

Member rights and responsibilities

Keystone Health Plan East would like to take this opportunity to thank you for being a Keystone HMO Children's Health Insurance Program (CHIP) member. We are dedicated to keeping our members healthy and informed. We not only respect your rights, but we also encourage you to exercise your responsibilities. The following are your rights and responsibilities as a Keystone HMO CHIP member.

Member rights

- You have the right to receive information about the health plan, its benefits, services included and excluded from coverage, policies and procedures, participating practitioners/providers, and member rights and responsibilities. Written and web-based information provided to members will be readable and easily understood.
- You have the right to be treated with courtesy, consideration, respect, and recognition of your dignity and your right to privacy.
- You have the right to participate with providers in decision-making regarding your health care. This includes candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage.
- You have the right to voice complaints or grievances about the health plan or the care it provides and receive a timely response. You have the right to be notified of the disposition of grievances/complaints and the right to further appeal, as appropriate.
- Upon exhaustion of the internal member appeal process, you may have the right to file for external review.
 - **For Keystone HMO CHIP members:**
You may have the right to file for external review by state regulatory authorities or an independent review organization. For more information, see the appeal instructions in the decision letter for your final level of internal member appeal review.
- You have the right to choose providers within the limits of the covered benefits availability, and participation within the plan's network.
- You have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment, after possible consequences of this decision have been explained in language you understand.
- You have the right to the confidential treatment of medical information. You have the right to have access to your medical records in accordance with applicable federal and state laws.
- You have the right to reasonable access to medical services, including availability of care 24 hours a day, 7 days a week, for urgent or emergency conditions.
- You have the right to receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, health status, genetic information, color, religion, gender, sexual orientation, national origin, source of payment, utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the filing by such member of any complaint, grievance, or appeal against Professional Provider, a Group Practice Provider (if applicable), or Independence Blue Cross.

Member rights and responsibilities (continued)

- You have the right to formulate advance directives. The plan will provide information to members and providers concerning advance directives and will support members through its medical record-keeping policies.
- You have the right to make recommendations regarding your health plan's policy on member rights and responsibilities. To make any recommendations, please call the Keystone HMO CHIP Member Help Team at **the number on the back of your ID card**.
- You have the right to call 911 in a potentially life-threatening situation without prior approval from Independence and the right to have Independence pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- You have the right to continue receiving services from a provider who has been terminated from the Independence network (without cause) in the timeframes as defined by the applicable state requirements of your benefit plan. The continuation of care does not apply if the provider is terminated for reasons which would endanger the member, public health or safety, breach of contract, or fraud.
- You have the right to be free from balance billing by participating providers for medically necessary services that were authorized or covered except as permitted for copayments, coinsurance, and deductibles by contract.

Member responsibilities

- You have the responsibility to communicate, to the extent possible, information Independence and participating providers need in order to provide care to you.
- You have the responsibility to follow the plans and instructions for care that you agreed on with your practitioners. This includes consideration of the possible consequences of failure to comply with recommended treatment.
- You have the responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- You have the responsibility to treat your health care providers with the same respect and courtesy you expect for yourself.
- You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.
- You have the responsibility to review all benefits and membership materials carefully and to follow the rules pertaining to the health plan.
- You have the responsibility to ask questions to ensure your understanding of the explanations and instructions given.
- You have the responsibility to pay deductibles, coinsurance, or copayments, as appropriate, according to your contract.
- You have the responsibility to pay for charges incurred that are not covered under, or authorized under, your benefit policy or contract.

Note: Magellan Behavioral Health, Inc., an independent company, provides similar rights and responsibilities. Magellan manages behavioral health and substance use benefits for Keystone HMO CHIP members.



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Physician review, utilization management, and language services

It is the policy of Keystone Health Plan East, Inc. that all utilization review decisions are based on the benefits available under the member's coverage and the medical necessity of health care services and supplies in accordance with the Plans' definition of medical necessity.

Only physicians can make denials of coverage of health care services and supplies based on a lack of medical necessity. The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for the Plans are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination. The Plans do not provide financial incentives for issuing denials of coverage or utilization review decisions that result in underutilization.

If you have questions about the utilization decision process, or a determination you have received, you can contact the Keystone HMO CHIP Member Help Team by telephone, by sending an email message, or by sending a fax. The Member Help Team Representatives will provide assistance with understanding the utilization/precertification process or transfer you to the Utilization Management Department to discuss your concerns. Utilization Management (UM) is available Monday through Friday from 8 a.m. to 5 p.m. You may call **1-800-ASK-BLUE** to reach UM staff. Representatives are available after business hours as well. For urgent issues related to UM after 5 p.m., call **1-800-ASK-BLUE**.

The representatives from the Keystone HMO CHIP Member Help Team also provide the following services at no cost for the member: multilingual staff, telephone language line services, interpreters, a separate phone number for receiving TTY/TDD messages, State/711 Relay Services for the deaf or hearing impaired, assistance in finding a provider that speaks your language, and providing information about your claims or benefit coverage. Call our Keystone HMO CHIP Member Help Team at the number on the back of your ID card. Follow the prompts or wait to speak with a Keystone HMO CHIP Member Help Team representative.

Utilization Management is available Monday through Friday, 8 a.m. to 5 p.m. For urgent issues relating to utilization management after business hours, call **1-800-ASK-BLUE**.



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Finding a network provider

Our *Find a Doctor* tool makes it easy to search our broad network for a doctor or hospital. Go online to find easy-to-follow, up-to-date, detailed listings of doctors and hospitals — information you can use to make informed decisions about your health care.

Find a Doctor is available at ibx.com. You can use the tool to:

- **Search for a participating doctor or hospital.*** In the *Find a Doctor* tool, you can:
 - Search by name, location, specialty, or medical procedure;
 - Access information about practitioners, including their gender, hospital admitting privileges, languages spoken, professional qualifications, medical school attendance, residency completion, and board certification status;
 - Review and compare the qualifications and experience of network physicians;
 - Research and compare hospitals based on procedure, diagnosis, and location, as well as hospital quality and safety information; and
 - Customize the way the results are displayed according to which measures (number of patients, complication and mortality rates, length of stay, and cost) are most important to you.
- **Read reviews.** Learn from the experience of others by reviewing online provider ratings.

Go online

Go to ibx.com to use these valuable resources. If you do not have Internet access, call the Keystone HMO CHIP Member Help Team at **the number on the back of your ID card** to obtain a copy of the Provider Directory for your coverage.

*The provider tool includes information on all physicians, hospitals, and ancillary providers who participate in our managed care plans. Managed care products include Keystone HMO/POS, Keystone HMO CHIP, Personal Choice® PPO, National BlueCard® PPO, and our Medicare Advantage plans.



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How to plan for your doctor visit

You can make your next trip to your child's doctor go as quickly and smoothly as possible with these helpful tips:

- **Check to make sure you have your child's current plan ID card with you** before leaving for the appointment.
- **Ask whether you can pay the copayment when you arrive for your child's appointment.** Your child's office visit copayment amount is located on the front of your child's ID card. Using some of the waiting room time for the business part of your child's visit lets you move on to the rest of your day as soon as your child is finished seeing the doctor.
- **Keep your child's medical records current.** If your address, phone number, or ID number has changed since your child's last visit, be sure to tell the doctor's office staff.
- **Take along a list of all the prescription medications, over-the-counter medications, and herbal remedies that your child is taking** to identify any possible drug interactions.

Also bring the names of any other doctors currently treating your child and details about any recent hospitalizations. This will help the doctor know how to treat your child and coordinate their care.

If your child has an appointment with a specialist, their primary care physician should have submitted a referral through the electronic submission process.



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Standards for doctor appointments, wait times, and access

When you need medical care, seeing a doctor should be fast and easy. Keystone Health Plan East, Inc. has put these standards in place to get you the service you need, when you need it.

Appointment availability

In conjunction with the doctors in our network, we have set standards for the scheduling of patients' appointments:

- In a medically urgent situation, you should receive an appointment within 24 hours.*
- For a routine visit, you should be able to schedule an appointment with your doctor within 10 business days.
- For a routine physical, you should be able to schedule an appointment with your doctor within three weeks.

In an emergency, you should get medical help as soon as possible.†

Wait times

No one likes to be kept waiting. We have asked our network doctors to set a goal of seeing you within 30 minutes of your scheduled appointment time. Of course, unforeseen events may prevent your doctor from achieving that goal all the time. You may experience an occasional delay. However, the objective is to ensure that you consistently have access to medical care within an acceptable waiting period.

Access after normal business hours

Urgent or emergency medical advice should be available 24 hours a day, 7 days a week. If an urgent issue arises after normal business hours, call your doctor's office for instructions on how to reach your doctor or a covering physician. A physician should call you within 30 minutes.

Your access to behavioral health care‡

To access behavioral health services (including mental health and substance use services), members may call the telephone number on their ID card. We have established the following standards for scheduling behavioral health services:

- In the case of a life-threatening emergency, you should be seen within one hour of the crisis call or be directed to your nearest emergency department.
- In a situation that is not life-threatening, you should be seen within six hours of the crisis call.
- For an urgent situation, you should be offered an appointment within 48 hours.
- For a routine visit, you should be offered an appointment within 10 business days.

Standards for doctor appointments, wait times, hours, and access (continued)

For Keystone HMO CHIP members

- **Primary care.** Keystone HMO CHIP members choose a primary care physician (PCP) on enrollment. To find out whether your PCP is a participating provider, or to find a participating provider, go to ibx.com. To change PCPs, call the Keystone HMO CHIP Member Help Team number on the back of your ID card.
- **Specialty care.** To have specialist visits covered, Keystone HMO CHIP members must request a referral from their PCP. This helps your PCP coordinate your treatment and any medication and helps avoid unnecessary or duplicate tests. Your PCP will submit an electronic referral to the specialist indicating the services authorized. Your referral is valid for 90 days from the issue date as long as you are a Keystone HMO CHIP member.

Make sure the specialist or facility has received the referral before the services are performed. Only services authorized on the referral are eligible for coverage. If the referred specialist recommends additional medically necessary care after the initial 90-day window has expired, another electronic referral from your PCP will be required.

- **Obstetrical/gynecological care.** Members may seek care from a Keystone HMO CHIP participating obstetrician or gynecologist without a referral for all gynecological care.

Note: Please refer to your benefits description materials for the terms, limitations, and exclusions of your health care coverage.

*Urgent care is medical attention you need right away for an unanticipated illness or injury.

†An emergency is defined as a medical condition manifesting itself in acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one's health in serious jeopardy. If you are experiencing symptoms that might reasonably indicate such a condition (such as severe chest pain or a broken arm), you may need emergency care and should go immediately to the emergency department of the closest hospital. Health concerns of a pregnant woman may also extend to her unborn child.

If you believe your situation is an emergency, you should call 911.

Please note that "emergency services" are covered benefits in accordance with your contract. Your benefits description materials contain a complete and more detailed definition of "emergency" with which you should become familiar. It is this definition that determines whether your condition, injury, or illness will be covered as an emergency service.

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Working with your primary care physician and health care providers to maintain your health

Members are encouraged to routinely visit their primary care physician (PCP) and/or other health care providers. Routine visits allow for monitoring of your health including, but not limited to:

- Immunizations
- Preventive health screenings
- Routine blood/lab work
- Blood pressure and heart rate
- Weight and height
- Review of medications
- Nutrition
- Chronic health conditions such as diabetes, asthma, and other chronic conditions
- Assessment for depression, anxiety, or other behavioral health conditions

When you arrive for your appointment, please show your current member ID card, which you should carry with you at all times. If, for some reason, you cannot keep your appointment, be sure to call the office to cancel it so that your scheduled time can be used by someone else.

Also, please remember that your PCP/health care provider is prepared to see only the member for whom an appointment is made. Please do not ask your doctor to see other family members as part of your appointment.

For HMO members

Keystone HMO CHIP members are required to choose a PCP. To schedule an appointment with your child's primary care physician, call the PCP's office and identify yourself as the parent/guardian of a Keystone HMO CHIP member who has selected the office as your child's PCP. Whenever possible, contact the office in advance of the day you want the appointment. If your child is injured or has an urgent medical problem that cannot wait, be sure to contact your child's PCP. You will be advised about what to do.



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Hospital care procedures

If you need outpatient services, surgery, or hospitalization, your child's primary care physician (PCP) will provide any referrals that your child's plan — Keystone Health Plan East (KHPE) — might require.

If your child's PCP refers you to a specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the prior authorization (approval in advance) with KHPE. Prior authorization is not needed if you require emergency admission.

If you are receiving care from a participating PCP or specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the precertification with your child's insurance. Precertification is not needed if you require emergency admission.

Once you are discharged from the hospital, we highly recommend that you follow up with your child's PCP to review your child's medications, especially if there has been a change during a hospital admission.

If you have questions, call the Keystone HMO Member Help Team at **the number on the back of your member ID card.**



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Differences between emergency care and urgent care

There is a difference between emergency care and urgent care. Understanding this important difference helps you know when to take your child to a hospital emergency room and when to seek care from your child's pediatrician or other health care provider, such as an urgent care center or retail clinic.

If your child needs to go to a hospital emergency room, remember that emergency rooms must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If your child is not in that category, they may wait a long time before receiving care.

What is an emergency?

A medical emergency is typically thought of as a medical or psychiatric condition in which symptoms are so severe that the absence of immediate medical attention could place one's health in serious jeopardy. A medical emergency could include severe chest pain. If your child is experiencing symptoms that may indicate an emergency condition, you should go immediately to the emergency room of the closest hospital.

If you believe your child's situation is life-threatening, you should call 911 or child's immediately to the emergency room of the nearest hospital. With an emergency condition, your child can directly access medical care that does not require prior approval. If your child received emergency care, be sure to notify your child's pediatrician, even if follow-up treatment is not needed.

What is urgent care?

Urgent care is necessary treatment for a non-life-threatening, unexpected illness or accidental injury that requires prompt medical attention when your child's pediatrician is unavailable. Examples include sore throat, fever, sinus infection, ear ache, cuts, rashes, sprains, and broken bones.

You may take your child to an urgent care center, which offers a convenient, safe, and affordable treatment alternative to emergency room care, when you can't get an appointment with your child's pediatrician. Many urgent conditions require follow-up care that is best provided or coordinated by your child's child's pediatrician.

For more information

For specific information

about what constitutes emergency services for the purposes of coverage, please refer to your child's benefits description materials. If you believe you have an emergent or life-threatening condition or illness you should always go to the ER for immediate evaluation and treatment.

Differences between emergency care and urgent care (continued)

What if my PCP is not available?

When you are unable to get an appointment with your child's pediatrician, and you have an urgent care benefit, urgent care centers and retail health clinics are an easy, safe, and less costly option to the emergency room. Urgent care centers have board-certified doctors who can give your child care for an illness or injury that needs medical attention right away but is not life-threatening.

Retail health clinics have certified nurse practitioners who can treat simple illnesses and injuries. If your child is seen at an urgent care facility or retail health clinic, notify your child's pediatrician. You may also need to schedule a follow-up appointment with your child's pediatrician, not the urgent care center or retail health clinic where your child was treated.

When in doubt, call your child's pediatrician

If you are unsure whether your child's condition is an emergency or an urgent condition, call your child's physician. He or she knows you and your child's medical history and can best assess your child's condition. Based on your child's symptoms, the pediatrician may send your child to a hospital emergency room. Your child's pediatrician may also arrange to see your child for an evaluation and treatment in the office or suggest another option.



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Evaluating new and emerging technologies

Every day, new technology is developed to fight disease. Many of these new products and procedures turn out to be highly effective, while some need further investigation. Many, however, fall short of their original intentions, and a few turn out to be unsafe or even harmful.

In an effort to provide coverage for safe and effective treatments, we evaluate new and emerging technologies for medical and behavioral health conditions. In accordance with accepted principles of technology assessment, we routinely evaluate the available evidence based on the following criteria:

- The technology must have final approval from the appropriate government regulatory bodies. This applies when organizations like the U.S. Food and Drug Administration (FDA) regulate the lawful use of a product. It is important to remember that the evidence required for FDA approval varies depending on the type of product being reviewed.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations. These studies should be published in peer-reviewed journals. The quality and the consistency of the results are considered crucial in evaluating the evidence. There should be evidence that the technology positively affects health outcomes. "Health outcomes" refers to the measurable physiologic responses of a medical nature.
- The technology must improve the net health outcome. That means that the advantages outweigh the disadvantages.
- The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as, or more than, established alternatives. Direct comparison of the technology with established standard treatments for the medical condition provides the best evidence.
- The improvement must be attainable outside investigative settings. Participating professional providers with direct experience in the practice of the service help us evaluate the evidence. Their assessment helps us decide whether the service is an acceptable medical practice that should be available to members in our plans and networks.



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Quality Management Program

Our Quality Management program is focused on keeping our members healthy and happy with their health care. Our program is wide-ranging and supports other areas of our organization in supplying quality service to our members. We have set goals to focus on the health and experience of our members.

- Assess and improve the safety of health care and services our members receive.
- Assess the ability of our members to access timely and appropriate care.
- Ensure the most current and effective health care and services for our members based on their medical and behavioral health care needs.
- Promote efficient care and reduce health care waste.
- Promote health equity by identifying and addressing the needs of our members.
- Assess and improve the satisfaction of our members and support patient-centered system improvements.

Our activities seek to improve member safety, meet member health needs, and ensure a quality network of providers. Our program works with delegates, provider credentialing, and clinical services compliance. We also maintain organization-wide policies which make sure we meet all regulations and standards of practice.

If you want to learn more about our program, a yearly description or report on progress is available. To request this information or ask a question, call the Keystone HMO CHIP Member Help Team number listed on the back of your member ID card.

We want to know if you have a concern or complaint about the quality of care or service that you received from a provider. To file a concern or complaint, call the Keystone HMO CHIP Member Help Team number listed on the back of your member ID card.



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Transitioning from pediatric to adult care

In most cases, pediatric care is generally provided by pediatricians or family practice practitioners. Pediatricians usually follow patients until the age of 21. However, not all children want to be seen in the pediatrician's office once they reach adolescence and they may not know when or how they can switch to an adult care provider. Parents or guardians can help by answering questions and providing information.

If your adolescent or teenager is being seen in a pediatric office, you can discuss if he/she wants to switch to an adult primary care physician, and at what age they prefer to switch providers. You might ask if there are any special concerns such as being seen by a female or male physician. If your child wants to change, it's important to review all available options. Your child's primary care doctor may be able to see your child, or your child may already have an idea of who they want to see. When you're looking to change from pediatric to adult care, our *Find a Doctor* tool provides information on network providers that can be helpful, making it easy to search our broad network for a new primary care doctor.

You can use the Find a Doctor tool to:

- **Search for a participating doctor.** You can:
 - Search by name, location, or specialty;
 - Access valuable information, such as the provider's gender, hospital admitting privileges, and languages spoken at the practice;
 - Review and compare the qualifications and experience of network physicians. For members of childbearing age, the *Find a Doctor* tool can help with finding a gynecologist and/or obstetrician.
- **Read reviews.** Learn from the experience of others by reviewing online provider ratings.

Go to ibx.com to use these valuable resources. If you do not have Internet access, call the Keystone HMO CHIP Member Help Team at **the number on the back of your child's member ID card** to obtain a copy of the Provider Directory for your child's coverage.



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Vision Benefits

Did you know that your child has vision benefits as part of your child's Keystone HMO CHIP coverage?

It's important that you remember:

Emergency, preventive, and routine vision care includes:

- The cost of exams, corrective lenses, frames, and medically necessary contacts; and
- Replacement of broken, lost, or scratched corrective lenses, frames, and medically necessary contacts.

Note: Such replacement must be determined medically necessary.

Your child cannot exceed two prescriptions per year, that is, the original and the replacement.

If you have questions regarding your child's routine vision benefits or to locate a participating provider, please call **Davis Vision** at **1-888-393-2583**.

Vision benefits are underwritten by Keystone Health Plan East and administered by Davis Vision, an independent company.



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Registered Nurse Health Coaches Offer Support for Managing Your Child's Health

Living with a chronic condition or coordinating care after a hospital stay can be overwhelming, but you and your child don't have to do it alone. Keystone Health Plan East, Inc. provides members with access to Health Coaches — registered nurses who are available to help you manage your child's care and make informed health decisions — at no additional cost to you. Health Coaches are available 24 hours a day, 7 days a week, 365 days per year by calling **1-833-444-6428 (TTY/TDD: 711)**.

Our Health Coaches support members with chronic conditions and/or pregnancy through our condition management program, and also members who require more intensive case management and coordination of care through our case management program. Health Coaches have access to health information that may help identify members as being eligible for one of our programs. These members may receive a telephone call from a Health Coach offering support for their condition.

In addition, Health Coaches can address general health questions and concerns you may have. Once you speak with a Health Coach, he or she is dedicated to you and your child. Whatever your child's health concern, your child's personal Health Coach works with you to set goals and develop a plan to manage your child's health care through telephone calls and/or educational materials and health reminders mailed to your home.

Together, you and your child's Health Coach will:

- Assess your child's current health status and history
- Confirm your child's needs
- Develop a care plan designed to meet your child's needs that could include home care, education, and coaching
- Review the plan and goals, and communicate with your child's doctor as necessary

Speaking with a Health Coach is voluntary. You can talk to a Health Coach just once or establish a relationship and set up follow-up calls — whatever works best for you. If at any time you wish to stop your relationship with your Health Coach, simply call **1-833-444-6428 (TTY/TDD: 711)** and ask that you not be contacted by a Health Coach in the future.

To contact a Health Coach, call **1-833-444-6428 (TTY/TDD: 711)**.

Translation services are available through the CryaCom. There is no additional cost to you for using the Health Information Line.



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Reaching multilingual Customer Service

If you or a member you know has difficulty communicating because of an inability to speak or understand English, and needs language assistance, call **the number on the back of your member ID card**. Follow the prompts or wait to speak with a Keystone HMO CHIP Member Help Team representative.

Keystone Health Plan East has multilingual staff, telephone language-line services, and TTY/TDD for the deaf or hearing impaired. Our Keystone HMO CHIP Member Help Team representatives can answer questions or provide information about your child's claims or benefits coverage. They can also assist you in finding a participating provider who speaks your language.



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Submitting a claim

When you use a network provider, there's no need for you to submit a claim for most services. Your child's provider does that for you. However, you may be required to submit a reimbursement form for some services such as getting reimbursed for hearing aids.

Here's what to do:

- You may have to pay the full charges and then submit a claim for reimbursement.
- Contact the Keystone HMO CHIP Member Help Team at **the number on the back of your ID card** to get reimbursement instructions.
- Log into your account on the IBX member website at ibx.com.login to search for, organize, and view a full list of your claims, including claims status.
- Remember to always keep a copy of the completed reimbursement form and itemized bills for your records.



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Making an appeal or complaint

Informal Member Complaint Process

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

If you have a concern you should:

- call our Keystone HMO CHIP Member Help Team at **1-800-464-5437**; or
- write or fax to:

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

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

Appeals

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

To file an appeal:

- call Member Appeals at **800-464-5437**; or
- write or fax to:

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

Grievances (Medical Necessity)

Internal Grievance for a Standard or Expedited Appeal (KHPE makes the decision) –

There is one level of internal grievance appeal for both standard and expedited requests. The enrollee or their designee may submit a standard appeal request within 60 calendar days of the receipt of the original determination. KHPE makes a determination and notifies the enrollee or the designee within 30 calendar days of receipt of a standard grievance request. For expedited requests, if the grievance request is submitted by a physician, KHPE makes a decision and notifies the service provider and or prescribing physician, the enrollee or designee, if applicable, within 48 hours of receipt of the request.

Making an appeal or complaint (continued)

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

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

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

Complaints (Administrative)

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

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

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

Making an appeal or complaint (continued)

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

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

Appeal Classification

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

Copies of Relevant Information

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

Learn more about your benefits

As a member of our Keystone HMO CHIP health plan, you may have questions about your coverage and benefits. Our article database can provide answers. You can find the database at ibx.com/CHIP.

Note: The procedures summarized here vary based on plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information, call the Keystone HMO CHIP Member Help Team at the number on the back of your ID card.



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Using coverage when traveling

We're here for you whenever, wherever you need us. When it comes to your good health, we understand there are no geographic boundaries. The BlueCard® program is available for emergency and urgent care services, and access is just a phone call away.

BlueCard

The BlueCard program enables members who travel to access participating providers affiliated with Blue Cross® and/or Blue Shield® plans for emergency and urgent care services. HMO members are eligible to use the program and are reminded of the following:

- Always carry your current ID card.
- In an emergency, go to the nearest hospital.
- To find names and addresses of nearby doctors and hospitals, call 1-800-810-BLUE (2583) or use the *Find a Doctor* tool on ibx.com.
- Call Keystone Health Plan East, Inc. for prior authorization, if required. Refer to the telephone number on your ID card.



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Prescription drug guidelines

Our prescription drug plans are administered by FutureScripts®, an independent pharmacy benefits management company that is responsible for providing a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service.

When using your prescription drug plan, it's important to know how to find out what's covered by your plan and whether there are any guidelines that apply to those drugs. Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. This document will explain the prior authorization process, age and quantity limits, and a number of other ways we support the safe prescribing practice of covered medications.

Formulary

The formulary is a list of drugs covered by your prescription drug plan. If you're not yet a member, you can visit ibx.com/rx to view the Select Drug Program® formulary guides or searchable tools. You can also call **1-888-678-7012** to find out if a drug is included in your plan's formulary. As a member, you can log in at ibx.com to find drugs on the formulary and view and manage your prescription drug plan. The pharmacy tools and services available will help you to better understand your prescription drug coverage so you can take full advantage of the cost-saving options available to you.

Log in at ibx.com:

- Review your prescription records — what you spent, and when and where your prescriptions were filled
- Locate a network retail pharmacy near you
- Review your coverage and cost-sharing information
- Price a specific drug and compare savings with a generic equivalent
- Access formulary information
- Check on drug-to-drug interactions

To see the formulary status of a drug, or to find out if the drug requires prior authorization, please refer to the Select Drug Program® formulary guide or searchable tool which can be found at ibx.com/rx. You can also call FutureScripts at the number **on the back of your ID card** if you want to find out whether a drug is included in your formulary.

Prior authorization

Prior authorization is a requirement that your doctors obtain approval from your health plan for coverage of, or payment for, your medication. Independence requires prior authorization of certain covered drugs to confirm that the drug prescribed is medically necessary and appropriate and is being prescribed according to U.S. Food and Drug Administration (FDA) guidelines. Some examples of drugs that require a prior authorization are drugs to treat conditions like hemophilia, cancer, and hepatitis C. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee, a group of doctors and pharmacists from the area.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by your prescribing doctor, and your available prescription drug therapy history. Their evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary.

What you need to know

- How to find out what prescription drugs are covered by your plan
 - You may need additional approval from your health plan before you receive prescription drugs
 - Age limits apply to some prescription drugs
 - Safety edits apply to some prescription drugs
 - Your doctor may request coverage for medications that are not on your prescription drug formulary
 - You have a right to appeal a coverage decision you disagree with
 - How we work with FutureScripts
-

Prescription drug guidelines (continued)

Without prior authorization, your prescription will not be covered at the retail or mail-order pharmacy. The prior authorization process may take up to two business days once complete information from the prescribing doctor has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the doctor wants you to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Age limits

Some drugs, such as zafirlukast, are approved by the FDA only for individuals age 5 and older. If the member's prescription falls outside of the FDA guidelines, it may not be covered until prior authorization is obtained. In addition, an age limit may be applied when certain drugs are more likely to be used in certain age groups. For example, drugs to treat Alzheimer's disease may require prior authorization for use in young adults. The provider may request coverage for drugs outside of the age limit when medically necessary. The approval criteria for this review were developed and approved by the Pharmacy and Therapeutics Committee. The member should contact the provider to initiate the prior authorization process. To determine if a covered prescription drug prescribed for you has an age limit, visit ibx.com/rx or call FutureScripts at the number on the back of your ID card.

Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses, standard dosing, and/or length of therapy. We have several different types of quantity limits that are explained in detail below. The purpose of these limits is to ensure safe and appropriate utilization. If you require more than the limit, your doctor will need to submit a prior authorization request. Note: If applicable, quantity limits will apply if a formulary exception is approved allowing coverage of a non-formulary drug.

Quantity over time. This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and you went to the pharmacy on January 1 for one of these medications, the plan would have looked back 30 days to December 2 to see how much medication was dispensed. The purpose of these limits is to prevent the dispensing of excessive quantities. Examples of quantity limits over time are:

- Ibandronate 150 mg (generic for Boniva[®]) = 1 tablet per 30 days
- Naratriptan (generic for Amerge[®]) = nine 2.5 mg tablets per 30 days
- Sumatriptan (generic for Imitrex[®]) = eighteen 50 mg tablets per 30 days
- Diabetic supplies such as blood glucose test strips = 200 strips per 30 days and lancets = 200 lancets per 30 days

Prescription drug guidelines (continued)

Maximum daily dose. This quantity limit defines the maximum number of units of the drug allowed per day. This limit is based on the maximum daily dose approved by the FDA, the formulation, and/or availability of multiple strengths of the drug where a dose can be achieved with another available strength. Examples of maximum daily dose quantity limits are:

- Zolpidem (Ambien®) = 1 tablet per day
- Oral opioid drugs, such as oxycodone/acetaminophen (generic for Percocet®) 5/325 mg = 12 tablets per day
- Guanfacine ER 24 hour = 1 tablet per day

Refill too soon. This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this limit, you are able to receive a refill of a prescription after 75% utilization. Additional refills will pay once 75% of the supply has been consumed. The following examples illustrate how the refill-too-soon limit works:

- A 30-day supply of a prescription filled on January 1 will be refillable again on or after January 24
- A 90-day supply of a prescription filled on July 1 will be refillable again on or after September 7

Day supply limit. This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day supply limits apply to some classes of drugs, such as opioids. If a quantity limit applies, you will be limited to the maximum daily dose for that drug. The following are examples of drugs that have a day supply and a quantity limit:

- Butalbital-containing headache agents such as butalbital/aspirin, or opioids, such as oxycodone tablets
 - Day supply limit = 5-day supply per 30 days, for adults age 18 or older
 - Quantity limit = 6 per 1 day
 - Maximum quantity allowed without prior authorization = 30 (6 per day x 5 days)
- Opioid-containing cough and cold products, such as hydrocodone/homatropine
 - Day supply limit = 5-day supply per 30 days, for adults age 18 or older
 - Quantity limit = 30 ml per 1 day
 - Maximum quantity allowed without prior authorization = 150 ml (30 ml per day x 5 days)

Morphine Milligram Equivalent limits. Independence applies additional safety measures to opioid products by limiting the total daily dose. This limit accounts for various opioid products through a measurement called the Morphine Milligram Equivalent (MME) dose. The MME is a number that is used to determine and compare the potency of opioid medications. It helps to identify when additional caution is needed. The daily limit is calculated based on the number of opioid drugs, their potencies, and the total daily usage. Prior authorization is required for an opioid dose that exceeds 90 MME per day. The MME limit applies to opioid products containing the following active ingredients: benzhydrocodone, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, tapentadol, or tramadol.

Prescription drug guidelines (continued)

Cumulative stimulant limit

Central Nervous System (CNS) stimulants such as amphetamine and methylphenidate, when used in high doses, are associated with increased risk for cardiac-related adverse events such as hypertension and new or worsening psychosis, including manic behavior. The cumulative stimulant limit is a safety measure designed to ensure that the provider has assessed the member for alternative medication and advised the member about the risks associated with stimulant use. The cumulative stimulant limit works by calculating the total daily stimulant dose by the drug's active ingredient. Stimulant prescriptions that exceed the limit outlined below would require prior authorization.

Active ingredient	Medications impacted (brands and generics)	High cumulative daily dose
Amphetamine	Adzenys ER[ODT], Dyanavel, Evekeo [ODT]	60mg/day
Amphetamine-Dextroamphetamine	Adderall [IR/XR], Mydayis	60mg/day
Dextroamphetamine	Dexedrine, Zenzedi, ProCentra	60mg/day
Lisdexamfetamine	Vyvanse	70mg/day
Methamphetamine	Desoxyn	60 mg/day
Dexmethylphenidate	Focalin [IR/XR]	40mg/day
Methylphenidate	Ritalin [IR/LA], Daytrana, Cotempla, Metadate [ER/CD], Methylin, Quillivant XR, Concerta, Aptensio XR, QuilliChew ER, Jornay PM, Adhansia XR	72mg/day

Note: Prior authorization and other safety edits including quantity limit and age limit continue to apply.

Concurrent Drug Utilization Review (cDUR). cDURs are built into the pharmacy claim adjudication system to review a member's prescription history for possible drug-related problems, including drug-drug interactions and drug therapy duplications. Drugs may be rejected at the point of sale and/or generate a message to the dispensing pharmacist when there is a safety concern. The dispensing pharmacist can review the issue with the provider and override the rejection if appropriate for most cases. Examples of cDURs are:

- Drug-drug interaction: Sildenafil (Viagra® /Revatio®) and nitroglycerin in combination may lead to potentially fatal hypotension.
- Drug therapy duplication: Simvastatin and atorvastatin in combination will trigger a message in the claim adjudication system to alert the dispensing pharmacist that there is a duplication of statin therapy.

To determine if a covered prescription drug prescribed for you has a prior authorization requirement, age limit, quantity limit, MME limit, or cumulative stimulant limit, visit ibx.com/rx or call FutureScripts at the phone number on the back of your member ID card.

Prescription drug guidelines (continued)

96-hour Temporary Supply Program

The 96-hour Temporary Supply Program is available for certain drugs that require prior authorization.

If your doctor writes a prescription for a drug that requires prior authorization, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to you with either no out-of-pocket copay or the appropriate percentage cost-sharing as defined by your benefit.
2. By the next business day, FutureScripts will contact your doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by FutureScripts, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost-sharing will be applied.
5. If denied, notification will be sent to you and your doctor.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. This program limits a one-time release of a 96-hour supply per drug. Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations such as Retin-A® (tube).

Requesting a prior authorization/preapproval:

- The provider prescribing the drug can access electronic prior authorization (ePA) platforms such as CoverMyMeds® and SureScripts™ to submit a prior authorization request. Alternatively, the provider can complete a prior authorization fax form or write a letter of medical necessity and submit it to FutureScripts by fax at **1-888-671-5285**. The forms are available online at futurescripts.com/prior-authorization¹. The form must be completed and submitted by your doctor.
- FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing doctor will be notified of approval via fax or telephone, and the claims system will be coded with the approval. Note: ePA approval can occur in real time, which means you can be approved for the drug prior to leaving the provider's office with a prescription.
- You can call the **Keystone HMO CHIP Member Help Team number on the back of your ID card** to determine if the prescription is approved.
- If denied, the prescribing doctor will be notified via letter, fax, or telephone.
- You are also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to you and your doctor.

Prescription drug guidelines (continued)

Appealing a decision

If a request for prior authorization/preapproval or exception results in a denial, you, or your doctor on your behalf (with your consent), may file an appeal. Both you and your doctor will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that you keep your doctor involved to provide any additional information on the basis of the appeal.

Prescription Drug Program provider payment information

FutureScripts administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. FutureScripts also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. KHPE may incorporate certain savings resulting from rebates into reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member cost-share.

FutureScripts® Secure is an independent company that provides pharmacy benefit management services.



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