Welcome!

Thank you for enrolling your child in the Children’s Health Insurance Program (CHIP) brought to you by Geisinger Health Plan Kids. Your child has broad coverage through CHIP, including:

- Doctor’s visits
- Dental and eye care
- Check-ups
- Tests and X-rays
- Prescriptions
- Emergency department visits
- Hospital stays
- And more

This handbook will help you to understand your benefits, how to get care and lots more. Remember to:

1. **Get care through your primary care provider** (PCP). In an emergency, you can go immediately to a hospital emergency department.

2. **File a complaint or grievance** if you have a concern about your benefits or care. This is reviewed and a decision made. See section 7 (page 83) to find out about filing a complaint or grievance.

3. **Call our customer service team** for answers to your questions at our toll-free number,
   
   866-621-5235 (PA Relay 711), 8 a.m. to 6 p.m., Monday through Friday.

If you don’t already have your child’s member ID card, it will arrive in the mail soon. This card includes information about your child’s benefits, PCP name and phone number and the GHP customer service team phone number. Keep the card and this handbook nearby for easy reference.

Please note that due to privacy regulations, we will direct future communications to the attention of your child.

We are pleased to provide health coverage to your child through CHIP. We look forward to serving you.

Sincerely,

Steven R. Youso
President and Chief Executive Officer
Geisinger Health Plan
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1. Introduction

A. Tips for understanding your handbook

What is important about the service area?
This handbook explains how your Geisinger Health Plan (GHP) Kids CHIP coverage works. While reading this handbook, keep in mind the following:

1. Key terms

- A **benefit limit** is a restriction on a benefit, such as a certain number of visits that are covered for a member or a total dollar amount for a benefit that is covered by this CHIP plan. The covered services in section 5 (page 26) of this handbook lists all benefit limits.
- **Benefit period** is the 12-month period your child is covered by this CHIP plan. The benefit period begins on the day noted in your eligibility notification letter as the effective date and continues for one full year unless the coverage is terminated.
- A **covered service** is service or supply listed in this handbook in section 5. These are the dental, vision, medical, preventive and well-child services your child receives with this CHIP plan.
- **HMO** means health maintenance organization. Please see section 2 (B) (page 14) of this handbook for a more detailed explanation of what an HMO is and how it operates.
- **Medical necessity** means the process the plan uses to determine if your child’s care is necessary and appropriate. See section 3 (E) (page 20) of this handbook for a more detailed explanation of this process.
- **Member** is the child enrolled in CHIP.
- **Non-participating provider** means a healthcare provider who is not part of the GHP Kids network of healthcare providers.
- **Participating provider** or **provider** means a healthcare provider who is part of the GHP Kids network of healthcare providers.
- **PCP** means your child’s primary care provider. This provider is the main source of medical care for your child and will coordinate referrals for tests or to other providers as needed. See section 3 (C) (page 19) of this handbook for information on how to choose a PCP.
- **Plan** means your child’s CHIP coverage through GHP.
- A **referral** is the process where your child’s PCP directs your child to be evaluated and/or treated by another provider. This process is explained in more detail in section 3 (D) (page 20) of this handbook.
- **Service** means a healthcare benefit or covered service available under this plan.
- **We** or **us** means GHP Kids.
- **You** are the parent or guardian of a child enrolled in CHIP and/or the child member.
2. How to contact us

Mailing address: If you need to send anything to GHP, please use the following address –
Geisinger Health Plan
M.C 3220
100 N. Academy Ave.
Danville, PA 17822

The customer service team can help you with questions you have about anything covered in
this handbook. Call the team weekdays from 8:00 a.m. to 6:00 p.m. at our toll-free number:
866-621-5235 (PA Relay 711).

People with visual impairment can contact the customer service team at 866-621-5235
(PA Relay 711) for assistance with this handbook or any other CHIP forms and documents.
The customer service team can help with CHIP-related requirements such as completing the
application or selecting a PCP.

Please visit our website at GHPKids.com for any forms, brochures or information on
CHIP. The site also contains basic health information and helpful links to other sites of
interest.
3. Needs of non-English speaking members

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 800-447-4000 (PA RELAY 711).

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Líame al 800-447-4000 (PA RELAY 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (PA RELAY 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000 (PA RELAY 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (PA RELAY 711) để biết thêm thông tin.

नॉट: अंग्रेजी भाषा में यात्रा के समय आपको ये सेवा मुफ्त में मिलेगी। कॉल करें 800-447-4000 (PA RELAY 711)।

주의: 한국어로 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (PA RELAY 711)에서 연락해 주십시오.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (PA RELAY 711)로 연락해 주십시오.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (PA RELAY 711)으로 연락해 주십시오.

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4. Tel-A-Nurse

Call Tel-A-Nurse at 877-543-6061 for health information from a nurse 24-hours a day. You can also find Tel-A-Nurse’s number on the back of your child’s identification card. Visit GHPKids.com to live chat with a Tel-A-Nurse representative.

Tel-A-Nurse can be used for finding out more information about a test your doctor ordered, asking what a medical term means or discussing non-emergency symptoms your child is having.

Tel-A-Nurse is **not** for emergencies. The service should not be used to schedule an appointment or to ask if CHIP covers a specific medical treatment.

2. Facts about the plan

A. Schedule of benefits

These are the covered services offered by this CHIP plan. For more information on the covered services or to see if a service is excluded, please refer to section 5 of this handbook, Covered Services (page 5. Covered services 26).

<table>
<thead>
<tr>
<th>Covered services</th>
<th>Free</th>
<th>Low cost</th>
<th>Full cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTISM SPECTRUM DISORDER SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Psychological</td>
<td>$0</td>
<td>Per visit</td>
<td>Per visit $15 (PCP or specialist)</td>
</tr>
<tr>
<td>Psychological Psychological</td>
<td></td>
<td>$5 (PCP or specialist)</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Therapeutic</td>
<td></td>
<td>$10 (Specialist)</td>
<td>$25 (Specialist)</td>
</tr>
<tr>
<td>CARDIAC REHABILITATION</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>DENTAL CARE and ORTHODONTIC CARE</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Benefit limit per year (dental care)</td>
<td>$0, unlimited benefit</td>
<td>$0, unlimited benefit</td>
<td>$0, unlimited benefit</td>
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<td>Benefit limit per lifetime (orthodontic care)</td>
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<td>$0, unlimited benefit</td>
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<td>DIABETIC TREATMENT</td>
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<tr>
<td>Drugs</td>
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<td>$9 (Brand)</td>
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<td>Equipment</td>
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<tr>
<td>Supplies</td>
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<tr>
<td>Provider office visits</td>
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<td>Per visit $15 (PCP)</td>
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<tr>
<td></td>
<td></td>
<td>$10 (Specialist)</td>
<td>$25 (Specialist)</td>
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<td>DIAGNOSTIC, LABORATORY</td>
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<td>$0</td>
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<td>and X-RAY SERVICES</td>
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<td>DISEASE MANAGEMENT PROGRAMS</td>
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<td>FAMILY PLANNING SERVICES</td>
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<tr>
<td>(Generic or brand)</td>
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<td>$0 (Brand)</td>
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<td>Contraceptive implantation device</td>
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<td>Contraceptive insertion/implantation</td>
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<td>HEARING CARE</td>
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<tr>
<td>HOME HEALTHCARE</td>
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<tr>
<td>Nursing services</td>
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</tr>
<tr>
<td>Provider home visit services</td>
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<td>Per visit $5 (PCP)</td>
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<td>$10 (Specialist)</td>
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<tr>
<td>Category</td>
<td>Benefit limit per lifetime</td>
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<tr>
<td><strong>HOSPICE</strong></td>
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<td>$0, Unlimited benefit</td>
<td>$0, Unlimited benefit</td>
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<td><strong>HOSPITAL</strong></td>
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<tr>
<td>Inpatient/outpatient</td>
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<td>Ambulatory surgical center services</td>
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<td><strong>IMPLANTED DEVICES</strong></td>
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<td>Non-contraceptive devices</td>
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<td>Contraceptive implantation device</td>
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<tr>
<td>Implantation procedure (contraceptive and/or other)</td>
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<td><strong>MASTECTOMY/BREAST CANCER OR MEDICALLY NECESSARY BREAST RECONSTRUCTIVE SURGERY</strong></td>
<td>$0</td>
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<tr>
<td><strong>MATERNITY CARE</strong></td>
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</tr>
<tr>
<td>Inpatient services, hospital, home health, midwife</td>
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<tr>
<td>Initial office visit-provider</td>
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<td>Per visit $5 (PCP) $10 (Specialist)</td>
<td>Per visit $15 (PCP) $25 (Specialist)</td>
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<td><strong>MEDICAL FOODS</strong></td>
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<td><strong>BEHAVIORAL HEALTH SERVICES</strong></td>
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<tr>
<td><strong>NEWBORN COVERAGE</strong></td>
<td>$0</td>
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<tr>
<td><strong>ORAL SURGERY</strong></td>
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</tr>
<tr>
<td><strong>ORTHOTIC DEVICES</strong></td>
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<tr>
<td><strong>OSTEOPOROSIS SCREENING</strong></td>
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<tr>
<td><strong>OSTOMY SUPPLIES</strong></td>
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</tr>
<tr>
<td><strong>OUTPATIENT MEDICAL THERAPY SERVICES</strong></td>
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<td>$0</td>
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<tr>
<td><strong>OUTPATIENT PHARMACY SERVICES</strong></td>
<td>$0</td>
<td>$6 (Generic) $9 (Brand)</td>
<td>$10 (Generic) $18 (Brand)</td>
</tr>
<tr>
<td><strong>OUTPATIENT REHABILITATIVE THERAPY SERVICES</strong></td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PROVIDER OFFICE SERVICES (PCP &amp; SPECIALIST)</td>
<td>$0</td>
<td>Per visit $5 (PCP)</td>
<td>Per visit $15 (PCP)</td>
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<td>See section 5, FF (page 59)</td>
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**B. What is an HMO?**

This plan is an HMO, which stands for health maintenance organization. An HMO is a health insurance plan that works with specific health providers. These providers make up the HMO’s network. A person covered under the plan is a plan member. Our HMO serves a certain part of Pennsylvania. This part is called our service area and all our members must live within our service area to be covered.

HMOs must meet specific standards set by the state to operate. The state of Pennsylvania licenses HMOs to operate when the HMO meets specific standards set by the state. GHP received its license in 1985. To operate as an HMO, the organization must follow special state regulations. These regulations include minimum coverage requirements for certain diseases and making sure there are enough providers within the service area to provide the member’s medical care.

In an HMO, a member selects a PCP to provide and manage the member’s medical care. You may also visit other in-network providers, including facilities (such as a hospital or pharmacy) or specialists who are licensed or certified to provide healthcare services (such as a physical therapist or a surgeon). The healthcare services covered under this plan are called covered services or just services.

These concepts will be explained in more detail later in this guide.

**C. What is important about the service area?**

The service area is made up of the Pennsylvania counties where your child must live to be a member of Geisinger Health Plan and where your child can receive medical care with this plan. A list of all the counties in the GHP service area is at the end of this handbook. If your child moves out of the service area, he or she cannot be covered under GHP. We will transfer your child to another CHIP health plan available in the Pennsylvania county your child moves to. The state may allow the plan to expand its service area. We will notify you of any expansions in our newsletters. If you have any questions about the service area, please call the customer service team at 866-621-5235 (PA Relay 711). If your child needs medical care while you are outside of the service area, the plan will only pay for emergency care or other medical care that has been given prior authorization (approved in advance) by the plan.
D. What are my child’s rights under this plan?

1. Member rights and responsibilities

As a member of the plan, your child has certain rights. As a parent or guardian of a member, GHP wants you to understand these rights. These rights are listed below.

- Your child has the right to timely and effective consideration of complaints, appeals and grievances.
- Your child has the right to health maintenance literature and material about Geisinger Health Plan, its services and providers.
- Your child has the right to be treated with respect and recognition of his or her right to privacy.
- You have the right to obtain current information concerning your child’s health in terms you can reasonably be expected to understand from plan providers, unless it is not medically advisable.
- You have the right to be given the name, professional status and function of any personnel providing health services to your child.
- You have the right to give informed consent before the start of any procedure or treatment.
- You have the right to an open discussion of appropriate or medically necessary treatment options for your child’s condition, regardless of cost or benefit coverage.
- You have the right to participate with providers in decision making regarding your child’s healthcare.
- You have the right to be advised if a healthcare facility or any of the providers participating in your child’s care want to engage in or perform human experimentation or research affecting their care or treatment. You may refuse on your child’s behalf to participate in or to continue in any experimentation or research program for which you have given an informed consent at any time.
- You have the right to refuse any drugs, treatment or other procedure offered by Geisinger Health Plan or its providers to the extent permitted by law. You have the right to be informed by a provider about what may happen if drugs, treatments or procedures are refused.
- You have the right to have all records pertaining to your child’s medical care treated as confidential unless sharing them is required to make coverage decisions or is otherwise required by law.
- You have the right to all information contained in your child’s medical records unless access is specifically restricted by the attending provider for medical reasons.
- When emergency services are necessary, you have the right to obtain such services for your child without unnecessary delay.
- You have the right to make recommendations regarding your child’s rights and responsibilities policies.
- You have the right to be told about these rights and responsibilities.
To get the most out of your child’s CHIP health plan, you have the following responsibilities as a parent or guardian:

- Know your child’s PCP and site, as well as the nearest participating hospital.
- Contact your child’s PCP for all medical care except in emergencies.
- Be prepared when talking with your child’s doctor.
- You have a responsibility to attempt to schedule appointments with the same primary care team each time.
- If your child is admitted to a non-participating hospital, contact the plan or your child’s PCP to arrange for transport to a participating hospital when his or her condition stabilizes.
- You have a responsibility to identify your child as a GHP member whenever you call or visit the doctor.
- You have a responsibility to offer information your child’s doctor or other healthcare providers will need to care for them and to follow the instructions or guidelines you receive from the provider, such as taking prescriptions as directed.
- You have a responsibility to participate in understanding your child’s health problems and developing mutually agreed upon treatment goals.

### 2. Confidentiality and privacy of medical records

Your child has important rights about the privacy of their medical records. The plan follows all the regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including the HITECH Act of 2009. This law protects the privacy of a person’s medical records and health information. The plan also follows all other state and federal regulations regarding privacy of medical records and health information. A member’s medical record and other information (which includes information relating to HIV/AIDS, substance abuse and behavioral health treatments) received by the plan concerning members will be kept confidential (private) as required by law. Such records and other information will be released by the plan only as required by law or court order, when you provide written authorization to release the information or in connection with any of the following actions by the plan:

- To verify a member’s coverage, including coordination of benefits between two insurers, claims payments and care coordination
- To share information between the plan and its agents/contractors and healthcare providers for medical purposes or in connection with a member’s complaint or grievance. See section 7 (page 83)
- To gather demographic data (statistical information about age, location, sex, etc.)
- For internal and external audits
- For the use of the plan’s quality improvement and utilization management programs
- For general administration of this handbook and the plan
If you have any questions about the release of information from a member’s medical records or the right to the privacy of such information, please call the customer service team at 866-621-5235 (PA Relay 711).

### 3. Getting more information about this plan

If you have questions on any of the information provided to you about the plan, please contact the customer service team at 866-621-5235 (PA Relay 711), 8:00 a.m. to 6:00 p.m., Monday through Friday. We will explain any information that you do not understand, answer any questions or send you additional information. Below is a list of information we can provide:

- A list of the names, business addresses and official positions of GHP’s board of directors or officers of GHP
- The procedures we use to protect the confidentiality (privacy) of medical records and other enrollee information
- A description of the credentialing process for providers (how we verify their medical licenses and such)
- A list of the participating providers affiliated with participating hospitals
- Whether a specific drug is included or excluded from coverage
- A description of how you can get coverage for specific drugs prescribed by a participating provider, drugs used for an off-label purpose, drugs not included in the drug formulary, drugs requested when a similar drug on the formulary hasn’t successfully treated the member’s disease or if the drug causes or is reasonably expected to cause harmful reactions to the member
- A description of the procedures followed by the plan when it makes decisions about the experimental nature of individual drugs, medical devices or treatments
- A summary of the methods used by the plan to reimburse for healthcare services
- A description of the procedures used in the plan’s quality assurance program

We encourage you to use our website, GHPkids.com. On the site you can:

- Learn additional information about CHIP benefits and GHP
- Print copies of CHIP plan documents and application forms
- Find documents and forms are available in Spanish
- View the current provider list, service area map and drug formulary
- Read medical information for parents

### E. How to protect against insurance fraud and abuse

The plan has an anti-fraud program that is designed to help detect and eliminate fraud and abuse.

Fraud and abuse take on many forms. Some examples include, but are not limited to:

- Selling or sharing one’s insurance identification number so false claims can be filed
- Selling or sharing other private insurance information so false claims can be filed
• Using a member identification number that is not your child’s, (or yours if you are the member), to receive treatment

Protect yourself. Use caution when you are providing health insurance information (including you or your child’s member identification number). Never give your information in exchange for free services or gifts.

You have the right to remain anonymous when you contact us. If you suspect fraud or abuse, you can contact us in any of the ways listed below:

• Email: FA@TheHealthPlan.com
• Telephone: 866-621-5235 (PA Relay 711)
• Mail:
  Geisinger Health Plan
  Anti-Fraud Program
  100 N. Academy Ave.
  Danville, PA 17822-3220

3. Getting care

A. Identification cards

You will receive an identification card (ID card) by mail for your child within 10 days of enrolling and paying your first copay (if required). This card entitles your child to all the benefits explained in section 5 (page 26) and lists any copayments (fees which must be paid at the time of service) required for some of these benefits. It also has the telephone number for the GHP customer service team, the behavioral health provider (for behavioral health and substance abuse) and Tel-A-Nurse (24-hour-a-day access to nurse advice).

You need to show your ID card to all providers when your child receives services. If you lose the ID card submit a request for a replacement card online at GHPKids.com. You can also call the customer service team at 866-621-5235 (PA Relay 711) and request another card. Remember, the ID card is issued by the plan for the member only. If you have multiple children enrolled in CHIP, each one will receive their own ID card. Don’t let anyone else use the ID card.
B. Plan providers, facility providers and the provider list

The plan contracts with two different kinds of participating providers: plan providers and facility providers. Plan providers are providers and other healthcare professionals in our network that we contract to provide covered services (the benefits a member is entitled to under this plan). Facility providers are hospitals and other facilities in our service area network that we contract to provide covered services to our members. We list both kinds of providers in the provider list, which includes the names, addresses and telephone numbers of all the current participating providers.

The provider list is organized by location (county) and by the type of provider. This list can be found on the plan’s website GHPKids.com or you can request a copy by calling the customer service team at 866-621-5235 (PA Relay 711). We update the provider list as participating providers are added. You will get a list of all new primary care providers in each GHP quarterly newsletter or you can check the plan’s website for nightly updates to the list.

Remember that participating providers are not employees of the plan. They are independent contractors with whom the plan contracts to provide covered services to members. The plan requires them to agree to certain terms and conditions that help members receive high quality care.

C. Choosing a primary care provider (PCP)

You need to choose a PCP for your child. Your child’s PCP is the main source of preventive and medical care for your child. The PCP will also coordinate any necessary referrals, tests and hospital admissions for your child. Select one from the provider list. If you choose a PCP who is not already treating your child, you need to check with the selected PCP and make sure they are taking new patients. You can reach the PCP at the telephone number given in the provider list. If the PCP agrees to take your child as a patient, notify the plan by phoning the customer service team at 866-621-5235 (PA Relay 711), by mail (at the address on page 7) or online at our website GHPKids.com. You have ten days from the receipt of your notice of enrollment letter to select a PCP or the plan will assign one for your child.

You can change your child’s PCP at any time by calling the customer service team at 866-621-5235 (PA Relay 711). If you don’t already have a new PCP selected, the customer service representative can help you find another PCP close to where you live. Any PCP you select must be contacted to see if they are taking new patients. You cannot choose a PCP who is your child’s parent, grandparent, aunt, uncle, brother or sister.
D. Getting a referral

A referral is when your PCP (or someone working for them) tells you (and us) that your child needs to get medical care from another participating provider. CHIP members can arrange specialty services without a referral from a PCP. Members are still required to see in-network specialist providers and some services covered under plan benefits may still require prior authorization from GHP Kids.

E. Getting prior authorization

Certain medical procedures, tests, drugs and equipment (called services) will need prior authorization by the plan. This means that your child’s doctor or other participating provider will request that the plan review the service before your child receives the service. The plan keeps a list of all services that need prior authorization. Call the customer service team at 866-621-5235 (PA Relay 711) to have this list mailed to you or to find out if a service is on this list. The plan bases its prior authorization review decision on medical necessity. To be receive prior authorization, the service must be a covered service rendered by a healthcare provider that the plan determines is:

- Appropriate for the symptoms and diagnosis and treatment of the member’s condition, illness, disease or injury
- Provided for the diagnosis and the direct care and treatment of the member’s condition, illness, disease or injury
- In accordance with current standards of good medical treatment practiced by the general medical community
- Not primarily for the convenience of the member or the member’s healthcare provider
- The most appropriate source or level of service that can safely be provided to the member.

When applied to hospitalization, this means the member requires acute care as an inpatient due to the nature of the services rendered or the member’s condition and the member cannot receive safe or adequate care as an outpatient

If the plan denies a prior authorization request, you and your child’s provider will receive letters explaining the denial and how to appeal the decision. You have the right to appeal any decisions made by the plan when prior authorization was denied. See section 7, what to do if you have a complaint or grievance (page 83), for more information on how to appeal a decision. Prior authorization can be denied only if a medical director was involved in the decision. A medical director is a licensed provider who directs the medical and scientific aspects of the plan and oversees the quality and appropriateness of the health services the plan manages for its members.
F. Getting care from a specialist

A specialist is a participating provider who has training, education, board certification or a license in a specialized area of healthcare. A specialist is usually not your PCP. The plan’s provider list includes specialists listed by their medical specialty.

1. What if your child gets a referral for a specialist who is not part of the plan?

If your child gets a PCP referral for a specialist who is non-participating provider, you must get permission from the plan to see the specialist. Your PCP will request this permission from the plan. If the plan’s medical director concludes that a participating provider can provide the service, the request will be denied and you and your PCP will receive notice of the denial. You will receive information on how to appeal the denial with the denial notice.

2. What if your child’s current specialist is not part of the plan?

When you enroll in this plan, you must let the plan know if your child is being treated by a provider who does not participate with the plan. To assure continuity of care, the plan allows members to continue seeing that provider for up to 60 days if they are continuing a course of treatment. Under certain circumstances, this period may be extended past the 60 days. The plan can also help you find a specialist who is a participating provider.

3. What if your child’s provider is no longer going to be part of the plan?

If your child’s provider (PCP or other healthcare provider) is not going to continue to be part of the plan or has terminated with the plan, please call the customer service team at 866-621-5235 (PA Relay 711) to find a new provider. Under certain circumstances we may allow your child to continue with that provider for a period to assure continuity of care. If your child is in the second or third trimester of pregnancy, the period for continuing with the provider will be extended after the baby’s birth for care that is related to the delivery. Services will only be covered by the plan if the provider accepts our terms and conditions.

G. Getting a second opinion

Your child is entitled to a second opinion regarding the medical necessity of surgery or any other recommended medical treatment. You can contact the plan for prior authorization of a second opinion. If you have any questions about a second opinion, please call the customer service team at 866-621-5235 (PA Relay 711).
H. Getting emergency service (what to do in an emergency)

If you think your child needs emergency service, follow the plan of action in section 1 below. Emergency service is any healthcare service provided for the member after a sudden medical condition causes symptoms that lead you to think that if you don’t get medical care, your child will:

- Have their health seriously jeopardized (or if she is pregnant, the health of her unborn child will be jeopardized)
- Have serious impairment of bodily functions
- Have serious dysfunction of any body organ or part

A few examples of an emergency are:

- If your child has a broken bone
- If your child cannot breathe
- If your child is unconscious.

If your child needs emergency transportation to get the emergency treatment, the transportation will also be covered as an emergency service.

For more information on the cost of emergency services and what is covered in an emergency, see section 5 (I), emergency services (page 40).

1. Emergency services plan of action

   a) When an emergency happens, call 911 or immediately go to the nearest emergency services provider (an emergency department that is on the provider list). If you are out of the service area, go immediately to the nearest emergency department. You will not be charged any additional amount for using a non-participating provider.

   b) If your child needs to be admitted to the hospital following an emergency, the emergency services provider should notify the plan within 48 hours or on the next business day (whichever is later) of the emergency services provided to your child. Remember that if your child is treated in a non-participating provider emergency facility, it is your responsibility to call the customer service team at 866-621-5235 (PA Relay 711) and let them know about the admission or to arrange to have the non-participating provider make the call to us.

   c) If your child is not admitted to the hospital, the claim submitted to the plan by the emergency service provider serves as notice of the emergency services provided to your child.

   d) Any medically necessary follow-up care received from a participating provider after the response to the emergency situation is not an emergency service and must be authorized by the provider before the care is given to your child.

   e) Any medically necessary follow-up care received from a provider who is not a participating provider (part of the HMO) after the response to the emergency situation is not an emergency service and you must contact the plan for prior authorization before your child receives the service.

   f) If your PCP tells you to take your child to the emergency department for a service that the PCP would normally provide during normal working hours, you will not be charged the emergency department copayment. Your copayment will be what your PCP copayment would be, had you been able to go there for service.
I. Getting urgent care

Urgent care is any service provided to a member with a condition or injury that needs to be treated within twenty-four (24) hours. Urgent care is not an emergency and the emergency service plan of action (above) should not be followed. If you take your child to an urgent care center that is a participating provider (listed on the provider list as an urgent care center) the service is covered. If you are out of the service area and your child needs urgent care, the care must be in response to a sudden and unexpected condition or injury that needs care that cannot be put off until you return to the service area for the care to be covered.

J. Getting obstetrician/gynecological (OB/GYN) care

You can schedule an appointment with an in-network OB/GYN provider without a referral. This care includes any routine and preventive gynecological services (see section 5 (PP) page 69), Women’s health or any medically necessary follow-up care or tests the OB/GYN provider may order for your child.

K. Getting hospital inpatient care

All hospital admissions must have prior authorization before your child can be admitted as a patient. The only exception to this is if your child is admitted directly from the emergency department. In addition, the hospital your child is being admitted to must be a participating facility provider in the provider list. Your PCP or specialist will contact us to get prior authorization for the admission. Your child can be admitted to a non-participating facility provider (not part of the plan) if that hospital is providing medical care that is not available from a participating hospital.

If necessary, your provider will work with the plan to get the prior authorization for an out-of-plan hospital admission. If your child is admitted to the hospital directly from an emergency department, the plan must be notified within 48-hours or on the next business day (whichever is later) of the emergency services provided to your child. If the hospital is a participating facility, they will supply us with the necessary information. If you have any questions on hospital care, please call the customer service team at 866-621-5235 (PA Relay 711). In certain cases, a case manager from the plan will be assigned to assist you with the hospital admission and services.
1. What if my child is in the hospital when I enroll them in CHIP?

If your child is a hospital inpatient when their CHIP coverage begins, he or she will be covered under this plan for services which are part of this plan’s covered services (listed in section 5, page 26) unless they are still covered by another health insurance plan or they are in a hospital that is not part of this plan’s facility provider network and that hospital does not accept our terms or benefits.

2. What if my child is in the hospital when their CHIP coverage ends?

If your child is a hospital inpatient when their CHIP coverage ends under this plan, they will be covered for services that are part of this plan’s benefits:

   a) Until your child is discharged from the hospital;
   b) Until the maximum amount of benefits has been paid by the plan; or
   c) Until your child is covered without limitation under any other group coverage for the condition they are receiving inpatient care for.

4. Your cost for covered services

Your family’s income determines which CHIP option is available for your child. You may be able to get the free coverage, the low-cost coverage or the full-cost coverage. Depending on your child’s coverage, there may be some out-of-pocket costs called copayments that you will be required to pay at the time of the service. Copayments are paid to the provider at the time of the appointment or visit. You must pay the copayment each time your child gets a service from a provider if the service is one which requires a copayment. Some services are free under all the CHIP options. These are called preventive or well-child visits. A preventive visit is one where your child receives a service to prevent a future disease or condition. A well-child visit is to make sure your child stays healthy. These preventive/well-child visits are explained in more detail in section 5 (DD), preventive well-care services (page 56).

There is no copayment required for routine preventive or diagnostic dental or vision services. The costs for each covered service offered under this plan are listed in section 5 (page 26) of this handbook with the covered service. For a quick reference, you can refer to the schedule of benefits on page 8.

A. How and when to pay premiums

If you qualify for low-cost or full-cost CHIP, you will receive a monthly invoice (bill) for the premium (monthly cost for the CHIP insurance) due for the following month. If the premium is not paid by the due date on the invoice or within the 30-day grace period, your child will lose CHIP coverage and may not be eligible for CHIP coverage for ninety days from the date the coverage ends. If a premium amount changes during the benefit period, you will receive notice of the change 30-days before the change takes effect.
B. Situations where you may be billed by a provider

There are certain situations where you may get a bill you must pay. These situations are:

- If your child has a copayment for any service. See handbook section 2, Schedule of Benefits (page 10).
- If your child receives a medical service that is not covered by this plan. The provider will bill you for any medical service your child receives that is not listed in this CHIP handbook as a covered service. If you have any questions about whether a certain medical service or supply (including drugs) is covered, please call the customer service team at 866-621-5235 (PA Relay 711). A representative will tell you if it will be covered.
- If your child receives a service from a healthcare provider who is not a GHP participating provider. You will be billed for any services received from a healthcare provider who is a non-participating provider if you do not have prior authorization from the plan to see that provider. The only exception to this is if the service received by your child is: an emergency service (see handbook section 3 (H), getting emergency services, page 22) or an urgent care service out of the service area (see handbook section 3 (I) getting urgent care, page 23).

C. How claims are paid and Explanation of Benefits

When your child receives a service from a participating provider, that provider submits the charges (called a claim) to the plan. You will get an Explanation of Benefits (or EOB) in the mail which will show the claim(s) submitted by the provider, the amount paid by the plan to the provider for the claim(s) and any amount which may be your responsibility to pay. Please remember that this is not a bill. If there are any amounts you owe to the provider (see section 3 (B), page 19) the provider will send you a separate bill. If you feel that you do not owe the amount due on a bill from a provider or you need help understanding the EOB, call the customer service team at 866-621-5235 (PA Relay 711).

D. How to submit claims from providers who are not part of the plan (non-participating)

You must submit a claim from the provider to the plan if your child receives an authorized service from a non-participating provider, that was an emergency service or that was an urgent care service. Below are instructions on how to submit a claim.

1) To file a claim, call the customer service team at 866-621-5235 (PA Relay 711) and ask us to mail you a claim form.
2) Fill out the claim form and submit it, along with a bill from the provider that lists all services received, to the following address:
   Geisinger Health Plan
   P.O. Box 8200
   Danville, PA 17821-8200

M-151-642-F Rev. 08/16 Rev. 5/17 Rev. 4/18
**Important:** You must sign Section A of the claim form before the plan will issue payment to a provider or reimburse you for the covered services.

3) If you don’t get a claim form from the plan within 15 days of asking for it, you may send us an itemized bill from the provider with the following information:

a) Full name of the member (your child covered by CHIP) who received the services
b) The date(s) the service was provided to your child
c) A description of services received by your child and if available, any diagnosis descriptions and coding that is on the bill
d) The charges for each service
e) The provider’s address and if available, the provider’s telephone number and tax identification number.

Send the above information to the following address:
Geisinger Health Plan
P.O. Box 8200
Danville, PA 17821-8200

4) You have one year from the date of the service to send the plan either the claim form (in numbers 1 and 2 above) or the itemized bill (number 3 above).

5) If you pay a provider for anything other than the required copayment at the time your child gets the service, send the information in number 3 a – e (above) along with a receipt showing your child’s insurance ID number from his or her identification card to the plan’s address listed above. The plan will send you a check for the payment you made to the provider if the service was a covered service under this plan. You have one year to submit this to the plan.

If you have any questions on how or when to submit a claim, please call the customer service team at 866-621-5235 (PA Relay 711) and a representative will assist you.

### 5. Covered services

This section lists the medical services available through CHIP brought to you by GHP. The covered services are the same for all three CHIP plans (free CHIP, low-cost CHIP and full-cost CHIP). Only the copayments are different between low-cost CHIP and full-cost CHIP. There are no copayments associated with free CHIP.

- **What this plan covers:** This section lists what medical services, procedures, tests, equipment and/or drugs are covered.

- **Not covered (what the plan does not cover):** Items or services which are not covered by this plan are listed as **not covered** under the service. Section 5 lists all items and services not covered under this plan. Items and services not covered under this plan may apply to several different services. Please take notice of the **not**
**covered** listings both under the service and in section 5 (QQ) (page 70) to avoid the possibility of having the item or service provided and billed to you.

- **Benefit limit:** This section explains any restrictions on the service. A benefit limit could be a certain number of visits the plan will cover in a benefit period or a total dollar amount for a benefit that is covered. Keep in mind that the benefit period is the one-year period that begins with your child’s enrollment in CHIP and ends one year later.

- **Cost chart.** This chart tells you how much your copayment will be for the service. If the service costs you nothing, $0 or no cost will appear after the listed service. If the service has a copayment, consult the cost chart showing the amount you must pay. To find your copayment on the cost chart, look in the box under your child’s CHIP plan (either the low-cost plan or the full-cost plan). The free CHIP plan does not have any copayments.

**Questions?** If you have any questions about the services offered by this plan, please call the customer service team at 866-621-5235 (PA Relay 711). Your customer service representative will tell you if a service is covered by the plan, if there are any benefit limits, what providers your child can see for a service and what you may need to pay for the service.

The customer service representative can also tell you how much money or how many visits you have remaining for any service with a benefit limit.

### A. Autism spectrum disorder services

If your child is diagnosed with an autism spectrum disorder, he or she will be referred by the plan to the Pennsylvania Medical Assistance Program to see if they are eligible for the Medical Assistance program. Until your child’s eligibility is determined, your child will be covered for autism spectrum disorder by this CHIP plan. Once a determination is made, your child will be enrolled in the program he or she is eligible for. This program may be CHIP through GHP Kids or Medical Assistance if your child meets the requirements for that program.

**Definitions.** The following definitions apply to this section:

- **Autism spectrum disorder** means any of the developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or its successor, including autistic disorder, Asperger’s disorder and pervasive developmental disorders not otherwise specified.

- **Autism spectrum disorder provider** means a Pennsylvania licensed or certified person, entity or group that provides treatment of autism spectrum disorders pursuant to a treatment plan.

- **Treatment of autism spectrum disorders** are identified in a treatment plan (a plan for the treatment of an autism spectrum disorder which is developed by a licensed provider or licensed psychologist) and includes any medically necessary pharmacy care services, psychiatric care services, psychological care services, rehabilitative care services and therapeutic care services that are:
a) Prescribed ordered or provided by a licensed provider, licensed provider assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner;
b) Provided by an autism spectrum disorder provider
c) Provided by a person, entity or group that works under the direction of an autism spectrum disorder provider

What this plan covers:

1. Autism spectrum disorder services. Subject to the benefit limit below, coverage for autism spectrum disorder services is provided to CHIP members for the diagnosis and treatment of autism spectrum disorders when provided by an autism spectrum disorder provider. Such assessment for diagnosis and treatment may include the following medically necessary services below.

   a) Pharmacy care services. Pharmacy care services include medications prescribed by a licensed provider, licensed provider assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed provider, licensed provider assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. Prescriptions for prescribed medications must be obtained from a participating pharmacy. (See the medication cost chart below).

   b) Psychiatric care services. Psychiatric care services include direct care or consultative services for your child provided by an autism spectrum disorder provider who specializes in psychiatry. These services must be provided by an autism spectrum disorder provider who participates in the plan’s designated behavioral health benefit program. (See the psychiatric, psychological, rehabilitative, therapeutic care services cost chart below).

   c) Psychological care services. Psychological care services include direct or consultative services for your child provided by a psychologist autism spectrum disorder provider. Psychological care services must be provided by an autism spectrum disorder provider who participates in the plan’s designated behavioral health benefit program. (See the psychiatric, psychological, rehabilitative, therapeutic care services cost chart below).

   d) Rehabilitative care services. Rehabilitative care services include professional autism spectrum disorder provider services and treatment programs for your child, provided to improve behavior or to prevent loss of skill or function. These services must be provided by an autism spectrum disorder provider who participates in the plan’s designated behavioral health benefit program. (See the psychiatric, psychological, rehabilitative, therapeutic care services cost chart below).

   e) Therapeutic care services. Therapeutic care services require the plan’s prior authorization and include services for your child provided by speech language pathologist, occupational therapist or physical therapist autism spectrum disorder providers. You must select a participating provider for your child’s therapeutic care services. (See the psychiatric, psychological, rehabilitative, therapeutic care services cost chart below).

2. Expedited review process
If the plan denies your child’s claim for diagnostic assessment or treatment of autism spectrum disorder, you are entitled to use the expedited grievance review process in section 7 (D) (page 91) of the handbook and any other external review process established and administered by the Pennsylvania Insurance Department. For more information on the expedited review process and the options available to you if a claim is denied, please call customer service at 866-621-5235 (PA Relay 711).

Not covered:
- Psychiatric care services, psychological care services and rehabilitative care services received from providers who do not participate in the plan’s designated behavioral health program are not covered. Only services from participating providers will be covered.
- Pharmacy care services received from non–participating pharmacy providers are not covered. Only pharmacy services from participating pharmacy providers will be covered.
- Therapeutic care services received from a non-participating provider are not covered. Only therapeutic services from a participating provider will be covered.

Medication cost chart

<table>
<thead>
<tr>
<th></th>
<th>Free CHIP</th>
<th>Low-cost CHIP</th>
<th>Full-cost CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication cost chart</td>
<td>$0</td>
<td>$6 copayment for generic drugs (up to 34-day supply)</td>
<td>$10 copayment for generic drugs (up to 34-day supply)</td>
</tr>
<tr>
<td></td>
<td>$9 copayment for brand name drugs (up to 34-day supply)</td>
<td>$18 copayment for brand name drugs (up to 34-day supply)</td>
<td></td>
</tr>
</tbody>
</table>

Rehabilitative and therapeutic care

<table>
<thead>
<tr>
<th></th>
<th>Free CHIP</th>
<th>Low-cost CHIP</th>
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<td></td>
<td>$10 copayment per visit for specialist</td>
<td>$25 copayment per visit for specialist</td>
<td></td>
</tr>
</tbody>
</table>

B. Cardiac rehabilitation (outpatient)

The plan covers outpatient cardiac rehabilitation services provided by a participating provider when ordered in advance by your child’s PCP or specialist provider. An example of cardiac rehabilitation is a post-heart surgery cardiac exercise program.

Cost: $0 up to benefit limit

Benefit limit. Your child is limited to 36 sessions of cardiac rehabilitation per benefit period.
C. Chiropractic care

For the plan to cover services, chiropractic care must be provided by a participating chiropractor. Visit GHPKids.com for a list of participating chiropractors. Chiropractic services require prior authorization.

Cost: $0

Benefit limit: 20 visits per benefit year for chiropractic care including consultations, spinal manipulations and X-rays.

D. Dental and orthodontic care

Dental and orthodontic care must be provided by a participating dentist or orthodontist in the plan’s dental network for the plan to cover services. Visit GHPKids.com for a list of participating dental providers. You can make an appointment with any participating dental provider in the plan’s network. You do not need a referral from your PCP to make a dentist or orthodontic appointment. You can receive emergency dental services (#7 below) from a non-participating dentist provider if the need for such services meets the requirements of an emergency as explained in section 3 (H), getting emergency service (Page 22).

Cost: $0

What dental care this plan covers:

1. **Preventive and diagnostic care** is important to the dental health of your child. The plan allows for two examinations per benefit period where the dentist will check for any teeth problems and perform dental treatments to keep your child’s teeth and gums healthy. Preventive and diagnostic covered services are listed below.

   • **Routine examinations.**

     **Benefit limit:** Your child is limited to one routine examination every six months. For children under 3 years of age, one oral evaluation is covered and counseling with primary caregiver.

   • **Routine prophylaxis (cleaning)**

     **Benefit limit:** Your child is limited to one routine cleaning in a six consecutive month period. Members under the care of a medical professional for pregnancy are eligible one additional prophylaxis during pregnancy.
• Fluoride, supplements/rinses

**Benefit limit:** $0, unlimited benefit

• Occlusal guard

**Benefit limit:** One occlusal guard in 12 months for patients 13 years and older.

• X-rays

  a) Bitewing X-ray

    **Benefit limit:** Your child is limited to one occurrence of bitewing X-rays (consisting up to four) per occurrence during a consecutive six-month period.

  b) Full mouth X-ray (panoramic X-ray)

    **Benefit limit:** Your child is limited to one full mouth X-ray per five-year period.

• Topical fluoride application

  **Benefit limit:** Your child is limited to one topical application per six-month period

• Sealant

  **Benefit limit:** Sealants are available to children under age 19 and limited to permanent first and second molars. Your child is limited to one sealant per tooth in a three-year period.

• Space maintainers

  **Benefit limit:** Space maintainers are covered for all teeth. One space maintainer per tooth is covered in a five-year period.

    Recementation of space maintainers: $0, unlimited benefit

• Services not covered

  - Oral hygiene instruction
  - Fluoride gel carrier
  - Topical medicament carrier
  - Preventive resin restoration in a Moderate to High Caries Risk Patient permanent tooth
2. **Minor restorative care** is the treatment of decayed (cavities) with fillings, defective or missing teeth.

   **Benefit limit:** $0, unlimited benefit

   - **Services not covered**
     - Labial veneers primarily done for cosmetic or esthetic purposes.
     - Enamel micro abrasion

3. **Crowns, caps, inlays and onlays** services could include: crowns, inlays, onlays, buildups, post and cores not part of a bridge and repairs to crowns, inlays and onlays not as an abutment or pontic to bridgework.

   **Benefit limit:**
   - Crown coverage is limited to one per tooth every 60 months.
   - Replacement of gold foils is covered once in a two-year period.
   - Replacement of crowns, inlays, onlays, build-ups and post and cores: $0, unlimited benefit
   - Prefabricated resin crowns are limited to one per tooth every 60 months
   - Crown repairs: $0, unlimited benefit.

   - **Services not covered**
     - Crown, ¾ porcelain/ceramic
     - Provisional crown
     - Temporary crown
     - Laboratory veneer
     - Canal preparation and fitting of post

4. **Endodontics** (root canal) is the treatment of the tooth pulp and root. An example of an endodontic treatment is a root canal. Prior authorization is required.

   **Benefit limit:**
   - Initial endodontic therapy: $0, unlimited benefit
   - Therapeutic pulpotomy is covered, if a root canal is within 45 days of the pulpotomy
   - Apicoectomy: $0, unlimited benefit
   - Root amputation: $0, unlimited benefit

   - **Services not covered**
     - Surgical stents
     - Tooth transplantation
     - Vestibuloplasty
     - Operculectomy
5. **Adjunctive care** is dental care related to an injury or disease.

6. **Periodontal services** are services for the tissues that support the teeth (gums and bone):
   - Periodontal evaluation (new or established patient): covered once every six months
   - Periodontal scaling and root planning: one to three teeth are covered once every 24-month period

7. **Prosthodontic services** are services for the replacement of teeth and related mouth or jaw structures by artificial devices (such as a denture). Prior authorization is required.
   - Full or partial dentures are covered.
     **Benefit limit:** Your child is limited to one full or partial denture every five years.
   - Denture adjustments **complete or partial** are covered.
     **Benefit limit:** $0, unlimited benefit
   - Fixed partial denture repairs: $0, unlimited benefit.

8. **Surgical procedures:** Treatment of disease or injury consisting of operating and cutting procedures are covered subject to the benefit limits below:
   - **Benefit limit:**
     - Incision and drainage of abscess
     - Biopsy of oral tissue: covered once every 12 months
     - Appliance removal
     - Oroantral fistula closure
9. Emergency treatment of sound, natural teeth must result from an accidental injury, not chewing or biting.

10. Inpatient or outpatient hospital and ambulatory surgical center services
and related professional services which are provided in connection with a covered or non-covered dental procedure are covered only if the hospital or ambulatory surgical center services are required for an existing medical condition which is not related to the dental procedure. Such coverage requires prior authorization.

11. Anesthesia is covered as set forth below:

- Nitrous oxide is covered.
- Non-intravenous conscious sedation is covered when medically necessary.
- Deep sedation/general anesthesia

Benefit limit: $0, unlimited benefit

12. Services and supplies necessary for the emergency treatment of sound, natural teeth. The need for these services must result from an accidental injury (not from chewing or biting).

13. Occlusal guard, implants, implant repairs, implant-related prosthetics:

Benefit limit:

Occlusal guard with report: one in a benefit year for patents 13 and older, when medically necessary

Implants, implant repairs, implant related prosthetics: $0, unlimited benefit

What orthodontic care this plan covers:

All orthodontic services require prior authorization and a written plan of care. A participating provider must provide services and the services must be medically necessary. Your child must be diagnosed with a significant handicapping malocclusion (including but not limited to an irregular bite, a crossbite or an overbite) or other severe condition (such as cleft palate) to be eligible for orthodontics. This condition would interfere with your child's ability to eat, speak or breathe normally. GHP Kids requires the use of the Salzmann Evaluation Criteria Index form as the basis for determining whether a child qualifies for orthodontic treatment. A child must score a minimum of 25 points to automatically qualify for coverage. In addition, the orthodontia must be
the only method that can prevent irreversible damage to your child’s teeth or their supporting structures or that can restore your child’s oral structure to health and function. Braces for cosmetic purposes are not covered.

Cost: $0, unlimited benefit.

1. Evaluation for braces

Benefit limit: Your child is limited to one evaluation per benefit period.

2. Comprehensive orthodontic treatment includes the evaluation for braces, the pre-orthodontic treatment visit, diagnostic X-rays and the braces.

Benefit limit: Your child is limited to one comprehensive orthodontic treatment per lifetime. Cephalometric X-rays are covered when performed in conjunction with orthodontic treatment. Limited to once in a three-year period.

• Not covered
  - TMJ related services, such as: arthrogram, dental X-rays
  - Collection of microorganism

### E. Treatment, equipment, drugs and supplies for the treatment of diabetes

Treatment, equipment, drugs and supplies for the treatment of diabetes are covered when they are prescribed by a healthcare professional who is legally authorized to prescribe such items and when they are received from a participating provider. The plan reserves the right to approve the manufacturer of medical equipment, supplies, blood glucose monitors, foot orthotics and prescription drugs for diabetes care.

What this plan covers:

1. Medical equipment for diabetes: (no cost)
   • Insulin infusion devices
   • Blood glucose monitors
   • Injection aids (includes: needle-free injection devices, bent needle set for insulin pump infusion and non-needle cannula for insulin infusion).

   Not covered:
   • Batteries for medical equipment for diabetes
   • Real time blood glucose monitor and supplies

2. Foot orthotics for diabetes (no cost)
3. Prescription drugs: (See the drug/equipment cost chart below)
   - Oral agents for controlling blood sugar
   - Disposable syringes and blood glucose monitor supplies (lancets and blood glucose test strips)

### Drug/Equipment cost chart

<table>
<thead>
<tr>
<th>Free CHIP</th>
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<tbody>
<tr>
<td>$0</td>
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</tr>
<tr>
<td></td>
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<td>$0 copayment for brand name drugs/equipment (up to 34-day supply)</td>
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</tbody>
</table>

4. Outpatient training and education: See the provider office visit cost chart below
   - Proper diet education
   - Self-management training and education

5. Eye examination for diabetes: See the provider office visit cost chart below

### Provider office visit cost chart

<table>
<thead>
<tr>
<th>Free CHIP</th>
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</tr>
</tbody>
</table>

### F. Diagnostic, laboratory and X-ray services

Diagnostic tests, services and materials, (including diagnostic laboratory and X-ray services, electrocardiograms (EKG) and other diagnostic services related to the diagnosis and treatment of sickness and injury) are covered when ordered by a participating provider. The diagnostic testing must be related to the services within the participating provider’s scope of care and will be provided on an inpatient or outpatient basis.

Cost: $0
**What this plan covers:** at no cost to all members:

1. Laboratory services

2. X-ray services

3. Other imaging services:
   - Magnetic resonance imaging (MRI)
   - Computer aided tomography (CAT scan)
   - Positron emission tomography (PET)
   - Magnetic resonance angiogram (MRA)

4. Electrocardiograms

**G. Disease management programs**

The plan offers special programs where we work with your PCP to help manage certain health conditions. These programs include teaching you and your child how to handle the condition and properly use medications. You will receive preventive health reminders and learn how to coordinate with other resources/specialists. If your child participates in a GHP Kids disease management/care management program, your child’s coverage may include certain services that would not normally be covered. These programs are at no cost to you. If your child is eligible for such programs, you will be contacted by the plan and/or your child’s PCP.

**Cost:** $0

**What this plan covers:**

Disease management programs for the following health conditions:
- Asthma
- Diabetes
- Heart failure
- Hypertension
- Osteoporosis
- Chronic kidney disease (CKD)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Tobacco cessation
- Weight management
H. Durable medical equipment (DME)

Durable medical equipment (DME) is equipment:

- That is designed to serve a medical purpose
- Which is not useful to a person unless they have an illness or injury
- Can stand repeated use
- Is not disposable or for a single patient’s use
- Is required for use in the home or school.

DME must be prescribed in advance by a provider and there must be prior authorization by the plan for the DME. You must get the DME from a participating DME provider (please see your provider list or the GHP Kids CHIP website at GHPKids.com for durable medical equipment suppliers). Before getting the DME, you can ask the plan to consider approving another DME provider. The plan can repossess any durable medical equipment paid for by the plan when such device or piece of equipment is no longer medically necessary or if your child is not using the equipment as instructed. The plan reserves the right to limit the manufacturers and providers from whom you may rent or buy durable medical equipment. Examples of common durable medical equipment are crutches, wheelchairs and hospital beds.

Cost: $0, unlimited benefit

What this plan covers:

1. Durable medical equipment (DME): DME is covered by the plan if it meets the plan's medical necessity criteria, is the usual and routine treatment requirements of your child and is readily available. In the absence of plan criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations.

   This benefit is limited to the following types of durable medical equipment:

   - Ambulatory assistive devices such as canes, crutches and walkers
   - Apnea monitors
   - Breast pumps
   - Continuous passive range of motion devices
   - Dynamic splinting devices
   - Enuresis alarms
   - External cardiac defibrillator devices
   - Manual wheelchair and medically necessary attachments (such as anti-tip devices and reclining backs)
   - Negative pressure wound therapy and related equipment (such as canisters and dressings)
   - Neuromuscular electrical stimulation devices (NMES) for disuse atrophy
   - Non-electric, hydraulic patient lifts and slings
   - Non-implanted, non-invasive spinal and non-spinal osteogenesis stimulators
   - Oxygen and oxygen equipment, including humidification
   - Pediatric prone standers and gait trainers
• Photo therapy (bilirubin) lights
• Pneumatic compression devices and required sleeves
• Portable bedside commodes
• Respiratory equipment including assistive devices such as continuous positive airway pressure (CPAP), bilevel positive Airway Pressure (BIPAP) and intermittent positive pressure breathing (IPPB), percussors and humidification, mechanical ventilators, high frequency chest wall oscillation air pulse generator systems for airway clearance and nebulizers (non-disposable and air compressors with nebulizers as indicated)
• Semi-electric hospital beds and medically necessary accessories such as trapezes and pressure reducing support surfaces (gel or water cushions and alternating pressure pads)
• Suction pumps
• Traction devices: cervical, lumbar, over door, extremity frames and stands
• Transcutaneous electrical stimulation (TENS) units

2. The following apply to the DME covered under this plan.

• The cost of renting (unless it costs more to rent than to buy the equipment) or buying medically necessary DME and related supplies is covered when prescribed by a participating provider.
• The DME must be appropriate for home or school use.
• The costs of delivery and installation of the DME are covered.
• Repair and replacement of DME are covered only as required with normal wear and tear.

Not covered:

• Cold therapy and/or ice packs. Continuous hypothermia machine cold therapy and/or ice packs are not covered.

• Computerized devices and communicative equipment. Communicative equipment or devices, computerized assistive devices and communication boards are not covered.

• Disposable supplies, which include but are not limited to: soft collars, elastic bandages, support stockings, self-administered catheters, peak flow meters or incentive spirometers are not covered.

• Exercise equipment or facilities. Exercise equipment such as a whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools and saunas are not covered.

• Experimental or research equipment which, as determined by the plan, is not accepted as standard medical treatment of the condition being treated or any such item that requires federal or other governmental agency approval which is not given at the time the DME is provided is not covered. The experimental or non-experimental nature of
any DME will be determined by the plan according to the terms and conditions in section 5 (QQ) (page 70) of this handbook

- Items for personal comfort or convenience including but not limited to bed boards, air conditioners and over-bed tables are not covered.
- More than one piece of equipment that serves the same function, including rental or back up of owned or rented equipment is not covered.
- No longer medically necessary. Any piece of equipment which is determined by the plan to be no longer medically necessary is not covered.
- Non-medical self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides are not covered.
- Repair or replacement of any piece of equipment, such as for loss, theft or misuse are not covered, except that repair or replacement for normal wear and tear is covered.
- Specifically listed items, devices and equipment. The following are Not covered:
  - Access ramps for home or automobile
  - Air filtration units
  - Anodyne infrared therapy (a method of pain or wound care using an infrared device)
  - Batteries
  - Equipment with non-medical or non-therapeutic features (deluxe equipment)
  - Hairpieces and wigs
  - Heating lamps
  - Hypoallergenic sheets
  - Motor driven equipment
  - Motor vehicles or vehicle modifications (including but not limited to car seats)
  - Pads, pillows and/or cushions
  - Paraffin baths
  - Safety equipment (including but not limited to: gait belts, harnesses and vests)
  - Seasonal affective disorder lights
  - Vaporizers
  - Vitrectomy face support devices (assists in holding the face down following certain eye surgery)

**Benefit limit:** See costs listed previously in this section.

**I. Emergency services**

Emergency services do not need prior authorization from the plan. If your child needs emergency services and cannot be cared for by a participating provider, you can take your child to a non-participating provider and the plan will pay for the emergency services received from a non-participating provider as if your child were cared for by a participating provider. **For information on what to do in an emergency situation and what would be considered an emergency, see handbook section 3 (H), getting emergency service (page 22).**

**What this plan covers:**
1. Emergency transportation: no cost (Also see handbook section 5 (KK) transportation services (page 65) for more information).

2. Hospital emergency department: see the emergency services cost chart below

Includes the evaluation, testing and stabilization of your child’s condition during the period of emergency

There is no copayment if your child is admitted to the hospital directly from the emergency department

3. Non-participating provider emergency services: see the emergency services cost chart below

Emergency services are covered when your child can’t be treated by a participating provider during an emergency;

Non-participating provider emergency services are covered only until the plan finds that your child’s condition is stable enough that he or she can safely be transferred to a participating provider.

<table>
<thead>
<tr>
<th></th>
<th>Free CHIP</th>
<th>Low-cost CHIP</th>
<th>Full-cost CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>If admitted to hospital from emergency department</td>
<td>$0</td>
<td>$25 copayment per visit</td>
<td>$50 copayment per visit</td>
</tr>
</tbody>
</table>

J. Family planning services

Family planning services cover the professional services provided by your child’s PCP or OB/GYN provider related to the prescribing, fitting and/or insertion of a contraceptive.

What this plan covers:

1. Oral contraceptives (birth control pills): See the drug/device cost chart below.
2. Injectable contraceptives (when the contraceptives are injected by needle): See the drug/device cost chart below.
3. Transdermal contraceptives (contraceptive patches): See the drug/device cost chart below.
4. Implanted contraceptive devices: Both the device itself and the insertion and implantation of contraceptive devices are covered. For example, IUDs and under-the-skin devices.
Drug/device cost chart

<table>
<thead>
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</tr>
</tbody>
</table>

Voluntary sterilization: Covered

6. Preventive laboratory services including chlamydia screening

7. Other preventive services
Counseling, education and related services to prevent and address the consequences of sexually transmitted diseases (STDs) and pregnancy.

Not covered:

- Abortions: Abortions are not covered except for those certified by a provider as necessary for the life or physical health of the mother or to end a pregnancy that was caused by rape or incest and was reported within 72 hours from the date the female learned she was pregnant.
- Infertility procedures: In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), embryo transplants, artificial insemination and similar procedures as determined by the plan are not covered. Expenses related to a member’s or member’s spouse’s voluntary sterilization are not covered. Sperm, ova and embryo storage is not covered.
- Reversal of sterilization: Surgical procedures to reverse voluntary sterilization are not covered.
- Sexual dysfunction services: Devices and equipment for males or females are not covered.

K. Gender dysphoria and gender confirmation treatment

Requires prior authorization by a GHP Kids plan medical director or designee.

Upon prior authorization, GHP Kids covers psychological evaluation and treatment, provider’s services, inpatient and outpatient hospital services and prescribed drugs when medically necessary for gender reassignment.

Reversal of genital surgery is **not covered**
Reversal of surgery to revise secondary sex characteristics is **not covered**.
Services that are otherwise considered not medically necessary are non-covered.

**L. Habilitative services**

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

**Cost:** $0

**What the Plan Covers:**

- 30 visits per benefit year for physical therapy; AND
- 30 visits per benefit year for occupational therapy; AND
- 30 visits per benefit year for speech therapy.

**Benefit Limit:** Habilitative services are covered for up to 30 visits per therapy per benefit period (for example, your child can get 30 physical therapy visits AND 30 speech therapy visits AND 30 occupational therapy visits in a benefit period).

Covered services also include inpatient therapy up to 45 visits per calendar year for treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery.

**M. Hearing care**

Emergency, preventive and routine hearing care services are covered when the services are provided by a participating hearing care provider. A listing of hearing care providers can be found on the provider list and on the GHP Kids CHIP website at GHPKids.com.

**Cost:** $0

**What this plan covers:**

1. Hearing devices, for example hearing aids
2. Emergency, preventive and routine hearing examinations

**Benefit limit:**

One routine hearing examination per benefit year
One audiometric examination per benefit year
One hearing aid or device per ear every two years
Not covered:

Batteries for hearing aids and devices are not covered

N. Home healthcare

Home healthcare is covered only if your child is homebound. Your child is homebound when their medical condition prevents them from leaving home without a great deal of effort, except for leaving home to get medical treatment that cannot be reasonably provided in the home (such as doctor appointments or therapy). To get home healthcare, your child must have an approved treatment plan for the home healthcare which was written by a participating provider provider and a home health agency. This section does not apply to home healthcare services for early discharge follow-up maternity care which is described in handbook section 5 (S), maternity care (page 48).

What this plan covers:

1. Home healthcare services as follows: Home healthcare services must be provided under the supervision of a participating provider(s) and include the following services provided at no cost to the member. This benefit is offered with no co-payments and no limitations

   • Nursing services
     - Must be provided by skilled nurse participating providers
     - Must be supervised by the participating provider
   • Physical, speech and occupational therapy services
   • Medical and surgical supplies
   • Oxygen and its administration
   • Home medical equipment
   • Well-mother/well-baby care following the discharge from an inpatient maternity admission.

2. PCP home visits. $0 copayments

3. Specialist home visits. $0 copayments

Benefit limit:

$0, unlimited benefit

O. Hospice

Hospice care requires a prior authorization, certification by a provider that your child has a terminal illness and a plan of care based on your child’s hospice needs. The plan of care provides details and outlines your child’s hospice needs. It is prepared and reviewed throughout the care period by the hospice medical director (or other appointed provider),
your child’s provider and the interdisciplinary group (hospice employees such as a medical
doctor, registered nurse and a pastoral or other counselor).

Hospice care is covered for both inpatient and outpatient services.

Cost: $0, unlimited benefit

What this plan covers:

1. Hospice services as follows:
   - Palliative services (pain relief) and supportive services
   - Professional services of a nurse
   - Medical care provided by a provider working with the hospice agency
   - Therapies: physical, speech and occupational (this does not include dialysis
treatments)
   - Medical and surgical supplies
   - Home medical equipment
   - Prescribed drugs
   - Respite care (provides your child’s family with a break from caring for the child at
   home)
   - Respite care includes care for your child for one or more days, including overnight
   stays in a hospital, skilled nursing facility or hospice inpatient facility
   - Oxygen and its administration
   - Medical social service consultations
   - Home health aides
   - Family counseling

2. By accepting hospice care for your child, you agree that:

   a) Your child won’t receive any further care to attempt to cure their terminal disease or
condition, but will receive care only to lessen the intensity of such disease or condition or to
help manage such disease or condition

   b) You waive the right to standard benefits under this plan for treatment of your child’s
terminal disease or condition

   c) Your child will have coverage for all other service under this plan not related to the
terminal illness

P. Hospital (inpatient and outpatient) and ambulatory surgical center services

Hospital benefits may be provided at a hospital participating provider on either an inpatient
or outpatient basis or at an ambulatory surgical center (a non-hospital facility which provides
outpatient surgical services). Inpatient hospital admissions require prior authorization. To be
covered, the services must be performed by a participating provider or under the orders of a participating provider (unless it is an emergency). Except for mastectomy covered services (see handbook section 5 (R) (page 47), inpatient hospital services are covered if the hospital stay is medically necessary as determined by the plan.

Cost: $0

What this plan covers:

1. **Hospital services include:**
   - Semi-private room and board (your child can get a private room when it is determined medically necessary by the plan)
   - General nursing care
   - Consultation with and treatment by consulting providers
   - Inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed behavioral health professional in an acute hospital
   - Pre- and post-operative care
   - Primary care provider services
   - Provider services (the provider must be a participating provider unless the service is in response to an emergency)
   - Surgical services (does not include cosmetic surgery intended solely to improve appearance)
   - The following facilities, services and supplies as prescribed through a participating provider (or another provider in response to an emergency):
     - Use of operating room and related facilities
     - Use of intensive care unit or cardiac care unit and services
     - Radiology, laboratory and other diagnostic test services
     - Drugs, medications and biologicals
     - Anesthesia and oxygen services
     - Physical therapy, occupational therapy and speech therapy, (subject to the benefit limits set forth in this section (below) as to inpatient services and as set forth in handbook section 5 (BB) (page 55) as to outpatient rehabilitative therapy services)
     - Radiation therapy
     - Inhalation therapy
     - Renal dialysis
     - Administration of whole blood and blood plasma
     - Medical social services
     - Cancer chemotherapy and cancer hormone treatments and to the extent medically necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

   **Benefit limit:** $0, unlimited benefits
3. Inpatient private duty nursing

**Benefit limit:** $0, unlimited benefit

**Not covered:**

- Personal comfort items/services including but not limited to telephones, televisions and special meals are not covered.

### Q. Implanted devices

Implanted devices are covered upon referral by your child’s PCP or OB/GYN provider. These devices are only covered to correct dysfunction due solely to disease or injury or for purposes of contraception.

**What this plan covers:**

1. **The following implanted devices are covered at no cost to any members:**
   - Implanted devices for drug delivery
   - Implanted devices for contraception (for example: IUDs and under-the-skin devices)
   - Cardiac assistive devices
   - Cochlear implants (implanted devices for children with impaired hearing)
   - Artificial joints

2. **The implantation procedure for the above listed devices:** See the implantation procedure cost chart below

### Implantation procedure cost chart

<table>
<thead>
<tr>
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<th>Free CHIP</th>
<th>Low-cost CHIP</th>
<th>Full-cost CHIP</th>
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<tbody>
<tr>
<td>Per visit to PCP</td>
<td>$0</td>
<td>$5 copayment</td>
<td>$15 copayment</td>
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<tr>
<td>Per visit to specialist</td>
<td>$0</td>
<td>$10 copayment</td>
<td>$25 copayment</td>
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### R. Mastectomy and breast cancer reconstructive surgery

Covered services for members who choose to have breast reconstructive surgery related to a medically necessary mastectomy include the services below.

**Cost:** $0

**What this plan covers:** (inpatient or outpatient)
Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy.

Physical complications of all stages of mastectomy, including lymphedemas.

Coverage is also provided for one home healthcare visit, as determined by the child’s provider, received within 48 hours after discharge.

Reconstructive surgery will only be covered:
- When required to restore function following accidental injury, as a result of a birth defect, infection or malignant disease to achieve reasonable physical or bodily function.
- In connection with congenital disease or anomaly through the age of 18.
- In connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment.
- Breast reconstruction following a mastectomy.

Not covered:

Surgery for male or female breast reduction is not covered unless it is needed for breast reconstructive surgery in connection with a medically necessary mastectomy as described in #1 or #2 above.

Cosmetic surgery intended solely to improve appearance of the breast (s) is not covered.

The attending participating provider, in consultation with the member’s parent or guardian will determine the way covered services are provided.

**S. Maternity care**

Hospital and provider services relating to antepartum, intrapartum and postpartum care, including complications resulting from the member’s pregnancy or delivery, are covered. A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Covered services are stated below.

**What this plan covers:**

1. Inpatient hospital services that include: (no cost)
   - A minimum of 48 hours of care following a normal vaginal delivery. A shorter length of stay may be allowed if the discharge is made by an attending provider in consultation with the mother or in the case of a newborn, in consultation with the
mother or the newborn’s authorized representative. There is no limit to the member’s length of stay.

- A minimum of 96 hours of care following caesarean section delivery. A shorter length of stay may be allowed if the discharge is made by an attending provider in consultation with the mother or in the case of a newborn, in consultation with the mother or the newborn’s authorized representative. There is no limit to the member’s length of stay.
- Use of the delivery room
- Medical services (includes specialist and/or PCP visits)
- Operations and special procedures such as caesarean section; anesthesia and injectables
- Complications of pregnancy and delivery
- X-ray and laboratory services

2. One home healthcare visit within 48 hours of an early hospital discharge which shall include at no cost:

- Parent education
- Assistance and training in breast and bottle feeding
- Infant screening and clinical tests
- The performance of any necessary maternal and neonatal physical assessments

An early discharge is before 48 hours for a normal vaginal delivery or before 96 hours for a caesarean section delivery

A licensed healthcare provider whose scope of practice includes postpartum care must make the home healthcare visits. At the mother’s sole discretion, the home healthcare visit may occur at the facility of the provider. Home healthcare visits following an inpatient stay for maternity services are not subject to copayments, deductibles or coinsurance.

3. Hospital and provider services required by a newborn child of a member when ordered or provided by participating providers to include at no cost:

- Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care.

Newborns are automatically covered for 31 days from their date of birth. After the 31-day period, the newborn must be enrolled in CHIP to be covered for services.

4. Participating provider services from a certified licensed nurse midwife are covered only if provided in a participating hospital or a participating licensed free-standing birthing center.

5. Maternity care initial office visit (other than #2 above): see the initial office visit cost chart below
Initial office visit cost chart

<table>
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<tr>
<th>Free CHIP</th>
<th>Low-cost CHIP</th>
<th>Full-cost CHIP</th>
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<tr>
<td>$0</td>
<td>$0 copayment per visit for PCP</td>
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<tr>
<td>$0</td>
<td>$0 copayment per visit for specialist</td>
<td>$0 copayment per visit for specialist</td>
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Not covered:

- **Maternity care outside the service area**: Maternity care for normal term delivery outside the service area is not covered except in the case of an emergency.

T. Medical foods

Medical foods (enteral feedings/food supplements) are covered as stated below when used under the direction of a participating provider.

Cost: $0

What this plan covers:

1. Outpatient enteral tube feedings including:

   Administration, supplies and formula used as food supplements for the therapeutic treatment of aminoacidopathic hereditary metabolic disorders (phenylketonuria [PKU], branched-chain ketonuria, galactosemia and homocystinuria).

   Upon prior authorization from the plan, your child may also be covered for medical foods when enteral or parenteral feeding is their only source of nutrition.

U. Behavioral health services

All behavioral health covered services must be received from a psychiatrist, a licensed clinical psychologist or other licensed behavioral health professional who participates in the plan’s designated behavioral health benefit program. For a list of behavioral health providers:

- Visit the GHP Kids CHIP website at GHPKids.com
- Call the number on the back of your child’s identification card listed as mental health or substance abuse
- Check the provider list

Inpatient/outpatient substance abuse and mental health rehabilitation services do not require prior authorization (this includes treatment in a non-hospital residential setting). Members as young as 14 years old can self-refer.
The initial treatment for a behavioral health emergency is covered even when provided by non-participating behavioral health providers or rendered at a non-participating facility if the symptoms are severe enough to need immediate attention. Inpatient behavioral health services can only be provided by participating providers at participating facilities unless the admission occurred as a result of a psychiatric emergency. If your child is admitted to a non-participating facility, you must contact Geisinger Health Plan within 24-hours to notify them of the admission. Once your child’s condition is determined to not be an emergency, your child may be transferred to a participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the non-participating facility may not be covered.

The following apply to behavioral health services:

**Cost: $0**

**What this plan covers:**

1. Inpatient behavioral health services.

**Benefit limit:** $0, unlimited benefit.

2. Outpatient behavioral health services include:
   - Psychological testing
   - Consultations
   - Individual, group or family therapy
   - Targeted behavioral health case management and resource coordination
   - Prescription drugs.

**Benefit limit:** $0, unlimited benefit. No prior authorization required.

3. Partial hospitalization behavioral health services:
   - Partial hospitalization includes medical, nursing, counseling or therapeutic services.

   **Benefit limit:** $0, unlimited benefit

**Not covered:**
- Hypnosis is not covered.

### V. Newborn coverage

Newborn children of CHIP members are covered from the time of birth for the first 31 days of life. After 31 days, the newborn must be enrolled in CHIP to continue receiving services under this plan.

**Cost: $0**
What this plan covers:

1. Medically necessary hospital and provider services for medically diagnosed congenital defects and birth abnormalities
2. Routine nursery care
3. Prematurity services
4. Newborn hearing screens
5. Treatment for injury or sickness
6. Well-child and preventive healthcare services (see handbook section 5, DD (page 56).

Please note: The newborn is covered under the mother’s CHIP plan for the first 31 days after birth. After 31 days, the newborn will either be eligible for CHIP or Medical Assistance until age 1, as appropriate. The plan will refer the newborn to the local county assistance office for a Medical Assistance eligibility determination.

W. Oral surgery

Oral surgery is non-dental treatment to the mouth (please see handbook section 5 (W), dental and orthodontic care, page 52). The following oral surgical services are covered when provided by a participating provider.

Cost: $0

What this plan covers:

1. Extraction of impacted molars. In accordance with the plan’s medical necessity criteria, the plan will pay the cost of services, including the consultation, for the extraction (removal) of partially or totally bony impacted wisdom teeth (third molars) when performed by a participating provider. Such coverage requires prior authorization.

2. Frenectomies (tissue removal) are covered each tooth, once per lifetime per member.

3. Inpatient or outpatient hospital and ambulatory surgical center services and related professional services provided in connection with oral surgery procedure(s).
   a. These services are covered only if the hospital or ambulatory surgical center services are required for an existing medical condition which is not related to the oral surgical procedure. Such coverage requires prior authorization.

4. The following Anesthesia is covered:
   a. Nitrous oxide: $0, unlimited benefit
   b. Non-intravenous conscious sedation: covered at $0 when medically necessary
   c. Deep sedation/general anesthesia: $0, unlimited benefit
X. Orthotic devices

Orthotic devices are rigid appliance or apparatus used to support, align or correct bone and muscle deformities. Orthotic devices must be prescribed by a participating provider or approved in advance by the plan (with the prior authorization process) and must be provided by a participating orthotic device provider. Orthotic device providers are listed in your provider list and can also be found on the GHP Kids CHIP website at GHPKids.com. Examples of orthotic devices are splints, wrist braces and back supports.

Cost: $0

What this plan covers:

The purchase, fitting, necessary adjustments, repairs and replacements of standard rigid or semi-rigid supportive orthotic devices. Replacements are covered only when the replacement is deemed medically necessary and appropriate due to the normal growth of the child. Orthotic devices: Only devices that are in accordance with the plan's medical necessity criteria (in the absence of plan criteria, Medicare coverage criteria shall serve as a definitive guideline for coverage determinations), in keeping with the usual and routine treatment requirements of your child and readily available are covered.

Not covered:

• Corrective shoes, shoe inserts and supports, heel cups, lifts or foot orthoses of any sort are not covered, except for foot orthotics for diabetes, which are covered as a covered service in this handbook under section 5 (E), Treatment, equipment, drugs and supplies for diabetes (page 35).

• Dental appliances of any sort which include, but are not limited to, bridges, braces and retainers are not covered except those which may be covered in handbook section 5 (D), dental and orthodontic care.

• Disposable supplies which include but are not limited to, support stockings, gloves and ace bandages are not covered.

• Experimental or research equipment as determined by the plan, is not accepted as standard medical treatment of the condition being treated or any such item requiring federal or other governmental agency approval not granted at the time the orthotic device was provided is not covered. The experimental or non-experimental nature of any orthotic device shall be determined by the plan according to the terms and conditions in handbook section 5 (QQ) (page 70).

• Non-medical or non-therapeutic devices. Appliances or apparatuses with non-medical or non-therapeutic features are not covered.
Orthotic devices for personal comfort or convenience. Orthotic devices which are mostly used for personal comfort or convenience are not covered.

Please note: The plan reserves the right to restrict the manufacturer of orthotic devices covered under this plan. Such restriction is subject to change by the plan without the consent of the members.

Y. Osteoporosis screening (bone mineral density testing)

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

Cost: $0

Z. Ostomy supplies

Ostomy supplies are medical supplies necessary for the care and drainage of a stoma (an artificial opening in the body that remains after a surgical procedure).

Cost: $0

What this plan covers:

1. The plan will cover ostomy supplies only for members who have had a surgical procedure which resulted in the creation of a stoma.

AA. Outpatient medical therapy services

Outpatient medical therapy services are covered for an unlimited number of sessions when ordered in advance by a participating provider and received from a participating provider.

Cost: $0

What this plan covers:

1. Cancer chemotherapy and cancer hormone treatments and to the extent medically necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer

2. Dialysis
3. Respiratory therapy

4. Radiation therapy

**BB. Outpatient rehabilitative therapy services**

Outpatient rehabilitative services must be ordered in advance by a participating provider and require prior authorization from the plan. Rehabilitative services must be received from a participating provider. Rehabilitative providers can be found in the provider list or on the GHP Kids CHIP website at www.GHPKids.com.

**What this plan covers:**

1. Physical therapy outpatient services
2. Occupational therapy outpatient services
3. Speech therapy outpatient services

**Benefit limit:** Outpatient rehabilitative therapy services are covered for up to 30 visits per therapy per benefit period (for example, your child can get 30 physical therapy visits, 30 speech therapy visits and 30 occupational therapy visits in a benefit period).

**CC. Provider office services (PCP and specialist)**

The services in this section are covered when provided during an office visit with your child’s PCP or specialist.

**What this plan covers:**

1. PCP office visits including: See the provider office visit chart below.
   - Diagnostic and treatment services
   - Cancer chemotherapy and cancer hormone treatments and to the extent medically necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer
   - Injectable drugs and medications when determined by the provider to be a necessary part of the care given by the provider during an office visit, limited to the amount of drug given during the visit
   - Preventive and well-child services (see handbook section 5 (DD) (page 56). There is no copayment charge for preventive and well-child services.

2. Specialist provider office visits including: See the provider office visit chart below.
   - Diagnostic and treatment services
• Cancer chemotherapy and cancer hormone treatments and to the extent medically necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer
• Injectable drugs and medications when determined by the provider to be a necessary part of the care given by the provider during a visit, limited to the amount of drug given during the visit
• Preventive and well-child services (see handbook section 5 (DD) (page 57) there is no copayment charge for preventive and well-child services
• Medical care in any generally accepted medical specialty or subspecialty when referred by the member’s PCP
• Second opinion consultation (with prior authorization from the plan)

**Benefit limit:**

$0, unlimited visits.

### Provider office visit cost chart

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### DD. Preventive well-care services

Preventive well-care services are very important to help keep your child healthy. Regular preventive and well-care visits can help make it less likely for your child to get ill in the future and will also help your child’s provider to find health conditions which may benefit from early treatment. It is important to talk about the services in this section with your child’s PCP and schedule appointments for preventive and well-care services as your child’s PCP recommends.

**Cost:** $0

**What this plan covers:**

1. Well-child care from birth and health examinations on a schedule recommended by your child’s PCP which includes:
   • Newborn hearing screening
   • Newborn screening including one hematocrit and one hemoglobin screening for infants under the age of 24 months
• Pediatric well-child visits, which generally includes a medical history, height and weight measurement, physical examination and counseling
• Blood lead levels screening for all children at the ages of one and two and all children at the ages of three through six who have not had a confirmed prior blood lead test
• A comprehensive health and developmental history
• A comprehensive physical examination, including:
  • Basic ear screening examinations to determine the need for further hearing evaluation
  • Basic eye screening examinations to determine the need for further vision evaluation
• Oral health risk assessment, fluoride varnish for children ages 5 months through 5 years old, (US Preventative Task Force recommendation)
• Cholesterol screening and lipid panel
• Necessary laboratory tests
• Health education
• Developmental screenings
• Nutritional screening
• Health education which includes preventing tobacco use and information on how to quit smoking
• Tuberculosis testing
• We periodically review the primary and preventive care covered services based on recommendations from organizations such as the American Academy of Pediatrics, the American College of Providers, the American Cancer Society, the Health Resources and Services Administration (HRSA) and all items or services with a rate of A or B in the current recommendations from the U.S. Preventive Services Task Force (USPSTF).
  o Examples of covered USPSTF A recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women and tobacco use counseling and interventions.
  o Examples of covered USPSTF B recommendations are dental cavities prevention for preschool children, healthy diet counseling oral fluoride supplementation/rinses and vitamins, breast cancer susceptibility gene (BRCA) risk assessment and genetic counseling and testing, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women and sexually transmitted infections counseling.
  o Examples of covered HRSA required benefits include all Food and Drug Administration approved contraceptive methods, sterilization procedures, breast feeding equipment and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered.

2. Immunizations:
• Coverage is provided for pediatric immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services.
3. Preventive services including:
   - Dental care (see section 5 (D) (page 30) of this handbook for more information on dental care services)
   - Vision care (see section 5 (NN) (page 67) of this handbook for more information on vision care services)
   - Hearing care (see section 5 (M) (page 43) of this handbook for more information on hearing care services)
   - Obesity prevention

4. Preventive laboratory services including:
   - Chlamydia screening
   - Routine pap smear

5. Diabetes care for children with diabetes that includes:
   - HbA1c, LDL-C and nephropathy screening tests

6. Allergy diagnosis and treatment

7. Other preventive services
Counseling, education and related services to prevent and address the consequences of sexually transmitted diseases (STDs) and pregnancy
Any mammogram based on the member’s PCP or OB/GYN participating provider’s recommendation

**EE. Prosthetic devices**

Prosthetic devices replace all or part of a missing body part. They are also used to help a non-functioning organ to work again. Prosthetic devices must be prescribed by a participating provider or approved in advance by the plan, and must be provided by a participating prosthetic device provider. Prosthetic device providers are listed in your provider list and can also be found on the GHP Kids CHIP website at GHPKids.com.

Examples of prosthetic devices are artificial arms or legs for amputees and artificial eyes for people who have lost an eye.

**Cost:** $0, unlimited benefit

**What this plan covers:**

1. New prosthetic devices and supplies to replace all or part of a missing body part or to restore function to permanent malfunctioning body organ.
2. The fitting and necessary adjustment of prosthetic devices.
3. Replacements are covered only when the replacement is medically necessary and appropriate due to the normal growth of the child.

4. Prosthetic devices are covered when they meet the plan’s medical necessity criteria, are the usual and routine treatment requirements of your child and are readily available. In the absence of plan criteria, Medicare coverage criteria serves as a definitive guideline for coverage determinations.

**Not covered:**

- Disposable supplies which include but are not limited to, stump socks and gradient compression stockings are not covered.
- Experimental or research equipment which as determined by the plan is not accepted as standard medical treatment for the condition or any such item requiring federal or other governmental agency approval not granted at the time the prosthetic device was provided is not covered. The experimental or non-experimental nature of any prosthetic device shall be determined by the plan according to the terms and conditions in handbook section 5 (OO) (page 69).
- Non-medical or non-therapeutic devices. Prosthetic devices with non-medical or non-therapeutic features are not covered.
- Repair of any prosthetic device is not covered.

Please note: The plan reserves the right to restrict the manufacturer of prosthetic devices covered under this plan. Such restriction is subject to change by the plan without the consent of the members.

**FF. Qualifying clinical trials**

Qualifying clinic trials are phase I, II, III, IV clinical trials conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1. The National Institutes of Health (NIH)
2. The Centers for Disease Control and Prevention (CDC)
3. The Agency for Healthcare Research and Quality (AHRQ)
4. The Centers for Medicare and Medicaid Services (CMS)
5. Cooperative groups or centers of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)

6. Any of the following, if the condition for departments are met:
   i. The Department of Veterans Affairs (VA)
   ii. The Department of Defense (DOD)
   iii. The Department of Energy (DOE), if for a study or investigation conducted by a department, are that the study or investigation has been reviewed and approved through a system of peer review that
the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

B. The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA)

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

In the absence of meeting the criteria listed above, the clinical trial must be approved by the plan as a qualifying clinical trial.

**Benefit limit:**
Benefits are provided for routine patient costs associated with participation in a qualifying clinical trial. To ensure coverage, the plan must be notified in advance of the member’s participation in a qualifying clinical trial.

Benefits are payable if a participating provider conducts the qualifying clinical trial at a participating facility. If there is no comparable qualifying clinical trial being performed by a participating provider and in a participating facility, then the plan will consider the services by a non-participating provider in the clinical trial, as covered if the clinical trial is deemed as a qualifying clinical trial by the plan.

Routine patient costs include all items and services consistent with the coverage provided under this plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.

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<thead>
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<th>GG. Restorative or reconstructive surgery</th>
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Services for restorative or reconstructive surgery are covered with prior authorization by the plan and when provided by a participating provider.

**Cost: $0**

**What this plan covers:**

- Restorative or reconstructive surgery to correct a deformity resulting from disease, trauma, congenital or developmental anomalies (birth defects or abnormalities).
- Surgery to reasonably restore your child to the approximate physical condition they were in before the defect which resulted from a) an accidental injury, b) incidental to surgery or c) covered sickness.
Not covered:

- Cosmetic surgery done only to improve one’s appearance and not expected to result in improved bodily function (as determined by the plan) is not covered.
- Panniculectomy, lipectomy and abdominoplasty. Removal of extra skin and tissue including but not limited to panniculectomy, abdominoplasty or lipectomy by any method (such as suction assisted, liposuction or aspiration) is not covered. These procedures may involve areas such as, but not limited to, head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks and hips.
- Revision of the external ear. Cosmetic reshaping of the outer part of the ear is not covered.

**HH. Skilled nursing inpatient facility services**

With prior authorization, medically necessary skilled nursing inpatient facility services are covered in a participating skilled nursing facility. Such skilled nursing services are available to children requiring skilled nursing services but do not need to be in a hospital. Skilled nursing facility providers are listed in your provider list and can also be found on the GHP Kids CHIP website at GHPKids.com.

**Cost: $0**

**What this plan covers:**
- Semi-private room and board on a skilled bed status in a skilled nursing facility
- Private duty nursing. Hourly nursing care on a private duty basis

**Benefit limit:** $0, unlimited benefit

**Not covered:**
Custodial, convalescent or domiciliary care. These are services to help your child with the activities of daily living that don’t need the attention of skilled, trained medical or paramedical personnel. An example of this type of care is placing someone in a skilled nursing facility for non-medical reasons.

**II. Substance abuse**

All substance abuse covered services must be received from a provider who participates in the plan’s designated behavioral health benefit program. You can call the number on the back of your child’s identification card listed as “behavioral health or substance abuse” for a list of behavioral health providers in your area or find a provider on the GHP Kids CHIP website at GHPKids.com. Inpatient/outpatient substance abuse and behavioral health rehabilitative services do not require prior authorization (this includes treatment in a non-hospital residential setting). Members as young as 14 years old can self-refer.
The initial treatment for a substance abuse emergency is covered even when provided by non-participating substance abuse providers or rendered at a non-participating facility if the symptoms are severe enough to need immediate attention. Inpatient substance abuse services can only be provided by participating providers at participating facilities unless the admission occurred as a result of an emergency. If your child is admitted to a non-participating facility, you must contact Geisinger within 24-hours to notify them of the admission. Once your child’s condition is determined to be not an emergency your child may be transferred to a participating facility. If you refuse to transfer your child to a participating facility after the emergency has ended, the services your child receives at the non-participating facility may not be covered.

**What this plan covers:**

- Inpatient detoxification and related medical treatment for substance abuse. (no cost)
  - Inpatient detoxification and related medical treatment for substance abuse are covered when provided in a hospital or non-hospital facility provider which participates in the plan’s designated behavioral health benefit program, except for the exception mentioned above. The following inpatient detoxification services are covered when provided by an employee of the facility:
  - Lodging and dietary services
  - Provider, psychologist, nurse, certified addiction counselors and trained staff services
  - Diagnostic X-ray
  - Psychiatric, psychological and medical laboratory testing
  - Drugs, medicines, equipment use and supplies
  - **Benefit limit:** $0, unlimited benefit. No prior authorization required.
- Non-hospital residential inpatient rehabilitation for substance abuse. (no cost)
  - Non-hospital residential inpatient rehabilitation for substance abuse is covered when provided in a facility which participates in the plan’s designated behavioral health benefit program. The following inpatient non-hospital residential care services are covered when provided by an employee of the facility:
    - Lodging and dietary services
    - Provider, psychologist, nurse, certified addiction counselors and trained staff services
    - Rehabilitation therapy and counseling
    - Family counseling and intervention
    - Psychiatric, psychological and medical laboratory testing
    - Drugs, medicines, equipment use and supplies
    - **Benefit limit:** $0, unlimited benefit. No prior authorization required.
- Outpatient rehabilitation services for substance abuse.
  - Outpatient rehabilitation services for substance abuse are covered when provided by a facility which participates in the plan’s designated behavioral health benefit program. The following outpatient facility rehabilitation services for substance abuse are covered when provided by an employee of the facility:
    - Provider, psychologist, nurse, certified addiction counselors and trained staff services
    - Rehabilitation therapy and counseling
Family counseling and intervention
Psychiatric, psychological and medical laboratory testing
- Drugs, medicines, equipment use and supplies

Benefit limit $0, unlimited benefit. No prior authorization required.

Not covered:
- Drug maintenance programs for the outpatient treatment of drug dependency or addiction are not covered. This includes but is not limited to the medications Suboxone® and Subutex™.

**JJ. Transplant services**

With prior authorization, transplant services are covered when provided in a designated transplant facility. A transplant facility is a facility that has an agreement with the plan or is recognized by the plan as a transplant facility provider. The facility may or may not be in the service area.

**Cost: $0**

**What this plan covers:**

1. When provided in a designated transplant facility: Hospital, provider organ procurement, tissue typing and ancillary services related to the following transplants are covered:
   - Bone marrow (allogeneic and autologous)
   - Cornea (see #2 below)
   - Heart
   - Heart and lung
   - Kidney
   - Kidney and pancreas
   - Liver
   - Liver and kidney
   - Lung (single or double)
   - Pancreas transplant after successful kidney transplant
   - Small bowel
   - Stem cell

Members who have received a covered transplant under this plan may also receive coverage for certain services that would not otherwise be provided for in this handbook.

2. Prior authorization.
   All transplant surgery and transplant-related services listed above (except for corneal transplants) require prior authorization by the plan. Medical criteria for any approved
transplants will be applied and each transplant must be appropriate for the medical condition for which the transplant is proposed. Corneal transplants are covered when medically necessary and performed by a participating provider.

3. Covered services for patient selection criteria.
Covered services for patient selection criteria will be covered at one designated transplant facility. If you request payment for covered services and supplies for patient selection criteria at more than one transplant center, you will be responsible for the costs. This includes your desire to have your child placed on more than one list for organ acquisition or for another transplant medium.

Please note: Patient selection criteria are tests required by the transplant facility to make sure your child meets the requirements for a transplant.

4. Additional opinion policy for transplants.
If you get written notice from the plan stating that your child is not eligible for a transplant procedure by a designated transplant facility, you may request a second opinion by another designated transplant facility. You must contact the plan to request a second opinion. If the second designated transplant facility also finds that your child is not eligible for the transplant procedure, no coverage will be provided for further transplant-related services. If the second designated transplant facility’s opinion differs from the opinion of the first designated transplant facility’s opinion, a third opinion may be requested by the plan to get enough information to make a determination regarding the proposed transplant procedure.

5. Organ donation.
Covered services needed by your child as an organ donor for transplanting an organ into another CHIP member are covered with prior authorization from the plan. Medical expenses of non-member donors of organs for transplantation into your child are covered to the extent benefits remain and are available under the plan after the benefits for your child’s own expenses have been paid and only:

a) When the organ transplantation is approved by the plan
b) For the medical expense directly associated with the organ donation
c) To the extent not covered by any other program of insurance

6. Human leukocyte antigen (HLA) typing. Human leukocyte antigen (HLA) typing performed in connection with a transplant is a covered service subject to the benefit limit below.

**Benefit limit:** The maximum amount the plan will pay for HLA typing benefits provided for any one member per approved transplant is limited to $10,000.

7. Self-administered prescription drugs:
• Self-administered prescription drugs for your child are subject to the terms of the outpatient pharmacy services, handbook section 6 (page 76).

• Self-administered outpatient prescription drugs provided to the non-member donor of organs for transplantation into your child are:
  a) Covered only when the organ transplantation is approved by the plan
  b) Limited to the prescription drug cost directly associated with the organ donation
  c) Covered only to the extent the drugs are not covered by any other program or insurance

8. Travel, lodging and meal expense reimbursement

  According to plan guidelines, certain costs for travel, lodging and meals occurring with a member’s transplant procedure will be reimbursed to a member organ recipient, a member donor and/or a non-member donor of organs (as applicable) at a $200 daily limit up to a maximum amount of $5,000.00 per transplant. For information on submitting receipts and the specific guidelines for travel, lodging and meal reimbursement, please contact the customer service team at 866-621-5235 (PA Relay 711).

9. Re-transplantation services

  Re-transplantation surgery and re-transplantation related services require prior authorization by the plan.

Not covered:
• Organ donation to non-members. All costs and services related to a member donating an organ to a non-member are not covered.

**KK. Transportation services**

Transportation services by land or air ambulance are covered as stated below.

Cost: $0

What this plan covers:

1. Transportation by land or air ambulance is covered when provided in response to an emergency (as defined in handbook section 3 (H), getting emergency service (page 22).

2. Scheduled non-emergency ambulance transportation is covered when it is medically necessary.

Not covered:

• Transportation services: Stretcher and wheelchair van transportation or transportation services for convenience are not covered.

**LL. Urgent care**
Urgent care is a covered service provided to your child in a situation that requires care within 24-hours.

What this plan covers:

1. Urgent care services received through participating providers in the service area are covered. See the in-service area urgent care facility cost chart below.

<table>
<thead>
<tr>
<th>Free CHIP</th>
<th>Low-cost CHIP</th>
<th>Full-cost CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$10 copayment per visit</td>
<td>$25 copayment per visit</td>
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2. Urgent care services received from a non-participating provider outside of the service area are covered when they are provided in response to a sudden and unexpected need for medical care while your child is outside the service area. The need for medical care must be such that it cannot wait until your child returns to the service area. See the out-of-service area urgent care facility cost chart below.

<table>
<thead>
<tr>
<th>Free CHIP</th>
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<tbody>
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</table>

**MM. Urological supplies**

Urological supplies are covered when the plan determines your child has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected for your child within three months.

**Cost: $0**
NN. Vision care

Visits for routine eye exams and glasses or medically necessary contacts are covered. A participating vision provider must be used. Participating vision providers can be found in the provider list or on the GHP Kids CHIP website GHPKids.com.

Your child does not need a referral from a PCP to see a vision provider. There are no copayments for routine eye examinations. If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus or aphakia, a copayment may apply.

- **Frames and lenses:**
  One set of eyeglass lenses that may be:
  - Plastic or glass
  - Single vision
  - Bifocal
  - Trifocal
  - Lenticular lens powers and/or oversize lenses
  - Fashion and gradient tinting
  - Oversized glass-grey #3 prescription sunglass lenses
  - Polycarbonate prescription lenses with scratch resistance coating
  - Low vision items.

- **Frequency of eye exam:** In network: one routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member in network. Out-of-network: no coverage.
- **Frequency of lens and frame replacement:** One pair of eyeglasses every 12 months, when medically necessary for vision correction.
- **Lenses:** In network: one pair covered in full every calendar year. Out-of-network: no coverage.
  - There are no copayments for covered standard eyeglass lenses (Single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular)
  - Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.
  - All lenses include scratch resistant coating
  - There may be copayments for optional lens types and treatments:
    - Intermediate vision lenses No copay
    - Ultraviolet protective coating No copay
    - Polycarbonate lenses (if not child, monocular or prescription >+/−6.00 diopters) $30
    - Blended segment lenses $20
    - Standard progressives $50
    - Premium progressives (Varilux®, etc.) $50

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1 Out of network exclusion only applies if the child is in their coverage area at time of the eyeglass/contact replacement. If the child is unexpectedly out of the area, e.g. vacation and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.
- Photochromic glass lenses $20
- Plastic photosensitive lenses (Transitions®) $20
- Polarized lenses $75
- Standard anti-reflective (AR) coating $35
- Premium AR coating $35
- Ultra AR coating $35
- High-index lenses $55

- **Frames**: Expenses above the $130 allowance are payable by the member. A 20% discount applies to any amount over $130. Out-of-network – No coverage.¹
- **Replacement of lost, stolen, broken frames and lenses**: One original and one replacement per calendar year, when deemed medically necessary.
- **Contact lenses**: One prescription every year, instead of eyeglasses or when medically necessary for vision correction.

Expenses above the $130 allowance, which may be applied toward the cost of evaluation, materials, fitting and follow-up care, are payable by the member. Additionally, a 15% discount applies to any amount over $130.²

**Please note**: In some instances, participating providers charge separately for the evaluation, fitting or follow-up care relating to contact lenses. If this occurs and the value of the contact lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).

- **Expenses more than $600 for medically necessary contact lenses, with pre-approval.**
  Medically necessary conditions include:
  - **Aphakia, pseudophakia or keratoconus**: Covered if the patient had cataract surgery or implant or corneal transplant surgery or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

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

**Not covered**:

- Vision exercise therapy: Vision exercise (orthoptic) therapy is not covered.
- Refractive surgery: Any surgery to correct the refractive error of the eye is not covered.

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¹ Additional discounts may be available from participating providers.

² Additional discounts may be available from participating providers.
OO. Weight management program

The plan offers a program for weight management that includes education and management for diet and nutrition, exercise and ongoing monitoring (coaching) to make the most of your child’s health. This program is offered only through the plan’s designated vendors contracted for these services. Contact the customer service team at 866-621-5235 (PA Relay 711) for specific information on how to access the plan’s designated participating weight management program vendors.

PP. Women’s health

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

Well-woman preventive care includes services and supplies as described under the women's preventive services provision of the Patient Protection and Affordable Care Act. Covered services and supplies include, but are not limited to, the following:

Cost: $0

- **Annual preventive gynecological examination, including:**
  - **Routine gynecological exam, pap smear:** Members are covered for one routine gynecological exam each benefit period. This includes a pelvic exam and clinical breast exam; and routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Members have direct access to care by an in-network obstetrician or gynecologist. No primary care provider referral needed.
  - **Mammograms:** Coverage is provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.
  - **Breastfeeding:** Comprehensive support and counseling from trained providers, access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother’s Option visits and obstetrician or pediatrician visits for pregnant and nursing women
  - **Routine laboratory services:** Coverage includes laboratory services performed during a preventive gynecological examination; such a chlamydia screening and pap smear.
  - **Contraception:** Coverage includes Food and Drug Administration-approved contraceptive methods at no cost share to the member, including:
    - Contraceptive devices
    - Injectable contraceptives
QQ. Items and services not covered under this plan

The following items and services are not covered by this CHIP plan. If you have questions about any of the exclusions listed below or would like to find out if something is covered under one of the services in this handbook, please call the customer service team at 866-621-5235 (PA Relay 711).

- **Abortions**: Abortions are **not covered** except for those certified by a provider as necessary for the life or physical health of the mother or to end a pregnancy which was caused by rape or incest and was reported within 72 hours from the date the female learned she was pregnant.
- **Acupuncture**: Acupuncture is **not covered**.
- **Batteries for medical equipment for diabetes**: Batteries are **not covered**.
- **Behavioral services**: Any care related to hyperkinetic syndrome, learning disabilities, behavioral problems or mental retardation which extend beyond traditional medical management are **not covered**, except as provided in handbook section 5 (U), Behavioral health Services (page 50) or section 5 (A), autism spectrum disorder services (page 27).
- **Biofeedback**: Biofeedback is **not covered**.
- **Blood and other body tissue and fluids, including storage**: Blood and its components or any artificially created blood products are **not covered**. Storage of blood, including autologous and cord blood, other body tissue and fluids is **not covered**.
- **Breast surgery**: Surgery for male or female breast reduction is **not covered**, unless it is reconstructive surgery when required to restore function following accidental injury, result of a birth defect, infection or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.
- **Charges covered under certain acts or laws**: Charges which are the result of illness or bodily injury that are covered by any:
  - Workers’ Compensation Act
  - Occupational Disease Law
  - By United States Longshore and Harbor Workers’ Compensation Act
- **First party valid and collectible claims covered by a motor vehicle policy**: Claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law are **not covered**. This exclusion applies whether or not the member claims the benefit compensation under the applicable act or law.
- **Cosmetic surgery**: Restorative or reconstructive surgery performed for cosmetic purposes which is not expected to result in significantly improved bodily function (as determined by the plan), is **not covered**, except as provided in this handbook in section 5
(R), mastectomy and breast cancer (page 47) and section 5 (GG,) restorative or reconstructive surgery (page 60).

- **Covered services received outside the service area:** Covered services needed because of circumstances that could reasonably have been foreseen before your child left the service area and covered services which can be put off until your child returns to the service area are **not covered**.

- **Custodial, convalescent or domiciliary care:** Custodial, convalescent or domiciliary care (services to help a member with the activities of daily living that do not require the attention of skilled, trained medical or paramedical personnel) are **not covered**. An example of this type of care would be placing someone in a facility for non-medical reasons.

- **Dental and orthodontic care:** The following are **not covered** under the dental and orthodontic care services in handbook section 5 (D):
  - Veneers
  - Fluoride gel carriers
  - Temporomandibular (TMJ) diagnosis and treatment

- **Durable medical equipment (DME) exclusions:** The following are **not covered** under the DME covered services in handbook section 5 (H), **durable medical equipment** (page 38):
  - Cold therapy and/or ice packs: Continuous hypothermia machine cold therapy and/or ice packs are **not covered**.
  - Computerized devices and communicative equipment: Communicative equipment or devices, computerized assistive devices and communication boards are **not covered**.
  - Disposable supplies: which include but are not limited to: soft collars, elastic bandages, support stockings, self-administered catheters (if not covered under the terms and conditions of section 5 (LL), **urological supplies** (page 65), peak flow meters or incentive spirometers are **not covered**.
  - Exercise equipment or facilities: Exercise equipment such as a whirlpool bath, other multipurpose equipment or facilities, health spas, swimming pools and saunas are **not covered**.
  - Experimental or research equipment which, as determined by the plan, is not accepted as standard medical treatment of the condition being treated or any such item that requires Federal or other governmental agency approval which is not given at the time the DME is provided is **not covered**. The experimental or non-experimental nature of any DME will be determined by the plan by the terms and conditions in section 5 (PP) (page 69).
  - Items for personal comfort or convenience: Items which are mostly for personal comfort or convenience, including but not limited to bed boards, air conditioners and over-bed tables are **not covered**.
  - More than one piece of equipment that serves the same function, such as the rental or back up of owned or rented equipment is **not covered**.
  - No longer medically necessary: Any piece of equipment which is determined by the plan to be no longer medically necessary is **not covered**.
  - Non-medical self-help devices which are not primarily medical in nature, such as elevators, lift-chairs, bath or shower benches and stair glides are **not covered**.
- **Repair or replacement of any piece of equipment**, such as for loss, theft or misuse are **not covered**. Repair or replacement for normal wear and tear is covered.
- **Specifically listed items, devices and equipment**: The following are **Not covered**:
  - Access ramps for home or automobile
  - Air filtration units
  - Anodyne infrared therapy (method of pain/wound care using an infrared device)
  - Batteries
  - Equipment with non-medical or non-therapeutic features (deluxe equipment)
  - Hairpieces and wigs
  - Heating lamps
  - Hypoallergenic sheets
  - Motor driven equipment
  - Motor vehicles or vehicle modifications (including but not limited to car seats)
  - Pads, pillows and/or cushions
  - Paraffin baths
  - Safety equipment (including but not limited to: gait belts, harnesses and vests)
  - Seasonal affective disorder lights
  - Vaporizers
  - Vitrectomy face support devices (assists in holding the face down following certain eye surgery)

- **Drug maintenance programs**: Programs for the outpatient treatment of drug dependency or addiction are **not covered**. This drug maintenance program exclusion includes but is not limited to the outpatient use of the medications Suboxone™ (buprenorphine/naloxone) and Subutex™ (buprenorphine).

- **Experimental, investigational or unproven services**: Any medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the plan to be:
  - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service as appropriate for the proposed use and are referred to by the treating healthcare provider as being investigational, experimental, research based or educational
  - The subject of an ongoing clinical trial that meets the definition of a phase I, II or III clinical trial set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight
  - The subject of a written research or investigational treatment protocol being used by the treating healthcare provider or by another healthcare provider who is studying the same service.
• If the requested service is not represented by criteria listed above, the plan reserves the right to require demonstrated evidence available in the published, peer-reviewed medical literature. This demonstrated evidence should support that:
  o The service has a measurable, reproducible positive effect on health outcomes as evidenced by well-designed investigations and has been endorsed by national medical bodies, societies or panels with regard to the efficacy and rationale for use.
  o The proposed service is at least as effective in improving health outcomes as are established treatments or technologies or is applicable in clinical circumstances in which established treatments or technologies are unavailable or cannot be applied.
  o The improvement in health outcome is attainable outside of the clinical investigation setting.
  o The majority of healthcare providers practicing in the appropriate medical specialty recognize the service or treatment to be safe and effective in treating the particular medical condition for which it is intended.
  o The beneficial effect on health outcomes outweighs any potential risk or harmful effects.

• Experimental, investigational or unproven services are not covered.

• Failure to get prior authorization: If a service requires prior authorization and the prior authorization was not obtained before your child received the service, the service is not covered.

• Foot care services: Except for children with diabetes, the treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet and chronic foot strain are not covered.

• Government responsibility: If care for military service-related disabilities is provided in a U.S. military facility where the member does not have a legal responsibility to pay for such care, the care is not covered.

• Government-sponsored health benefits program: Charges to the extent payment has been made under Medicare when Medicare is the primary carrier are not covered. You must have all required prior authorizations even when the plan is the secondary carrier.

• Hair removal: Hair removal is not covered.

• Hypnosis: Hypnosis is not covered.

• Illegal activity: Covered services needed as a result of a member’s commission of or attempt to commit a felony or being engaged in an illegal occupation, are not covered.

• Infertility procedures: In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), embryo transplants, artificial insemination and similar procedures as determined by the plan, are not covered. Expenses incurred or covered services required for any infertility procedures resulting from a member’s spouse’s voluntary sterilization are not covered. Sperm, ova and embryo storage is not covered.

• Insertion and removal of non-covered implanted devices: Any costs, charges or fees associated with the insertion, fitting or removal of an implanted device, when such device is not covered under the terms of this certificate, are not covered.

• Insured obligations: Any fees for a covered service which are over the plan’s benefit limit (except costs associated with emergency services) or amounts for any covered service which are required as a copayment amount are not covered.
• Maternity care outside the service area for normal term delivery is **not covered, unless in the case of an emergency.**

• **Missed appointment charge:** Charges for missed appointments by a member are **not covered.**

• **Non-participating provider behavioral health and substance abuse services:** Behavioral health/substance abuse services obtained from a provider who does not participate in the plan’s designated behavioral health benefit program are **not covered** except for emergency services as stated in section 5 (I) (page 40).

• **Non-participating providers:** Covered services or supplies received from non-participating providers are **not covered.** The only exceptions are:
  o Emergency services, as provided in section 5 (I) (page 40)
  o Urgent care received outside the service area, as provided in this handbook in section 5 (KK) (page 65)
  o Covered services under this handbook in keeping with the continuity of care provisions as provided in handbook sections 3 (F) (page 21)
  o Covered services which are not available from a participating provider and for which prior authorization has been obtained from the plan

• **No obligation to pay:** Any type of drug, service, supply or treatment which, if not covered by this CHIP plan, the member would not have to pay for, is **not covered.**

• **Non-rigid elastic garments:** Non-rigid elastic garments are **not covered.**

• **Not medically necessary:** Covered services which are not considered medically necessary by the plan are **not covered** unless and only if such services are required by state or federal law or are covered in this handbook under section 5 (CC) **preventive well-care services** (page 55).

• **Oral nutrition products or supplements:** Oral nutrition products or supplements not used to treat inborn errors of metabolism are **not covered** including, but not limited to:
  o Supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc.
  o Lactose free foods
  o Banked breast milk
  o Standardized or specialized infant formulas

• **Organ donation to non-members:** All costs and services related to a member donating organ(s) to a non-member are **not covered.**

• **Orthodontia:** Orthodontia is **not covered** except as provided in section 5 (D) **dental and orthodontic care** (page 30). An example of this orthodontia coverage is braces for aligning teeth for cosmetic purposes

• **Orthoptic therapy (vision exercises) is not covered.**

• **Orthotic exclusions:** The following are **not covered** under the orthotic devices covered services in handbook section 5 (W) (page 52):
  o Corrective shoes, shoe inserts and supports, heel cups, lifts or foot orthoses of any sort are **not covered**, except for foot orthotics for diabetes which are covered as a covered service in this handbook under section 5 (E), **Treatment, equipment, drugs and supplies for diabetes** (page 35).
• **Dental appliances** of any sort including, but not limited to, bridges, braces and retainers are **not covered** except those which may be covered under handbook section 5 (D), **Dental and orthodontic care**.

• **Disposable supplies** which include but are not limited to, support stockings, gloves and ace bandages are **not covered**.

• **Experimental or research equipment** which as determined by the plan is not accepted as standard medical treatment of the condition being treated or any such item requiring federal or other governmental agency approval not granted at the time the orthotic device was provided is **not covered**. The experimental or non-experimental nature of any orthotic device shall be determined by the plan as set forth in handbook section 5 (QQ) (page 70).

• **Non-medical or non-therapeutic devices**: Appliances or apparatuses with non-medical or non-therapeutic features are **not covered**.

• **Orthotic devices for personal comfort or convenience**: Orthotic devices which are mostly used for personal comfort or convenience are **not covered**.

• **Panniculectomy, lipectomy and abdominoplasty**: Removal of excessive skin and tissue including but not limited to panniculectomy, abdominoplasty or lipectomy by any method (such as suction assisted, liposuction or aspiration) is **not covered**. These procedures may involve areas such as but not limited to head and neck, upper and lower extremities, abdomen, breasts, back, pelvis, buttocks and hips.

• **Personal comfort items/services** including but not limited to, telephones, televisions and special meals are **not covered**.

• **Personal and athletic trainer services**: Services provided by a personal or athletic trainer are **not covered**.

• **Prescription drug use by a non-member**: Use of a prescription drug, device or equipment provided to a member according to the terms and conditions of handbook section 5, **covered services**, by anyone other than the member is **not covered**.

• **Prescription bandages and wound dressings**: Prescription bandages and other wound dressing products are **not covered**.

• **Prosthetic exclusions**: The prosthetic devices listed as not covered in section 5 (EE) (page 58) are **not covered**.

• **Disposable supplies** which include but are not limited to, stump socks and gradient compression stockings are **not covered**.

• **Experimental or research equipment** which as determined by the plan, is not accepted as standard medical treatment of the condition being treated or any such item requiring Federal or other governmental agency approval not granted at the time the prosthetic device was provided is **not covered**. The experimental or non-experimental nature of any prosthetic device shall be determined by the plan as explained in handbook section 5 (QQ) (page 70).

• **Non-medical or non-therapeutic devices**: Prosthetic devices with non-medical or non-therapeutic features are **not covered**.

• **Prosthetic devices for personal comfort or convenience** are **not covered**.

• **Repair** of any prosthetic device is **not covered**.

• **Real time blood glucose monitor and supplies** are **not covered**.

• **Refractive procedures**: Any surgery to correct the refractive error of the eye is **not**
covered.

- **Reversal of sterilization**: Surgical procedures to reverse voluntary sterilization are **not covered**.
- **Revision of the external ear**: Cosmetic reshaping of the outer part of the ear is **not covered**.
- **Riot or insurrection**: Covered services required as a result of a member’s participation in a riot or insurrection are **not covered**.
- **Routine nail trimming** is **not covered**.
- **Services provided by a member’s relative or self**: Services provided by a PCP who is the spouse, child, parent, grandparent, aunt, uncle, niece, nephew or sibling of the member are **not covered**.
- **Services provided in conjunction with a non-covered service**: Any service which would otherwise be a covered service under this handbook when provided in conjunction with a non-covered service is **not covered**. Such services may include but are not limited to anesthesia or diagnostic services. This exclusion does not include medically necessary covered services incurred due to complications resulting from a member’s receipt of a non-covered service.
- **Sexual dysfunction services, devices and equipment**, male or female, are **not covered**.
- **Transportation services**: Transportation services for convenience, or any stretcher or wheelchair van transportation are **not covered**.
- **Unauthorized services**: All unauthorized services are **not covered**. This includes any covered service **not**:
  - Provided by the member’s PCP
  - Provided by the member’s OB/GYN participating provider (for services within their scope of practice)
  - Performed upon prior authorization by the plan (for covered services which are not available from a participating provider).
  - Emergency services provided inside or outside the service area do not require prior authorization. See handbook section 3 (H), **Getting emergency service** (page 22), of this for the emergency services protocol.
- **Vein sclerosing**: Injection of sclerosing solution into superficial veins (commonly called spider veins) is **not covered**. Injection of sclerosing solution into varicose leg veins is **not covered** unless medically necessary as determined by the plan.
- **Weight control**: Weight management programs for non-morbid obesity are **not covered** unless provided for in this handbook in section 5 (OO), **weight management program** (page 69).

6. Outpatient pharmacy services

This section provides information on your child’s outpatient pharmacy services with your CHIP plan. The services described in this section are for prescription drugs, drugs or medicines required by law to be provided by a licensed pharmacist or provider. Such drugs and medicines require a written or verbal prescription from a healthcare provider with the legal authority to give a prescription. The drugs and medications must be prescribed for outpatient use. Prescription drugs do not include those drugs excluded under section 6 (F)
If you have any questions about your child’s pharmacy services, please call the pharmacy service team at 800-988-4861.

### A. Outpatient prescription drugs covered under this CHIP plan

Some over-the-counter (OTC) products may be covered if mandated by the Patient Protection and Affordable Care Act (PPACA). If the member has a prescription for the over-the-counter medication, the medication is listed in the formulary and the member is diagnosed with certain medical conditions, the medication may be covered. If you have questions about if an over-the-counter medication is covered, call customer service at 800-988-4861.

When a generic version of a prescription drug is available we will only provide benefits for that prescription drug at the generic drug level. If the prescribing provider indicates that the brand name drug is medically necessary and should be dispensed, the brand name drug is covered at the generic cost-share amount by the contractor.

When clinically appropriate drugs are requested by the member, but are not covered by the health plan, the member can call customer service to find out more information about getting those specific drugs.

**Covered preventive medications:**

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen and raloxifene are considered preventive medications and covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call customer service at 800-988-4861.

Outpatient prescription drugs must be provided by a participating pharmacy, which can be found in the provider list or on the GHP Kids CHIP website GHPKids.com. Preventive medication must be listed in our formulary to be covered under the plan. A formulary is a frequently updated list of the current prescription drugs and medicines covered by the plan. The formulary has both brand name drugs and generic drugs approved by the U.S. Food and Drug Administration (FDA). The formulary tells you if a certain drug requires prior authorization. A list of drugs included on the formulary will be sent to you upon request. To see if a certain drug is on the current formulary, call the pharmacy services team at 800-988-4861 or visit the GHP Kids CHIP website at GHPKids.com.

Your child can get over-the-counter medications when the drug is part of the formulary, your child has a prescription for the drug and the drug is medically necessary. All other over-the-counter drugs are not covered.

The following is information on the drugs covered by this plan.

1. **Outpatient prescription drugs are covered for your child when:**
   - They are included on the formulary (prior authorization from the plan may be required for certain drugs)
   - The prescription is for no longer than a 34-day period (additional restrictions as to the amount may apply)
   - They are prescribed for your child as a result of a service provided in this handbook in section 5, covered services (page 26)
   - You get the drugs from a participating pharmacy
2. Restricted drugs, non-formulary drugs and drugs requiring prior authorization: Restricted drugs (drugs listed in the formulary that require prior authorization), non-formulary drugs and certain drugs requiring prior authorization are covered when:
   • They are prescribed for your child as a result of a service provided in this handbook in section 5, covered services (page 24)
   • You have prior authorization for the drugs from the plan
   • You get the drugs from a participating pharmacy

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

4. Human growth hormone: Human growth hormone is covered subject to the benefit limit below.
   **Benefit limit:** Your cost for human growth hormone is 20% coinsurance per 34 day use of the drug. The plan pays for 80% of the cost of human growth hormone.
   Example: if the human growth hormone treatment costs $100.00, you will pay $20.00 to the pharmacy and the plan will pay $80.00.

5. Prescriptions requiring compounding: A compound prescription is a mixture of two or more ingredients when at least one of the ingredients is a prescription drug. Compound prescriptions are covered if they contain one or more medications required by Pennsylvania or federal law to be given only by prescription. Compound prescriptions may require prior authorization by the plan depending on the cost of the prescription.

6. Contraception: Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures and patient education and counseling are covered at no cost share to the member. Abortifacient drugs are not covered. Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.

7. Over-the-counter medications: Over-the-counter medications are covered when the drug is part of the formulary, your child has a prescription for the drug and the drug is medically necessary.
   **Benefit limit:** Vitamins prescribed by a provider are covered.

   To get prior authorization for a drug, please call the pharmacy services team at 800-988-4861.

B. Generic and brand name drugs

Your child may get a prescription for either a brand name drug or a generic drug. In most cases, the generic drug will cost less than a brand name drug. It is a good idea to ask the provider prescribing the drug to prescribe a generic, if available. Under Pennsylvania law, if a provider gives your child a prescription for a brand name drug, the pharmacist can fill it with the generic version of that drug if a generic is available. Sometimes, a drug will not
have a generic so only the brand name can be prescribed. Below is a description of the difference between a brand name drug and a generic drug:

1. **Brand name drug** as used in this plan means:
   - The non-generic form of a medication when a generic is available
   - A medication which doesn’t have a generic form available

2. **Generic drug or generic** means a prescription drug that is:
   - Designated as a generic drug by the United States Department of Health and Human Services or designated as a generic by another third party (selected at the plan’s sole discretion)
   - Approved by the plan

If the prescribing provider indicates that a brand name drug is medically necessary and should be dispensed, the brand name drug is covered at the generic cost-share amount.

### C. Cost of drugs

The following chart shows you how much your copayment is for brand name prescription drugs and generic prescription drugs. To find your copayment on the cost chart, look in the box under your child’s CHIP plan (either the low-cost plan or the full-cost plan), where you will find the amount of your copayment. The free CHIP plan does not have copayments. Please note that whenever a generic drug can be legally substituted for a brand name drug, the plan will pay only the cost of the generic drug, unless the brand name drug is less expensive or unless the brand name is listed as payable on the formulary. If the prescription requests that the pharmacist dispenses the brand name drug when a generic is available or if you choose to get the brand name drug when a generic is available, you will be responsible to pay any cost above the cost of the generic drug. You will pay the pharmacy filling the prescription at the time the prescription is filled.

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### D. Limitations on outpatient drugs and medicines
The following are limitations to outpatient prescription drug services.

1. **Prenatal vitamins and fluoride.** Your child can get no more than one-hundred (100) tablets or capsules of prenatal vitamins or fluoride; or fifty (50) ml (in original package sizes) of prenatal vitamins and vitamin fluoride combinations.

2. **Smoking cessation drugs: Chantix® and generic Zyban™ (buproban):** The following terms and conditions apply to the smoking cessation drugs Chantix and generic Zyban (buproban). These drugs are used to help a person quit smoking tobacco:

   - **Chantix:** The plan will cover the drug Chantix for smoking cessation only when your child is enrolled in the plan’s tobacco cessation program.
     - **Benefit limit:** Your child is limited to coverage for Chantix for a total of 24 weeks in their lifetime.
     - **Benefit limit:** Chantix is available only to children over the age of 18.

   - **Generic Zyban™ (buproban).** The plan will cover the generic drug Zyban (buproban) for the purpose of smoking cessation.
     - **Benefit limit:** Generic Zyban (buproban) is available only to children over the age of 18.

3. **Manufacturer:** The plan has the right to restrict the manufacturer of prescription drugs covered under this section. Such restriction is subject to change by the plan without the consent of the member (or their parent or guardian).

4. **Prescription drug tiers** are set forth as follows:
   - **Tier 1:** This includes most generic drugs. Prior authorization is usually not necessary for drugs in this tier.
   - **Tier 2:** This includes certain formulary brand name drugs with no generic drug equivalent. Prior authorization may be necessary to cover some drugs in this tier.

5. **Assignment of drugs to tiers:** The plan reserves the sole discretion in assigning drugs to certain tiers and in moving drugs from tier to tier. Several factors are considered when assigning drugs to tiers, including, but not limited to: the availability of a generic equivalent, the absolute cost of the drug, the cost of the drug relative to other drugs in the same therapeutic class, the availability of over-the-counter alternatives and/or clinical and economic factors.

5. **Own use:** Prescription drugs shall be only for the use of the member for whom the drugs were prescribed.

**E. Preventive medications**

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen and raloxifene are considered preventive medications and covered at no cost to you when filled at

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a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call the customer service team at 800-988-4861.

F. Outpatient pharmacy services not covered under this plan

The following are not covered under outpatient pharmacy services. If you have questions about any of the exclusions listed below or would like to find out if a certain drug or prescription is covered under outpatient pharmacy services, please call the pharmacy service team at 800-988-4861.

1. **Cosmetic drugs.** Prescription drugs prescribed for cosmetic use are not covered. Such drugs may include but are not limited to: drugs for hair loss or growth, drugs for wrinkles or skin bleaching and drugs used for the treatment of onychomycosis (fungal nail infection).

2. **Devices** of any type are not covered, even if the device may require a prescription. Such devices include but are not limited to therapeutic devices and artificial appliances (except those covered in handbook sections 5 (H) (page 38), 5 (X) (page 53) and 5 (EE) (page 58)) DME, prosthetic devices and orthotic devices), hypodermic needles and syringes (except those which are listed as a covered service in section 5 (E), **Treatment, equipment, drugs and supplies for diabetes** (page 35)) and diagnostic devices and supplies.

3. **Drugs available without a prescription:** Prescriptions for drugs which are available in the same strength without a prescription are not covered. This does not include the over-the-counter medications covered in section 6 (A) (6) **over-the-counter medications** (page 77).

4. **Drugs which are not prescription drugs:** A prescription drug is any drug or medicine in a written or verbal prescription that is required by law to be dispensed by a licensed pharmacist or provider. If a drug is not a prescription drug it is not covered. This does not include the over-the-counter medications covered in section 6 (A) (6) **over-the-counter medications** (page 77).

5. **Erectile dysfunction medications** are not covered.

6. **Experimental drugs are not covered** including:
   - Those labeled “Caution-limited by federal law to investigational use”
   - Non-FDA approved drugs
   - FDA approved drugs for investigational indications or for non-FDA approved uses or at investigational doses
   - Drugs found by the FDA to be ineffective

8. **Failure to get prior authorization.** If the following drugs are provided before getting prior authorization from the plan, they are Not covered:
   - Non-formulary drugs
   - Restricted drugs
• Drugs requiring prior authorization by the plan which were gotten before receiving prior authorization.

9. **Immunizations** are not covered except those covered in this handbook in section 5 (DD), Preventive well-care services (page 56).

10. **Non-participating pharmacies.** Outpatient prescription drugs provided by non-participating pharmacies (pharmacies not listed on the provider list or on the GHP Kids CHIP website) are not covered.

11. **Not medically necessary.** Drugs the plan determines are not medically necessary are not covered.

12. **Over-the-counter drugs and other items available without a prescription,** dispensed with or without a prescription are not covered, including but not limited to: aspirin, oxygen, cosmetics, medicated soaps, food supplements, vitamins and bandages. This does not include the over-the-counter medications covered in section 6 (A) (6) over-the-counter medications (page 77).

13. **Prescription bandages and other wound dressing products** are not covered.

14. **Re-packaged medications.** Medications that are re-packaged by the supplier and sent to a pharmacy for fulfillment of prescriptions are not covered.

15. **Replacement prescriptions** for lost, destroyed or stolen prescriptions are not covered.

16. **Smoking cessation aids,** including but not limited to, nicotine replacement drugs (except Chantix and generic Zyban (buproban) which are covered as explained in handbook section 6 (D) (page 79)) are not covered.

17. **Specifically listed items.** The following drugs, supplements, products and items are not covered:
   • Dietary supplements
   • Anabolic steroids
   • Blood plasma products
   • Irrigation solutions
   • The drug maintenance medications known as Suboxone™ (buprenorphine/naloxone) and Subutex™ (buprenorphine).

18. **Standard medical treatment.** Prescription drugs that are not accepted as standard medical treatment of the condition being treated (as determined by the plan) or any drug requiring federal or other governmental approval which has not been granted at the time the drug is dispensed are not covered.

19. **Unit doses of prescriptions.** Prescriptions dispensed in unit doses (blister packs), when bulk packaging is available are not covered.
20. Use of a prescription drug by anyone other than the member listed on the prescription is not covered.

21. **Weight loss or weight management.** Prescription drugs prescribed for weight loss or weight management are **not covered.**

### 7. What to do if you have a complaint or grievance

The plan has complaint and grievance processes available to you if you are not satisfied with your child’s CHIP services or a decision about a service made by GHP. Each process has two levels of internal review (within GHP) and the opportunity to appeal the decision to state agencies through an external review process. There is also an expedited or faster grievance review for situations where a decision needs to be made quickly due to your child’s medical condition.

You have the right to choose someone to help you through the complaint and grievance process by acting on your behalf. This person is called your member representative. If you want to appoint someone to be your representative, you must notify us in writing and we will send you a form to return to us that will confirm your decision.

We will act fairly if you file a complaint or grievance. We will not cancel your child’s CHIP coverage because you filed a complaint or grievance. If you ask, we will appoint a GHP employee to help you through the complaint/grievance process. This will not cost you anything. The person we appoint for you will not have been involved in any decisions which are the subject of your complaint or grievance. This person is committed to act fairly on your behalf.

You have the right to send us any written comments, records, documents or other information you have regarding your complaint or grievance. We will fully and fairly consider any material you send to us.

If at any time during the complaint or grievance process you feel that we have misclassified a complaint or grievance, you may contact the Pennsylvania Department of Health or Pennsylvania Department of Insurance for their opinion as to whether your issue is a complaint or grievance and we will follow their decision and use the correct process. The contact information for these departments is as follows:

**Bureau of Managed Care**  
**Pennsylvania Department of Health**  
Health and Welfare Building, Room 912  
625 Forster St.  
Harrisburg, PA 17120  
Telephone number: (717) 787-5193 or (888) 466-2787 (PA relay 711)  
Fax Number: (717) 705-0947

**Pennsylvania Department of Insurance**
If you have any questions about the complaint or grievance process or would like information on a complaint or grievance you have filed, please call the customer service team at 866-621-5235 (PA Relay 711).

A. Filing a complaint

You have the right to let us know if you are not satisfied with GHP’s policies, any of your child’s providers or the coverage of services in your child’s CHIP plan by filing a complaint. Examples of complaints include:

- Not being satisfied with the care your child is getting from a provider
- Not being satisfied with how GHP is managing your CHIP plan (including issues regarding services that are not included in your CHIP plan)
- Not being satisfied with the coverage your child has under your CHIP plan

A complaint does not include decisions based on medical necessity or the appropriateness of a healthcare service for your child.

Your first step in filing a complaint calling the customer service team at 866-621-5235 (PA Relay 711) and telling the representative about your complaint. The representative will try to resolve your issue informally. If your issue cannot be taken care of by the representative, you can move to a first level complaint.

1. First level complaint

To file a first level complaint, send the plan a written complaint or call the customer service team at 866-621-5235 (PA Relay 711). If you file a written complaint, send it to:

Geisinger Health Plan
Appeal Department M.C. 32-20
100 N. Academy Ave.
Danville, PA 17822

a) First level complaint process

i) You have 180 calendar days to file your complaint with the plan. This is 180 days from either:

- The date of the event triggering your complaint
• The date you were notified the plan either decided your child could not get a service or item because it is not covered under the plan, or the date the plan decided not to pay a provider for a service or item your child received.

ii) Once we receive your complaint, we will let you know we received your complaint by mail. The letter explains the complaint process. You are permitted to provide the plan with additional information or material related to your complaint. If you ask, you will be permitted to have access to information we have that is related to your complaint at no cost.

iii) Within 30 calendar days, the first level review committee (made up of plan employees who were not involved in making decisions related to your complaint) will meet and review your complaint.

di) Within five business days of the committee’s decision on your complaint, we send a letter informing you of the decision and what the committee based their decision on. This letter explains how to file a request for a second level complaint if you are not satisfied with the first level decision. If you don’t file a second level complaint, the decision of the first level review committee is final.

2. Second level complaint

To file a second level complaint, send the plan a written complaint or call the customer service team at 866-621-5235 (PA Relay 711) and a representative will take your information over the telephone. If you file a written complaint, send it to:

Geisinger Health Plan
Appeal Department M.C. 32-20
100 N. Academy Ave.
Danville, PA 17822

a) Second Level Complaint Process

i) The plan does not impose a time period as to when you need to request a second level complaint.

ii) Once we receive your second level complaint, we will send you a letter letting you know we received your complaint. The letter explains the second level complaint process. In the second level complaint process, you have the right to attend the second level review committee meeting. Your letter explains this right to you.

iii) Within 30 calendar days of receiving your second level complaint, the second level review committee (made up of both non-employees and plan employees who were not involved in making decisions related to your complaint) meet and review your second level complaint. You may attend this meeting and will be
notified of the date and time of this meeting at least 15 days in advance. Before this meeting, you will be permitted to give the plan additional information or material related to your complaint. If you ask, you will also get access to information we have related to your complaint at no cost.

iv) Within five business days of the committee’s decision on your complaint, we will send a letter informing you of the decision and what the committee based their decision on. This letter explains how to appeal the decision to the Pennsylvania Department of Health or the Pennsylvania Department of Insurance and provides addresses and telephone numbers for each of these agencies. If you do not file an appeal, the decision of the second level review committee is final.

3. External complaint appeal review

Appealing the second level review committee’s decision to the Pennsylvania Department of Health or the Pennsylvania Department of Insurance is called an external complaint review.

a) External complaint review process.

i) You have 15 days from the date you received your second level complaint decision letter to request an external complaint review from the Pennsylvania Department of Health or the Pennsylvania Department of Insurance – reviewing department. This request must be in writing.

ii) The plan forwards all records from the first and second level complaint reviews to the appropriate state reviewing department within 30 days of the reviewing department’s request. You (and the plan) have the right to submit any other materials for the reviewing department for review. If you or the plan submit material to the reviewing department, copies of these materials will also be provided to the other party. Additionally, you have the right (as does the plan) to be represented by an attorney or another individual at this review.

iii) The decision of the reviewing department is the final decision on your complaint.

B. Filing a grievance

In addition to filing a complaint, you also have the right to file a grievance. A grievance is a request for the plan to reconsider a decision it made regarding the medical necessity or appropriateness of a healthcare service for your child. Examples of grievances are:

- The plan denies full or partial payment for a healthcare service
- The plan approves a healthcare service for a lesser service than requested or for a shorter period of time than requested
• The plan will not pay for the requested healthcare service but will pay for a different healthcare service

You, a member representative or a provider with your written consent can file a grievance.

1. First level grievance review

To file a grievance, you (or the provider if they are filing the grievance) must send a letter explaining the grievance to the plan at the following address:

Geisinger Health Plan
Appeal Department M.C. 32-20
100 N. Academy Ave.
Danville, PA 17822

If you are unable to file a written grievance because of disability or a language barrier, you may call the customer service team at 866-621-5235 (PA Relay 711) and ask the representative to take your grievance information over the telephone.

a. First level grievance review process

i) You have 180 calendar days from the date you were notified of any of the examples in section B, filing a grievance (above) to file your grievance with the plan.

ii) Once we receive your grievance, we will send you (and the provider if they filed the grievance) a letter informing you that we received your grievance. The letter explains the grievance process. You (and the provider if they filed the grievance) can send the plan additional information or material related to your grievance. If you ask, you (and the provider if they filed the grievance) can access information we have related to the matter being grieved at no cost.

iii) Within 30 calendar days, the first level internal review committee (made up of plan employees who were not involved in making decisions related to your grievance along with a licensed provider or psychologist if appropriate, with experience in the specialty related to your grievance) meets and reviews your grievance.

iv) Within five business days of the committee’s decision on your grievance, we will inform you of the decision and what the committee based the decision on in a letter. This letter explains how to file a request for a second level grievance review if you are not satisfied with the decision of the first level review committee. If you do not file a second level grievance review, the decision of the first level internal review committee is final.

2. Second level grievance review
To file a second level grievance review, you (or the provider if they are filing the grievance) must send a letter requesting a second level grievance review to the plan at the following address:

Geisinger Health Plan
Appeal Department M.C. 32-20
100 N. Academy Ave.
Danville, PA 17822

If you are unable to file a written grievance because of disability or a language barrier, call the customer service team at 866-621-5235 (PA Relay 711) and ask the representative to take your grievance information by telephone.

a. Second level grievance review process

i) The plan does not impose a time period for a request of a second level grievance review.

ii) Once we receive your second level grievance, we will send you (and the provider if they filed the grievance) a letter informing you we received your grievance. The letter explains the second level grievance review process. You (and the provider if they filed the grievance) can send the plan additional information or material related to your grievance. If you ask, you (and the provider if they filed the grievance) can access information we have related to the matter being grieved at no cost to you.

iii) Within 30 calendar days, the second level internal review committee will meet and review your grievance. The committee will be made up of three or more people who were not involved in making decisions related to your grievance. One person will be a licensed provider or psychologist if appropriate, with experience in the specialty related to your grievance. You (and the provider if they filed the grievance) may attend this meeting and will be notified of the date and time of this meeting at least 15 days in advance. Before this meeting, you (and the provider if they filed the grievance) can send the plan additional information or material related to your grievance. Additionally, if you ask, you (and the provider if they filed the grievance) can get information we have related to the matter being grieved at no cost. At this meeting, you (and the provider if they filed the grievance) have the right to appear before the committee or be represented by an attorney or another individual at the meeting.

iv) Within five business days of the committee’s decision on your grievance, we will send you a letter (and the provider if they filed the grievance) explaining the decision and what the committee based their decision on. This letter informs you of how to file a request with an independent review organization (“IRO”) for an external grievance review if you are not satisfied with the decision of the second level review committee.
3. Expedited grievance review

If you feel that your child’s life, health or ability to regain maximum function is at risk by the timing of the plan’s grievance review procedure, you (or the provider if they file the grievance with your consent) may request an expedited grievance review by calling the customer service team at 866-621-5235 (PA Relay 711) or sending the request to us at the following address:

Geisinger Health Plan
Appeal Department M.C. 32-20
100 N. Academy Ave.
Danville, PA 17822

a. Expedited grievance review process:

i) The plan performs an expedited grievance review when:

- Upon review by the plan, the request meets medical criteria to go through expedited grievance review process
- It is the healthcare provider’s opinion that your child is subject to severe pain that cannot be managed without the care or treatment being requested
- You provide the plan with a certification, in writing, from your child’s provider stating your child’s life, health or ability to regain maximum function would be at risk by a delay caused by the pre-service grievance process of 30 days. The certification must include a clinical rationale and facts to support the provider’s opinion
- You submit a request concerning admissions, continued stay or other healthcare service for your child who has received emergency services but has not been discharged from the facility.

ii) The review will be done by the expedited internal review committee that is made up of three or more people who were not involved in making decisions related to your grievance. One person on the committee will be a licensed provider or psychologist if appropriate, with experience in the specialty which is the subject of your grievance. The plan will give you a decision within 48 hours of your request.

iii) If you (or the provider if they filed the grievance), are not satisfied with the decision of the expedited internal review committee, you may appeal the decision to an independent review organization by filing a request (over the phone or in writing) to the plan within two business days of receiving the review decision. The procedure in section 7 (D) (page 91), expedited external grievance/adverse benefit determination review (below) will be followed.

C. External grievance

If you are not satisfied with the final adverse benefit determination (the decision made by the plan regarding a grievance filed according to sections 7 (B)(1). or 7(B)(2). (pages 87 and 87)
that results in a denial), you may have the opportunity to request an external review. Final adverse benefit determinations that meet the federally regulated external appeal criteria can be reviewed by an IRO. Information about any appeal rights you have will be provided to you in the appeal decision notification letter you receive.

1. External grievance review

a. Requesting an external grievance review

i) You can file a request for an external review with the plan within four months after receiving notice of the final adverse benefit determination.

ii) Within five days of receiving your external review request, the plan determines if you are eligible for an external review. The plan checks whether your child was covered under the plan at the time of the service, if the grievance process has been exhausted and if you have provided all necessary information to process an external review.

iii) Within one day of completing the review, the plan sends you a letter about your request. If your request is complete but not eligible for review, the plan will tell you why you are not eligible and give you information on how to contact the Employee Benefits Security Administration. If the request is not complete, the plan will tell you what you need to do to make the request complete. You will have the rest of the four-month filing period (see (i) above) or 48 hours from receiving the letter, whichever is later, to complete your incomplete request for an external review.

b. The external review procedure

i) If you are eligible for an external review, the plan assigns an independent review organization (IRO) according to state and federal regulations.

ii) The IRO notifies you of acceptance and lets you know that you have 10 days to send the IRO any additional information you would like the IRO to consider in the review. You must send this information in writing.

iii) The IRO performs an independent review of your grievance and will not be bound by the decisions of the plan during our review process. The IRO’s review is performed in accordance with state and federal laws.

iv) The IRO gives you notice of the final external review within 45 days of receiving the request for an external review. The IRO’s decision will be in writing and explains the reasons for its decision, what documentation or evidence was used to make the decision and other information required by regulation.

v) The decision of the IRO is final unless there are other remedies available under state or federal law. The plan is also bound by the IRO’s decision and must provide any benefits (including paying claims) according to the IRO’s decision.
D. Expedited external grievance/adverse benefit determination review

You or the provider (with your written consent), may appeal verbally or in writing to the plan within two business days of receiving the expedited grievance review decision (from section 7 (C) (page 89)). You have two business days from receiving the expedited grievance review decision to appeal.

Under certain circumstances, which are outlined to the member in the plan’s appeal letter, an expedited external review may be requested at the same time the member requests an expedited appeal.

a. Expedited external grievance/adverse benefit determination review

   i) If the plan determines the expedited external review request meets the same requirements as section 7 (C). (page 89), we will notify you within one business day after the review completes. If your request is complete but not eligible for review, the plan will tell you why you are not eligible and give you information on how to contact the Employee Benefits Security Administration. If the request is not complete, the plan will tell you what you need to do to make the request complete.

   ii) If you are eligible for an expedited external review, the plan assigns an IRO according to state and federal regulations. The plan sends the IRO all necessary documents and information used in making the adverse benefit determination. The IRO will perform an independent review and will not be bound by the plan’s prior decisions.

   iii) The IRO provides you with notice of the final external review as quickly as the member’s medical condition requires, but no later than 72 hours after the IRO receives a request for an expedited external review. If your notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO provides written confirmation of the decision to you and the plan.

8. Enrollment and Eligibility

A. Who is eligible to enroll in CHIP?

To be eligible to enroll in CHIP, your child must meet the following requirements.

- Must be under the age of 19
- Must be a Pennsylvania resident
- Must be a citizen of the United States (U.S.) or a U.S national or qualified alien
- For children in families whose income falls in the low-cost and full-cost CHIP range, the parents must show the child (children) they want to enroll have not been covered under other health insurance for the past six months unless:
• The child is under age two
• That they have lost health insurance because a parent lost a job
• That they are coming from coverage by another public health insurance program
• Must not be eligible for or covered by Medical Assistance

B. What CHIP programs are available?

The three CHIP plans are free CHIP, low-cost CHIP and full-cost CHIP. Your family income and family size determines plan eligibility.

• Free CHIP requires no premiums or copayments. It is completely free. Most families are eligible for free CHIP.
• Low-cost CHIP requires monthly premiums and copayments for certain services.
• Full-cost CHIP requires monthly premiums and copayments for certain services.

Enrollment in CHIP is dependent on the availability of program funding. If funding is not available, it is possible that your child may be added to a waiting list for CHIP enrollment. Eligible children will be enrolled in the program on a first-come, first-serve basis as funds become available. You will be notified in writing if funds become available that remove your child from the waiting list and actively enrolled them.

If your child is eligible for CHIP, but is placed on the waiting list due to lack of funding, you will be offered the option to purchase coverage for your child at full-cost. Electing to pay for coverage has no effect on the length of time your child remains on the waiting list.

C. Annual renewal of CHIP

Your child’s CHIP coverage runs for a benefit year (12 months) from the first day of your child’s enrollment until one year later. This time period is called the benefit period. You will receive a renewal letter and renewal form 90 days before the end of the benefit period. You must complete the renewal form and return it to the plan before the deadline or your child’s CHIP coverage will end on the date stated in the letter.

It is possible that your child’s coverage program will change upon yearly renewal. The plan must review your family’s income at each yearly renewal. You will be told in your renewal letter and on the renewal form what information we need for this annual review. Within 15 days of receiving your renewal form and any requested documents, we will send you notice as to your renewal and whether there will be changes in coverage for the new benefit period (new year).

If your child is not found to be eligible for renewal, you will be given the reason(s) why and details on how you can have the Pennsylvania Insurance Department perform an independent eligibility review. If appropriate, we will forward the renewal application to the county assistance Office for possible Medical Assistance coverage for your child. All this will be explained in a letter to you regarding your renewal for the following year. Please call the...
You can also renew your child’s CHIP coverage by using COMPASS, an online renewal process provided by the Commonwealth of Pennsylvania. To access COMPASS, visit www.compass.state.pa.us. You can complete the renewal form online but you must either mail your proof of income in the envelope that came with your renewal form or fax your proof of income to 570-271-5970. If you choose to renew using COMPASS, you must renew by the termination date stated in your renewal letter.

### D. How to add another child for CHIP coverage

If your family already has one child enrolled in CHIP, you can add another child in the family by notifying us. No additional financial information is required. The child being added must be under age 19, a Pennsylvania resident and a U.S. citizen. After that is determined, the child will be added. Upon renewal, the plan reviews financial information and follow the procedure described in C, above.

### E. How to add a CHIP member’s newborn to the CHIP plan

If a CHIP member has a newborn baby while enrolled in CHIP, the newborn is automatically covered by CHIP for the first 31 days of his or her life. The newborn is eligible for either CHIP or Medical Assistance, as appropriate, until age 1 without a separate application being filed for the newborn. **Please call the customer service team at 866-621-5235 (PA Relay 711) immediately after the child is born to notify us of the pregnancy** and we will begin the determination process as to the newborn’s eligibility for CHIP or Medical Assistance.

### F. How to request re-assessment of eligibility during a CHIP coverage period

At your request, the plan will reassess your child’s eligibility during the CHIP benefit period to see if they might qualify for a less expensive CHIP option. A change in the size of your family or a change in your family income qualifies you for re-assessment. The plan re-assesses your child’s eligibility based on the above factors and notifies you if they would or would not result in a change of CHIP options (for example: if your child is in full-cost CHIP and you lose your job and lose monthly income, your child could be eligible for a lower cost CHIP coverage). It is important to note that you do not have to agree to the change in options, you can wait until the end of the current benefit period to make the change.

### G. Other changes during the benefit period you need to report

Other things the plan should be notified of during your child’s coverage are:

1) A change in your address within the service area: If your address changes within the service area, we will make the change in your file so that we can send any mailings to your new address. Also, we may contact you if you move, to help you select a new PCP who is
closer to where you are living (if you are moving several miles from where you had lived before).

2) If you would prefer to change to another insurance company that participates in CHIP: If you would like to change companies, we will make the change within 48 hours after you have contacted us, with no lapse in CHIP coverage for your child.

3) If you move out of the service area. If you move out of the service area, we will work with you to find a CHIP carrier in your new area and your coverage will transfer with no lapse in coverage. You will have 30 days to select a new CHIP carrier and PCP.

If you move out of state. This will result in a termination of your coverage, because CHIP is a program for Pennsylvania residents only.

If your child obtains other health insurance coverage. If your child enrolls under a private health insurance plan, they are no longer eligible for CHIP. CHIP is only for children who have no other health insurance coverage.

9. Termination of CHIP Coverage

A. Circumstances which will result in termination of your child’s CHIP coverage

The following circumstances will result in termination of your child’s CHIP coverage under this plan. In all cases you will get advance notice of the termination in a letter.

1) **Your child is no longer eligible for CHIP.** If your child is no longer eligible for CHIP, coverage will end at renewal. This can happen if your family income is too low for CHIP coverage. If it is too low for CHIP, you may be eligible for Medical Assistance and we will transfer your information to the county assistance Office for consideration. We will provide you with notice telling you that we’ve done on this.

2) **Non-payment of the premium in low-cost or full-cost CHIP.** If your child is a low-cost or full-cost CHIP member and you don’t pay the premium by the due date, you will receive a letter from GHP letting you know your premium is past due and you have a 30-day grace period to pay the premium. This letter states the date the premium must be paid to continue CHIP coverage. If the premium is not paid by this date, CHIP coverage will end for your child. The effective date of termination will be the end of the 30 day grace period. This means no claims will be paid by GHP for your child after the end of the 30-day grace period. The letter will provide you with this last coverage date as well as ways you can make your premium payment.

3) **Voluntary termination.** The head of household can end the child’s CHIP coverage at any time either in writing or by calling the customer service team at 866-621-5235 (PA Relay 711).
4) **Your child is age 19.** A child is eligible for CHIP only until they are 19. Coverage will end on the last day of the calendar month the child turns 19. For example, if your child’s 19th birthday is on August 12, 2016, coverage will end on August 31, 2016.

5) **Your child is covered under other insurance.** This termination goes back to the first day of the month after the other coverage took effect. For example, if you get insurance coverage for your family at work on July 20, 2016, the CHIP termination will go back to August 1, 2016. We will refund any premiums paid to the plan after this date.

6) **Your child moves out of state.** CHIP only covers Pennsylvania residents.

7) **Your child is a prison inmate or a patient in a public institution for mental diseases.** Your child cannot be covered if he or she is a prison inmate or a patient in a public institution for mental diseases. Once your child is no longer in prison or a public mental institution and meets the other eligibility requirements, he or she will be eligible for CHIP.

8) **Failure to respond to renewal notices.** CHIP coverage may also terminate if you do not respond to any renewal notices we send you.

9) **Incorrect information given at time of application or renewal.** We will end CHIP coverage if we determine you used incorrect or fraudulent information when applying for or renewing CHIP coverage for your child.

10) **Eligibility for state health benefits through parent’s employment.** If you or the child’s other parent (if applicable) is employed by the state or a public agency and has a health benefit plan through the state, your child will be terminated from CHIP if they are eligible for coverage under the state health benefit plan.

### B. Your rights to an impartial review

You are entitled to an impartial review by the plan if:

1) any termination; 2) notice that your child is not eligible for CHIP renewal; 3) change in your cost of CHIP; or 4) your child changes to a new CHIP plan (for example, from a low-cost to a full-cost plan).

You may request the review within 30 days of getting your letter from the plan about the change or termination. To request a review, contact the plan at the following address:

Geisinger Health Plan  
Attn: Enrollment  
100 N. Academy Ave.  
Danville, PA 17822-3229

In the termination letter, you will receive detailed instructions on how to request an impartial review. Any review you request must be in writing and requested within the time period.
stated in your notice. If your written request is received within the correct time period, the plan’s impartial review officer will review the eligibility decision in question. Your child’s CHIP coverage will continue if an impartial review is requested. If your child has free CHIP, it will continue until the review is completed. If your child has low-cost or full-cost CHIP, you can choose to continue coverage during the review period by paying any premiums due as required for those options. If the plan’s review results in confirming the negative action, the plan will refer your appeal to the Pennsylvania Insurance Department (PID). The PID will contact you to schedule an interview.

If you are not satisfied with the results of the insurance department review, you can ask in writing for a reconsideration of the review by the insurance commissioner. This must be done within 15 days of the review decision. If this second review results in another decision you are not satisfied with, you have the right to appeal the insurance commissioner’s decision to the Commonwealth court within 30 days of the decision.

10. General information

The information in this section has to do with you and your child’s relationship with the plan as a CHIP provider and an insurer. If you have any questions on information in this section, please call the customer service team at 866-621-5235 (PA Relay 711).

A. Disclaimer of liability. It is understood that the plan (as a corporation or otherwise) does not perform any health services. The plan contracts with professional healthcare Providers for the covered services received by members under this handbook. The plan’s obligation is limited to making covered services available through contracts with healthcare providers. The plan (as a corporation or otherwise) is not, in any event, liable (responsible) for any act or omission of the professional personnel of any medical group, hospital or other provider of services.

B. Authorization to disclose confidential information. Subject to the medical records confidentiality provisions set forth in this handbook, the plan can receive from any provider offering covered services to a member, the information reasonably necessary to administer the provisions of the handbook (for example, to pay the claims submitted by a provider).

C. Policies and procedures. The plan may put in place reasonable policies, procedures, rules and interpretations to ensure orderly and efficient administration of this handbook.

D. Computation of time. Unless otherwise stated, all references in this handbook to “day” means calendar day. All references to “effective date” means 12:01 a.m. on the date coverage and enrollment under this plan begins.

E. Notices. Any notice under this handbook can be sent to the following address:

Geisinger Health Plan
Attention: Administration
M.C. 3220

M-151-642-F Rev. 08/16 Rev. 5/17 Rev. 4/18
100 N. Academy Ave.
Danville, PA 17822

Please send claims and requests for reimbursement to the attention of the Claims Department. Notice to a member will be sent to the member’s last address known to the plan.

F. Substitution of non-covered services. Other provisions of this handbook notwithstanding, the plan reserves the right to provide any service, supply, equipment or benefit which is otherwise not COVERED or which is limited or excluded, when, in the sole judgment of the plan, providing such service, supply, equipment or benefit is medically necessary and is a less costly than an equivalent benefit available under this plan. Any such substitution shall be subject to any quality assurance standards as the Pennsylvania Department of Health may establish.

G. Designation of an authorized representative. Members have the right to designate an authorized representative who, in addition to the member (or parent or guardian of the member) receiving services, will receive explanation of benefits forms from the plan. If a member wishes to designate an authorized representative, he or she must complete and sign an Authorized Representative form. You can have this form mailed to you by calling the customer service team at 866-621-5235 (PA Relay 711).

H. Release of information. All personally identifiable information (Protected Health Information) about your child is subject to various privacy standards, including state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations adopted under that Act by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In keeping with these standards, the plan may use and disclose Protected Health Information to receive payment, treatment and healthcare operations as described in the plan’s Notice of Privacy Practices (NPP). Copies of the plan’s current NPP are available on the plan’s website at www.GHPkids.com or by calling the customer service team at 866-621-5235 (PA Relay 711).

I. Reports and records. You agree, in connection with the benefits under this plan a) to let any insurer, employer organization and healthcare services provider to release to the plan all personal health information relating to past, present and future healthcare examinations, treatments and diagnoses regarding your child and b) to allow the plan to release the personal health information described above, including medical records, claims, benefits and other administrative data to insurers, healthcare service providers and outside vendors. The information will only be released for the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, preventive measures, audits, utilization management, case management, pharmacy management, provider review, research, fraud investigations, underwriting review, reviews by regulatory and accrediting bodies, claims processing, billing and reimbursement.
You further agree that approval by the plan of benefits for any services rendered under this plan may depend upon the furnishing of such information or records or copies of records.

You are responsible for maintaining all claims information and correspondence. If you request claims information from the plan with a date of more than 12 months before the request, it will be your responsibility to pay for the cost of getting such information.

J. Governing law. This plan is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or unenforceability of any terms or conditions in this handbook shall in no way affect the validity or enforceability of any other terms or provisions. The waiver by either party of a breach or violation of any provision of this plan shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

**Exhibit 1: Geisinger Health Plan Service Area**

**SERVICE AREA** means the following counties located in Pennsylvania:

Discrimination is against the law

Geisinger Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Geisinger Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Geisinger Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

Geisinger Health Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Geisinger Health Plan at 800-447-4000.

If you believe that Geisinger Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

- Civil Rights Grievance Coordinator
  Geisinger Health Plan Appeals Department
  100 North Academy Avenue,
  Danville, PA 17822-3220
  Phone: (866) 577-7733, PA Relay 711,
  Fax: (570) 271-7225, or
  Email: GHPCivilRights@thehealthplan.com

- The Bureau of Equal Opportunity
  Room 223, Health and Welfare Building,
  P.O. Box 2675,
  Harrisburg, PA 17105-2675
  Phone: (717) 787-1127, PA Relay 711,
  Fax: (717) 772-4366, or
  Email: RA-PWBE0A0@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Geisinger Health Plan and the Bureau of Equal Opportunity are available to help you.

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

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


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GHPKids.com