the right to change primary care physicians as described below.

How to See a Specialist

- Call your child's primary care physician for a referral. He or she will submit an electronic referral for specific care or will obtain a preapproval form from Keystone when required.
- A standing referral may be available to your child if he or she has a life-threatening, degenerative, or disabling disease or condition. For more information, see page 24.
- You may take your female child to any participating obstetrical/gynecological specialist without a referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care, or problem-related obstetrical/gynecological conditions. For more information, see page 54.
- 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 his or her 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. Outpatient services are **not covered** when performed by any provider other than your child's primary care physician's designated provider. Before selecting your child's primary care physician, you may want to speak to the primary care physician regarding his or her designated providers.

How to 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 28.

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 Customer Service (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 Keystone prior to your child receiving them. The primary care physician or referred specialist will obtain this approval from Keystone 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 decisions 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 Participating Providers

All medical services must be received from Keystone participating providers unless preapproved by Keystone, or except in cases requiring emergency services or urgent care while outside the service area. See "Preapproval for Nonparticipating Providers" on page 26 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 the individual providers, including hospitals and primary care physicians and referred specialists and their affiliated

hospitals. You can also obtain other information, for example, whether the provider is accepting new patients, the office hours, and a provider who is fluent in a particular foreign language. If you cannot access this website or you need assistance, please contact Customer Service 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 Customer Service 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 in order to select another primary care physician.

When you change your child's primary care physician, he or she will receive a new Keystone 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

Independence'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.

Independence offers interpreter services for 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 Keystone's Care Management and Coordination department to make arrangements to provide interpreter services for a CHIP member.
2. A parent of a CHIP member may call Customer Service 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, Independence also has:

- multilingual staff members;
- telephone language services; and
- TTY/TDD (call 711) for the deaf or hearing impaired.

If you have questions about how Independence can assist with language barriers in communication with your child's health care provider, call Customer Service at **1-800-464-5437**.

Prescription Drugs are Covered Under CHIP

Under CHIP, prescription drugs, including medications and biologicals, are covered services or supplies when ordered during your child's inpatient hospital stay. In addition, your child also has prescription drug coverage for outpatient prescription drugs. (For more information, see page 79.)

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.

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

Keystone, 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 Customer Service 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 35.

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 to children with certain chronic conditions as well as 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, as well as 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.

Keystone will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g. to identify children with chronic disease, to predict which children would most likely benefit from these services, and to communicate results to a child's treating primary care physician and treating physicians. Keystone will decide what chronic conditions are included in the Disease Management or Decision Support program.

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 Keystone that they decline participation; or (2) Keystone determines that the program, or aspects of the program, will not continue.

Other Important Information About Keystone

How Keystone Reimburses Providers

Keystone'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 Keystone'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 the 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 (PCPs) 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 Keystone 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 Keystone'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 Keystone 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.

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/physicians organizations called Integrated Delivery Systems (IDS). The IDS provide or arrange for some of the hospital, physicians and ancillary covered services provided to some members who select PCPs which are employed by or otherwise participate with the IDS. The IDS are paid a global fee to cover all such covered services, whether provided by the IDS or other providers. These IDS are therefore “at risk” for the cost of these covered services. Some of these IDS may provide incentives to their IDS-affiliated professional providers for meeting certain quality, service or other standards.

Hospital-Based Provider

When your child receives covered services from a hospital-based provider while he or she 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 the 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 Keystone’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 Customer Service at **1-800-464-5437**. When you notify Keystone about these bills, Keystone will resolve the balance billing.

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, Keystone 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 Keystone'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 Abuse and Dependency

A Mental Health/Alcohol or Drug Abuse 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 18.) 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 Keystone, 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. Keystone 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, Keystone 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 Keystone to be reimbursed.

This contract does not coordinate benefits with other dental plans.

Utilization Review Process

Two conditions of Keystone'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 Keystone in making coverage determinations for certain requested health care services, Keystone 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 Keystone 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 Keystone 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 which are 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. Keystone follows applicable state and federally required standards for the timeframes in which such reviews are to be 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 Keystone'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.

Keystone's utilization review program encourages peer dialogue regarding coverage decisions based on medical necessity by providing physicians with direct access to Keystone 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. Keystone 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.

Pre-Certification or Preapproval

When required and applicable, pre-certification or preapproval evaluates the medical necessity, including the appropriateness of the setting, of proposed services for coverage under the member's benefit plan. Examples of these services include certain planned or elective inpatient admissions and selected outpatient procedures according to the member's benefit plan. Where required by the member's benefit plan, preapproval is initiated by the provider.

Where pre-certification or preapproval is required, Keystone's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied when pre-certification is required for a procedure but is not obtained. If the primary care physician or referred specialist fails to obtain preapproval when required, and provides covered services or referrals without obtaining such preapproval, the member will not be responsible for payment.

While the majority of services requiring pre-certification or preapproval are reviewed for medical appropriateness of the requested procedure setting (e.g. inpatient, short procedure unit, or outpatient setting), other elements of the medical necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Pre-certification or preapproval is not required for emergency services and is not performed where an agreement with the participating provider does not require such review.

The following are general examples of current pre-certification or preapproval requirements under benefit plans; however, these requirements vary by benefit plan and state and are subject to change.

- hysterectomy
- nasal surgery procedures
- potentially cosmetic or experimental/investigative services

Concurrent Review

Concurrent review may be performed while services are being performed. This may occur during an inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is medically necessary. When performed, the review assesses the level of care provided to the member and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all inpatient stays are reviewed concurrently. Concurrent review is generally not performed where an inpatient facility is paid based on a per-case or diagnosis-related basis, or where an agreement with the facility does not require such review.

Retrospective Review

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including Keystone not being notified of a member's inpatient admission until after discharge or where medical charts are unavailable at the time of a required concurrent review. Certain services are only reviewed on a retrospective basis.

Prenotification

In addition to the standard utilization reviews outlined above, Keystone also may determine coverage of certain procedures and other benefits available to members through prenotification, as required by the members' benefit plan, and discharge planning. Prenotification is advance notification to Keystone of an inpatient admission or outpatient service where no medical necessity review (pre-certification or preapproval) is required, such as maternity admissions/deliveries. Prenotification is primarily used to identify members for concurrent review needs, to ascertain discharge planning needs proactively, and to identify who may benefit from Case Management programs.

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 Keystone'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, Keystone 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, Keystone reserves the right to waive medical review for certain covered services for certain providers, if Keystone 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 Keystone'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 Keystone 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 Keystone'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 Keystone's plan determinations for similar medical issues and requests, and reduce practice variation among Keystone'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. hysterectomy 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 Keystone's medical policies are applied include, but are not limited to:

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

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

Delegation of Utilization Review Activities and Criteria

In certain instances, Keystone 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 Keystone's approval.

Utilization Review and Criteria for Mental Health/Substance Abuse Services

Utilization review activities for mental health/substance abuse ("behavioral health") services have been delegated by Keystone to a behavioral health management company, which administers the behavioral health benefits for Keystone'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 Keystone

- 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.
- Keystone 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, Keystone researches scientific information available from expert sources. Following this analysis, Keystone makes a decision about 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.

Special Circumstances

In the event that 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 Keystone, Keystone may, on a selective basis, waive certain procedural requirements 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.

Keystone shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Keystone shall provide access to covered services in so far as practical, and according to its best judgment. Neither Keystone nor providers in Keystone'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 Keystone and appropriate regulatory authority, are extraordinary circumstances not within the control of Keystone, 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 his or her primary care physician for the following covered services:

- Emergency services;
- Care from a participating obstetrical/gynecological specialist;
- Mammograms;
- Mental health care and substance abuse 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 referred specialist or facility just follow these steps:

- Your child's primary care physician will supply an electronic form which indicates the services authorized.
- 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 CHIP when the specialist sees him or her.
- 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.
- 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 Keystone in addition to the electronic referral from your child's primary care physician. See "Preapproval for Nonparticipating Providers" on page 26 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, he or she 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 Keystone and in consultation with your child's primary care physician.

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

- Call Customer Service 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 Keystone'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 Keystone 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 Keystone'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 Customer Service 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 Keystone’s Care Management and Coordination department.
- The 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 Keystone 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 Keystone.
- You do not need to get an electronic referral from your child’s primary care physician.
- When Keystone’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 Keystone 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 his or her 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 Keystone 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 Keystone 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 Keystone 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 Keystone, to continue your child's ongoing course of treatment with that physician for up to **ninety (90) 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 her second or third trimester of pregnancy at the time of her enrollment or the termination of a participating provider's contract, the continuity of care with that physician will extend through postpartum care related to the delivery.

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

- Call Customer Service 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 as 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

Keystone 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 (a referral from your child's primary care physician is required);

- Been advised by the participating provider that there are no participating providers that can provide the requested covered services; and
- Obtained authorization from Keystone prior to receiving care. Keystone reserves the right to make the final determination whether there is a participating provider that can provide the covered services.

If Keystone approves the use of a nonparticipating provider, you will not be responsible for the difference between the provider's billed charges and Keystone'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 Customer Service at **1-800-464-5437**. When you notify Keystone about these bills, Keystone will resolve the balance billing. Applicable program terms including medical necessity, referrals and preapproval by Keystone, when required, will apply.

Section 4

Emergency Care, Urgent Care and Follow-up Care

What is Emergency Care?

Emergency Care is any health care services 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 her 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.

Emergency Services are Provided Inside and Outside the Service Area

Emergency services are covered whether they are provided inside* or outside Keystone's service area. Emergency services do not require a referral for treatment from your child's primary care physician. After your child receives emergency care, you must notify your child's primary care physician to coordinate all continuing care. Medically necessary care by any provider other than your child's primary care physician will be covered until he or she can, without medically harmful consequences, be transferred to the care of his or her primary care physician or a referred specialist.

Examples of conditions requiring emergency services are:

- excessive bleeding;
- broken bones;
- serious burns;
- sudden onset of severe chest pain;
- sudden onset of acute abdominal pain;
- poisoning;
- unconsciousness;
- convulsions;
- choking; and
- mental health and substance abuse crisis.

***Your child is in the service area if he or she is in Bucks, Chester, Delaware, Montgomery or Philadelphia County of Pennsylvania.**

Note: It is your responsibility to contact Keystone 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 Customer Service at **1-800-464-5437**. When you notify Keystone about these bills, Keystone 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 Keystone, 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.

Continuing Care After Your Child Receives Emergency Services

After your CHIP child receives emergency services, ask the health care provider to notify Keystone of the situation and the condition of your child. If your child's condition has stabilized and he or she can be moved, Keystone may arrange to relocate your child to a participating provider facility to receive continuing care and treatment.

All continuing care must be provided or referred by your child's primary care physician or coordinated through Customer Service.

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.

Note: Emergency services do not require a referral for treatment from the primary care physician. If you believe your child needs emergency services, you should call 911 or go immediately to the emergency department of the closest hospital. Reasonably necessary costs associated with emergency services provided during the period of the emergency are covered by Keystone.

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, x-rays that are not preventive care or follow-up care.

Urgent Care Inside Keystone's Service Area

Your child is in the service area if he or she is in Bucks, Chester, Delaware, Montgomery or Philadelphia County in Pennsylvania.

- If you are within the service area above and your child needs urgent care, you must call his or her primary care physician first.
- Urgent care provided within the service area will be covered only when provided or referred by your child's primary care physician, or when provided at an Urgent Care Center or Retail Health Clinic without a referral.
- If your child's primary care physician is not in the office, leave a message requesting a return call.
- Your child's primary care physician provides coverage 24 hours a day, 7 days a week for urgent care.

Urgent care services may also be accessed directly at an Urgent Care Center or Retail Health Clinic.

- Your child's primary care physician or the physician covering for your child's primary care physician will arrange for appropriate medically necessary treatment.
- Call your child's primary care provider if he or she needs more care after getting urgent care.

What is Follow-up Care?

Follow-up Care is medically necessary follow-up visits that occur while your child is outside Keystone'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 Keystone's service area. An example is dialysis.
- must be preapproved by your child's primary care physician prior to traveling.

This service is available for temporary absences (less than **ninety (90) consecutive days**) from Keystone's service area.

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

CHIP members have access to health care services when traveling outside of Keystone'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 he or she receives;
- your portion of cost-sharing, if any; or
- the procedures you must follow to obtain care for your child.

Through the BlueCard Program, your child has access to medically necessary urgent care needed while traveling outside Keystone's service area during a temporary absence (less than **ninety (90) consecutive days**). Covered services will be provided by a contracting Blue Cross and Blue Shield Association traditional participating provider ("BlueCard Provider"). This contract describes the steps to follow to obtain the needed urgent care.

Follow-up care benefits under the BlueCard Program cover medically necessary follow-up care required while your child is traveling outside of Keystone's service area. The care must be needed for ongoing treatment of an injury, illness, or condition that occurred while your child was in Keystone's service area. Follow-up care must be pre-arranged by your child's primary care physician and preapproved by Keystone prior to leaving the service area.

Under the BlueCard Program, coverage is provided only for the specified, preapproved service(s) authorized by your child's primary care physician in Keystone's service area and Keystone'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 Keystone's service area.

Covered services will be provided by a contracting 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 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 Keystone service area, go to the nearest emergency or urgent care facility.

Urgent Care Benefits When Traveling Outside Keystone’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 Keystone’s service area.

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

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

- You call 1-800-810-BLUE 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 you will take your child to.
- You call 1-800-227-3116 to get prior authorization (approval) for the service from Keystone.
- After receiving Keystone’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 Keystone ID Card when seeking services from the BlueCard Provider.
- You pay any applicable copayment at the time of his or her visit.

Follow-up Care Benefits When Traveling Outside Keystone'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 Keystone'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 Keystone's service area.

- Follow-up care must be pre-arranged and preapproved by your child's primary care physician in Keystone'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 Keystone's service area and Keystone'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 Keystone's service area.

Follow-up care required during a temporary absence (less than **ninety (90) consecutive days**) from Keystone'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 Keystone's service area with your child temporarily, and your child's primary care physician recommends that he or she continues treatment.
- Your child's primary care physician must call 1-800-227-3116 to get prior authorization for the service from Keystone. 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.
- 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 you will take your child to:

- You or your child's primary care physician must inform Keystone by calling 1-800-227-3116.
- 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 Keystone ID Card when seeking services from the BlueCard Provider.
- You pay any applicable copayment at the time of his or her visit.

Additional Information about the BlueCard Program

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements

with your healthcare 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 healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Keystone 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 healthcare 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 Keystone. Show the provider your child's Keystone ID Card for necessary information about his or her coverage. For direct billing, the provider should mail the bill to the address listed below. If direct billing to Keystone by the provider cannot be arranged, send a letter explaining the reason care was needed and an original itemized bill to:

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

Note: It is your responsibility to forward to Keystone 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 CHIP child is injured in a motor vehicle accident, contact his or her primary care physician as soon as possible.

Note: Keystone will always be secondary to your auto insurance coverage. However, in order for services to be covered by Keystone 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 provider refers your child to for treatment.

Call Customer Service 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 Keystone to coordinate your child's Keystone 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 Keystone.

Work-Related Accident

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

Note: Keystone will always be secondary to your child's Worker's Compensation coverage. However, in order for services to be covered by Keystone 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 his or her employer's Worker's Compensation coverage. Give this same information to any provider to whom your child's primary care provider refers your child to for treatment.

Call Customer Service 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 Keystone to coordinate your child's Keystone benefits with coverage provided through his or her employer's Worker's Compensation coverage. Only services provided or referred by your child's primary care physician will be covered by Keystone.

Section 5

Membership Rights and Filing a Complaint or Grievance

If you have questions, suggestions, problems, or concerns regarding benefits or services rendered, Independence is ready to assist you. Don't hesitate to call Customer Service at 1-800-464-5437. Our representatives will respond to any inquiry.

Your Child's Membership Rights

Keystone and the participating providers honor the following rights of all members:

- The member has the right to information about the health plan, its benefits, policies, participating providers and member's rights and responsibilities. Written information that is provided will be readable and easily understood.
- The member has the right to be treated with respect, and recognition of his or her dignity and right to privacy.
- The member has the right to participate in decision-making regarding his or her health care. This right includes open discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- The member has a right to voice complaints and appeals about the health plan or care provided, and to receive a timely response.
- The member has the right to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.
- The member has the right to confidential treatment of medical information. The member also has a right to have access to his or her medical records from a provider in accordance with the applicable state and federal laws.
- The member has the right to reasonable access to medical services.
- The member has the right to receive health care services without discrimination based on race, color, religion, gender, sexual orientation, or national origin.
- The member has the right to formulate advance directives (living wills). Keystone will provide information concerning advance directives to members and practitioners and will support members through its medical keeping policies.

You Can File a Complaint or Grievance for Your Child

General Information About the Member Appeal Processes

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

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 or other issues related to coverage.
- You file a grievance appeal when you disagree with a decision by Keystone about the provision of a covered health care service that was based primarily on medical necessity or appropriateness. (See medical necessity, page 115.)

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 CHIP eligibility are not handled through the complaint appeal or grievance appeal processes. Please refer to the “Eligibility Review Process” (page 10) 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 his/her 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
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll-free: 1-888-671-5276
Fax: 1-888-671-5274

Except in the case of an expedited appeal, Keystone 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, Keystone 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 Keystone employee in preparing or presenting your child’s appeal; this assistance will be available at no charge. Please note that a Keystone employee designated to assist you will not have participated in the previous decision to deny coverage for the issue in dispute 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. Keystone will provide, at any time during the appeal process, 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. You may request, at no charge, the name(s) of the individual(s) who participated in the decision.
- **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 Keystone’s member appeals department or your child’s assigned appeals specialist at the address and telephone number shown above 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

Appeals are also subject to the following classifications that affect the time available to conduct the appeal review:

- **A Pre-service appeal** is any appeal for benefits with a coverage requirement that preapproval or precertification by Keystone must be obtained before medical care and services are received. A maximum of **fifteen (15) days** is available for each of the two (2) levels of internal review available for a standard pre-service appeal.
- **A Post-service appeal** includes any appeal for benefits for medical care or services that a member has already received. A maximum of **thirty (30) days** is available for each of the two (2) levels of internal review available for a standard post-service appeal.
- **An urgent care or expedited appeal** is an appeal that occurs upon the request of the CHIP member's physician certifying, and/or when Keystone determines, that a delay in decision-making based on standard appeal timeframes could seriously jeopardize the CHIP member's life, health, or ability to regain maximum function or subject the member to severe pain that cannot be adequately managed while awaiting a standard appeal decision. A maximum of **forty-eight (48) hours** is available for internal review of an expedited appeal.
- **Changes in Member Appeals Processes.** Please note that member appeal processes may change due to changes in the applicable state and federal laws and regulations, accreditation standards, and/or to improve the member appeals processes.

Member Complaint Appeal Process

Informal Member Complaint Appeal Process

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

If you have a concern you should:

- call Customer Service at **1-800-464-5437**; or
- write or fax to:

Manager of Customer Service
Independence Blue Cross
P.O. Box 13449
Philadelphia, PA 19101-3449
Fax: 215-241-3679

Most concerns are resolved informally at this stage. If Independence cannot immediately resolve your concerns, we will acknowledge it in writing within **five (5) business days** of receiving it. If you are not satisfied with the response to your concern from Independence, you have the right to file a formal complaint within **one hundred eighty (180) calendar days**, through the formal member complaint process described below.

Formal Member Complaint Appeal Process

You may file a formal complaint regarding an unresolved dispute or objection regarding your child's coverage, including:

- contract exclusions and non-covered services;
- participating or nonparticipating health care provider status; or
- the operations or management policies of Keystone.

The complaint process consists of

- two (2) internal levels of review by Keystone—a first level standard complaint and a second level standard complaint; and
- one (1) external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department.
- There is also an internal expedited complaint process in the event your child's condition involves an issue that, if reviewed in standard pre-service appeal timeframes, may jeopardize his or her life, health, ability to regain maximum function, or would subject your child to severe pain that cannot be adequately managed, as determined and validated by your child's physician.

Remember that no legal action can be taken until all of the complaint procedures below have been followed.

Internal Complaint Appeals

Internal First Level Standard Complaint Appeals

You may file a formal, first level standard complaint appeal on behalf of your child within **one hundred eighty (180) calendar days** from either your receipt of the original notice of denial from Keystone or completion of the informal complaint process described above.

To file a first level standard complaint:

- call Member Appeals at 1-888-671-5276; or
- write or fax Member Appeals at:

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

Keystone will acknowledge receipt of your complaint appeal in writing.

The first level complaint committee will complete its review of your child's standard complaint appeal within:

- **fifteen (15) calendar days** from receipt of a pre-service appeal; and
- **thirty (30) calendar days** from receipt of a post-service appeal.

A pre-service complaint includes any appeal for benefits for which preapproval is required prior to receiving coverage for medical care. A post-service complaint appeal includes any appeal for benefits for care or services that your child has already received.

The first level complaint committee is composed of one (1) or more of Keystone's employees who have had no previous involvement with your child's case and who are not subordinates of the person who made the original determination. You will be sent their decision in writing within the timeframes noted above.

If your child's complaint appeal is denied, the decision letter states:

- the specific reason for the decision;
- the plan provision on which the decision is made and instructions on how to access the provision; and
- how to appeal to the next level if you are not satisfied with the decision.

Internal Second Level Standard Complaint Appeals

If you are not satisfied with the decision from your child's first level standard complaint, you may file a second level standard complaint to the second level complaint committee within **sixty (60) calendar days** from receipt of the first level complaint committee's decision from Keystone. To file a second level standard complaint, call, write or fax the member appeals department at the address and telephone numbers listed above.

You have the right to present your child's complaint appeal to the committee in person or by way of a conference call. Your child's appeal can also be presented by his or her provider or another appeal representative if your authorization is obtained. (See "General Information About Member Appeal Processes" above for information about authorizations.) Keystone will attempt to contact you to schedule the second level complaint committee meeting for your child's standard complaint appeal.

Upon receipt of your child's appeal, you will be notified in writing, when possible, **fifteen (15) calendar days** in advance of a date and time scheduled for the second level complaint committee's meeting. You may request a change in the meeting schedule. Keystone will do its best to accommodate your request while remaining within the established timeframes. If you do not participate in the meeting, the second level complaint committee will review your child's complaint appeal and make its decision based on all available information.

The second level complaint committee meets and renders a decision on your child's standard complaint appeal within:

- **fifteen (15) calendar days** from receipt of a pre-service appeal; and
- **thirty (30) calendar days** from receipt of a post-service appeal.

The second level complaint committee is composed of at least three (3) persons who have had no previous involvement with your child's case and who are not subordinates of the person who made the original determination. The second level complaint committee members will include Keystone staff, with one-third of the committee being members or other persons who are not employed by Keystone. You may submit supporting materials both before and at the appeal meeting. Additionally, you have the right to review all information considered by the committee that is not confidential, proprietary or privileged.

The second level complaint committee meetings are a forum where parents have an opportunity to present their child's issues in an informal setting that is not open to the public. Two (2) other persons may accompany you unless you receive prior approval from Keystone for additional assistance due to special circumstances. Members of the press may participate only in their personal capacity as your child's appeal

representative or to provide general, personal assistance. Parents, appeal representatives and others assisting your child may not audiotape, videotape or transcribe the proceedings.

Keystone will send you the decision letter of the second level complaint committee on your child's standard complaint appeal within the timeframes noted above. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or Pennsylvania Department of Health as described in the decision letter. (See also, "External Complaint Appeals" below.)

Internal Expedited Complaint Appeals

If your child's case involves an issue that, if reviewed in standard pre-service appeal timeframes, may jeopardize his/her life, health, ability to regain maximum function, or would subject your child to severe pain that cannot be adequately managed, as determined and validated by his/her physician, then you or your child's physician may ask to have his/her case reviewed in a faster manner, as an internal expedited complaint. There is only one (1) level of appeal review for an expedited complaint appeal.

To request an internal expedited complaint by Keystone, call Customer Service at **1-800-464-5437** or call or fax the member appeals department at the address or telephone numbers listed above. Keystone will promptly inform you whether your child's appeal request qualifies for expedited review or instead will be processed as a standard complaint appeal.

The expedited complaint committee has the same composition as a second level complaint committee for a standard complaint appeal—at least three (3) persons who have had no previous involvement with your child's case and who are not subordinates of the person who made the original determination. The committee members include Keystone staff, with one third of the committee being members or other persons who are not employed by Keystone.

You have the right to present your child's expedited complaint to the committee in person or by way of a conference call. Your child's appeal can also be presented by his/her provider or another appeal representative if your authorization is obtained. (See "General Information About Member Appeal Processes" above for information about authorizations.) If you do not participate in the meeting, the expedited complaint committee will review your child's complaint appeal and make its decision based on all available information.

The expedited complaint committee meeting is a forum where parents have an opportunity to present their child's issues in an informal setting that is not open to the public. Two (2) other persons may accompany you unless you receive prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as your child's appeal representative or to provide general, personal assistance. Parents, appeal representatives and others assisting your child may not audiotape, videotape or transcribe the committee proceedings.

The expedited complaint appeal review is completed within **forty-eight (48) hours** after Keystone receives your request for an expedited complaint appeal for your child. During this time you will be notified by telephone of the decision and a decision letter will be sent to you. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or the Pennsylvania Department of Health as described in the decision letter. (See also, "External Complaint Appeals" below.)

External Complaint Appeals

External Standard and Expedited Complaint Appeals

If you are not satisfied with the decision of the second level complaint committee or expedited complaint committee, your child has the right to an external appeal. Your child's external complaint appeal is to be filed within **fifteen (15) calendar days** of your receipt of the decision letter for a second level standard complaint appeal and within **two (2) business days** of your receipt of the decision letter for your child's expedited complaint appeal.

Your request for an external complaint appeal review for your child is to be filed in writing to the Pennsylvania Insurance Department or Pennsylvania Department of Health at the addresses noted below:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Toll-free: 1-877-881-6388
1-717-787-2317
Fax: 1-717-787-8585
TTY/TDD: 1-717-783-3898

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

Your request for external review of your child's standard or expedited complaint appeal should include your name, your child's name, address, daytime telephone number, the name of Keystone Health Plan East as your child's managed care plan, your child's Keystone ID number, and a brief description of the issue being appealed. Also include a copy of your original request for an internal second level standard or expedited complaint appeal review to Keystone and copies of any correspondence and decision letters from Keystone.

When an external standard or expedited complaint appeal request is submitted to the Insurance Department or Department of Health, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles your external complaint appeal will provide you and Keystone with a copy of the final determination of its decision.

Member Grievance Appeal Process

Formal Member Grievance Appeal Process for Decisions Based on Medical Necessity

Parents of a CHIP member may file a formal grievance appeal of:

- a decision made by Keystone regarding a covered services that was denied or limited based primarily on medical necessity;
- the cosmetic or experimental/investigative exclusions; or
- other grounds that rely on a medical or clinical judgement.

The grievance appeal process consists of:

- two (2) internal grievance reviews by Keystone—a first level standard grievance and a second level standard grievance; and
- an external review through an external certified review entity or utilization review agency assigned by the Pennsylvania Department of Health.

There is also an internal and external expedited grievance appeal process in the event your child's condition involves an issue that, if reviewed in standard pre-service appeal timeframes, may jeopardize his or her life, health, ability to regain maximum function, or would subject your child to severe pain that cannot be adequately managed, as determined and validated by his or her physician.

Remember, no legal action can usually be taken until all of the grievance appeal procedures have been followed.

Internal Grievance Appeals

Internal First Level Standard Grievance Appeals

You may file a first level standard grievance on behalf of your child within **one hundred eighty (180) calendar days** from the date of receipt of the original denial by Keystone, by:

- calling Member Appeals at 1-888-671-5276; or
- writing or faxing:

Keystone Health Plan East
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll-free: 1-888-671-5276
Fax: 1-888-671-5274

Keystone will acknowledge receipt of your grievance appeal in writing.

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

The first level grievance committee completes its review of your child's standard grievance appeal within:

- **fifteen (15) calendar days** from the date of receipt of a pre-service appeal; and
- **thirty (30) calendar days** from receipt of a post-service appeal.

A pre-service grievance appeal includes any appeal for benefits for which preapproval is required prior to receiving medical care. A post-service grievance appeal is any appeal for benefits for care or services that your child may have already received.

You will be sent the committee's decision on your child's first level standard grievance appeal in writing within the timeframes noted above. If your child's grievance appeal is denied, the decision letter states:

- the specific reason for the denial;

- the plan provision on which the decision is made and instructions on how to access the provision; and
- how to appeal to the next level if you are not satisfied with the decision.

Internal Second Level Standard Grievance Appeals

If you are not satisfied with the decision from your child's first level standard grievance, you may file a second level standard grievance within **sixty (60) calendar days** of your receipt of the first level standard grievance decision from Keystone. To file a second level standard grievance, call, write or fax the member appeals department at the address and numbers listed above.

You have the right to present your child's grievance appeal to the committee in person or by way of a conference call. Your appeal can also be presented by your child's provider or another appeal representative if your authorization is obtained. (See "General Information About Member Appeal Processes" above for information about authorizations.)

The second level grievance committee for a standard grievance appeal is composed of at least three (3) persons who have had no previous involvement with your child's case and who are not subordinate to the original reviewer. The second level grievance committee members include Keystone employees familiar with managed care operations and benefits. At least one (1) of these employees is a Keystone medical director who holds an active, unrestricted license to practice medicine. Additionally, one-third of the committee consists of other persons not employed by Keystone.

Upon receipt of your child's appeal, you will be notified in writing, when possible, **fifteen (15) calendar days** in advance of a date and time scheduled for the second level grievance committee's meeting. You may request a change in the meeting schedule. Keystone will try to accommodate your request while remaining within the established timeframes. If you do not participate in the meeting, the second level grievance committee will review your child's grievance appeal and make its decision based on the information available in your child's file at the time of the meeting.

The second level grievance committee, will meet and render a decision on your child's standard grievance appeal within:

- **fifteen (15) calendar days** from receipt of a pre-service appeal; and
- **thirty (30) calendar days** from receipt of a post-service appeal.

The committee's review will include the matched specialist report prepared for the first level grievance committee. Upon written request you will be provided with a copy of this report, when possible, within at least **seven (7) calendar days** prior to the review by the second level grievance committee. The matched specialist's report includes the relevant board certifications and/or the specialty of the licensed physician or psychologist. You may submit supporting materials both before and at the time of the appeal meeting. Additionally, you have the right to review all information considered by the committee that is not confidential, proprietary or privileged.

The second level grievance committee meetings are a forum where parents have the opportunity to present their child's issues in an informal setting that is not open to the public. Two (2) other persons may accompany you unless you receive prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as your child's appeal representative or to provide general, personal assistance. Parents, appeal representatives and others assisting your child may not audiotape, videotape or transcribe the proceedings.

You will be sent the decision of the second level grievance committee in writing within the timeframes noted above. The decision is final unless you choose to file an external standard grievance within **fifteen (15) calendar days** of your receipt of the decision notice from Keystone.

Internal Expedited Grievance Appeals

If your child's case involves a serious medical condition which you believe, if reviewed in standard pre-service appeal timeframes, may jeopardize his/her life, health, ability to regain maximum function, or would subject your child to severe pain that cannot be adequately managed, as determined and validated by his/her physician, then you or your child's physician may ask to have his/her case reviewed in a faster manner, as an internal expedited grievance. There is only one (1) internal level of appeal review for an expedited grievance appeal.

To request an internal expedited grievance by Keystone, call Customer Service at **1-800-464-5437** or call or fax the member appeals department at the address or telephone numbers listed above. Keystone will promptly inform you whether your child's appeal request qualifies for expedited review or instead will be processed as a standard grievance appeal.

The expedited grievance committee has the same composition as a second level grievance committee for a standard grievance appeal, which includes Keystone employees familiar with managed care operations and benefits. At least one (1) of these employees is a Keystone medical director who holds an active, unrestricted license to practice medicine. Additionally, one-third of the committee consists of other persons not employed by Keystone. The committee members include Keystone staff.

You have the right to present your child's expedited grievance to the committee in person or by way of a conference call. Your child's appeal can also be presented by his/her provider or another appeal representative if your authorization is obtained. (See "General Information About Member Appeal Processes" above for information about authorizations.) If you do not participate in the meeting, the expedited grievance committee will review your child's grievance appeal and make its decision based on the information available in your child's file at the time of the meeting.

The expedited grievance committee meeting is a forum where parents have an opportunity to present their child's issues in an informal setting that is not open to the public. Two (2) other persons may accompany you unless you receive prior approval from Keystone for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as your child's appeal representative or to provide general, personal assistance. Parents, appeal representatives and others assisting your child may not audiotape, videotape or transcribe the committee proceedings.

The expedited grievance review is completed promptly based on your child's health condition. Within **forty-eight (48) hours** of receipt of your internal expedited grievance, Keystone will notify you by telephone, as well as in writing of the decision. If not satisfied with the decision from Keystone, you may file an external grievance appeal as described below.

External Grievance Appeals

The two types of external grievance appeals—standard and expedited—are described below. The parent of a CHIP member is not required to pay any of the costs associated with the external standard or expedited grievance appeal review.

An independent Certified Review Entity (CRE) assigned by the Pennsylvania Department of Health reviews an external grievance appeal. For standard and expedited grievance appeals, Keystone authorizes the service(s) or pays claims, if the CRE decides that the requested care or service(s) are covered services that are medically

necessary. You are notified in writing of the time and procedure for claim payment or approval of the service(s) in the event that the CRE overturns the prior appeal decision. The CRE's decision may be appealed to a court of competent jurisdiction within **sixty (60) calendar days**.

External Standard Grievance Appeals

You have **fifteen (15) calendar days** from receipt of the decision letter for your child's second level standard grievance to request an external standard grievance appeal review. To file a request for an external standard grievance review by a Department of Health-assigned CRE, contact the member appeals department as directed in the second level grievance appeal decision letter or as follows:

Keystone Health Plan East
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll-free: 1-888-671-5276
Fax: 1-888-671-5274

You will be sent written acknowledgement that Keystone has received your child's external standard grievance request within **five (5) business days** of its receipt. Keystone notifies you of the name, address and telephone number of the CRE assigned by the Department of Health to your child's grievance within **two (2) business days** of Keystone's receipt of the assignment from the Department of Health. You and Keystone have **seven (7) business days** to notify the Department of Health, if there is an objection to the assignment of the CRE on the basis of conflict of interest.

To submit additional information, you or your child's appeal representative should send it to Keystone at the address appearing above and to the CRE within **fifteen (15) calendar days** of its receipt of your external standard grievance review appeal.

The CRE will send you or your child's appeal representative a written decision within **sixty (60) calendar days** of the date when you filed your child's request for an external review. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.

External Expedited Grievance Appeals

You have **two (2) business days** from your receipt of the internal expedited grievance appeal decision to contact Keystone at the telephone number and address listed above to request an external expedited grievance appeal. Keystone forwards your request to the Department of Health within **twenty-four (24) hours**, which assigns a CRE within **twenty-four (24) hours**. Keystone forwards a copy of the internal grievance appeal case file to the CRE on the next business day and the CRE issues a decision within **two (2) business days** of receipt. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.

You Can Accept or Refuse Treatment for Your Child

- When your child joins the Keystone CHIP program, you agree that your child will receive care according to the recommendation of his or her 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 providers and to be informed by the physician of the medical consequences to your child of your refusal of any drugs, treatment or procedure.
- Keystone 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 plan of treatment for your child, Keystone 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

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

By enrolling your child in CHIP, you give consent to Keystone 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 Keystone'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

In support of your child's rights as a member and to help your child participate fully in the health plan, it is your responsibility to:

- Know about your child's benefits and the proper procedures to follow to obtain those benefits. Look through this Benefits Handbook. Keep it where you can refer to it.
- Call Customer Service at **1-800-464-5437** if you have trouble understanding anything in this handbook.
- Make premium payments, if required, on time.
- Identify your child as a Keystone member before obtaining covered medical services.
- Call Customer Service at **1-800-464-5437** and tell us when there are any changes in your child's status. For example, please notify us if:
 - you change your address;
 - your child begins to receive other health insurance benefits;
 - your child becomes eligible for Medicare or Medicaid;
 - there are errors on your child's Keystone medical ID Card; or
 - you lose your child's Keystone medical ID Card.
- Call United Concordia at **1-800-332-0366** if:
 - there are errors on your child's dental ID Card; or
 - you lose your child's dental ID Card.
- Communicate, to the extent possible, information participating providers need in order to care for your child.
- Follow the plans and instructions for your child's care that you have agreed on with his or her practitioner. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand your child's health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Ask questions to assure understanding of the explanations and instructions given.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Treat others with the same respect and courtesy expected for yourself.
- Understand that you may be financially responsible for the cost of any service or supply, received after the date your child's coverage is terminated under the CHIP program.

Subrogation and Reimbursement Rights

By accepting benefits for covered services, you agree that Keystone 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.

Subrogation Rights

Subrogation rights arise when Keystone 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. Keystone is subrogated to the member's right to recover from the Responsible Third Party. This means that Keystone "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 Keystone 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 Keystone 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. Keystone has a right to full reimbursement. By accepting benefits for covered services from Keystone, you agree to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by you, or anyone acting on your behalf, from any Responsible Third Party.

- 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.
- Keystone is entitled to recover the full amount of the benefits paid to the member or on the member's behalf out of amounts recovered from a Responsible Third Party without regard to whether the member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of Keystone will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- Keystone 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 Keystone agrees to do so in writing. The recovery rights of Keystone will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this contract, the benefits paid by Keystone will be secondary to any no-fault auto insurance benefits and to any worker's 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.

- Keystone is entitled to recover the full 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 Keystone 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 Keystone 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 Keystone or its delegated representative.
- Fully cooperate with Keystone 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 Keystone's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse Keystone or its designated representative immediately out of amounts received from a Responsible Third Party (whether the funds are received by court judgment, settlement or otherwise).
- Serve as trustee for any and all monies paid to (or payable to) you or for your benefit by any Responsible Third Party to the full extent Keystone paid benefits for an injury or illness.
- 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 Keystone's network. The following applies if a claim must be submitted by the parent or the personal representative of the child.

Notice of claim – Keystone will not be liable for any claims under this contract unless proper notice is furnished to Keystone that covered services in the contract have been rendered to your child. Written notice of a claim must be given to Keystone 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 Keystone that includes information sufficient to identify your child who received covered services shall constitute sufficient notice of a claim to Keystone. You can give notice to Keystone by calling Customer Service at **1-800-464-5437**. A charge shall be considered incurred on the date your child receives the covered service for which the charge is made.

Proof of loss – Claims cannot be paid until a written proof of loss is submitted to Keystone. Written proof of loss must be provided to Keystone within **ninety (90) days** after the charge for covered services is incurred. Proof of loss must include all data necessary for Keystone to determine benefits. Failure to submit a proof of loss to Keystone within the time specified will not invalidate or reduce any claim if it is shown

that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will Keystone be required to accept a proof of loss later than **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 Keystone on the appropriate claim form. Keystone, 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 the giving of such notice, you (or your child’s personal representative) shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for covered services as described below. Itemized bills may be submitted to Keystone. Call Customer Service at **1-800-464-5637** to request a claim form. Itemized bills cannot be returned.

Submission of claim forms – For claims submitted for a child, the completed claim form, with all itemized bills attached, must be forwarded to Keystone at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this 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. Keystone reserves the right to require additional information and documents as needed to support a claim that a covered service has been rendered.

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

Physical Examinations and Autopsy – Keystone 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 Keystone 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, Keystone 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 Keystone to be equitably entitled thereto. Any payment made by Keystone in good faith pursuant to this provision shall fully discharge Keystone 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.

Section 7

Primary and Preventive Health Care

Keeping Your Child Healthy

Regular check-ups and immunizations are a key part of preventive care because they help to keep your child from getting sick in the first place. Keystone 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.

Keystone periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics; The American College of Physicians; the U.S. Preventive Services Task Force (USPSTF), all items or services with a rate of A or B in the current recommendations; The American Cancer Society; and the Health Resources and Services Administration (HRSA). Examples of covered “USPSTF A” recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, 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, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women, 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 women with reproductive capacity. All services required by HRSA are covered. Accordingly, the Preventive Services are provided at no cost to the member. Keystone 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 CHIP, you should have selected a primary care physician in the Keystone network for your child. Always call your child’s primary care physician, which is listed on his or her Keystone ID card, before you go for medical care (except for conditions requiring emergency services as described on page 28). Your child’s primary care physician will provide the services or refer your child to an appropriate specialist when medically necessary.

Pediatric Preventive Care

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

- Physical Examination, Routine History, Routine Diagnostic Tests.
- Oral Health Risk Assessment, Fluoride varnish for children ages 5 months -5 years old (as a U.S. Preventative Task Force recommendation).
- Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling.
- Blood Lead Screening and Lead Testing. This blood test detects elevated lead levels in the blood.
- Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.

- Immunizations, except those required for travel or work, including the immunizing agents, which 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: <http://www.cdc.gov/vaccines/recs/schedules/default.htm>.

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 preventative 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:** Female 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. Female members have “direct access” to care by an obstetrician or gynecologist. This means that no referral is needed from her primary care physician.
- **Mammograms:** Coverage will be provided for screening and diagnostic mammograms. 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 women at no cost-sharing to the member.
- **Contraception:** Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost-sharing to the member when provided by a participating provider. Contraception drugs and devices are covered under the Prescription Drug benefit issued with this contract.

Please refer to the “Make Your Child’s Health a Priority” document for further information on regular check-ups, 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 8

Outpatient Services

Please refer to the “Benefits at a Glance” document 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 Keystone, where specified.

Ambulance Services

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

- the vehicle is licensed as an ambulance where required by applicable law;
- the ambulance transport is appropriate for your child’s clinical condition; 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 be contraindicated (i.e., would endanger your child’s medical condition); and the ambulance transport satisfies the destination and other requirements stated below.

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

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

All non-emergency ambulance transports must be preapproved by Keystone to determine medical necessity, which includes specific origin and destination requirements specified in Keystone’s policies.

Non-emergency air or ground transport may be covered to return the child to a participating facility provider within the Keystone service area for required continuing care (when a covered service), when such care immediately follows an inpatient emergency admission and the child is not able to return to the service area by any other means. Non-emergency transportation back to the Keystone service area is provided when the child’s medical condition requires uninterrupted care and attendance by qualified medical staff during transport by either ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance. Transportation back to the service area will not be covered for family members or companions.

Also, non-emergency ambulance transports are not provided for the convenience of the child, the family, or the provider treating the child.

Autism Spectrum Disorders (ASD)

Keystone will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for 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 Keystone once every six months. A more or less frequent review can be agreed upon by Keystone 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 his 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.

Dental Benefits (See page 84)

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 Keystone. 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, ultrasound and nuclear medicine), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), Nuclear Cardiology Imaging, and other diagnostic medical procedures approved by Keystone) and allergy testing (consisting of percutaneous, intracutaneous and patch tests);
- Non-routine diagnostic services, including operative and diagnostic endoscopies, 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 mental disorders. When clinical usefulness of specific genetic tests has been established by Keystone, 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 Keystone, 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, Keystone will provide repair or replacement only if the DME's warranty has expired and it has exceeded its reasonable useful life as determined by Keystone.

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:

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

Keystone 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

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 Customer Service 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 which may be approved by Keystone.

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

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 Keystone 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 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 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 healthcare provider regarding safety, side effects, and compliance; and access to the drug may be limited.

Preapproval is required for those specialty drugs noted in the preapproval list, which is available online at ibx.com/chip, or by calling Customer Service 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 Medical 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 his or her 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 female 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 CHIP member is released prior to **forty-eight (48) hours** for a normal 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 Keystone 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 pre- and post-natal care.

In the event of early post-partum 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 the woman, 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 which 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 Independence, 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 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 given by way of a tube into the alimentary tract; or
- The nutritional formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory 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 supplier or in connection with infusion therapy as provided for in this contract.

Mental Health Care (See page 89)

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

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 79)

Private Duty Nursing

Benefits will be provided for outpatient private duty nursing performed by a licensed registered nurse (RN) or a licensed practical nurse (PN) when ordered by your child's primary care physician or a referred specialist as part of a home health care treatment plan and that are medically necessary.

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; 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 his or her 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 his or her primary care physician’s designated provider.

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, Keystone 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 Keystone 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 Keystone.

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 Abuse Treatment (See page 91)

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 which 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.
- **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 Keystone.
- **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 Keystone 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 that surgery which 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.

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**

Chemotherapeutic agents, if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes) will be covered. The cost of prescription drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

- **Dialysis**

Benefits are provided for dialysis treatment when provided in the outpatient facility of a hospital, a free standing 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 Keystone. The covered services performed in a participating facility provider or by a participating professional provider for dialysis are available without a referral.

- **Infusion Therapy**

The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a healthcare 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 healthcare 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 Keystone.

- **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 which includes evaluation and training sessions.

- **Pulmonary Rehabilitation Therapy**

Includes treatment through a multidisciplinary program which 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 which are generally accepted as not experimental/investigative services by medical organizations of national reputation. These organizations are recognized by Keystone as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services which 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, each is entitled to the benefits of this plan.
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this contract. 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 donor is a member, the donor is entitled to the benefits of this contract, subject to the following additional limitations:
 - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this contract; 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 Keystone. 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 95)

Section 9

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 Keystone, where specified.

Note: All inpatient stays must be preapproved by Keystone 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 his 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.

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 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 Keystone 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 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. (Keystone reserves the right to apply quantity level limits as conveyed by the FDA or Keystone'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 Keystone 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.

Mastectomy Care and Breast Reconstruction

Benefits are provided for a mastectomy performed on an inpatient 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 female 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 CHIP member is released prior to **forty-eight (48) hours** for a normal 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 Keystone 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 pre- and post-natal 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 the event of early post-partum 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 woman, 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 which 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 his or her 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 pre- or post-operative or pre- or post-natal periods 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 which are required by the participating facility provider's rules and regulations.

Medical Foods

Benefits are provided for nutritional products which are specifically formulated for the therapeutic treatment of: phenylketonuria, branch-chain ketonuria, galactosemia, and homocystinuria. These foods may be taken by mouth and may not be a person's sole source of nutrition. This treatment must be administered by your child's primary care physician or referred specialist.

Mental Health Care (See page 89)

Private Duty Nursing

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

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 which 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, Keystone 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 Keystone 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 Keystone.

Skilled Nursing Facility Services

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

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

During your child's admission, members of Keystone's Care Management and Coordination team are monitoring your child's stay to assure that a plan for his or her discharge is in place. This is to make sure that your child has a smooth transition from the facility to home or other setting. A Keystone 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 Keystone 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 Abuse Treatment (See page 91)

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 which 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.
- **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 Keystone.

- **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 Keystone 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 that surgery which 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 which are generally accepted as not experimental/investigative services by medical organizations of national reputation. These organizations are recognized by Keystone as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services which 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, each is entitled to the benefits of this plan.
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this contract. 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 donor is a member, the donor is entitled to the benefits of this contract, subject to the following additional limitations:
 - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this contract; 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 10

Prescription Drug Benefits

Please refer to the “Benefits at a Glance” document 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-formulary 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, the member should call Customer Service 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.
- **Drugs From a Nonparticipating Pharmacy** – Covered drugs or supplies furnished by a nonparticipating pharmacy when you submit acceptable proof of payment with a direct reimbursement form. Your cost share amount for prescription drugs purchased from a nonparticipating pharmacy is listed in the “Benefits at a Glance” document. However, for emergency or urgent care, the member will pay the same prescription drug cost share level as for a participating pharmacy. The member must submit to Keystone acceptable proof of payment with a direct reimbursement form.

All claims for payment must be received by Keystone or an agent of Keystone within **ninety (90) days** of the date of purchase. Direct reimbursement forms may be obtained by contacting Customer Service at **1-800-464-5437**.

- **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-Injectable Medications** – Benefits are provided for self-injectable 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.
- **Dermatological Drugs** – Compounded dermatological preparations containing at least one Federal Legend or State Restricted Drug.
- **Specialty Drugs** – Keystone will only provide benefits for covered specialty drugs, except insulin, through the pharmacy benefits manager's (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. If the member's doctor wants the member to start the drug immediately, an initial supply may be obtained at a retail participating pharmacy. However, all subsequent fills must be purchased through the PBM's Specialty Pharmacy Program. 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.

Select specialty drugs will be subject to 'split fill', whereby the initial prescription will be dispensed in two separate amounts. The first amount is dispensed without delay. The second amount may be dispensed subsequently, allowing time for any necessary clinical intervention due to medication side effects that may require dose modification or therapy discontinuation. Any cost share is prorated for each amount of the split fill.

- **Prescription drug benefits** are subject to dispensing level limits as conveyed by the Food and Drug Administration ("FDA") or Keystone's Pharmacy and Therapeutics Committee.
- **Keystone 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 how to request an exception by calling Customer Service at **1-800-464-5437**.

The member, or his or her 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 Affordable Care Act for generic products approved by the Federal Food and Drug Administration and for certain brand products (when a generic alternative or equivalent to the brand product does not exist) 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, IUDs and implants, cervical caps, rings, transdermal patches, emergency contraceptives and certain over-the-counter contraceptive methods. This does not include abortifacient drugs. The noted brand name cost-sharing in the "Prescription Drugs" section of the "Benefits at a Glance" document applies for all other brand 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 cost to the member when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Customer Service 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 Customer Service at **1-800-464-5437**.

Prescription Drug Limitations

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

- A pharmacy need not dispense a prescription order which, 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 Customer Service at **1-800-464-5437**.
- Prescription refills will not be provided beyond six (6) months from the most recent dispensing date.
- Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed.
- Members must present their Identification 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 his or her Identification Card. A claim for reimbursement for covered drugs or supplies may be submitted to Keystone;
 - 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, Keystone 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 Customer Service at **1-800-464-5437**.
- In certain cases, Keystone may determine that the use of certain covered prescription drugs for a member's medical condition requires preapproval for medical necessity.
- Keystone reserves the right to apply dispensing limits for certain covered drugs or supplies as conveyed by the FDA or Keystone's Pharmacy and Therapeutics Committee.
- In certain cases where Keystone determines there may be prescription drug usage by a member that exceeds what is generally considered appropriate under the circumstances, Keystone 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 Keystone, the member shall call Customer Service at **1-800-464-5437** to obtain information for the process required to obtain the prescription drugs.

96-Hour Temporary Supply Program

The 96-Hour Temporary Supply Program applies to the following covered medications:

- most medications that require prior authorization;
- medications that are subject to age limits (preapproval required for ages outside of recommended ranges); and
- migraine medications with quantity level limits (preapproval of quantity override required for amounts over the quantity level limits).

Under the 96-Hour Temporary Supply Program, if a child's doctor writes a prescription for a drug that requires prior authorization, has an age/gender limit or exceeds the quantity limit for a medication and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

- The participating retail pharmacy will be instructed to release a 96-hour supply of the drug for your child.
- By the next business day, Keystone's Pharmacy Services department will contact your child's doctor to request that they submit the necessary documentation of medical necessity or medical appropriateness for review.
- Once the completed medical documentation is received by Pharmacy Services, Keystone's review will be completed and the medication will be approved or denied.
- If approved, the remainder of the prescription order will be filled.
- If denied, notification will be sent to you and your child's doctor.

This program is available to CHIP children for a one-time supply of medication in emergent situations only. Obtaining a 96-hour urgent temporary supply does not guarantee that the prior authorization/ preapproval request will be approved. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations (tube, 2-week or monthly supply). Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually obtained at the pharmacy and must be specially ordered; therefore, they are not eligible for the 96-hour temporary supply.

Prescription Drug Exclusions – What is Not Covered

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 Keystone, 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 Worker's 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 Keystone (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 which 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, biological sera, blood or plasma, or allergy serum;
- Prescription drugs not approved by Keystone or prescribed drug amounts exceeding the quantity level limits as conveyed by the FDA or Keystone's Pharmacy and Therapeutics Committee;
- Specialty drugs that are not purchased through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program. This exclusion does not apply to insulin; and
- Any charge where the usual and customary charge is less than the member's applicable cost-sharing amount.

Section 11

Dental Benefits

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 CHIP dental benefits are administered by United Concordia Companies, Inc., which is a separate 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.

Whom 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 Customer Service at **1-800-332-0366**.

If you need help finding a dental provider or getting an appointment, please call United Concordia Customer Service at **1-800-332-0366** 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 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 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 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 Customer Service at **1-800 332-0366** 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
- Alveoplasties
- 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

Dental Specific Exclusions

- 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) which 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

Section 12

Mental Health and Substance Abuse Benefits

Your child is eligible for mental health and substance abuse benefits under CHIP. Benefits are provided in a managed care setting and offered through an arrangement with a behavioral health management company, Magellan Behavioral Health Services (Magellan).*

All inpatient services and certain outpatient services must be coordinated and authorized through Magellan to determine that medical necessity criteria are met for the services. (See “Utilization Review Process” on page 18.) 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 mental health and substance abuse services outside of Magellan’s network, see “Preapproval for Nonparticipating Providers” on page 26 for obtaining preapproval for use of a nonparticipating provider.

How to Access Mental Health and Substance Abuse Benefits

All mental health and substance abuse services are accessed through Magellan’s help line:

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 mental health or substance abuse 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 Magellan and your child’s mental health and substance abuse benefits.

Your Child’s Mental Health Benefits—What is Covered

Outpatient Services

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

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

- Psychiatric visits
- Psychiatric consultations

*Magellan Healthcare, Inc., an independent company, manages mental health and substance abuse benefits for most Independence members.

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

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 himself/herself 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 mental 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, Magellan will schedule your child for an urgent 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 28.

Inpatient Services

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

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

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

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

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) is care which 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 mental 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 18.) 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 mental health and substance abuse services outside of Magellan’s network, see “Preapproval for Nonparticipating Providers” on page 26 for obtaining preapproval for use of a nonparticipating provider.

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

Your Child’s Substance Abuse Benefits – What is Covered

Outpatient Services

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

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

A referral from your child’s primary care physician is **not** required. Call Magellan at **1-800-294-0800**; TTY/TDD Service: 1-800-409-8640. A child as young as the age of 14 can self-refer.

Outpatient substance abuse treatment covered services include:

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

Inpatient Services

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

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

During a substance abuse 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 abuse treatment facility or a residential treatment facility that is a behavioral health/substance abuse 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 abuse 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 18.) 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 mental health and substance abuse services outside of Magellan’s network, see “Preapproval for Nonparticipating Providers” on page 26 for obtaining preapproval for use of a nonparticipating provider.

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

Section Intentionally Omitted

Complaints and Grievances

If you have a concern about your child's mental health or substance abuse services, call Independence at **1-800-464-5437**. If a Customer Service representative is not able to resolve your problem, you may file a formal complaint or grievance with Keystone. See "You Can File a Complaint or Grievance for Your Child" on page 35.

Section 13

Routine Vision Care Benefits

Please refer to the “Benefits at a Glance” document for copayment information.

Routine vision care benefits are administered by Davis Vision.[†] No referrals are necessary to access 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 Keystone Health Plan East; and
- your child’s ID number located on his or her Keystone 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.

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

Additionally, a 20% discount applies to any amount over \$130.

- **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 he or she 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.

Vision Care Exclusions – What is Not Covered

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

Section 14

Medical Exclusions – What is Not Covered

The following are excluded from your child's coverage:

1. Services or supplies which are:
 - not provided by or referred by your child's primary care physician except in an emergency or as specified elsewhere in this handbook;
 - not medically necessary, as determined by your child's primary care physician or referred specialist or Keystone, 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 handbook; or
 - provided by family members, relatives, and friends.
2. Services for any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of Worker's 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 which your child is legally entitled to receive at government facilities which are not Keystone 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 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 which 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 handbook, and which have been preapproved by Keystone.

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 nursing home, home for the aged, convalescent home, school, camp, 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 Keystone 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: ongoing outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond the plan's day limits, if any; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions.
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. Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or intellectual disability; or treatment or care to effect environmental or social change; or Autism Spectrum Disorder.
18. Immunizations required for employment or travel. This exclusion does not apply to travel immunizations required by the Advisory Committee on Immunization Practices (ACIP).
19. Custodial and domiciliary care, residential care, protective and supportive care, including educational services, rest cures and convalescent care.

20. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary. This exclusion does not apply to Keystone's weight reduction program or nutrition counseling visits/sessions as provided by Keystone through its nutrition counseling for weight management benefit. This exclusion does not include weight reduction services that are required to be covered under the Affordable Care Act.
21. For appetite suppressants.
22. For oral non-elemental nutritional supplements (e.g. Boost[®], Ensure[®], PediaSure[®]), casein hydrolyzed formulas (e.g. Nutramigen[®], Alimentum[®], Pregestimil[®]), or other nutritional products including, but not limited to, basic milk, milk-based, and soy-based products. Also excluded are orally administered elemental (amino acid) formulas (e.g. Neocate[®], Elecare[®]) when such formulas do not represent the sole source of nutrition (NOTE: sole source of nutrition is defined as the substances accounting for more than 75% of the individual's estimated basal caloric requirement). This exclusion does not include nutritional supplements that are required to be covered under the Affordable Care Act.
23. Customized wheelchairs.
24. Personal or comfort items such as television, telephone, air conditioning, humidifiers, barber or beauty service, guest service and similar incidental services and supplies which are not medically necessary.
25. For any treatment leading to or in connection with transsexual surgery except for sickness or injury resulting from such surgery.
26. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury.
27. For palliative or cosmetic foot care including treatment of bunions (except capsular or bone surgery); toenails (except surgery for ingrown nails); the treatment of subluxations of the foot; care of corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain; and other routine podiatry care, unless associated with the medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including, but not limited to, diabetes.
28. Marriage or religious counseling.
29. In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to artificial insemination; 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.
30. Services for repairs or replacements of prosthetic devices or Durable Medical Equipment needed because the item was abused, lost or misplaced.
31. Reversal of voluntary sterilization and services required in connection with such procedures.
32. Wigs and other items intended to replace hair loss due to male/female pattern baldness; or due to illness or injury including, but not limited to, injury due to traumatic or surgical scalp avulsion, burns or chemotherapy.
33. Ambulance service, unless medically necessary, and as provided in the subsection entitled "Ambulance Services" specified in Outpatient Services of this handbook.

34. 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 handbook and provided under the contract. No payment will be made for human organs which are sold rather than donated.
35. Charges for completion of any insurance form.
36. For self-administered prescription drugs under your 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.
37. Foot orthotic devices except as described in this handbook and provided under the contract. This exclusion does not apply to foot orthotic devices used for the treatment of diabetes.
38. Any services, supplies or treatments not specifically listed in this 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. Keystone 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.
39. For prescription drugs and medications, except as provided under the Prescription Drug Benefit described in this handbook.
40. For contraceptives, except as covered under the Prescription Drug Benefit described in this handbook.
41. 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 Keystone:
 - 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.
42. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational, and speech therapies in a multidisciplinary, goal-oriented, and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy).
43. Medication furnished by any other medical service for which no charge is made to the member.
44. Charges in excess of benefit maximums.
45. 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.
46. 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 Keystone.

47. Services incurred prior to the effective date of coverage.
48. Services which were or are incurred after the date of termination of the member's coverage, except as provided in this handbook.
49. Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trust or similar person.
50. Counseling with patient's relatives except as may be specifically provided in the subsection entitled "Substance Abuse Treatment" or "Transplant Services" specified in the Inpatient and Outpatient sections of this handbook.
51. Equipment 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. Items not covered include, but are not limited to: incontinence pads; lamb's wool pads; ace bandages; antiembolism stockings; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits;
- **That is not primarily medical in nature.** Equipment which 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: ear plugs; exercise equipment; ice packs; speech teaching machines; strollers; silverware/utensils; feeding chairs; toileting systems; toilet seats; 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; set-up 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 utilized 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.

52. 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 abuse and mental illness health care; or
 - After the member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.
53. The cost of home blood pressure machines except for members: a) with pregnancy-induced hypertension; b) with hypertension complicated by pregnancy; or c) with end-stage renal disease receiving home dialysis.
54. 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.
55. 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.
56. For health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.
57. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.
58. Charges not billed/performed by provider.
59. 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.
60. 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.

61. Treatment of obesity, however, this exclusion does not apply to:

- surgical procedures specifically intended to result in weight loss (including bariatric surgery) when Keystone:
 - Determines the surgery is medically necessary; and
 - The surgery is limited to one surgical procedure per lifetime, regardless (or even) if:
 - a new or different diagnosis is the indication for the surgery;
 - a new or different type of surgery is intended or performed, or
 - a revision, repeat, or reversal of any previous weight loss Surgery is intended or performed.

The exclusion of coverage for a repeat, reversal or revision of a previous surgery does not apply when the intended procedure is performed to treat technical failure or complications of a prior surgical procedure which, if left untreated, would result in endangering the health of the member. Failure to maintain weight loss or any condition resulting from or associated with obesity does not constitute technical failure.

- this nutrition counseling visits/sessions as described in the "Nutritional Counseling" provision in this handbook or treatment of obesity that is required to be covered under the Affordable Care Act.

62. For the maintenance of chronic conditions, illness or injury.

63. 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.
64. For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
65. For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

Section 15

Important Definitions

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

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

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE — Complementary and alternative medicine, as defined by the National Institute of Health’s National Center for Complementary and Alternative Medicine (NCCAM). NCCAM is a group of diverse medical and health care systems, practices and products currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications:

- Alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine);
- Mind-body interventions (a variety of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms (e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance));
- Biologically based therapies using natural substances, such as herbs, foods, vitamins, or nutritional supplements to prevent and treat illness (e.g., diets, macrobiotics, megavitamin therapy);
- Manipulative and body-based methods (e.g., massage, equestrian/hippotherapy); and
- Energy therapies, involving the use of energy fields. They are of two types:
 - Biofield therapies—intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch.
 - Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

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 DISORDERS (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 DISORDERS 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 SPECIALIST — an individual with appropriate certification or licensure by the applicable state, who designs, implements or evaluates a behavior modification intervention component of an ASD (Autism Spectrum Disorder) Treatment Plan, through Applied Behavioral Analysis which includes:

- Skill acquisition and reduction of problematic behavior;
- Improve function and/or behavior significantly; or
- Prevent loss of attained skill or function.

BENEFITS — see COVERED SERVICE.

BLUECARD® PROGRAM — a program that enables members obtaining health care services while traveling outside Keystone’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 single source, FDA-approved drug manufactured by one company for which there is no FDA-approved substitute available. For the purposes of this coverage, the term “Brand Name Drug” shall also mean devices known 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.

COGNITIVE REHABILITATIVE THERAPY — medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g., trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities that mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a physician, neuropsychologist, or psychologist, as well as physical, occupational, or speech therapist using a team approach.

COMPLAINT — a dispute or objection regarding coverage, including exclusions and non-covered services under the plan, participating or nonparticipating providers’ status or the operations or management policies of Keystone. This definition does not include a grievance (medical necessity appeal). It also does not include disputes or objections that were resolved by Keystone and did not result in the filing of a complaint (written or oral).

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.

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.

CONTROLLED SUBSTANCE — any medicinal substance as defined by the Drug Enforcement Administration which requires a prescription order in accordance with the Controlled Substance Act—Public Law 91-513.

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 specified dollar amount applied to a specific covered service for which the member is responsible per covered service. Copayments, if any, are identified in the “Benefits at a Glance” document.

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 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 his/her 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 which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DAY REHABILITATION PROGRAM — is a level of outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as physical therapy, occupational therapy, and speech therapy, as otherwise defined in this contract and other medical services such as nursing services, psychological therapy and case management services. Day rehabilitation sessions also include a combination of one-to-one and group therapy. The member returns home each evening and for the entire weekend.

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 Keystone 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, 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 risk to the patient at a minimum.

DIABETIC EDUCATION PROGRAM — an outpatient diabetic education program provided by a participating facility provider which 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 — 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, primary care physicians and participating specialists, matching interventions to members with greatest opportunity for improved clinical or functional outcomes. Disease management programs may employ education, primary care physicians' and participating specialists' feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist members with chronic disease(s). Disease management interventions are intended to both improve delivery of services in various active stages of the disease process as well as to 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 Independence.

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 identified by Independence as eligible for the Children's Health Insurance Program (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 her 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.

ESSENTIAL HEALTH BENEFITS — a set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. The Affordable Care Act ensures health plans offered in the individual and small group markets offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

- Is the subject of ongoing Clinical Trials;

- Is the research, experimental, study or investigational arm of an on-going 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.

A drug will not be considered experimental/investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process (e.g., 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 the drug for another diagnosis or condition shall require that one or more of the established referenced compendia identified in the company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered experimental/investigative if it meets all of the criteria listed below:

- Reliable evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.
- Reliable evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
- Reliable evidence clearly demonstrates that the biological product, device, medical treatment or procedure 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.
- Reliable evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure 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.

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

- | | |
|--|-----------------------------|
| A. Ambulatory surgical facility | F. Hospice |
| B. Birth center | G. Hospital |
| C. Freestanding dialysis facility | H. Rehabilitation hospital |
| D. Freestanding ambulatory care facility | I. Short procedure unit |
| E. Home health care agency | J. 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 Keystone's service area.

FREESTANDING AMBULATORY CARE FACILITY — a facility provider, other than a hospital, which provides treatment or services on an outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a physician. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREESTANDING DIALYSIS FACILITY — a facility provider, licensed or approved by the appropriate governmental agency and approved by Keystone, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.

FULL-COST CHIP — health insurance for eligible children of families with incomes above 300% of the Federal Poverty Guidelines.

GENERIC DRUG — pharmacological agents approved by the FDA as a bioequivalent substitute and manufactured by a number of different companies as a result of the expiration of the original patent.

GRIEVANCE — a request by a member or a health care provider, with the written consent of the member, to have Keystone reconsider a decision solely concerning the medical necessity or appropriateness of a health care service. This definition does not include a complaint. It also does not include disputes or objections regarding medical necessity that were resolved by Keystone and did not result in the filing of a grievance (written or oral).

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, (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 Keystone 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 which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by Keystone 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 mental illness; place for treatment of substance abuse; 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 Keystone.

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 Keystone. 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 CHIP child by Keystone Health Plan East and United Concordia which must be presented when a covered service is requested.

IMMUNIZATIONS — pediatric and medically necessary adult 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.

INDEPENDENT CLINICAL LABORATORY — a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a hospital, physician or facility provider.

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 abuse 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 mental illness or substance abuse/substance abuse dependency. Intensive outpatient treatment is an alternative to inpatient hospital treatment or partial hospitalization and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until he or she is able to transition to less intensive outpatient treatment, as required.

KEYSTONE HEALTH PLAN EAST, INC. (KEYSTONE) — 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 SOCIALWORKER — 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.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) — any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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 handbook.

LOW-COST CHIP — health insurance for eligible children of families with incomes between 200% and 300% of the Federal Poverty Guidelines.

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 Keystone, used for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

MASTER’S PREPARED THERAPIST — a therapist who holds a Master’s degree in an acceptable human services-related field of study and is licensed as a therapist at an independent practice level by the appropriate state authority to provide therapeutic services for the treatment of mental health care.

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 Keystone 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 which 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. Keystone 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, Keystone researches all scientific information available from these expert sources. Following this analysis, Keystone 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.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) — health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease; and (3) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors.

MEDICARE — hospital or medical insurance benefits provided by the United States Government under Title XVIII of the Social Security Act of 1965, as amended.

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

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

MULTI-SOURCE DRUG — a branded FDA approved drug for which an FDA approved generic drug substitute is available.

NON-FORMULARY DRUG — a covered drug or supply not included in the drug formulary.

NONPARTICIPATING PHARMACY— a pharmacy (whether a retail or mail service pharmacy) which has not entered into a written agreement with Keystone or an agent of Keystone 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 Keystone’s network.

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-AREA SERVICES—services provided outside Keystone’s service area. Covered services are limited to:

- Emergency services and services that are arranged or referred by a Keystone primary care physician in Keystone’s service area, and preapproved by Keystone; and
- Urgent care and follow-up care available through the BlueCard program.

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 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.

OUTPATIENT MENTAL HEALTH CARE/OUTPATIENT SUBSTANCE ABUSE 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 abuse treatment program or any other mental 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.

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’s network.

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

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

PARTICIPATING PROFESSIONAL PROVIDER — a professional provider who is a member of Keystone’s network.

PARTICIPATING PROVIDER — a provider with whom Keystone has contracted directly or indirectly 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 his or her specialty and upon referral from a primary care physician. In the event 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 Keystone. See “Preapproval for Nonparticipating Providers” on page 26 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 Obstetricians or Gynecologists** — a participating provider selected by a female member who provides covered services without a referral. All non-facility obstetrical and gynecological covered services are subject to the same copayment that applies to office visits to your child’s primary care physician. Participating obstetricians and gynecologists have the same responsibilities as referred specialists. For example, seeking preapproval for certain services. Similarly, just as you have the right to designate a referred specialist as your child’s primary care physician, you may designate a participating obstetrician or gynecologist as your child’s primary care physician.
- **Dialysis Specialist** — a professional provider who provides services related to dialysis without a referral.

- **Participating Hospital** — a hospital that has contracted with Keystone to provide covered services to members.
- **Durable Medical Equipment (DME) Supplier** — a participating supplier of Durable Medical Equipment that has contracted with Keystone to provide covered supplies to Keystone members.
- **Behavioral Health/Substance Abuse Provider** — A provider in a network made up of professionals and facilities contracted by a behavioral health management company on Keystone’s behalf to provide behavioral health/substance abuse covered services for the treatment of mental illness and substance abuse (including detoxification) to Keystone’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 Keystone.

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 Keystone to confirm Keystone 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. Keystone also reserves the right to apply dispensing limits for certain covered drugs or supplies as conveyed by the FDA or Keystone’s Pharmacy and Therapeutics Committee. The parent may call Customer Service at **1-800-464-5437** to find out if the covered drug or supply has been approved by Keystone, or may ask the child’s primary care physician to call Provider Services.

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

PRIOR AUTHORIZATION — with respect to dental benefits, the determination of benefits for dental covered services before the services are performed.

PRENOTIFICATION — the requirement that a member provide prior notice to Keystone 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 Customer Service at **1-800-464-5437** to find out if your prescription drug has been approved by Keystone 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 COPAYMENT (PRESCRIPTION DRUG COPAY) — the amount as shown in the "Benefits at a Glance" document charged to the member by the participating retail pharmacy or participating mail service pharmacy for the dispensing or refilling of any prescription drug order or refill. The member is responsible at the time of service for payment of the prescription drug copay directly to the participating retail pharmacy or participating mail service pharmacy.

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 his or her 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 his or her professional practice.

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) which 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 — 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 mental 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 Food and Drug Administration (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 Keystone as a Qualifying Clinical Trial.

REFERRED (REFERRAL) — written documentation from the CHIP member’s primary care physician that authorizes covered services to be rendered by a Keystone 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 Keystone. See “Preapproval for Non-Participating Providers” on page 26 for procedures for obtaining preapproval for use of a nonparticipating provider. A referral must be issued to the 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 and physical 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.

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

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.

SELF-ADMINISTERED PRESCRIPTION DRUG — a prescription drug that can be administered safely and effectively by either the member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of self-administered prescription drugs include, but are not limited to:

- Oral drugs;
- Self-injectable drugs;
- Inhaled drugs; and
- Topical drugs.

SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG) — a prescription drug that:

- is introduced into a muscle or under the skin with a syringe and needle; and
- can be administered safely and effectively by either the member or a caregiver without medical supervision regardless of whether initial medical supervision and/or instruction is required.

SERVICE AREA — the geographical area within which Keystone 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 Keystone 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 abuse and has contracted with Keystone 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 Keystone.

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 healthcare provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.
- Keystone reserves the right to determine which specialty drug vendors and/or healthcare 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 Keystone 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.

STATE RESTRICTED DRUG — any non-Federal legend drug which, according to State law, may not be dispensed without a prescription drug order or refill.

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

SUBSTANCE ABUSE — 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 ABUSE 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 abuse.

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**

Treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

- **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 healthcare 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 healthcare 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 Keystone.

- **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 which includes evaluation and training sessions.

- **Pulmonary Rehabilitation Therapy**

Multidisciplinary treatment which 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.

- **Speech Therapy**

Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

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).



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

Questions about your child's health insurance?

Contact us:

By phone:

1-800-464-5347 (TTY/TDD: 711)

By mail:

Independence Blue Cross

P.O. Box 13449

Philadelphia, PA 19101-3449

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