Benefits Handbook
CHIP of Pennsylvania

Free or Low Cost Health Coverage through Keystone Health Plan East HMO

Look inside for...

• Services Covered
• Services Not Covered
• Using Your Child’s Insurance
• How to File a Complaint or Grievance
• Seeing a Specialist
The Independence Blue Cross & Highmark Blue Shield Caring Foundation For Children, in agreement with Keystone Health Plan East, independent licensees of the Blue Cross and Blue Shield Association, is an administrator of the Children's Health Insurance Program (CHIP). For additional information regarding CHIP, call 1-800-986-KIDS.
Benefits

Services Your Child Can Get

- Doctor Office Visits (well and sick)
- Immunizations
- Pediatric Preventive Care
- Dental Care (cosmetic and orthodontia not included)
- Hearing Care and Hearing Aids
- Vision Care and Eyeglasses
- Prescription Drugs
- Surgery
- Emergency Care
- X-ray and Laboratory Services
- Routine Allergy Injections
- Home Health Care
- Maternity Care
- Mental Health Services
- Substance Abuse Treatment
- Up to 90 Days of Inpatient Hospitalization
- Durable Medical Equipment

This is a brief summary of the CHIP services your child can get. Read this handbook carefully for more details about covered benefits. If you have questions about the plan, please call member services at

1-800-464-5437
(TDD 215-241-2622)
# Table of Contents

**Required Disclosure of Information** ........................................... 9

**Introduction**

Welcome ................................................................. 10
Who Are We and What Do We Do? ....................................... 10
What Insurance is Available? ........................................... 10

**Section 1**

**Your Child's Eligibility, Coverage and Payments** .............. 11

Eligibility ............................................................. 11
Who is Eligible? ....................................................... 11
Proof of Eligibility ................................................... 11
Coverage ................................................................. 11
Who is Covered? ....................................................... 11
How Long is My Child Covered? ..................................... 11
Renewal of Coverage ................................................ 12

My Child’s ID Cards .................................................. 12
Does My Child Need an ID Card? .................................. 12
Look on the Back of the Keystone Medical ID Card .......... 12
If I Lose My Child’s Medical ID Card ............................ 13
If I Lose My Child’s Dental ID Card ............................. 13

Payment ................................................................. 13
Who Pays a Premium? ............................................... 13
What Happens if a Premium is Paid Late? ....................... 13

Termination of Coverage ............................................ 13
Conditions Under Which Your Child Can Be Terminated .... 13
Inpatient Provision .................................................. 14

Eligibility Review Process ......................................... 14
The Review ............................................................ 14
Continuation of Coverage for Enrollees/Free CHIP .......... 15
Continuation of Coverage for Enrollees/Low Cost CHIP .... 15

**Section 2**

**Your Child's Primary and Preventive Health Services** ....... 17

Keeping Your Child Healthy .......................................... 17
Routine Check-Ups ................................................... 17
Section 3
How to Use Your Child’s Insurance - A Summary of Things to Remember About the Keystone Plan

How to Get Basic Health Care .................................................. 21
How to See a Specialist ......................................................... 21
How to Deal With a Need for Emergency Medical Care ................. 21
How to Get Continuing Care After Emergency Medical Care ......... 21
What Medical Services Need Preapproval ............................... 22
To be Covered, Services Must be Received From Keystone Participating Providers ..................... 22
How to Change Your Child’s Primary Care Physician .................... 22
How to Change Your Child’s Referred Specialist ......................... 22
Interpreter Services ................................................................. 23
Other Important Information About Keystone ............................. 23
  How Keystone Reimburses Providers .................................. 23
  Professional Providers ......................................................... 23
  Institutional Providers ......................................................... 24
  Physician Group Practices and Physician Associations ................. 25
  Ancillary Service Providers ................................................... 25
Utilization Review Process ..................................................... 25
Medical Technology Assessment is Performed by Keystone .......... 28

Section 4
How to See a Specialist or Plan for Hospital Care ....................... 29
Your Child Has Direct Access to Certain Care .......................... 29
How to Get a Specialist Referral .............................................. 29
How to Obtain a Standing Referral .......................................... 30
  If the Standing Referral is Approved ..................................... 30
  If the Standing Referral is Denied ........................................ 30
Section 5

Emergency Care, Urgent Care and Follow-Up Care

What are Emergency Services

Continuing Care After Your Child Receives Emergency Services

Medical Screening Evaluation Determines Whether or Not an Emergency Exists

What is Urgent Care?

What is Follow-Up Care?

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

Urgent Care Benefits When Traveling Outside Keystone’s Service Area

Follow-Up Care Benefits When Traveling Outside Keystone’s Service Area

When You Don’t Use the BlueCard Program

Auto- or Work-Related Accidents

Section 6

Your Child’s Membership Rights/Filing a Complaint or Grievance for Your Child

Your Child’s Membership Rights

You Can File a Complaint or Grievance for Your Child

General Information About the Member Appeal Process

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

How to Pursue a Member Complaint or Grievance Appeal

Member Complaint Appeal Process

Informal Member Complaint Appeal Process

Formal Member Complaint Appeal Process

Internal Complaint Appeals

Internal First Level Standard Complaint Appeals

Internal Second Level Standard Complaint Appeals

Internal Expedited Complaint Appeals

External Complaint Appeals

External Standard and Expedited Complaint Appeals
Section 7

Your Responsibilities as the Parent or Guardian of a Keystone CHIP Member

Section 8

Summary of Benefits

Member Grievance Appeal Process

Formal Member Grievance Appeal Process for Decisions Based on Medical Necessity

Internal Grievance Appeals

Internal First Level Standard Grievance Appeals

Internal Second Level Standard Grievance Appeals

Internal Expedited Grievance Appeals

External Grievance Appeals

External Standard Grievance Appeals

External Expedited Grievance Appeals

You Can Accept or Refuse Treatment for Your Child

Confidentiality and Disclosure of Medical Information

Member Liability

Membership Responsibilities

Subrogation

Allergy Testing and Treatment

Ambulance Services

Anesthesia

Autologous Blood Drawing/Storage/Transfusion

Cardiac Rehabilitation Therapy

Chemotherapy

Dental Benefits

Diabetic Self-Management and Education

Diabetic Supplies

Diagnostic Services

Dialysis

Durable Medical Equipment

Emergency Care

Genetic Testing and Counseling

Gynecological Care

Hearing Care

Home Health Care
<table>
<thead>
<tr>
<th>Service</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visits</td>
<td>57, 64</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>57, 64, 69</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>57, 70</td>
</tr>
<tr>
<td>Illness (treatment for)</td>
<td>57, 60</td>
</tr>
<tr>
<td>Immunizations</td>
<td>20, 57, 64</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>57, 64</td>
</tr>
<tr>
<td>Injections</td>
<td>57, 64</td>
</tr>
<tr>
<td>Injuries (treatment for)</td>
<td>57, 60</td>
</tr>
<tr>
<td>Insulin and Oral Agents</td>
<td>57, 64</td>
</tr>
<tr>
<td>Lab Work (see Diagnostic Services)</td>
<td>57, 62</td>
</tr>
<tr>
<td>Mammogram Screening</td>
<td>57, 64</td>
</tr>
<tr>
<td>Mastectomy Care</td>
<td>57, 70</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>57, 65</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>57, 65, 70</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>57, 80</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>57, 65, 71</td>
</tr>
<tr>
<td>Obstetrical Care</td>
<td>57, 65, 71</td>
</tr>
<tr>
<td>Office Visits</td>
<td>57, 65</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>57, 65, 71</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>58, 71</td>
</tr>
<tr>
<td>Orthotics</td>
<td>58, 66</td>
</tr>
<tr>
<td>Pap Smears</td>
<td>58, 60, 63</td>
</tr>
<tr>
<td>Physical Examinations</td>
<td>58, 60</td>
</tr>
<tr>
<td>Podiatric Care</td>
<td>58, 66</td>
</tr>
<tr>
<td>Prenatal and Obstetrical Care</td>
<td>58, 65, 71</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>58, 74</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>58, 66</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>58, 66, 72</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Services</td>
<td>58, 67, 72</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>58, 67, 72</td>
</tr>
<tr>
<td>Referral to a Specialist</td>
<td>21, 58</td>
</tr>
<tr>
<td>Rehabilitation Therapy Services (occupational, physical, hand, speech, lymphedema and orthoptic/pleoptic)</td>
<td>58, 67, 72</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>58, 68, 73</td>
</tr>
<tr>
<td>Routine Costs Associated With Qualifying Clinical Trials</td>
<td>58, 68, 73</td>
</tr>
<tr>
<td>Routine Pediatric Care</td>
<td>58, 60</td>
</tr>
<tr>
<td>Serious Mental Illness Health Care</td>
<td>58, 80</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>58, 73</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>58, 68, 73</td>
</tr>
<tr>
<td>Spinal Manipulation Services</td>
<td>59, 68</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>59, 80</td>
</tr>
<tr>
<td>Surgery</td>
<td>59, 68, 73</td>
</tr>
<tr>
<td>Termination of Pregnancy</td>
<td>59, 68</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>35, 59</td>
</tr>
<tr>
<td>Vision Care &amp; Eyewear</td>
<td>59, 85</td>
</tr>
<tr>
<td>Well-Baby Visits</td>
<td>17, 59</td>
</tr>
<tr>
<td>X-ray</td>
<td>59, 62</td>
</tr>
</tbody>
</table>
Section 9
Primary and Preventive Health Services ........................................ 60

Section 10
Outpatient and Inpatient Services .................................................. 61
Outpatient Services ................................................................. 61
Inpatient Services ................................................................. 69

Section 11
Prescription Drug Benefits .......................................................... 74
Prescription Drug Benefits—What is Covered ................................ 74
Prescription Drug Limitations ..................................................... 74
96-Hour Temporary Supply Program ............................................. 74
Prescription Drug Exclusions—What is Not Covered ....................... 75

Section 12
Dental Benefits ........................................................................... 77
How to Access Dental Services ...................................................... 77
Dental Services—What is Covered ............................................... 77
  Diagnostic Services ............................................................... 77
  Preventive Services .............................................................. 77
  Minor Restorations ............................................................... 78
  General Services ................................................................. 78
Dental Care Benefit Limitations .................................................. 78
Dental Exclusions—What is Not Covered .................................... 79

Section 13
Mental Health, Serious Mental Illness and Substance Abuse Benefits ........................................ 80
How to Access Mental Health, Serious Mental Illness and Substance Abuse Benefits ............. 80
Your Child’s Mental Health and Serious Mental Illness Benefits—What is Covered ............. 80
  Outpatient Services—Mental Health Care (Other Than Serious Mental Illness) ........... 80
  Outpatient Services—Serious Mental Illness .................................. 81
  Emergency Care—Mental Health and Serious Mental Illness ............................... 81
  Inpatient Services—Mental Health Care (Other Than Serious Mental Illness) ........... 82
  Inpatient Services—Serious Mental Illness ........................................ 82
  Partial Hospitalization—Mental Health and Serious Mental Illness ....................... 82
Your Child’s Substance Abuse Benefits—What is Covered .......................................................... 83
Outpatient Services—Substance Abuse ................................................................. 83
Intensive Outpatient Program (IOP)—Substance Abuse ............................................. 83
Inpatient Services—Substance Abuse ................................................................. 83
Mental Health, Serious Mental Illness and Substance Abuse Exclusions—
What is Not Covered ........................................................................................................ 84
Complaints and Grievances ............................................................................................ 84

Section 14

Routine Vision Care Benefits ......................................................................................... 85
How to Access Vision Care Benefits ............................................................................. 85
Vision Care—What is Covered ...................................................................................... 85
  Eye Examinations ........................................................................................................... 85
  Frames and Lenses ........................................................................................................ 85
    Purchased From a Davis Vision Participating Provider ................................................ 85
Guarantee ......................................................................................................................... 86
    Purchased From a Davis Vision Participating Provider ................................................ 86
    Purchased From a Non-Participating Provider .......................................................... 86
Contact Lenses ............................................................................................................... 86
    Purchased From a Davis Vision Participating Provider ................................................ 86
    Purchased From a Non-Participating Provider .......................................................... 86
Vision Care Exclusions—What is Not Covered .............................................................. 87

Section 15

Medical Exclusions—What is Not Covered ................................................................. 88

Section 16

Important Definitions ..................................................................................................... 94
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.

1. A list of names, business addresses and official positions of the membership of the Board of Directors or Officers of Keystone

2. The procedures adopted to protect the confidentiality of medical records and other enrollee information

3. A description of the credentialing process for health care providers

4. A list of the participating health care providers affiliated with participating hospitals

5. Whether a specifically identified drug is included or excluded from coverage

6. 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
   • Biologicals and medications not included in the drug formulary for prescription drugs or biologicals

7. A description of the procedures followed by Keystone to make decisions about the experimental nature of individual drugs, medical devices or treatments

8. 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.)

9. A description of the procedures used in Keystone’s quality assurance program

10. Other information that the Pennsylvania Department of Health or the Pennsylvania Insurance Department may require
Welcome

On behalf of the Independence Blue Cross & Highmark Blue Shield Caring Foundation, welcome to the Children’s Health Insurance Program, CHIP.

Who Are We and What Do We Do?

CHIP

- is a state and federally funded children’s health insurance program
- provides free or low cost health insurance to children who fall within CHIP income guidelines and are not eligible for Medical Assistance (Medicaid) or covered by private insurance

Independence Blue Cross & Highmark Blue Shield Caring Foundation

- determines eligibility for CHIP
- administers health insurance benefits provided by Keystone Health Plan East for the children enrolled in CHIP
- administers dental benefits provided by United Concordia for the children enrolled in CHIP
- subsidizes a portion of the parent’s premium for Low Cost CHIP

What Insurance is Available?

Free CHIP

- CHIP, a state and federally supported free health care program for children and adolescents through 18 years of age. Eligibility is based on family size and income.

Low Cost CHIP

- Low Cost CHIP, a state and Caring Foundation supported health care program for children and adolescents through 18 years of age. Eligibility is based on family size and income.
Eligibility

Who is Eligible?

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

He or she:

- Must be a resident of Pennsylvania for at least thirty (30) days prior to the date of enrollment (except newborns);
- Must be a U.S. citizen, permanent/resident alien or refugee;
- Must not be covered by any other health insurance plan, self-insured plan or self-funded plan;
- Must not be eligible for or covered by Medicaid offered through the Pennsylvania Department of Public Welfare;
- Must meet guidelines based on family size and income; and
- Must be under the age of 19.

Proof of Eligibility

You must provide proof of eligibility to the Caring Foundation whenever you are asked to do so. If you refuse to provide proof, 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 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

The Caring Foundation will check your child’s eligibility at least once each year. This is called renewal. We must receive the information requested on the renewal form we send you, your signature and income documentation before the due date in order for your child’s CHIP coverage to continue. You have two options for completing the renewal process.

**Option 1: Complete the form**

Fill out the form you receive in the mail, sign it and send it to us along with your income documentation.

**Option 2: On-line via COMPASS**

Go on-line to [www.compass.state.pa.us](http://www.compass.state.pa.us), fill out and submit your child’s renewal information on-line. Then print the signature page, sign it and send it to us with proof of your household income.

Remember with either option you must provide us proof of your household income by the due date on the renewal form you receive in the mail. The Caring Foundation will notify you of your child’s eligibility status. This will be based on the information you give on your renewal form.

The Caring Foundation 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.

**My Child’s ID Cards**

**Does My Child Need an ID Card?**

Yes. Each enrolled child in your family will receive two ID Cards: one from Keystone Health Plan East for medical services and one from United Concordia for dental services. Here are some important things to do and remember about your child’s ID Cards:

- **Check 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 eligible medical and dental benefits.

- **Check the information on each of your child’s ID Cards.** Make sure everything is correct.

- **Check the name of the primary care physician on the Keystone ID Card.** Make sure the name of the doctor you chose for your child is shown on the Keystone ID Card.

- **Carry your child’s ID Cards with you at all times.** You must show one of these cards any time he or she receives medical or dental services.

**Look on the Back of the Keystone Medical ID Card.**

**There you will find:**

- 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 to receive mental health, serious mental illness and substance abuse benefits.
If I Lose My Child’s Medical ID Card

• Call the Caring Foundation at 1-800-464-5437 if you find an error or if you lose your child’s medical ID Card.

If I Lose My Child’s Dental ID Card

• Call United Concordia at 1-800-332-0366 if you find an error or if you lose your child’s dental ID Card.

Payment

Who Pays a Premium?

Depending on your family income, your child may be eligible for either free or low cost health insurance.

• If your child is eligible for Free CHIP, you will not be required to pay a monthly premium.

• If your child is eligible for Low Cost CHIP, you will be required to pay a monthly premium which is a portion of the actual cost to insure your child. (The balance of the cost is paid for by state funds and the Independence Blue Cross & Highmark Blue Shield Caring Foundation.)

Note: You will be required to pay for the first month’s coverage up front for Low Cost CHIP. After that time, you will be billed monthly by Keystone.

What Happens if a Premium is Paid Late?

If you fail to pay your Low Cost CHIP premium within thirty (30) days of the due date, your child’s 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 that date.

If coverage is terminated for Low Cost CHIP because you fail to pay the premium on time, you will have to go through the application process from the beginning in order to have your child’s coverage reinstated.

Termination of Coverage

Conditions Under Which Your Child Can Be Terminated

The Caring Foundation may cancel your child’s coverage under the following conditions:

1. If you commit willful misrepresentation or fraud in applying for or obtaining coverage for your child from the Caring Foundation (subject to your rights under the complaint procedure);

2. 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;
3. If your child ceases to meet eligibility requirements;

4. If you fail to respond to the renewal request or return incomplete information with the renewal (See page 12); or

5. If you fail to pay your low cost premium.

**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:

1. the expiration of such benefits according to the limitations included with this handbook;

2. determination of the primary care physician and Keystone that inpatient care is no longer medically necessary; or

3. your child’s discharge from the facility.

NOTE: The Caring Foundation will not terminate your child’s coverage because of his or her health status or need for medically necessary covered services, or because you exercised your rights under the complaint and grievance process.

**Eligibility Review Process**

An impartial eligibility review may be requested when:

- An applicant is denied coverage;

- An enrollee’s coverage is to be terminated, except if terminated for non-payment; or

- An enrollee’s coverage is to change from Free CHIP to Low Cost CHIP.

**The Review**

You may request a review for your child within thirty (30) days of the date of the notice of ineligibility or termination of coverage. The review is an informal process and is not an administrative hearing. The primary objectives of the review are to, where possible, facilitate resolution of the matter at issue and to enroll the child, when appropriate.

A review officer will review the application/renewal documents and verification and the letter of request prior to the conference call (review interview) in order to become familiar with the case circumstances. You or your representative may submit additional documents that may have an impact on the outcome. The reviewer may ask for additional documentation as needed.

The reviewer will consider the eligibility factors, the documents provided and the relevant eligibility requirements. A written decision in the form of a letter will be prepared and sent to you and your representative (if appropriate) and to the Caring Foundation. The Foundation will implement the decision of the review officer upon receipt of the letter.
Continuation of Coverage for Enrollees/Free CHIP

Coverage of an enrolled child in Free CHIP should continue uninterrupted pending the outcome of the eligibility review. In the event that a child is terminated prior to the timely receipt of a request for review, coverage will be reinstated retroactively to the date of termination.

Continuation of Coverage for Enrollees/Low Cost CHIP

Coverage of a child enrolled in Low Cost CHIP should continue uninterrupted pending the outcome of the eligibility review if you elect to continue paying the monthly premium until the review process is completed.

When a request for review is received for an enrollee in Low Cost CHIP, you will be offered the option of paying the premium in order for coverage to continue pending the outcome of the review.

• If you elect to continue paying the premium, coverage will continue.
• If you elect not to pay, coverage will not continue.

Filing a Request for an Impartial Review

You may request a review for your child within thirty (30) days of the date of the notice of ineligibility, termination or change from free to low cost coverage. A request for a review should be sent to:

Pennsylvania Insurance Department
CHIP Eligibility Review Unit
333 Market Street, 2nd Floor Landing
Harrisburg, PA 17120
Fax: 717-705-1643

A request for an impartial review must:

• Be filed in written or printed form (e.g., letter, e-mail, Fax);
• Be post-marked or received within thirty (30) calendar days of the date of the notice of ineligibility, termination or change from free to low cost coverage;
• Contain the reason for the request along with a copy of the denial, termination or transfer letter from the Caring Foundation; and
• Be signed by the parent or guardian.

If you request assistance in filing a written request, the Caring Foundation or Pennsylvania Insurance Department will help in whatever way is determined necessary. A sample letter for filing a request for review may be obtained by calling the Foundation at 1-800-464-5437.

NOTE: You may withdraw your request for an impartial review at any time.
When a Request for an Impartial Review is Received

When a request for an impartial review is received:

- Coverage should continue or be reinstated until the review process has been concluded;
- The Insurance Department will schedule a review interview. (The review will be held by telephone unless you request a face-to-face review);
- The Foundation will be informed that the interview has been scheduled; and
- You will be informed in writing of the:
  - Date, time and location of the interview
  - Right to have a representative during the interview
  - Right to have appropriate interpretative service available during the interview if needed
  - Opportunity for continuation of coverage for an enrolled child so long as premium payments are made (when appropriate).

The Caring Foundation will:

- Conduct a management review of the decision of ineligibility within two working days of the date of notification by the Insurance Department to assure that the decision made regarding ineligibility was appropriate;
- Inform the review officer of the results of the management review;
- If the management review determines that the eligibility decision was not appropriate, the Caring Foundation will:
  - Inform you and the review officer in writing that an error occurred and the child is eligible
  - Enroll the applicant child retroactively to the date that the child should have been enrolled
  - Re-enroll an enrollee who has been terminated retroactively to the date the child was terminated.

Note: Re-enrollment of a member terminated from Low Cost CHIP is completely contingent upon the receipt of the applicable premium.

The Insurance Department will:

- Designate a review officer to conduct the eligibility review;
- Issue a written decision after the review has been completed; or
- Send confirmation that a request for a review has been withdrawn, if appropriate. Withdrawal of a request may occur if the Caring Foundation, applicant or enrollee informs the Department that the request for review has been withdrawn for any reason. Example: the Caring Foundation has resolved the matter at issue prior to the date of the scheduled review interview.
Section 2
Your Child’s Primary and Preventive Health Services

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. The Caring Foundation 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.

Routine Check-Ups

Preventive care includes a schedule of routine visits to the doctor’s office for periodic check-ups and immunizations. The following is a recommended schedule to maintain your child’s health and well-being. Your doctor may actually recommend alternatives to this program based on your child’s specific needs and history of health or illness in your family.

Use the schedule, or care plan, below to plan your child’s care with his or her doctor. Be sure to talk with your child’s physician about ways to keep your child healthy and to avoid illness. Also discuss individual risk factors and scheduling frequency with your child’s health care provider.

Birth – 10 Years

Screening/Testing Schedule

<table>
<thead>
<tr>
<th>Screening/testing</th>
<th>Recommended Frequency</th>
</tr>
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<tbody>
<tr>
<td>First office visit after birth: History and physical, including height, weight and head circumference (newborn hearing screening if not done at birth)</td>
<td>Between age 2 – 4 weeks*</td>
</tr>
<tr>
<td>Well visits: Height, weight, head circumference, vision and hearing, developmental/behavioral assessment</td>
<td>At ages 2, 4, 6, 9, 12, 15, 18 months</td>
</tr>
<tr>
<td>History and physical, including height, weight, blood pressure, vision and hearing developmental/behavioral assessment</td>
<td>At ages 2, 4, 6, 9, 12, 15, 18 months</td>
</tr>
<tr>
<td>Scoliosis screening</td>
<td>Annually starting at age 10 or earlier if at risk*</td>
</tr>
<tr>
<td>Blood count</td>
<td>Between ages 1 – 9 months; and as recommended by your health care provider*</td>
</tr>
<tr>
<td>Lead screening</td>
<td>Between ages 9 – 12 months initially, then at 24 months and thereafter based on risk*</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>If at risk* or as recommended by your health care provider</td>
</tr>
<tr>
<td>Tuberculosis test</td>
<td>If at risk*</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>If at risk*</td>
</tr>
<tr>
<td>Iron deficiency screening</td>
<td>9 – 12 months, thereafter based on risk*</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>At 5 years of age*</td>
</tr>
<tr>
<td>Dental care</td>
<td>Start when first tooth appears or as recommended by dental provider</td>
</tr>
</tbody>
</table>

*Discuss individual risk and screening frequency with your health care provider.
Topics to Discuss With Your Child’s Health Care Provider

- General newborn screening at birth
- Infant sleep environment—back to sleep/position
- Elements of good nutrition
- Effects of “second-hand” smoke
- Dental health: baby bottle tooth decay, fluoride supplements, tooth brushing with fluoride toothpaste, flossing daily and regular dental visits
- Risk of violence, signs of abuse or neglect
- Feelings of sadness or depression

Health Promotion

- CPR training for parents/caregivers
- Discuss avoidance of tobacco/alcohol/illegal drug use
- Encourage physical activity
- Adopt sun safety practices/protection
- Immunizations—see page 20

Safety

- Properly install and test smoke/carbon monoxide (CO) detectors
- Safely store medications and toxic chemicals
- Keep poison control number handy
- Safely store or remove firearms and matches
- Use flame retardant sleepwear for all children
- Use car safety seats and lap/shoulder belts as height and weight appropriateness indicates; airbag safety
- Avoid bicycling near traffic, obey all safety rules
- Use appropriate protective/safety gear when engaged in recreational activities
- Keep water heater temperature under 120 degrees, use window/stair guards and ensure pool is fenced in for safety
- Age appropriate toys
### 11 – 18 Years

#### Screening/Testing Schedule

<table>
<thead>
<tr>
<th>Screening/testing</th>
<th>Recommended Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and physical, including height, weight, blood pressure, vision and hearing, and developmental/behavioral assessment</td>
<td>Annually</td>
</tr>
<tr>
<td>Scoliosis screening</td>
<td>Annually</td>
</tr>
<tr>
<td>Screen for tobacco, alcohol, drug use, and environmental/occupational risk factors (lead screening)</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Tuberculosis test</td>
<td>If at risk*</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Once between 11 – 18 years</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>If at risk*</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>If at risk* or as recommended by health care provider</td>
</tr>
<tr>
<td>Iron deficiency screening</td>
<td>If at risk*</td>
</tr>
<tr>
<td>Sexually transmitted disease screening</td>
<td>If at risk* or as recommended by health care provider</td>
</tr>
<tr>
<td>Dental care</td>
<td>Every six months</td>
</tr>
</tbody>
</table>

#### Females only

<table>
<thead>
<tr>
<th>Screening/testing</th>
<th>Recommended Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic exam</td>
<td>Initial exam at age 18 or earlier if sexually active, then annually*</td>
</tr>
<tr>
<td>Pap screening</td>
<td>Start 3 years after onset of vaginal intercourse or by age 21; then every 1 – 2 years depending on type of tests*</td>
</tr>
</tbody>
</table>

#### Males only

<table>
<thead>
<tr>
<th>Screening/testing</th>
<th>Recommended Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testicular self-examination</td>
<td>If at risk* and as indicated by health care provider</td>
</tr>
</tbody>
</table>

*Discuss individual risk and screening with your health care provider.

### Topics to Discuss With Your Child’s Health Care Provider

- Feelings of sadness or depression
- Risk of violence, signs of abuse or neglect
- As appropriate, sexual development, ways to prevent sexually transmitted diseases, birth control options
- Dental health: fluoride supplements, tooth brushing with fluoride toothpaste, flossing daily, and regular dental visits

### Health Promotion

- Adhere to a healthy diet; limit fat and cholesterol intake, ensure adequate calcium/vitamin D intake, maintain adequate intake of fiber
- Practice regular physical activity as recommended by your health care provider
- CPR training for all parents/caregivers
- Avoid tobacco/alcohol/illegal drug use
- Adopt sun safety practices/protection
- Immunizations—see page 20
Safety

- Use of seat belts (check height and weight appropriateness), avoid bicycling near traffic and obey all safety rules
- Use appropriate protective/safety gear when engaged in recreational activities
- Safely store medications and toxic chemicals
- Safely store or remove firearms and matches
- Keep poison control number handy
- Teach when to use and how to utilize 911 properly in emergency situations
- Ensure home has working smoke/carbon monoxide (CO) detectors

**Recommended Childhood Immunization Schedule**

Please check your child’s immunization record provided by your child’s health care provider (which lists all vaccinations given and the dates) against this list. If any shots are missing, or if you do not have a record, please call your child’s health care provider now and schedule a visit.

Use this chart to keep track of your child’s vaccinations. Keep this record handy as a reminder to schedule your child’s visits.

<table>
<thead>
<tr>
<th>Vaccine*</th>
<th>Check off vaccinations and record dates received in boxes below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP: Diphtheria, Tetanus (Td), and Pertussis</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 2 Months Date:</td>
</tr>
<tr>
<td>Polio: IPV</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 2 Months Date:</td>
</tr>
<tr>
<td>MMR: Measles, Mumps, Rubella</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 12-15 Months Date:</td>
</tr>
<tr>
<td>Hib: Haemophilus influenza</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 2 Months Date:</td>
</tr>
<tr>
<td>Var: Varicella Zoster Virus (chicken pox)</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 12-18 Months Date:</td>
</tr>
<tr>
<td>Hep B: Hepatitis B</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose Birth-2 Months Date:</td>
</tr>
<tr>
<td>PCV: Pneumococcal</td>
<td>□ 1&lt;sup&gt;st&lt;/sup&gt; dose 2 Months Date:</td>
</tr>
<tr>
<td>Influenza</td>
<td>□ Annually 6-23 Months Date:</td>
</tr>
</tbody>
</table>

* There are combination vaccinations and acceptable variations in vaccination schedules available. Children identified at high risk or with certain chronic illnesses may be vaccinated on a different timetable or need additional vaccines such as Influenza, Hepatitis A, IPV, and Pneumococcal vaccine. Please discuss your child’s immunization schedule with your child’s health care provider. This schedule is adapted from several nationally recognized sources.

Temporary shortages of individual vaccines may lead to delay in scheduled immunizations. Be sure to have your child “catch-up” on any necessary vaccinations as soon as vaccine is available.
Section 3
How to Use Your Child’s Insurance—
A Summary of Things to Remember About the Keystone Plan

How to Get Basic Health Care

All medical treatment begins with your child’s primary care physician.

• **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 34).

• 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.

How to See a Specialist

• Call your child’s primary care physician for a referral. He or she must give you a written referral for specific care in order for your child to see a specialist.

• A standing referral may be available to your child if he or she has a life-threatening, degenerative or disabling disease. For more information, see page 30.

• 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 except in the case of treatment for reproductive endocrinology, infertility specialist or gynecologic oncology. For more information, see page 29.

How to Deal With a Need for 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 34.

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 member services.
What Medical Services Need Preapproval

Certain covered services need to be authorized by your child’s primary care physician and pre-approved 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. Services requiring preapproval are noted in your “Summary of Benefits,” pages 56-59. 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 Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating provider. If your child receives services from a non-participating provider without obtaining preapproval, the services will not be covered. Use your provider directory to find out more about the individual providers, including hospitals and primary care physicians and referred specialists and their affiliated hospitals. It includes a foreign language index to help you locate a provider who is fluent in a particular language. The directory also lists whether the provider is accepting new patients. If you need a provider directory, call the Caring Foundation 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 a Caring Foundation member services representative 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. 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

The Caring Foundation’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.

The Foundation 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 coordination department to make arrangements to provide interpreter services for a CHIP member.

2. A parent of a CHIP member may call the Caring Foundation directly 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, the Foundation also has:

• multilingual staff members;
• telephone language services; and
• TDD (215-241-2622) for the deaf or hearing impaired.

If you have questions about how the Foundation can assist with language barriers in communication with your child’s health care provider, call the Caring Foundation at 1-800-464-5437.

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 HMO 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, (for example, certain rehabilitation therapy, podiatry and radiology services) PCPs are required to select a designated provider to which they refer their patients for those particular services. Designated providers usually receive a set dollar amount per member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, members may want to speak to the PCP regarding the designated provider that PCP 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.

**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 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.

**Utilization Review Process**

A basic condition of Keystone’s benefit plan is that in order for a health care service to be covered or payable, the services must be medically necessary (see p. 100). To assist Keystone in making coverage determinations for requested health care services, Keystone uses established medical guidelines based on clinically credible evidence to determine the medical necessity of requested services. The appropriateness of the requested setting in which the services are to be performed may also be assessed. This process of determining the medical necessity of requested health care services for coverage determinations is called utilization review. The use of medical necessity criteria based on clinically credible evidence for this process promotes a balance of access to quality care, medically appropriate utilization and coverage based on the benefits available under our members’ benefit plans.

Utilization review includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a pre-service review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. Keystone follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.
Generally, nurses perform initial case review and evaluation for coverage approval using 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 appropriateness of specific procedures and the majority are computer-based. Information provided in support of the request is entered into clinical pathways that assist in the review of medical necessity of the request. Nurses apply all pertinent health plan policies and procedures, taking into consideration individual factors relevant to a given member 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, the rationale for the denial and the appeals process is explained to the requestor, and a confirmation letter is sent to the requesting provider and CHIP member’s parent in accordance with applicable law.

Our 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-Service Review**

Pre-service review evaluates the medical necessity and coverage for services which have not yet been performed. Examples of these services include planned or elective inpatient admissions and selected outpatient procedures. This proactive opportunity, which may be initiated by the provider or the member depending on the benefit plan, is utilized to assure that all elective care is medically necessary and performed in the most appropriate setting. Pre-service review is not required for emergency services or a maternity inpatient stay.

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

- Elective inpatient admissions
- Outpatient surgeries/procedures performed in a facility setting
- Requests for CHIP members to use other than their designated providers for those services provided by designated providers
- Requests to use non-participating providers
- Potentially cosmetic procedures
- Infusion performed in a facility setting
Concurrent Review

Concurrent review is performed while services are being performed. This may occur during an inpatient stay. The review evaluates the expected and current length of stay to determine if continued hospitalization is medically necessary. The review assesses the level of care provided to the CHIP member and coordinates discharge planning. Concurrent review continues until the patient is discharged.

Retrospective/Post-Service Review

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including Keystone not being notified of a CHIP member’s admission until after discharge or where medical charts are unavailable at the time of concurrent review.

Clinical Criteria, Guidelines and Resources

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

**InterQual Clinical Decision Support Criteria:** InterQual Clinical Decision Support Criteria is an externally validated and computer-based system. The evidence-based, InterQual criteria have been nationally recognized for over 20 years. Using a model based on evaluating intensity of service and severity of illness, InterQual assists our clinical staff evaluating the medical necessity of coverage based on a CHIP member’s specific clinical needs. The InterQual criteria helps promote consistency in our plan determinations for similar medical issues and requests, and reduces practice variation among our clinical staff to minimize subjective decision-making.

Covered services for which InterQual criteria are applied include, but are not limited to:

- Elective surgeries—settings for inpatient and outpatient procedures
- Inpatient hospitalizations
- Inpatient rehabilitation
- Home health care
- Durable Medical Equipment (supported by medical policy)
- Skilled Nursing Facility

**Centers for Medicare and Medicaid Services (CMS) Guidelines:** A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare members.

**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 web site.

Covered services for which Keystone’s medical polices are applied include, but are not limited to:

- Ambulance
- Infusion Therapy
- Speech Therapy
- Occupational Therapy
- Durable Medical Equipment (supplement to InterQual)
- 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.

Covered services for which internally developed guidelines are applied:

- Spinal Manipulations/Chiropractic care
- Physical Therapy

Delegation of Utilization Review Activities and Criteria

Keystone delegates its utilization review process to its affiliate, Independence Healthcare Management, a state licensed utilization review entity. In certain instances, Keystone has delegated certain utilization review activities, including pre-service review, 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 type of benefit (such as mental health/substance abuse). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized utilization review and quality assurance accreditation body 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 web site.

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.
- If a new drug, procedure or device is not considered to be safe and effective, it will be excluded from CHIP coverage as “experimental or investigative.” (See page 97.)
- 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.
Section 4
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/her primary care physician for the following covered services:

1. Emergency services;
2. The following obstetrical/gynecological care:
   • routine maternity care
   • routine gynecological care
   • other gynecological care
   This is true whether the visit is for preventive care, problem-related obstetrical/gynecological conditions or routine obstetrical/gynecological care. This does not include specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecological oncologist;
3. Mammograms;
4. Mental health care, serious mental illness health care and substance abuse treatment; and
5. Inpatient hospital services that require preapproval. This does not include a maternity hospital stay.

How to Get a Specialist Referral

If your child’s primary care physician refers your child to a participating specialist or facility just follow these steps:

• Get a written referral form which indicates the services authorized from your child’s primary care physician for a participating Keystone specialist or facility.

• 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.

• Give the form to the 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 written referral form from your child’s primary care physician if the specialist recommends additional treatment.

• Services by non-participating providers require preapproval by Keystone in addition to the written referral from your child’s primary care physician. See “Preapproval for Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating 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:

1. Call member services at 1-800-464-5437. (Or, you may ask your child’s primary care physician to call the provider services or care management coordination department to obtain a standing referral request form.)

2. A standing referral request form will be mailed or faxed to you.

3. 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 coordination department.

4. The care management 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 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 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:

1. Call member services at 1-800-464-5437. (Or, you may ask your child’s primary care physician to call the provider services or care management coordination department to initiate the request).

2. A “Request for Specialist to Coordinate All Care” form will be mailed or faxed to you.

3. 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 coordination department.

4. 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 coordination department approves the request, it will be sent to the provider service 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 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 a written referral from your child’s primary care physician.
Continuity of Care

If Your Child is in an Ongoing Course of Treatment and:

1. your child’s physician is no longer a participating provider because Keystone terminates its contract with that physician, for reasons other than cause; or

2. your child is newly enrolled in the plan and is already in an ongoing course of treatment with a non-participating 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 post-partum care related to the delivery.

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

• Call member services 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 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 Non-Participating Providers

Keystone may approve payment for covered services provided by a non-participating provider if you have:

1. First sought and received care from a participating provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the non-participating provider that you have requested for your child (a referral from your child’s primary care physician is required);

2. Been advised by the participating provider that there are no participating providers that can provide the requested covered services; and

3. 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 non-participating provider, you will not be responsible for any payment. Applicable program terms including medical necessity, referrals and preapproval by Keystone, when required, will apply.
What are Emergency Services?

“Emergency Services” are 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:

A. 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;
B. serious impairment to bodily functions; or
C. 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; and
- choking.

*Note: Your child is in the service area if he/she is in Bucks, Chester, Delaware, Montgomery or Philadelphia county.
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 member services.

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” is medically necessary covered services provided in order to treat an unexpected illness or accidental injury that does not require emergency services. Urgent care covered services are required in order to prevent a serious deterioration in the member’s health if treatment were delayed.

Examples of conditions requiring urgent care are:

- severe vomiting;
- severe eye pain with redness; and
- severe ear pain.

Urgent Care Inside Keystone’s Service Area

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

- 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.
- 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.

• 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:

(a) the benefits he or she receives; or

(b) the procedures you must follow to obtain care for your child covered under CHIP.

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.

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 Traditional 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).
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 traditional 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 traditional provider confirms your child’s eligibility.
- You show your child’s Keystone ID Card when seeking services from the BlueCard traditional provider.

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 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 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 traditional 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 traditional providers.
When you decide which BlueCard traditional 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 traditional provider to schedule an appointment for your child.
- The BlueCard traditional provider confirms your child’s eligibility.
- You show your child’s Keystone ID Card when seeking services from the BlueCard traditional provider.

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 non-participating 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 cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to:

Keystone Health Plan East
P.O. Box 898815
Camp Hill, PA 17089-8815

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.

Remember: 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 member services 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.

**Remember:** 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 Workers Compensation coverage. Give this same information to any provider to whom your child’s primary care provider refers your child to for treatment.

Call member services 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 6

Your Child’s Membership Rights/
Filing a Complaint or Grievance for Your Child

If you have questions, suggestions, problems, or concerns regarding benefits or services rendered, the Caring Foundation and Keystone are ready to assist you. Don’t hesitate to call member services 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/her dignity and right to privacy.

• The member has the right to participate in decision-making regarding his/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/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 100.)

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 14) 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 Member/Enrollee Authorization to Appeal by Provider or Other Representative and the Authorization to Release form. 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 of the individual(s) who reviewed your child’s appeal—by title, a general description of experience, and the board certification of any Physician-reviewer—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
P.O. Box 90
Harrisburg, PA 17108
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**

The Caring Foundation and Keystone 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 the Caring Foundation member services at 1-800-464-5437; or

• write or fax to:

  Supervisor of Member Services
  Independence Blue Cross & Highmark Blue Shield
  Caring Foundation
  P.O. Box 13449
  Philadelphia, PA 19101-3449
  Fax: 215-241-3679
Most concerns are resolved informally at this stage. If the Caring Foundation cannot immediately resolve your concern, 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 the Caring Foundation, 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 non-participating 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/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:

1) **fifteen (15) calendar days** from receipt of a pre-service appeal; and

2) **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:

1) the specific reason for the decision;

2) the plan provision on which the decision is made and instructions on how to access the provision; and

3) 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/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:

1) **fifteen (15) calendar days** from receipt of a pre-service appeal; and

2) **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 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 level of appeal review for an expedited complaint appeal.

To request an internal expedited complaint by Keystone, call member services 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 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
1321 Strawberry Square
Harrisburg, PA 17120
Toll-free: 1-877-881-6388
1-717-787-2317
Fax: 1-717-787-8585

**Pennsylvania Department of Health**
Bureau of Managed Care
Attn: Complaint Appeals
P.O. Box 90
Harrisburg, PA 17108-0080
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/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.

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 reviewed by a committee for which a Keystone medical director is the decision-maker. The decision-maker is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist or “same or similar specialty physician” is a licensed physician or psychologist who:

1) is in the same or similar specialty as typically manages the care under review;
2) has had no previous involvement in the case; and
3) is not a subordinate of the person who made the original determination.

The matched specialist must also hold an active license to practice medicine and be board certified.

If the matched-specialist physician is a consultant, his or her opinion on the grievance appeal issues will be reported to Keystone in writing for consideration by the committee. You may request a copy of the matched specialist’s opinion in writing, and when possible it will be provided to you at least **seven (7) calendar days** prior to the date of review by the first level grievance committee. The matched specialist’s report includes the relevant board certifications and/or the specialty of the licensed physician or psychologist.

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

1) **fifteen (15) calendar days** from the date of receipt of a pre-service appeal; and
2) **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:

1) the specific reason for the denial;
2) the plan provision on which the decision is made and instructions on how to access the provision; and
3) 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 staff. At least one of these committee members is a Keystone medical director, a physician who holds an active license and is board certified.

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:

1) **fifteen (15) calendar days** from receipt of a pre-service appeal; and

2) **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 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 internal level of appeal review for an expedited grievance appeal.

To request an internal expedited grievance by Keystone, call member services 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—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.

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 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. However, when a provider is a child’s appeal representative for external grievance appeal review, then the provider is required to:

1) place in escrow one-half of the estimated costs of the external grievance process; and

2) pay the full costs for the external process if the provider’s appeal on behalf of the child is not successful.
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 7
Your Responsibilities as the Parent or Guardian of a Keystone CHIP Member

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 the Caring Foundation 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 the Caring Foundation member services 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/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

In the event that legal grounds for the recovery of health care costs exist (such as when an illness or injury is caused by the negligence or wrong-doing of another party), Keystone has the right to seek recovery of such costs, unless prohibited by statute or regulation. When requested, the parent of the enrolled child must cooperate with Keystone to provide information, sign necessary documents and take any action necessary to protect and assure the subrogation rights of Keystone.
## Section 8

### Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How to Access</th>
<th>More Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing and Treatment</td>
<td>Provided or referred by primary care physician</td>
<td>page 61, 69</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Preapproval required, unless an emergency</td>
<td>page 61</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Provided or referred by primary care physician</td>
<td>page 61, 69</td>
</tr>
<tr>
<td>Autologous Blood Drawing/Storage/Transfusion</td>
<td>Provided or referred by primary care physician</td>
<td>page 61, 69</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy</td>
<td>Provided or referred by primary care physician</td>
<td>page 61, 69</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Provided or referred by primary care physician</td>
<td>page 61, 69</td>
</tr>
<tr>
<td>Dental Benefits</td>
<td>Provided or referred by a United Concordia Advantage Network Participating Provider</td>
<td>page 77</td>
</tr>
<tr>
<td></td>
<td>Call 1-800-332-0366 for services</td>
<td></td>
</tr>
<tr>
<td>Diabetic Self-Management and Education</td>
<td>Provided or referred by primary care physician</td>
<td>page 62</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>Provided or referred by primary physician</td>
<td>pages 62, 69</td>
</tr>
<tr>
<td></td>
<td>Needs preapproval by Keystone</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Provided or referred by primary care physician</td>
<td>page 62</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Provided or referred by primary care physician</td>
<td>pages 62, 69</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Preapproval, when required. Must be purchased through a participating DME provider</td>
<td>page 63</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Call 911 or go immediately to the emergency department of the closest hospital</td>
<td>page 34</td>
</tr>
<tr>
<td>Genetic Testing and Counseling</td>
<td>Provided or referred by primary care physician</td>
<td>page 63</td>
</tr>
<tr>
<td>Gynecological Care</td>
<td>Provided by primary care physician or participating gynecologist; No referral necessary</td>
<td>page 63</td>
</tr>
<tr>
<td>Hearing Care</td>
<td>Provided or referred by primary care physician</td>
<td>page 63</td>
</tr>
<tr>
<td>Benefit</td>
<td>How to Access</td>
<td>More Info</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Provided or referred by primary care physician Needs preapproval by Keystone</td>
<td>page 64</td>
</tr>
<tr>
<td>Home Visits</td>
<td>Provided or referred by primary care physician</td>
<td>page 64</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Provided or referred by primary care physician Needs preapproval by Keystone</td>
<td>page 64, 69</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Provided or referred by primary care physician</td>
<td>page 70</td>
</tr>
<tr>
<td>Illness (treatment for)</td>
<td>Provided or referred by primary care physician</td>
<td>page 60</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Provided by primary care physician</td>
<td>page 20, 64</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Provided or referred by primary care physician Needs preapproval by Keystone</td>
<td>page 64</td>
</tr>
<tr>
<td>Injections</td>
<td>Provided by primary care physician</td>
<td>page 64</td>
</tr>
<tr>
<td>Injuries (treatment for)</td>
<td>Provided or referred by primary care physician</td>
<td>page 60</td>
</tr>
<tr>
<td>Insulin and Oral Agents</td>
<td>Also, see Diabetic supplies</td>
<td>page 62, 64, 69</td>
</tr>
<tr>
<td>Lab Work</td>
<td>Provided or referred by primary care physician</td>
<td>page 62</td>
</tr>
<tr>
<td>Mammogram Screening</td>
<td>Referred by primary care physician or participating obstetrical/gynecological specialist</td>
<td>page 64</td>
</tr>
<tr>
<td>Mastectomy Care</td>
<td>Provided or referred by primary care physician</td>
<td>page 70</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Provided or referred by primary care physician or participating obstetrician/gynecologist; No referral necessary</td>
<td>page 65</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>Ordered by primary care physician or referred specialist; Needs preapproval by Keystone</td>
<td>page 65, 70</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Provided by a behavioral health management company; <strong>Call 1-800-294-0800 for services</strong></td>
<td>page 80</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>Provided by a participating pediatrician</td>
<td>page 65, 71</td>
</tr>
<tr>
<td>Obstetrical Care</td>
<td>Provided or referred by primary care physician or participating obstetrician; No referral necessary</td>
<td>page 65, 71</td>
</tr>
<tr>
<td>Office Visits</td>
<td>Provided or referred by primary care physician</td>
<td>page 65</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Provided or referred by primary care physician Needs preapproval by Keystone (in a facility)</td>
<td>page 65, 71</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td><strong>How to Access</strong></td>
<td><strong>More Info</strong></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Referred by primary care physician&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 71</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Referred by primary care physician&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 66</td>
</tr>
<tr>
<td>Pap Smears</td>
<td>Provided by primary care physician or participating gynecologist</td>
<td>page 60, 63</td>
</tr>
<tr>
<td>Physical Examinations</td>
<td>Provided by primary care physician</td>
<td>page 60</td>
</tr>
<tr>
<td>Podiatric Care</td>
<td>Referred by primary care physician</td>
<td>page 60</td>
</tr>
<tr>
<td>Prenatal and Obstetrical Care</td>
<td>Provided or referred by primary care physician or participating obstetrician/gynecologist; No referral necessary</td>
<td>page 65, 71</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Any participating pharmacy</td>
<td>page 74</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>Provided by primary care physician or participating gynecologist</td>
<td>page 66</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Referred by primary care physician&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 66, 72</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Services</td>
<td>Referred by primary care physician&lt;br&gt;Treatment for up to 60 days&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 67, 72</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Provided or referred by primary care physician</td>
<td>page 67, 72</td>
</tr>
<tr>
<td>Referral to a Specialist</td>
<td>Provided by primary care physician</td>
<td>page 21</td>
</tr>
<tr>
<td>Rehabilitation Therapy Services</td>
<td>Provided or referred by primary care physician&lt;br&gt;Treatment for up to 60 days&lt;br&gt;Needs preapproval by Keystone&lt;br&gt;for Speech and Lymphedema therapies</td>
<td>page 67, 72</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Provided or referred by primary care physician&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 68, 73</td>
</tr>
<tr>
<td>Routine Costs Associated With Qualifying Clinical Trials</td>
<td>Provided or referred by primary care physician&lt;br&gt;Need preapproval by Keystone</td>
<td>page 68, 73</td>
</tr>
<tr>
<td>Routine Pediatric Care</td>
<td>Provided by primary care physician</td>
<td>page 60</td>
</tr>
<tr>
<td>Serious Mental Illness Health Care</td>
<td>Provided by a behavioral health management company&lt;br&gt;&lt;strong&gt;Call 1-800-294-0800 for services&lt;/strong&gt;</td>
<td>page 80</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Referred by primary care physician&lt;br&gt;Needs preapproval by Keystone</td>
<td>page 73</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>Referred by primary care physician</td>
<td>page 68, 73</td>
</tr>
<tr>
<td>Benefit</td>
<td>How to Access</td>
<td>More Info</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Spinal Manipulation Services</td>
<td>Provided or referred by primary care physician</td>
<td>page 68</td>
</tr>
<tr>
<td></td>
<td>Needs preapproval by Keystone</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>Provided by a behavioral health management company; <a href="#">Call 1-800-294-0800 for services</a></td>
<td>page 80</td>
</tr>
<tr>
<td>Surgery</td>
<td>Provided or referred by primary care physician</td>
<td>page 68, 73</td>
</tr>
<tr>
<td></td>
<td>Needs preapproval by Keystone</td>
<td></td>
</tr>
<tr>
<td>Termination of Pregnancy</td>
<td>Provided or referred by primary care physician or participating gynecologist. Covered only when necessary to prevent the death of the woman or in the case of rape or incest; Elective abortions are not covered</td>
<td>page 68</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Provided by primary care physician</td>
<td>page 35</td>
</tr>
<tr>
<td>Vision Care &amp; Eyewear</td>
<td>Annual Routine Eye Exam and Refractive Services Administered by Davis Vision. Call 1-888-393-2583 to locate a Davis Vision participating provider</td>
<td>page 85</td>
</tr>
<tr>
<td>Well-Baby Visits</td>
<td>Provided by primary care physician</td>
<td>page 17</td>
</tr>
<tr>
<td>X-ray</td>
<td>Provided or referred by primary care physician</td>
<td>page 62</td>
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Prior to enrollment, you will have selected a primary care physician for your child. The following benefits are available through your child’s primary care physician listed on his/her Keystone ID Card:

- Treatment for illness and injury
- Physical examinations
- Routine pediatric care, including well-baby visits
- For female members, routine gynecological examinations and Pap smears
- Immunizations, except those required for travel or work (see definition for immunization on page 99)
- Hearing screening for diagnostic purposes
- Routine allergy injections
- Vision screening
- Office visits during and after regular office hours, including emergency visits, and home visits when medically necessary
- Referrals to a specialist for medically necessary care
Section 10
Outpatient and Inpatient Services

Outpatient Services

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.

Allergy Testing and Treatment

Allergy tests, testing materials and treatment

Ambulance Services (Preapproval, unless an emergency service and medical intervention and/or stabilization is medically necessary during transport)

Ambulance services on land, air or sea for medical intervention and/or stabilization of your child’s condition by a licensed medical professional during transit from the site where an emergency medical condition occurs to the facility of treatment. Other ambulance services will be covered only when ordered or referred by your child’s primary care physician and preapproved by Keystone. The vehicle used must be one that is specially designed and equipped for use only to transport sick or injured persons.

Anesthesia (Preapproval for outpatient epidural injection)

Anesthesia services performed in connection with covered services.

Autologous Blood Drawing/Storage/Transfusion

Services provided in conjunction with a planned episode of care that requires transfusion, including but not limited to, surgical procedures. Benefits are provided for storage of autologous blood until the date of scheduled care.

Cardiac Rehabilitation Therapy (Preapproval)

Chemotherapy (Preapproval for administration in a facility)

Dental Benefits (See page 77)
Diabetic Self-Management and Education

Benefits are provided for self-management training and education relating to diet when prescribed by a primary care physician or referred specialist. Covered services may be provided by a participating provider who is a licensed health care professional approved by Keystone. Covered services may also be provided by a participating community-based program which is approved by Keystone in accordance with criteria based on the certification programs for diabetic self-management training and education programs developed by the American Diabetes Association and the Pennsylvania Department of Health, or at a participating hospital on an outpatient basis as follows:

A. Visits medically necessary upon the diagnosis of diabetes;

B. Visits under circumstances whereby your child’s primary care physician identifies or diagnoses a significant change in your child’s symptoms or conditions that necessitates changes in his/her self-management; and

C. Where a new medication or therapeutic process relating to your child’s treatment and/or management of diabetes has been identified as medically necessary by your child’s primary care physician.

Diabetic Supplies (Preapproval)

Benefits are provided for equipment and supplies when purchased through a participating durable medical equipment provider for use when your child is not an inpatient. Covered supplies include blood glucose monitors, monitor supplies, injection aids, syringes, insulin infusion devices, and pharmacological agents for controlling blood sugar.

Diagnostic Services (Preapproval, when required)

Covered services include:

1. Routine Diagnostic Services, including routine radiology (consisting of x-rays, ultrasound and nuclear imaging), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), Nuclear Imaging, and other diagnostic medical procedures approved by Keystone);

2. Non-Routine Diagnostic Services, including operative and diagnostic endoscopies, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan), and Computed Tomography (CT Scan); and

3. Diagnostic laboratory and pathology tests.

Covered services must be performed by your child’s primary care physician’s designated provider, except as follows: Diagnostic outpatient radiology services for CHIP members less than age five (5) may be performed by any participating provider that is contracted by Keystone to perform radiology services.

Dialysis

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. Private duty nursing is not covered as a portion of dialysis. The decision to provide benefits for the purchase or rental of necessary equipment for home dialysis will be made by Keystone. When your child becomes eligible for Medicare coverage of dialysis, Keystone dialysis benefits will be coordinated with such Medicare coverage.
**Durable Medical Equipment** *(Preapproval)*

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:

A. It is used in the patient’s home; and

B. It is obtained through a participating durable medical equipment provider.

Benefits are provided for the replacement of a previously approved DME item with an equivalent DME item when the following are true:

A. There is a change in your child’s condition that requires a replacement; or

B. The DME breaks and exceeds its life duration as determined by the manufacturer.

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

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

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

**Genetic Testing and Counseling**

Benefits are provided for genetic testing and counseling. Covered services are those testing and counseling services provided to members at risk by pedigree for a specific hereditary disease. The services must be for the purpose of diagnosis and where the results will be used to make a therapeutic decision.

**Gynecological Care**

Benefits are provided for female members for covered services provided by any Keystone participating obstetrical/gynecological specialist without a referral. Covered services include:

A. Routine maternity care;

B. Routine gynecological care including Pap smears; and

C. Other gynecological care.

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.

A referral is required for specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecological oncologist.

**Hearing Care**

Benefits are provided for hearing screenings for diagnostic purposes and evaluation for hearing aid **once every two (2) years**. Benefits are provided for 100% reimbursement for one hearing aid, per ear, **every two (2) calendar years**. A reimbursement form may by obtained by calling 1-800-464-5437.
Home Health Care  (Preapproval)

Care provided to a CHIP member who is homebound by a home health care provider in the CHIP member’s home, if within the service area.

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.

Home Visits  (Preapproval)

Physician visits to your home, if within the service area.

Hospice Care  (Preapproval)

Palliative and supportive services provided to a terminally ill member through a hospice program by a hospice provider. This also includes respite care. Hospice care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the member cope with a terminal illness rather than cure it. Hospice care provides services to make the patient as comfortable and pain-free as possible. When a parent elects for their dependent child to receive hospice care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the parent may elect to revoke the election of hospice care for their dependent child at any time.

Immunizations

Pediatric and medically necessary adult immunizations (except those required for travel or work). 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 Center for Disease Control, U.S. Department of Health and Human Services.

Infusion Therapy  (Preapproval)

Treatment includes but is not limited to, infusion or inhalation parenteral and enteral nutrition, antibiotic therapy, pain management and hydration therapy.

Injections  (Preapproval, when required)

Injectable medication for the immediate treatment of an injury or acute illness when administered in the physician’s office.

Insulin and Oral Agents

Insulin and oral agent benefits will be available when dispensed by a prescription order for use when your child is not an inpatient. Insulin and oral agents are covered when prescribed by your child’s primary care physician or referred specialist. Generically equivalent pharmaceuticals will be dispensed whenever applicable.

Mammogram Screening

Screening and diagnostic mammograms are available without a referral. Benefits for mammography services are payable only if performed by a participating provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Standards Act of 1992, and as later amended.
Maternity Care

Benefits are provided for female members for covered services provided by a primary care physician or participating obstetrician/gynecologist without a referral.

Medical Foods (Preapproval)

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 80)

Newborn Care

Care of a newborn child, born to a CHIP member, is covered for a period of thirty-one (31) days following birth. Such care shall include routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. To ensure continuity of care for the newborn, the mother of the newborn should fill out a Medicaid application as soon as the baby is born. The social services department at the hospital or the Caring Foundation can assist the mother of the newborn with this process.

Obstetrical Care

Obstetrical care, including prenatal and postnatal care, complications of pregnancy and childbirth.

Office Visits

Covered services provided in the physician’s office.

Oral Surgery (Preapproval in a facility)

Limited oral surgical procedures in an outpatient setting and required in connection with the following:

A. The removal or exposure of teeth which are partially or totally covered by bone;

B. Accidental injury to the jaw or structures contiguous to the jaw or injury related to sound natural teeth;

C. The correction of a non-dental physiological condition which has resulted in a severe functional impairment; or

D. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
Orthotics (Preapproval)

Benefits are provided for:

A. 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

B. The replacement of covered orthotics for a covered child when required due to natural growth.

Foot orthotics ordered and covered as a result of diabetes, must be purchased through a participating durable medical equipment provider.

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 74)

Preventive Health Services

Preventive health care, including, but not limited to, periodic health assessments, well-child care, and periodic gynecological examinations, according to schedules approved by Keystone, when provided by your child’s primary care physician or a participating gynecologist.

Prosthetic Devices (Preapproval)

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

A. The purchase and fitting, and the necessary adjustments and repairs, of prosthetic devices and supplies (except dental prosthesis);

B. Supplies and replacement of parts necessary for the proper functioning of the prosthetic device; or

C. Eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular surgery (i.e. cataract surgery) or injury; pinhole glasses prescribed for use after surgery for detached retina; lenses prescribed in lieu of surgery for the following:
   1) contact lenses used for treatment of infantile glaucoma;
   2) corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
   3) scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   4) corneal or scleral lenses to reduce a corneal irregularity (other than astigmatism).
Benefits are provided for the replacement of a previously approved prosthetic device with an equivalent prosthetic device when:

A. There is significant change in your child’s condition that requires a replacement;
B. The prosthetic device breaks because it is defective;
C. The prosthetic device breaks because it has exceeded its life duration as determined by the manufacturer; or
D. The prosthetic device needs to be replaced for your child due to 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.

**Pulmonary Rehabilitation Services** (Preapproval)

Benefits are limited to treatment received within a *sixty (60) consecutive day period*.

**Radiation Therapy**

**Rehabilitation Therapy Services** (Preapproval is required for Speech and Lymphedema therapies)

Covered services for all covered therapies other than speech therapy must be performed by your child’s primary care physician’s designated provider. Covered services for acute conditions are subject to the determination that significant improvement can be expected within *sixty (60) days*.

Covered therapies include:

- Occupational
- Physical
- Hand
- Speech
- Lymphedema
- Orthoptic/pleoptic
Covered services include:

A. All therapeutic exercise, testing and soft tissue mobilization;

B. All physical modalities utilizing heat, cold, light, air, electricity, sound, all forms of water therapy, massage, mobilization and mechanical stimulation;

C. Checking out the fitting of splints, braces, prostheses and other orthotic devices (orthotic devices are not covered unless stated otherwise);

D. Reconditioning, including work reconditioning; and

E. Orthoptic/pleoptic therapy, provided by a licensed ophthalmologist or optometrist.

**Respiratory Therapy** (Preapproval)

Respiratory therapy services when provided by a licensed respiratory therapist.

**Routine Costs Associated With Qualifying Clinical Trials** (Preapproval)

Benefits are provided for routine costs associated with qualifying clinical trials.

**Serious Mental Illness Health Care** (See page 80)

**Specialist Services**

Covered services provided by referred specialists. Services resulting from referrals to non-participating providers will be covered when the referral is issued by your child’s primary care physician and preapproved by Keystone. See “Preapproval for Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating provider. The referral is valid for an enrolled member for **ninety (90) days** from the date of issue. Self-referrals are excluded, except for emergency care or obstetrical/gynecological care. Additional covered services recommended by the referred specialist will require another written referral from your child’s primary care physician.

**Spinal Manipulation Services** (Preapproval)

Covered services may be provided by your child’s primary care physician or referred specialist licensed to perform such services. Covered spinal manipulation services are provided in order to treat an acute condition related to an acute medical episode and are subject to the determination that significant improvement can be expected.

**Substance Abuse Treatment** (See page 80)

**Surgery** (Preapproval)

Surgical services required for treatment of disease or injury.

**Termination of Pregnancy** (Preapproval)

Covered only when necessary to prevent the death of the woman, or in the case of rape or incest. **Elective abortions are not covered.**

**Vision Care** (See page 85)
Inpatient Services

The following services are covered on an inpatient basis when:

• Medically necessary;
• Provided or referred by your child’s primary physician; and
• Preapproved by Keystone, where specified.

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

Allergy Testing and Treatment

Allergy tests, testing materials and treatment.

Anesthesia

Anesthesia services when performed in connection with covered services.

Autologous Blood Drawing/Storage/Transfusion

Benefits are available for services provided in conjunction with a planned episode of care that requires transfusion.

Cardiac Rehabilitation Therapy (Preapproval)

Chemotherapy (Preapproval for administration in a facility)

Diabetic Supplies (Preapproval)

Benefits are provided for equipment and supplies which include blood glucose monitors; monitor supplies; insulin; injection aids; syringes; insulin infusion devices; pharmacological agents for controlling blood sugar and orthotics.

Dialysis

Dialysis services are covered until your child becomes eligible for Medicare coverage of dialysis. Keystone dialysis benefits will then be coordinated with such Medicare coverage.

Hospice Care (Preapproval)

Palliative and supportive services provided to a terminally ill child through a hospice program by a hospice provider. This also includes respite care. 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 the patient as comfortable and pain-free as possible. When a parent elects for their child to receive hospice care, benefits for treatment provided to cure the terminal illness are no longer provided. However, a parent may elect to revoke the election of hospice care for their child at any time.
Hospital Services (Preapproval)

Benefits are provided for a maximum of **ninety (90) days** in a hospital per calendar year for medical/surgical and mental health services, **thirty (30) days** per calendar year for serious mental illness health care and **thirty (30) days** per calendar year for substance abuse treatment. The available inpatient mental health, serious mental illness and substance abuse days may be exchanged on a two-for-one basis for partial hospitalization sessions and/or outpatient visits.

Unless otherwise included in an insert in this benefits handbook, the following inpatient hospital services are covered hospital services:

A. Semi-private room and board (other accommodations if medically necessary);
B. General nursing care;
C. Prescription drugs, medications, and biologicals (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);
D. Use of operating room and related services;
E. Use of intensive care or cardiac units and related services;
F. Oxygen services;
G. Administration of whole blood and blood plasma;
H. Other medically necessary supplies and equipment; and
I. Diagnostic laboratory and x-ray.

Mastectomy Care

Benefits are provided for covered services following a mastectomy on one breast or both breasts for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Benefits are provided for breast prostheses required to replace the removed breast or portions of the breast as a result of mastectomy. This includes internal and external prosthetic devices inserted at the time of the mastectomy and during the reconstructive surgery subsequent to the mastectomy.

Medical Foods (Preapproval)

Benefits are provided for nutritional products 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 80)

Newborn Care
Care of a newborn child, born to a CHIP member, is covered for a period of thirty-one (31) days following birth. Such care shall include routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. To ensure continuity of care for the newborn, the mother of the newborn should fill out a Medicaid application as soon as the baby is born. The social services department at the hospital or the Caring Foundation can assist the mother of the newborn with this process.

Obstetrical Care
Obstetrical care, including prenatal and postnatal care, complications of pregnancy and childbirth. Maternity care inpatient benefits will be provided for a minimum of forty-eight (48) hours following a vaginal delivery. For a cesarean delivery, the minimum stay is ninety-six (96) hours. This applies to the CHIP member and her child, except as otherwise approved by Keystone.

Oral Surgery  (Preapproval in a facility)
Limited oral surgical procedures when required in connection with the following:

A. The removal or exposure of teeth which are partially or totally covered by bone;
B. Accidental injury to the jaw or structures contiguous to the jaw or injury related to sound natural teeth;
C. The correction of a non-dental physiological condition which has resulted in a severe functional impairment; or
D. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Organ Transplants  (Preapproval)
Benefits are provided for transplant services for a member recipient. Covered services include procedures which are generally accepted as not experimental or investigative 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.

In addition, 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.
If a member is an organ donor, expenses related to organ donation are not covered unless the recipient is also a Keystone member. If the recipient is a member, covered expenses of a member donor are:

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

**Physician Care**

Benefits are provided for covered services received during a preapproved inpatient admission.

**Prosthetic Devices** (Preapproval)

Surgically implanted prosthetic devices (except dental prosthetics). For benefits related to mastectomy care, see above.

**Pulmonary Rehabilitation Services** (Preapproval)

Benefits are limited to treatment received within a **sixty (60) consecutive day** period provided during a covered inpatient admission.

**Radiation Therapy**

Radiation therapy services when provided during a covered inpatient admission.

**Rehabilitation Therapy Services** (Preapproval is required for Speech and Lymphedema therapies)

Inpatient rehabilitation therapy provided by a hospital, a skilled nursing facility, or a rehabilitation hospital. Covered services include:

- Occupational
- Physical
- Hand
- Lymphedema
- Speech

Covered Services include:

- All therapeutic exercise, testing and soft tissue mobilization;
- All physical modalities utilizing heat, cold, light, air, electricity, sound, all forms of water therapy, massage, mobilization and mechanical stimulation;
- Checking out the fitting of splints, braces, prostheses and other orthotic devices (orthotic devices are not covered unless stated otherwise); and
- Reconditioning, including work reconditioning.
Respiratory Therapy (Preapproval)

Respiratory therapy services when provided by a licensed respiratory therapist.

Routine Costs Associated With Qualifying Clinical Trials (Preapproval)

Benefits are provided for routine costs associated with qualifying clinical trials.

Serious Mental Illness Health Care (See page 80)

Skilled Nursing Facility Services (Preapproval)

Benefits are provided for care in a skilled nursing facility as long as the services are not considered custodial or domiciliary care. Benefits are limited to semi-private accommodations (or an allowance equal to this rate which may be applied to private accommodations). During a skilled nursing facility admission, members of Keystone’s care management 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 referred specialist to help with his or her discharge and if necessary, arrange for other medical services.

If your child’s primary care physician or referred specialist agrees with Keystone that continued stay in a skilled nursing facility is no longer required, you will be notified in writing of this decision. If your child remains in the facility after 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.

Specialist Services

Covered services provided by referred specialists. Services resulting from referrals to non-participating providers will be covered when the referral is issued by your child’s primary care physician and preapproved by Keystone. See “Preapproval for Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating provider. The referral is valid for an enrolled member for ninety (90) days from the date of issue. Self referrals are excluded, except for emergency and routine gynecological care or if covered by a rider. Additional covered services recommended by the referred specialist will require another written referral from your child’s primary care physician.

Substance Abuse Treatment (See page 80)

Surgery (Preapproval)

Surgical services required for treatment of disease or injury.
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**

1. Prescription drugs and maintenance prescription drugs prescribed by your child’s primary care physician or referred specialist and furnished by a participating pharmacy.

2. Insulin and disposable insulin needles, syringes and/or testing materials, lancets and glucometers.

3. Compounded preparations containing at least one prescription drug.

4. 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 the Caring Foundation at 1-800-464-5437.

5. A member or member’s family shall pay to a participating pharmacy 100% of a non-covered drug or supply.

**Prescription Drug Limitations**

1. 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.

2. 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.

**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)

- Migraine medications with quantity level limits such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol®, NS and Zomig® (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 level limit for a medication and prior authorization/pre-approval 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 for your child.

2. 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.

3. Once the completed medical documentation is received by pharmacy services, Keystone’s review will be completed and the medication will be approved or denied.

4. If approved, the remainder of the prescription order will be filled.

5. 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/pre-approval 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:

1. Devices or supplies of any type, except for blood glucose meters, test strips, lancets and insulin syringes.

2. Drugs that do not by federal or state law require a prescription order (i.e., over-the-counter or over-the-counter equivalents), except insulin and drugs specifically designated by Keystone, whether or not prescribed by a physician.

3. Prescription refills resulting from loss or theft, or any unauthorized refills.

4. Experimental drugs or investigational drugs or drugs prescribed for experimental (non-FDA approved) indications.

5. Drugs used for cosmetic purposes, including, but not limited to, anabolic steroids, minoxidil lotion, or Retin A (tretinoin).

6. Pharmacological therapy for weight reduction or diet agents.

7. Contraceptives for birth control purposes.

8. Injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization.
9. Drugs prescribed and administered in the physician’s office (this would fall under the medical portion of the plan).

10. Medication for a member confined to a rest home, skilled nursing facility, sanitarium, extended care facility, hospital or similar entity (this would fall under the medical portion of the plan).

11. Medication furnished by any other medical service for which no charge is made to the member.

12. Any covered drug which is administered at the time and place of the prescription order (this would fall under the medical portion of the plan).

13. Immunization agents, biological sera, blood or plasma, or allergy serum.

14. Nicotine patches or gum or any other pharmacological therapy for smoking cessation.

15. 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.

16. Human growth hormones (this would fall under the medical portion of the plan).
Section 12
Dental Benefits

How to Access Dental Services

Dental benefits are provided through United Concordia. To receive dental services for your enrolled child, take your child to a participating United Concordia Advantage Network dentist.

Present your child’s dental ID Card to the Advantage Network participating dentist to receive covered dental benefits. The dentist will handle all the paperwork for you. Payment will be sent directly to the participating dentist. You will not be responsible for any portion of the bill for covered services.

If you take your child to a non-participating dentist, you must:

- Pay for your child’s treatment at the time it is received.
- Complete and submit a claim form or itemized bill to the dental benefits administrator identified on your child’s dental ID Card, if you wish to seek reimbursement for services. Note: You are responsible for the difference between the non-participating dentist’s actual charge and the allowance paid by United Concordia.

For a list of participating dentists in your area:

- Call 1-800-332-0366 weekdays from 8:00 a.m. – 8:00 p.m. to request a participating Advantage Network provider directory; or
- Log on to www.ucci.com for the most updated list of network providers.

Dental Services—What is Covered

1. Diagnostic Services

   A. One routine oral examination every six months; and
   B. Dental x-rays
      1) Full mouth x-rays, not more than once every five (5) years
      2) Bitewing x-rays, not more than twice every twelve (12) months

2. Preventive Services

   A. Routine cleaning, scaling and polishing of teeth, not more than once every six (6) months;
   B. Topical fluoride application, not more than once every six (6) months;
   C. Space maintainers that replace premature loss of primary posterior molars or permanent first molars; and
   D. Sealants for children five (5) years of age through nine (9) years of age on permanent first molars and from ten (10) years of age through fourteen (14) years of age on permanent second molars, only if teeth to be sealed are free of proximal cavities and there are no previous restorations on the surface to be sealed. There is a limitation of one (1) sealant per tooth with no repeats.
3. Minor Restorations

A. Amalgam (silver) and resin based composite (white) restorations for all permanent teeth. Amalgam restorations for all deciduous teeth. Other restorations not covered unless there is a special need;

B. Core build-ups including any pins, prefabricated post and core, cast post and core in addition to a crown. There is a five (5) year limitation for replacement. One build-up or cast post and core is allowed within a five (5) year period; and

C. Resin, porcelain and full cast single crowns (for permanent teeth; limited to once in a five-year period), stainless steel crown for deciduous teeth only – limited to once per tooth per lifetime.

4. General Services

A. Palliative (pain relief) emergency treatment of an acute condition requiring immediate care;

B. Simple extractions, as dentally necessary;

C. Surgical extractions;

D. Pulpotomies for deciduous teeth only;

E. Endodontic (Root Canal) therapy for permanent teeth, limited to once per tooth per lifetime;

F. Administration of anesthesia in connection with the performance of covered services when provided by or under the direct supervision of a dentist other than the surgeon, assistant surgeon or attending dentist; and

G. Consultations, limited to one (1) consultation per consultant during any one period of hospitalization when your child is an inpatient and the dental condition requires such consultation.

Dental Care Benefit Limitations

1. If an eligible child transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist performs covered services for one dental procedure, the plan shall be liable for not more than the amount that it would have been liable for had but one dentist performed the covered service.

2. In all cases involving covered services in which the dentist and an eligible child or the eligible child’s family select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this benefit will be based on the charge allowance for the lesser procedure.
3. A contract between the eligible child or the eligible child’s family and dentist prior to the effective date of coverage under the contract is not invalidated by a subsequent contract made between the plan and/or the eligible child or the eligible child’s family and/or dentist. The eligible child or the eligible child’s family will be liable for any difference due to the dentist under such a contract after the plan’s liability has been satisfied.

4. Any additional treatment that is necessitated by lack of cooperation by the eligible child or the eligible child’s family with the dentist or noncompliance with prescribed dental care that results in additional liability will be the responsibility of the eligible child or the eligible child’s family.

**Dental Exclusions—What is Not Covered**

The following are not covered under the dental benefits of CHIP:

- Labial veneers and laminates done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered;
- Duplicate and temporary devices, appliances and services;
- Plaque control programs and oral hygiene and dietary instructions;
- Implantology and related services;
- Alteration of vertical dimension and the restoration or maintenance of occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration formal-alignment of the teeth;
- Local anesthesia when billed for separately by a dentist;
- Gold foil restorations;
- Services submitted by another professional provider and/or a dentist which are the same services performed on the same dates for the same patient;
- Oral surgery;
- Prosthetics;
- Periodontics;
- Orthodontics; and
- Services covered under the medical portion of the contract.
Section 13

Mental Health, Serious Mental Illness and Substance Abuse Benefits

Your child is eligible for mental health, serious mental illness 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.

All services must be coordinated and authorized through the behavioral health management company. Unauthorized services are not covered. If your child receives mental health, serious mental illness or substance abuse services without an authorization or outside of the behavioral health management company, you will be responsible for paying the entire bill.

How to Access Mental Health, Serious Mental Illness and Substance Abuse Benefits

All mental health, serious mental illness and substance abuse services are accessed through the behavioral health management company’s help line:

1-800-294-0800

TTY Service for hearing and speech impaired: 1-800-409-8640

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

• Referral to a behavioral health network provider;
• Preapproval of mental health, serious mental illness or substance abuse care;
• Emergency assistance 24 hours a day, every day of the year; or
• General information about the behavioral health management company and your child’s mental health, serious mental illness and substance abuse benefits.

Your Child’s Mental Health and Serious Mental Illness Benefits—What is Covered

Outpatient Services—Mental Health Care (Other Than Serious Mental Illness)

Your child is eligible for up to fifty (50) mental health outpatient visits per calendar year. The following mental health benefits are provided in an outpatient setting:

• Psychiatric visits
• Psychiatric consultations
• Individual counseling
• Group counseling
• Family counseling
• Medication management
• Electroconvulsive therapy
Outpatient Services—Serious Mental Illness

The following biologically based mental illnesses are defined as serious mental illnesses by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual:

A. Schizophrenia
B. Bipolar disorder
C. Obsessive-compulsive disorder
D. Major depressive disorder
E. Panic disorder
F. Anorexia nervosa
G. Bulimia nervosa
H. Schizo affective disorder
I. Delusional disorder
J. Any other mental illness that is considered to be “Serious Mental Illness” by law

Benefits are provided for treatment of these conditions when determined to be medically necessary. Covered services may be provided in an outpatient or inpatient mental health care facility or through a partial hospitalization program.

Your child is eligible for up to sixty (60) serious mental illness outpatient visits per calendar year.

The following serious mental illness benefits are provided in an outpatient setting:

- Psychiatric visits
- Psychiatric consultants
- Individual counseling
- Group counseling
- Family counseling
- Medication management
- Electroconvulsive therapy

Emergency Care—Mental Health and Serious Mental Illness

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.

The initial treatment for psychiatric emergencies is covered even when provided by non-participating 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, the behavioral health management company 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 34.

**Inpatient Services—Mental Health Care (Other Than Serious Mental Illness)**

Your child is eligible for a **maximum of ninety (90) mental health inpatient days** per calendar year. The ninety (90) day maximum is a combination of both medical/surgical and mental health services.

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

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

**Inpatient Services—Serious Mental Illness**

Your child is eligible for a **maximum of thirty (30) serious mental illness inpatient days** per calendar year. If needed, you can exchange one (1) inpatient day for two (2) outpatient visits.

During a serious mental illness admission your child will be eligible for:

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

**Partial Hospitalization—Mental Health and Serious Mental Illness**

Partial hospitalization 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**.

Partial hospitalization includes 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 partial hospitalization services must be preapproved by the behavioral health management company and are covered in place of an inpatient hospital stay. For every two (2) partial hospitalization days your child uses, the available inpatient days are reduced by one (1).
**Your Child’s Substance Abuse Benefits—What is Covered**

**Outpatient Services—Substance Abuse**

Your child is eligible for **up to thirty (30)** substance abuse outpatient visits **per calendar year**. There is a **lifetime limit of 120 visits**. If needed, you can exchange one (1) inpatient day for two (2) outpatient visits for your child.

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 the behavioral health management company at 1-800-294-0800; TTY Service: 1-800-409-8640.

Outpatient substance abuse treatment covered services provided in an acute care hospital or a substance abuse treatment facility that is a behavioral health/substance abuse provider, include:

A. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
B. Services provided by the behavioral health/substance abuse providers on staff;
C. Rehabilitation therapy and counseling;
D. Family counseling and intervention; and
E. Covered prescription drugs, medicines, supplies and use of equipment provided by the substance abuse treatment facility.

**Intensive Outpatient Program (IOP)—Substance Abuse**

Intensive Outpatient Program (IOP) is care that is more intensive than outpatient care, but does not require an inpatient stay. IOP is a day or evening treatment program that lasts a minimum of **two (2) hours per session**, with your child attending **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 IOP services must be preapproved by the behavioral health management company. **One (1) IOP session equals one (1) outpatient session.**

**Inpatient Services—Substance Abuse**

Your child is eligible for a **maximum of thirty (30)** substance abuse inpatient days **per calendar year**. There is also a **lifetime limit of ninety (90) substance abuse inpatient days**.

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

- Individual counseling
- Group counseling
- Family counseling
- Medication management
- Detoxification

➢ Your child is eligible for **seven (7) days of detoxification per admission** with a limit of **four (4) admissions per lifetime**.
Mental Health, Serious Mental Illness and Substance Abuse Exclusions—What is Not Covered

- Chronic Care—services for the seriously mentally ill as defined by the Department of Public Welfare
- Court ordered care
- Educational activities
- EPSDT wraparound services and intensive case management services as defined by the Department of Public Welfare
- Evaluation or testing (and completion of forms) for:
  - adoption
  - attention deficit disorder
  - child custody
  - insurance
  - legal
  - neuropsychological
  - school
  - travel
- Mental retardation services
- Psychological testing, except brief testing to establish a diagnosis
- Long term care services provided in extended care facilities and state mental health facilities
- Psychiatric consults during a medical admission, unless authorized by the behavioral health management company
- Emergency room services or services provided by a non-participating provider unless deemed a psychiatric emergency or preapproved by the behavioral health management company
- Acupuncture, biofeedback, hypnosis, pastoral counseling, psychoanalysis
- Treatment of autism, sleep disorders or neuropsychiatric disorders
- Weight reduction or weight control services
- Services which are not medically necessary
- Treatment programs, medicines or drugs for obesity
- Methadone maintenance

Complaints and Grievances

If you have a concern about your child’s mental health, serious mental illness or substance abuse services call the Caring Foundation at 1-800-464-5437. If a Caring Foundation 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 40.
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

Call this number when you need to locate a provider for your child.

• Tell the provider your child is enrolled in Keystone Health Plan East.
• Give the provider’s office your child’s ID number located on his/her Keystone ID Card.
• The provider will obtain the necessary authorization for your child.
• No referral is necessary.

Your child’s frames and lenses will be covered 100%, at the time of purchase, and guaranteed unconditionally against breakage for one year if:

• purchased through a Davis Vision participating provider; and
• chosen from a large selection of quality frames in the Davis Vision “Tower Collection.”

You may purchase contact lenses, in place of eyeglasses, for your child. (See page 86)

Vision Care—What is Covered

Eye Examinations

All routine eye examinations and refractions must be performed by a Davis Vision participating provider. Routine eye examinations received from a Davis Vision participating provider are covered 100%, once every calendar year.

Frames and Lenses

Purchased From a Davis Vision Participating Provider

• Your child is entitled to one (1) pair of frames, once every calendar year, from the Davis Vision “Tower Collection” of frames at no additional cost; and
• One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular and/or oversized lenses.

Note: Other services are available at a discount.
Guarantee

Purchased From a Davis Vision Participating Provider

- Eyeglass frames and lenses, purchased from a Davis Vision participating provider and chosen from the “Tower Collection” are backed by an unconditional one-year guarantee against breakage. Lost or stolen eyewear is not covered.

- If a non-Davis Vision frame is purchased from a Davis Vision provider, only the lenses are covered by a one-year guarantee against breakage.

Purchased From a Non-Participating Provider

If you choose to purchase your child’s eyeglasses from a provider who does not participate in the Davis Vision network, you will be responsible for paying the entire amount at the time of purchase. To be reimbursed:

1. Call Davis Vision at 1-888-393-2583 for a reimbursement form.

2. Submit your receipt of purchase to Davis Vision for a reimbursement up to your child’s benefit amount of $100.

3. Balances in excess of $100 are your responsibility. There is no guarantee, by Davis Vision, on eyeglasses or frames purchased from a non-Davis Vision provider.

Contact Lenses

Purchased From a Davis Vision Participating Provider

If you choose to use your child’s eyewear benefit to purchase contact lenses, in place of eyeglasses, you will be credited for your child’s eyewear allowance of $100 at the time of purchase, eliminating unnecessary out-of-pocket expenses or the need to file and wait for reimbursement.

- Balances in excess of $100 are your responsibility at the time of purchase.

Purchased From a Non-Participating Provider

If you choose to purchase your child’s contact lenses from a provider who does not participate in the Davis Vision network, you will be responsible for paying the entire amount at the time of purchase. To be reimbursed:

1. Call Davis Vision at 1-888-393-2583 for a reimbursement form.

2. Submit your receipt of purchase to Davis Vision for a reimbursement up to your child’s benefit amount of $100.

3. Balances in excess of $100 are your responsibility.
Vision Care Exclusions—What is Not Covered

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

**Note:** Only eye examinations performed by a Davis Vision provider are covered. If you take your child to a provider who does not participate in the Davis Vision network you will be responsible for paying the entire amount of the examination. No reimbursement will be made for an examination received from a non-participating provider.
Section 15
Medical Exclusions—What is Not Covered

The following are excluded from your child’s coverage:

1. Services or supplies which are:
   A. Not provided by or referred by your child’s primary care physician except in an emergency or as specified elsewhere in this handbook;
   B. Not medically necessary, as determined by your child’s primary care physician 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
   C. Provided by family members, relatives, and friends;

2. The cost of services or supplies which are payable under Worker’s Compensation or employer’s liability laws or other legislation of similar purpose (or services for which you have no obligation to pay);

3. 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;

4. Care for conditions that federal, state or local law requires to be treated in a public facility;

5. The cost of services covered under the Medicare program;

6. The cost of hospital, medical or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such costs are payable under any medical expense payment provision by whatever terminology used, including benefits mandated by law of any automobile insurance policy unless otherwise prohibited by applicable law;

7. 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;

8. Services or supplies which are experimental or investigative, except routine costs associated with qualifying clinical trials that have been preapproved by Keystone.

Routine costs do not include any of the following:

A. The experimental/investigational drug, biological product, device, medical treatment or procedure itself;
B. The services and supplies provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
C. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the qualifying clinical trial;
9. Physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for camp, college or travel, and examinations for insurance, licensing and employment;

10. 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;

11. Rehabilitation therapy provided for: the ongoing outpatient treatment of chronic medical conditions that are not subject to significant improvement within sixty (60) days; additional therapy beyond the plan’s day limit, if any, shown on the schedule of copayments and limitations; work hardening; evaluations not associated with short term rehabilitation therapy; or therapy for back pain in pregnancy without specific medical conditions;

12. Any rehabilitation therapy service for: the maintenance of chronic conditions; for injuries or illnesses when response to treatment has reached the maximum therapeutic level; or when no additional functional improvement can be demonstrated or anticipated and continuation of the service will be of no therapeutic value to the member;

13. All 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;

14. Services for treatment of mental retardation or other mental health services, except as otherwise provided herein;

15. Immunizations required for employment or travel;

16. Custodial and domiciliary care, residential care, protective and supportive care, including educational services, rest cures and convalescent care;

17. 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;

18. Nutritional supplements, except when the member has no other source of nutritional intake due to a metabolic or anatomic disorder;

19. Customized wheelchairs;
20. Personal or comfort items such as television, telephone, air conditioners, humidifiers, barber or beauty service, guest service and similar incidental services and supplies which are not medically necessary;

21. Normal childbirth deliveries outside the service area within thirty (30) days of the expected delivery date established by the provider in charge of the case;

22. Any procedure or treatment designed to alter physical characteristics of the member to those of the opposite sex, and any other treatment or studies related to sex transformations;

23. Treatment of bunions (except capsular or bone surgery), toenails (except surgery for ingrown nails), horns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet or other routine podiatry care, unless associated with peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes and deemed medically necessary by your child’s primary care physician or Keystone;

24. Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of substance abuse in an acute care hospital;

25. Marriage counseling;

26. In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any services required in connection with these procedures;

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

28. 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;

29. Ambulance service, unless medically necessary;

30. 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;

31. Charges for completion of any insurance form;

32. Treatment for injuries sustained while committing a felony; or while intoxicated or under the influence of any narcotic not prescribed or authorized by your child’s primary care physician;

33. Whole blood or blood plasma;

34. Injectable medications except those necessary for the immediate treatment of an injury or acute illness when provided or referred by your child’s primary care physician and administered in the physician’s office;

35. 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;

36. 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;
37. 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;

38. The following outpatient services that are not performed by your child’s primary care physician’s designated provider, when required under the plan, unless preapproved by Keystone:

   A. rehabilitation therapy services (other than speech therapy);
   
   B. certain podiatry services; and
   
   C. diagnostic radiology services for children age five (5) or older;

39. Care for cognitive therapy;

40. Inpatient care private duty nursing services;

41. Medication furnished by any other medical service for which no charge is made to the member;

42. Any charges for the administration of injectable insulin;

43. Genetic counseling and genetic studies except as otherwise stated in this handbook;

44. Equipment for which any of the following statements are true is not DME and will not be covered.

   Any item:
   
   A. **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;
   
   B. **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;
   
   C. **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;
   
   D. **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; lambs wool pads; ace bandages; antiembolism stockings; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits;
   
   E. **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 pack; 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;
F. **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;

G. **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;

H. **Which 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; or

I. **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.

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

45. The cost of non-automated home blood pressure machines except for the following: members with end-stage renal disease receiving home dialysis; and, members with pregnancy induced hypertension and pregnancy complicated by hypertension;

46. In regard to Hospice Care:
   
   A. Private Duty Nursing care;
   
   B. Research studies directed to life-lengthening methods of treatment;
   
   C. 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
   
   D. Treatment to cure the member’s illness;

47. 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; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy;

48. Any Mental Health Care, Serious Mental Illness Health Care, or Substance Abuse Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as: Alternative Therapies/Complementary Medicine and obesity control therapy; Charges not billed/performed by provider;

49. Home Health Care services and supplies in connection with Home Health services for the following:

   A. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;

   B. Rental or purchase of durable medical equipment;
C. 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;

D. Prescription drugs;

E. Provided by family members, relatives and friends;

F. A member’s transportation, including services provided by voluntary ambulance associations for which the member is not obligated to pay;

G. Emergency or non-emergency ambulance services;

H. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy and/or social services;

I. Services provided to individuals (other than a member released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and

J. 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;

50. Treatment of obesity, except for surgical treatment of obesity when Keystone:

A. Determines the surgery is medically necessary; and

B. The surgery is not a revision, repeat or reversal of any previous obesity surgery. The exclusion of coverage for a revision, repeat or reversal of any previous obesity surgery does not apply when required for complications which, if left untreated, would result in endangering the health of the member; and

51. For the maintenance of chronic conditions, illness or injury.
Section 16

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:

A. Alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine);

B. 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));

C. 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);

D. Manipulative and body-based methods (e.g., massage, equestrian/hippotherapy); and

E. Energy therapies, involving the use of energy fields. They are of two types:

1. 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.

2. Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

**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 traditional 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.

**CARDIAC REHABILITATION THERAPY**—a medically supervised rehabilitation program designed to improve a patient’s tolerance for physical activity or exercise.
CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)—the program providing free or low cost health insurance to low-income, uninsured children in Pennsylvania, established by PA Act 113 of 1992, and expanded by PA Act 68 of 1998.

CHEMOTHERAPY—the treatment of malignant disease by chemical or biological antineoplastic agents.

COGNITIVE THERAPY—is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system.

COMPLAINT—a dispute or objection regarding coverage, including exclusions and non-covered services under the plan, participating or non-participating 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).

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.

COVERED SERVICE—a service or supply specified in the contract and summarized in the Summary of Benefits section of 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.

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

A. Appropriate for the symptoms and diagnosis or treatment of the member’s condition, illness, disease or injury;

B. In accordance with accepted standards of good dental practice;

C. Not primarily for the convenience of the patient or the provider; and

D. 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 certain therapy services (other than speech therapy), non-routine podiatry services or diagnostic radiology services for members age five (5) or older. The member’s primary care physician will provide a referral to the participating provider as its sole source for covered rehabilitation therapy services (other than speech therapy), podiatry services or diagnostic laboratory and x-ray 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.

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

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

A. It is durable. (This means it can withstand repeated use);

B. 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;

C. It is generally not useful to a person without an illness or injury; or

D. 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 Keystone and the Caring Foundation.

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 the Caring Foundation 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:

A. 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;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part. Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.
EXPERIMENTAL/INVESTIGATIONAL SERVICES—A drug, biological product, device, medical treatment or procedure which meets any of the following criteria is an Experimental/Investigational Service.

A. It is the subject of ongoing Phase I or Phase II Clinical Trials;

B. It is the research, experimental, study or investigational arm of ongoing Phase III Clinical Trials 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;

C. It is not of proven benefit for the particular diagnosis or treatment of your child’s particular condition;

D. It is not generally recognized by the medical community, as clearly demonstrated by reliable evidence, as effective and appropriate for the particular diagnosis or treatment of your child’s particular condition; or

E. It is generally recognized by either reliable evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of your child’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 for the particular diagnosis or condition. 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 (1) or more of the following established referenced compendia recognize the usage as appropriate medical treatment. The compendia are:

• The American Hospital Formulary Service Drug Information; or

• The United States Pharmacopeia Drug Information.

In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

In addition to the above criteria that pertain strictly to its use, a drug, biological product or device, any drug, biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below in paragraphs A – E:

A. Reliable evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).

C. 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.
D. 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.

E. 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.

**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.

**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).

**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.

**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).

**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.
HOSPICE PROVIDER—a licensed provider that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people whose estimated survival is 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.

HOSPITAL—any institution duly licensed, certified and operated as a hospital. In no event shall the term hospital include a convalescent facility, nursing home, or any institution or part thereof which is used as a convalescent facility, rest facility, nursing facility or facility for the aged.

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, preapproved by Keystone, and set forth in the Summary of Benefits.

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 Center for Disease Control, U.S. Department of Health and Human Services.

INPATIENT CARE—treatment received as a bed patient in a hospital, a rehabilitation hospital, a skilled nursing facility or a substance abuse treatment facility.

INTENSIVE OUTPATIENT PROGRAM—the provision of medical, nursing, counseling or therapeutic covered services on a planned and regularly scheduled basis in a facility licensed by the Pennsylvania Department of Health as a substance abuse treatment program or any other mental health therapeutic modality designed for a patient or client who would benefit from more intensive treatment than is offered on an outpatient basis but who does not require care as an inpatient.

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

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 235% of the Federal Poverty Guidelines.
MAINTENANCE—continuation of care and management of the member when:

A. The maximum therapeutic value of a medically necessary treatment plan has been achieved;
B. No additional functional improvement is apparent or expected to occur;
C. The provision of covered services ceases to be of therapeutic value; and
D. 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.

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 and serious mental illness.

MEDICAID—the program of Medical Assistance established by Title XIX of the Social Security Act of 1965, as amended, and Pennsylvania Statue, 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 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—an intervention is medically necessary if it is recommended by the primary care physician or referred specialist, and the HMO’s medical director or physician designee determines that it is all of the following:

A. It is a “health intervention.” A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a “medical condition” or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; or biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied;

B. It is the most appropriate supply or level of service, considering the potential benefits and harms to the member;
C. It is known to be “effective” in improving “health outcomes.” Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a “new” or “existing” intervention.

1. New interventions—Effectiveness is determined by “scientific evidence.” An intervention is considered new if it is not yet in widespread use for: (a) the medical condition and (b) the patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by: (a) the natural history of the medical condition or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

2. Existing interventions—Effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

For existing interventions scientific evidence is considered first and, to the greatest extent possible, is the basis for determinations of medical necessity.

If no scientific evidence is available, professional standards of care are considered.

If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions are based on expert opinion.

Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence.

Existing interventions can meet the definition of medical necessity in the absence of scientific evidence if: (a) there is strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or (b) in the absence of such standards, convincing expert opinion; and

D. It is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual member, the characteristics of the individual member shall be determinative.

An intervention may be medically indicated yet not be a covered service or meet this definition of medical necessity. An intervention is covered if: (a) it is a Covered Service, (b) it is not excluded from your Coverage, and (c) it is Medically Necessary.

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. For purposes of this handbook, conditions categorized as mental illness do not include those conditions listed under serious mental illness because the benefit limits for mental illness and serious mental illness are separate and not cumulative.

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:

A. 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

B. Urgent care and follow-up care available through the BlueCard program.

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

OUTPATIENT MENTAL HEALTH CARE/OUTPATIENT SERIOUS MENTAL ILLNESS 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 or serious mental illness 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.

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:

A. 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.
B. **Referred Specialist**—a provider who provides covered specialist services within his/her specialty and upon referral from a primary care physician. In the event there is no participating provider to provide the specialty or subspecialty services, referral to a non-participating provider will be arranged by your child’s primary care physician with preapproval by Keystone. See “Preapproval for Non-Participating Providers” on page 33 for obtaining preapproval for use of a non-participating provider.

C. **Participating Hospital**—a hospital that has contracted with Keystone to provide covered services to members.

D. **Durable Medical Equipment (DME) Supplier**—a participating supplier of durable medical equipment that has contracted with Keystone to provide covered supplies to Keystone members.

E. **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, serious 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 and serious mental illness only.

F. **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.

**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.

**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. Such approval must be obtained prior to providing your child with covered services or referrals. Approval will be given by the appropriate Keystone staff, under the supervision of the medical director. 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.
PRE-AUTHORIZATION—with respect to dental benefits, the determination of benefits for dental covered services before the services are performed.

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 member services 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.

PRESCRIPTION ORDER or REFILL—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.

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

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 or practitioner that is licensed to render health care services including, but not limited to: a physician, 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 and serious mental illness services only, a licensed clinical social worker and a master’s prepared therapist will also be considered a provider.

PULMONARY REHABILITATION—multi-disciplinary treatment that combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

QUALIFYING CLINICAL TRIAL—the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

A. It investigates a service that falls within a benefit category of this contract or handbook;
B. It is not specifically excluded from coverage;
C. It has a therapeutic intent upon enrolled patients with diagnosed disease;
D. It is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available reliable evidence;
E. It does not duplicate existing studies;
F. It is designed and conducted according to appropriate standards of scientific integrity;
G. It complies with Federal regulations relating to the protection of human subjects;
H. It has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
I. One of the following applies:

1) It is funded by or supported by centers or cooperative groups that are funded by one of the following:
   • The National Institutes of Health (NIH)
   • Centers for Disease Control and Prevention (CDC)
   • Centers for Medicare and Medicaid Services (CMS)
   • A research arm of the Department of Defense (DOD)
   • Department of Veterans Affairs (VA)

2) It is conducted under an investigational new drug application (IND) reviewed by the FDA, or an investigational new drug exemption as defined by the FDA; and

J. It is conducted by a primary care physician, referred specialist or a non-participating specialist, when preapproved by Keystone and conducted in a participating provider facility. See “Preapproval for Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating provider.

In the absence of meeting the criteria listed in A – J above, the clinical trial must be approved by Keystone as a qualifying clinical trial.

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.

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 non-participating providers must be preapproved by Keystone. See “Preapproval for Non-Participating Providers” on page 33 for procedures for obtaining preapproval for use of a non-participating 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.

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.

RELIABLE EVIDENCE—Any of the following:

A. Reports and articles that have been published in the authoritative medical and scientific literature;

B. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or

C. The written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.
**RESPIRATORY THERAPY**—medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

**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.

**ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS**—routine costs include all the following:

A. Covered services under this contract that would typically be provided absent a qualifying clinical trial;

B. Services and supplies required solely for the provision of the experimental/investigational drug, biological product, device, medical treatment or procedure;

C. The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and

D. The services and supplies required for the diagnosis or treatment of complications.

**SERIOUS MENTAL ILLNESS**—the following biologically based mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual:

A. Schizophrenia;

B. Bipolar disorder;

C. Obsessive-compulsive disorder;

D. Major depressive disorder;

E. Panic disorder;

F. Anorexia nervosa;

G. Bulimia nervosa;

H. Schizo affective disorder;

I. Delusional disorder; and

J. Any other mental illness that is considered to be “Serious Mental Illness” by law.

Benefits are provided for treatment of these conditions when determined to be medically necessary and provided by a mental health care provider. A referral from your child’s primary care physician is not required. Covered services may be provided in an outpatient or inpatient mental health care facility or through a partial hospitalization program.

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

**SKILLED NURSING FACILITY**—an institution that is licensed as a skilled nursing facility and has contracted with Keystone to provide covered services to members.
SPECIALIST SERVICES—all physician services providing medical care in any generally accepted medical or surgical specialty or subspecialty.

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.

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.

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.

URGENT CARE—medically necessary covered services provided in order to treat an unexpected illness or accidental injury that is not life- or limb-threatening. Such covered services must be required in order to prevent a serious deterioration in the member’s health if treatment were delayed.
If you have any questions about your child's health insurance, call

1-800-464-5437
(TDD 215-241-2622)

or write us at:

Independence Blue Cross & Highmark Blue Shield
Caring Foundation
PO Box 13449
Philadelphia, PA 19101-3449

or visit our website at:

www.caringfoundation.com
**What Insurance is Available?** (replaces the text under Introduction, page 10*) --- effective March 1, 2007

**Free CHIP**
A state and federally supported free health insurance program for uninsured children and teens up to 19. The family’s size and income are used to determine a child’s eligibility. The parent of an eligible child is not responsible for a monthly premium and/or copayments for covered services.

**Low Cost CHIP**
A state and federally supported health insurance program for uninsured children and teens up to 19. The family’s size and income are used to determine a child’s eligibility. The parent of an eligible child is responsible for a monthly premium, which is a portion of the full cost of the coverage, and the following copayments:
- $5 for each visit to the child’s primary care physician (except for well-child visits).
- $10 for each visit to a referred specialist.
- $25 for a visit to the emergency department of the closest hospital (waived if admitted).
- $6 for each generic and $9 for each brand name prescription drug.

**At Cost CHIP**
A health insurance program for uninsured children and teens up to 19. The family’s size and income are used to determine a child’s eligibility. The parent of an eligible child is responsible for a monthly premium, which is the full cost of the coverage, and the following copayments:
- $15 for each visit to the child’s primary care physician.
- $25 for each visit to a referred specialist.
- $50 for a visit to the emergency department of the closest hospital (waived if admitted).
- $10 for each generic and $18 for each brand name prescription drug.

**Eligibility – Who is Eligible?** (additional text under Section 1, Your Child’s Eligibility, Coverage and Payments, page 11) --- effective March 1, 2007

- For Low Cost and At Cost CHIP members ONLY: Must be uninsured for at least six (6) months prior to the date of enrollment in CHIP, EXCEPT if uninsured as a direct result of a parent no longer working; if transferring from another public insurance program; or if the child is under age two; and
- For At 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.

**Recommended Childhood Immunization Schedule** (additions to the table on page 20) --- effective March 1, 2005

- **Hepatitis A**: 1st dose, 12-23 months of age; 2nd dose, 6 months after 1st dose
- **Meningococcal**: 1 dose (The Centers for Disease Control and Prevention recommends for all 11 to 12-year-olds, those entering high school, and college freshmen living in dorms if they have not previously received this vaccine.)

**Emergency Care Copayment** (additional text under Section 5, Emergency Care, Urgent Care and Follow-Up Care, page 34) --- effective March 1, 2007

If a Low Cost CHIP or At Cost CHIP member has been referred to the emergency department of the closest hospital by the child’s primary care physician or Keystone Health Plan East, 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.

-**over**-
Durable Medical Equipment, Prosthetics, and Orthotics (clarification to the benefits listed under Section 10, Outpatient and Inpatient Services, pages 61-73) --- effective January 1, 2007

Durable medical equipment, prosthetics and orthotics with a purchase price of more than $500 will require preapproval.

Ambulance Services (replaces the text on page 61) --- effective January 1, 2007

Benefits are provided for ambulance services that are medically necessary, as determined by Keystone Health Plan East, 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;
- 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 Health Plan East to determine medical necessity, which includes specific origin and destination requirements specified in Keystone’s policies. Also, non-emergency ambulance transports are not provided for the convenience of the child, the family, or the provider treating the child.

Contraceptives (additional text under Section 10, Outpatient and Inpatient Services, pages 61-73 and Section 11, Prescription Drug Benefits, pages 74-76) --- effective March 1, 2007

- Prescription contraceptive devices, obtained from the provider and implanted while in the provider’s office, are covered benefits of this program.
- Oral contraceptives for birth control purposes are covered under the prescription drug benefits of this program.

Residential Treatment Center (additional text under Section 13, Mental Health, Serious Mental Illness and Substance Abuse Benefits, pages 80-84) --- effective January 1, 2007

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

Special Circumstances --- effective January 1, 2007

Independence Blue Cross and Keystone Health Plan East may waive certain contract requirements (e.g., referrals, preapproval, or use of participating providers) when faced with unforeseen events, such as natural disasters, pandemics, etc. These events are recognized in the community and by Keystone Health Plan East and appropriate regulatory authority as extraordinary circumstances not within the control of Keystone Health Plan East.

*All page listings refer to the CHIP Benefits Handbook (3/05).
What Happens if a Premium is Paid Late? (replaces the text under Section 1, Your Child’s Eligibility, Coverage and Payments, page 13*) --- effective September 1, 2007

If your child is eligible for Low Cost CHIP or At Cost CHIP and 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 six months after the date the CHIP benefits end. Also, you will need to complete a new application.

Recommended Childhood Immunization Schedule (additions to the table in Section 2, Your Child’s Primary and Preventive Health Services, page 20) --- We cover your child’s immunizations as recommended by the Centers for Disease Control and Prevention (CDC).

- **Tetanus, Diptheria, Pertussis (Tdap):** 1 dose, 11-12 years of age (if child did not receive a Td booster dose).
- **Varicella (chickenpox):** 1st dose, 12-15 months of age; 2nd dose, 4-6 years of age.
- **Influenza:** Annually, 6-59 months of age; annually, 5-18 years of age (if at high risk). Children under 9 who are receiving the influenza vaccine for the first time should receive two doses (separated by four or more weeks for TIV and six or more weeks for LAIV). If only one dose was received by a child in this age group during the first year of vaccination, two doses should be received the following year.
- **Rotavirus (Rota):** 1st dose, 2 months of age; 2nd dose, 4 months of age; 3rd dose, 6 months of age.
- **Human Papillomavirus (HPV):** for females only – 1st dose, 11-12 years of age; 2nd dose, 6 months after 1st dose; 3rd dose, 6 months after 2nd dose.
- **Hepatitis A (HepA):** 1st dose, 12-23 months; 2nd dose 6 months after 1st dose.
- **Meningococcal:** 1 dose, 11-18 years of age.

Diabetic Supplies (clarification to the benefit listed under Section 8, Summary of Benefits, page 56, and Section 10, Outpatient and Inpatient Services, Outpatient Services, page 62; and Inpatient Services, page 69) --- effective March 1, 2005

Diabetic supplies do not require preapproval.

(over)
Therapies (clarification to the benefits listed under Section 8, Summary of Benefits, pages 56-58, and Section 10, Outpatient and Inpatient Services, pages 61-73) --- effective December 1, 2005

- There is an annual maximum of 60 visits for each of the following Rehabilitation Therapy Services:
  - Speech
  - Occupational
  - Physical

- There is no maximum number of visits for Chemotherapy, Dialysis, Respiratory Therapy, or Radiation Therapy.

Nutritional Counseling (additional text under Section 10, Outpatient and Inpatient Services, Outpatient Services, pages 61-68) --- effective July 1, 2007

Benefits are provided for up to six outpatient nutritional counseling visits per year for the purpose of weight management when performed by a participating physician, including your primary care physician, or registered dietitian. When visits are with someone other than your child’s primary care physician, a referral must be obtained from your child’s primary care physician. If nutritional counseling visits are provided in addition to other covered services, a copayment may apply for Low Cost CHIP and At Cost CHIP members.

Private Duty Nursing (additional text under Section 10, Outpatient and Inpatient Services, Outpatient Services, pages 61-68) --- effective March 1, 2005

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.

Substance Abuse (replaces the first paragraphs of the Outpatient Services – Substance Abuse and Inpatient Services – Substance Abuse, under Section 13, Mental Health, Serious Mental Illness, and Substance Abuse Benefits, page 83) --- effective September 1, 2007

- **Outpatient Services – Substance Abuse**: Your child is eligible for up to 90 substance abuse outpatient visits per calendar year. There is a lifetime limit of 360 outpatient visits. If needed, you can exchange one inpatient day for two outpatient visits for your child.

- **Inpatient Services – Substance Abuse**: Your child is eligible for a maximum of 90 substance abuse inpatient days per calendar year. There is a lifetime limit of 360 substance abuse inpatient days.

*All page listings refer to the CHIP Benefits Handbook (3/05).
Independence Blue Cross & Highmark Blue Shield Caring Foundation

CHIP Benefits Update 3
(Please keep this update with your CHIP Benefits Handbook)

Renewal of Coverage (additional text under Section 1; Your Child’s Eligibility, Coverage and Payments; page 12*) – effective September 1, 2008

If by the end of the renewal period, you provide incomplete or no proof of income, the Caring Foundation will offer your child At Cost CHIP coverage.

Termination of Coverage (additional text under Section 1; Your Child’s Eligibility, Coverage and Payments; page 13-14) – effective January 1, 2008

5. If you fail to pay your child’s monthly premium for Low Cost CHIP or At Cost CHIP.
6. If you display a pattern of non-compliance with your child’s physician’s plan of treatment. You will receive written notice at least 30 days prior to termination. You have the right to use the Complaint Appeal and Grievance Appeal Process (see page 40).
7. If you do not cooperate with Keystone Health Plan East (“Keystone”) in obtaining information necessary to determine Keystone’s liability under this program.

Designated Providers (text added to How to Get Basic Health Care under Section 3, How to Use Your Child’s Insurance – A Summary of Things to Remember About the Keystone Plan, page 21) – effective January 1, 2008

Your child’s primary care physician will submit an electronic referral to his or her designated provider for the following outpatient specialist services: physical and occupational therapy, and diagnostic services for children 5 and older. 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 See a Specialist (replaces text under Section 3, How to Use Your Child’s Insurance – A Summary of Things to Remember About the Keystone Plan, page 21) – effective January 1, 2008

- 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 30.
- 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 29.
- Your child’s primary care physician must obtain a preapproval for specialist services by nonparticipating providers.
Note: Any reference in the CHIP Benefits Handbook saying that your child’s primary care physician will provide a written referral is deleted. The primary care physician will submit an electronic referral to the appropriate participating provider for your child’s specialty care.

**Designated Providers** (replaces text in How Keystone Reimburses Providers under Section 3, How to Use Your Child’s Insurance – A Summary of Things to Remember About the Keystone Plan, page 24) – effective January 1, 2008

For physical and occupational therapy and diagnostic services for children 5 and older, PCPs are required to select a designated provider to which they refer their patients for those particular services. Designated providers usually receive a set dollar amount per member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, a parent may want to speak to the child’s PCP regarding the designated provider that PCP has chosen.

**Your Child Has Direct Access to Certain Care** (replaces item 2, Your Child Has Direct Access to Certain Care under Section 4, How to See a Specialist or Plan for Hospital Care, page 29) – effective January 1, 2008

2. Care from a participating obstetrical/gynecological specialist;

**When You Don’t Use the BlueCard® Program** (change of address under Section 5; Emergency Care, Urgent Care, and Follow-up Care; page 38) – effective January 1, 2008

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

**Internal Second Level Standard Grievance Appeals** (change under Section 6, Your Child’s Membership Rights/Filing a Complaint or Grievance for Your Child, page 50) – effective January 1, 2008

The sentence “The committee’s review will include the matched specialist report prepared for the first level grievance committee” is replaced by “The committee’s review will include the matched specialist report.”

**Claim Procedures** (subsection is added to Section 7, Your Responsibilities as the Parent or Guardian of a Keystone CHIP Member, page 54) – effective January 1, 2008

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 the CHIP Benefits Handbook unless proper notice is furnished to Keystone that covered services in the handbook have been rendered to your child. Written notice of a claim must be given to Keystone within 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 Member Services 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 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 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 handbook, it must be submitted to Keystone on the appropriate claim form. Keystone, upon receipt of a notice of claim will, within 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 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 Member Services 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 handbook.

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:

A. Person or organization providing the service or supply;
B. Type of service or supply;
C. Date of service or supply;
D. Amount charged; and
E. 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 handbook will be processed immediately upon receipt of proper proof of loss.
Diabetic Self-Management and Education  (replaces text under Section 10, Outpatient and Inpatient Services, page 62) – effective January 1, 2008

Benefits are provided for self-management training and education relating to diet when prescribed by a primary care physician or referred specialist. Covered services may be provided by a participating provider who is a licensed health care professional approved by Keystone. Covered services may also be provided by a participating community-based program, which is approved by Keystone in accordance with criteria based on the certification programs for diabetic self-management training and education programs developed by the American Diabetes Association and the Pennsylvania Department of Health, as follows:

A. Visits medically necessary upon the diagnosis of diabetes;
B. Visits under circumstances whereby your child’s primary care physician or referred specialist identifies or diagnoses a significant change in your child’s symptoms or conditions that necessitates changes in his or her self-management;
C. Where a new medication or therapeutic process relating to your child’s treatment and/or management of diabetes has been identified as medically necessary by your child’s primary care physician or referred specialist.

Note: The text “or at a participating hospital on an outpatient basis” is deleted.

Home Health Care (Preapproval)  (additional text under Section 10, Outpatient and Inpatient Services, page 64) – effective January 1, 2008

Care within 48 hours following release from an inpatient admission when the discharge occurs within 48 hours following a mastectomy.

Rehabilitation Therapy Services  (change under Section 10, Outpatient and Inpatient Services, page 67) – effective January 1, 2008

The first sentence, “Covered services for all covered therapies other than speech therapy must be performed by your child’s primary care physician’s designated provider” is replaced by “Covered services for all covered therapies other than hand therapy and speech therapy must be performed by your child’s primary care physician’s designated provider.”

Organ Transplants  (replaces text under Section 10, Outpatient and Inpatient Services, page 71) – effective January 1, 2008

Eligibility for covered services related to human organ, bone, and tissue transplant are as follows:

When your child is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all covered services. Covered services for inpatient and outpatient care related to the transplant include procedures that are generally accepted as not experimental/investigational 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 that are directly and specifically related to your child’s 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.

If a human organ or tissue transplant is provided by a donor to a human transplant recipient:
A. when both the recipient and the donor are members, each is entitled to the benefits of this plan.
B. when only the recipient is a member, both the donor and the recipient are entitled to the benefits in this Benefits Handbook. However, donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.
C. when only the donor is a member, the donor is entitled to the benefits of this Benefits Handbook, subject to the following limitations:
   1. 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 Benefits Handbook;
   2. No benefits will be provided to the non-member transplant recipient.
D. 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:
1. Removal of the organ;
2. Preparatory pathologic and medical examinations;

**Dental Services – What is Covered** (replaces item A, Preventive Services under Section 12, Dental Benefits, page 77) – **effective December 1, 2007**

A. Routine prophylaxis (including cleaning, scaling, and polishing of teeth), but limited to not more than once in any period of six consecutive months with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during the pregnancy.

**Exclusions** (replaces text under Section 15, Medical Exclusions – What is Not Covered, pages 88-93) – **effective January 1, 2008, unless noted otherwise**

17. 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. (**effective July 1, 2007**)

39. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to, physical, occupational, and speech therapies in a multidisciplinary, goal-oriented, and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy).
45. 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.

50. Treatment of obesity, except for surgical treatment of obesity when Keystone:
   A. Determines the surgery is medically necessary;
   B. The surgery is not a revision, repeat, or reversal of any previous obesity surgery. The exclusion of coverage for a revision, repeat, or reversal of any previous obesity surgery does not apply when required for complications that, if left untreated, would result in endangering the health of the member.
   This exclusion does not apply to nutrition counseling visits/sessions provided by Keystone through its Nutrition Counseling for weight management benefit. (effective July 1, 2007)

Definitions (change under Section 16, Important Definitions, pages 94-107) – effective January 1, 2008, unless noted otherwise

- **Cognitive Rehabilitative Therapy** (replaces “Cognitive 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.

- **Participating Provider**
  G. **Obstetricians and Gynecologists** – a participating provider selected by a female member who provides obstetrical and/or gynecological covered services without a referral. Participating obstetricians and gynecologists have the same responsibilities as referred specialists. For example, they must seek preapproval for certain services. Similarly, just as you have the right to designate a referred specialist as your child’s PCP, you may designate a participating obstetrician or gynecologist as your child’s PCP.

- **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.

- **Professional Provider** (replaces “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, certified registered nurse, certified nurse midwife, chiropractor, dentist, independent clinical laboratory, licensed clinical social worker (for Mental Health Care and Serious Mental Illness services only), masters-prepared therapist, optometrist, physical therapist, physician, podiatrist, psychologist, registered dietitian, speech-language pathologist, and teacher of the hearing impaired.
**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.” *(effective July 1, 2007)*

*All page listings refer to the CHIP Benefits Handbook (3/05).*

The Independence Blue Cross & Highmark Blue Shield Caring Foundation For Children, in agreement with Keystone Health Plan East, independent licensees of the Blue Cross and Blue Shield Association, is an administrator of the Children’s Health Insurance Program (CHIP). For additional information regarding CHIP, call 1-800-986-KIDS, or visit www.chipcoverspakids.com.
What Insurance is Available? (clarification for Low-Cost CHIP specialist copayments under Introduction, page 10*) --- effective February 1, 2009

Low-Cost CHIP
“$10 for each visit to a referred specialist” should be deleted and replaced by
“$10 for each visit to a referred specialist (except for mental health and substance abuse services).”

Complaint or Grievance (changes to Section 6, Your Child’s Membership Rights/Filing a Complaint or Grievance for Your Child, pages 40-53) --- effective January 1, 2009

How to Pursue a Member Complaint or Grievance Appeal
The sentence, “In order to authorize someone else to be your child’s appeal representative, you must complete The Member/Enrollee Authorization to Appeal by Provider or Other Representative and the Authorization to Release form” should be deleted and replaced by, “In order to authorize someone else to be your child’s appeal representative, you must complete the appropriate forms.”

The sentence, “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” should be deleted and replaced by, “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 a valid consent form.”

The sentence, “The decision letter will also state the qualifications and titles of the individual(s) who reviewed your child’s appeal – by title, a general description of experience, and the board certification of any Physician-reviewer – and indicate their understanding of the nature of the appeal” should be deleted and replaced by, “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.”

The correct address for the Pennsylvania Department of Health is:

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
717-787-5193
Fax: 717-705-0947
**External Standard and Expedited Complaint Appeals**
The correct addresses for the Pennsylvania Insurance Department and the Department of Health are:

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

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
717-787-5193
Fax: 717-705-0947

**Internal First-Level Standard Grievance Appeals**
The second and third paragraphs should be deleted and replaced with the following single paragraph:

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 of the same profession and/or similar specialty that typically manages the care under review.

**Internal Second-Level Standard Grievance Appeals**
The third paragraph should be deleted and replaced with:

The second-level grievance committee for a standard grievance appeal is composed of at least three 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 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.

**Internal Expedited Grievance Appeals**
The third paragraph should be deleted and replaced with:

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 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.
**Over-the-Counter Drugs** (replaces item 2, Prescription Drug Exclusions – What is Not Covered under Section 11, Prescription Drug Benefits, page 75) --- effective January 1, 2009

2. 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.

**Dental** (changes to Section 12, Dental Benefits, pages 78) --- effective February 1, 2009

**Dental Services – What is Covered**

3. Minor Restorations
   A. Amalgam (silver) and resin-based composite (white) restorations for all permanent and deciduous teeth.

4. General Services
   H. Periodontics (nonsurgical and surgical treatment of diseases of the gums and bone supporting the teeth)
      - Scaling and root planing – one per 24 months per area of mouth;
      - Periodontal maintenance (prophylaxis) – two in 12 months;
      - Debridement (full mouth) to enable comprehensive evaluation and diagnosis – once per lifetime;
      - Gingivectomy and gingivoplasty – one per surgical area per 24 months;
      - Osseous surgery – one per surgical area per 24 months;
      - Guided tissue regeneration – once per site per lifetime;
      - Bone replacement graft – one per surgical area per 24 months;
      - Soft tissue grafts – one per surgical area per 24 months;
      - Gingival flap procedures – one per surgical area per 24 months;
      - Distal or proximal wedge – (when not performed in conjunction with surgical procedures in same anatomical region) – one per surgical area per 24 months;
      - Crown lengthening – one per tooth per lifetime.

**Dental Exclusions – What is Not Covered**

“Labial veneers and laminates done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered” should be deleted and replaced by “Labial veneers and laminates done for cosmetic purposes.”

*Note: Periodontics is deleted under Dental Exclusions.*

**Substance Abuse** (removes the lifetime limits for Outpatient Services – Substance Abuse and Inpatient Services – Substance Abuse, under Section 13, Mental Health, Serious Mental Illness, and Substance Abuse Benefits, page 83, and CHIP Benefits Update 2) --- effective February 1, 2009

- **Outpatient Services – Substance Abuse**: Your child is eligible for up to 90 substance abuse outpatient visits per calendar year. There is no lifetime limit. If needed, you may exchange one inpatient day for two outpatient visits for your child.
Inpatient Services – Substance Abuse: Your child is eligible for a maximum of 90 substance abuse inpatient days per calendar year. There is no lifetime limit.

– Your child is eligible for seven days of detoxification per admission. There is no lifetime limit.

Definitions (changes under Section 16, Important Definitions, pages 94-107)---effective January 1, 2009

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, serious 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.

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.

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.

*All page listings refer to the CHIP Benefits Handbook (3/05).

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Dental Benefits (replaces all of Section 12, Dental Benefits, pages 77-79*) --- effective January 1, 2011

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 PCP to make an appointment, so making sure your child gets high-quality dental care couldn’t be easier. Your 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 the 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 [www.ucci.com/pachip](http://www.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, up to the $1,500 per member per year maximum.

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;
- Additional treatment that is needed due to noncompliance with prescribed dental care.

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 twice per calendar year 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.

The CHIP dental program is limited to an annual maximum dental benefit expenditure of $1,500 per member with the exception of comprehensive medically necessary orthodontic services which are limited to a lifetime maximum of $5,200 per member.

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 – 2 per calendar year, including consultations
  - X-rays, including full mouth X-rays – 1 in any 5 consecutive years
  - Bitewing X-rays – 1 set per calendar year

- **Preventive services**
  - Routine cleanings – 2 per calendar year, 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) – 2 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) – 2 applications per calendar year; high risk members may receive 4 applications per calendar year
  - Sealants (under age 18) – 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 – 1 per lifetime per quadrant

- **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 lifetime – prior authorization not required
  - Root canals (permanent teeth only) – 1 per tooth per lifetime
  - Apicoectomy (may also be eligible after $1,500 maximum is met if medical emergency) – 1 per lifetime
Periodontic Services
- Periodontal scaling and root planing – 4 or more teeth per quadrant 1 per quadrant in 2 years; only 2 quadrants per visit
- Periodontal maintenance – 2 services per calendar year
- Gingivectomy or gingivoplasty – 1 service per quadrant every 3 years
- Full mouth debridement – 1 per lifetime after 3 years from last cleaning

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; replacement to 1 every 5 years
- Repairs/relines/adjustments – with limitations
- 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 per lifetime

Oral Surgery
- Simple extractions
- Surgical extractions

Oral and Maxillofacial Surgery (prior authorization mandatory) – Surgical extractions not covered by the member’s medical oral surgery benefit including those involving wisdom teeth
- Soft tissue wisdom teeth
- Brush biopsies
- Alveoloplasties
- Removal of tooth-related/non-tooth-related cysts
- Incision and drainage of abscesses
- Oroantral fistula closure
- Surgical exposure and placement of device for eruption facilitation
- Tooth reimplantation and/or stabilization of an accidentally evulsed tooth
- Frenulectomy/Frenotomy
- Removal of exostosis; mandibular or palatal tori; reduction of osseous tuberosities

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
- Payments associated with comprehensive orthodontic services are subject to a lifetime limit of $5,200 per member

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 – Service is covered in addition if $1,500 maximum is met and emergency service is required
- Palliative treatment of dental pain – Service is covered in addition if $1,500 maximum is met and emergency service is required
Dental Specific Exclusions

- Fixed partials (bridges) unless required as a result of an accident or an injury
- 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
- Implantology and related services
- 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
- 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

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