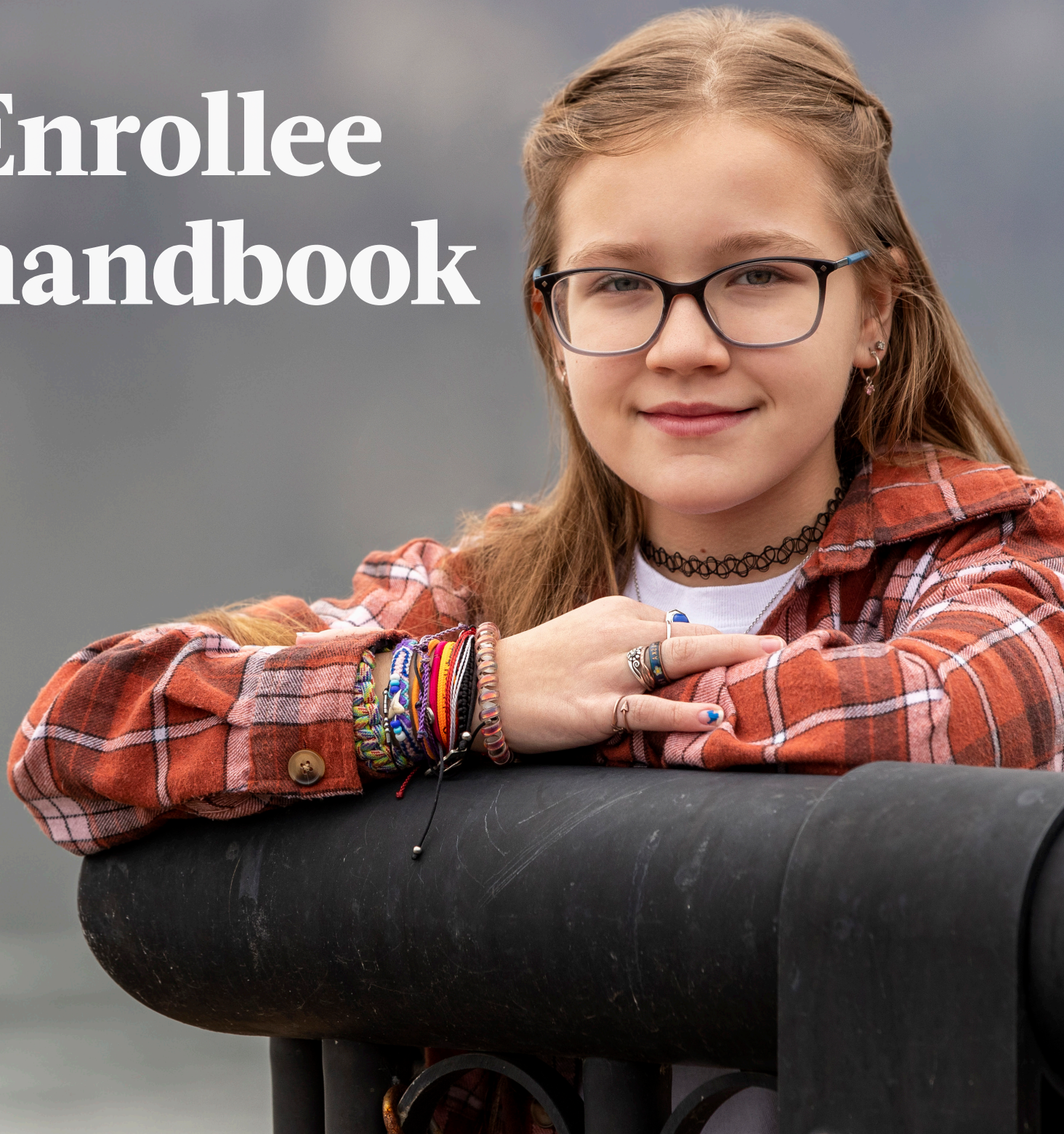


GEISINGER HEALTH PLAN KIDS

Enrollee handbook



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

Geisinger
HEALTH PLAN

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A. Welcome

Thank you for enrolling your child in the Children's Health Insurance Program (CHIP), brought to you by Geisinger Health Plan Kids (GHP Kids). This handbook will help you understand your child's CHIP benefits, how to access care and how to get in touch with us, if needed. It also provides information on enrollees' rights and responsibilities.

What is CHIP?

CHIP is a state and federally funded program that provides comprehensive health insurance to children up to 19 years of age. Our enrollees have a wide range of benefits available to them through the CHIP program. These include things like:

- Doctor's visits
- Checkups
- Emergency room visits
- Hospital stays
- Prescriptions
- Dental and eye care
- Behavioral healthcare



B. Customer care

For your convenience, GHP Kids customer care is available [Monday through Friday from 7 a.m. to 7 p.m., and Saturday from 8 a.m. to 2 p.m.](#), where you can:

- Find out about covered services
- Decide what kind of services you need
- Choose a provider near you
- Set up an appointment
- Resolve problems getting care
- Learn more about services for people with special healthcare needs
- Request to receive information in the format and/or language required for you to communicate your healthcare needs

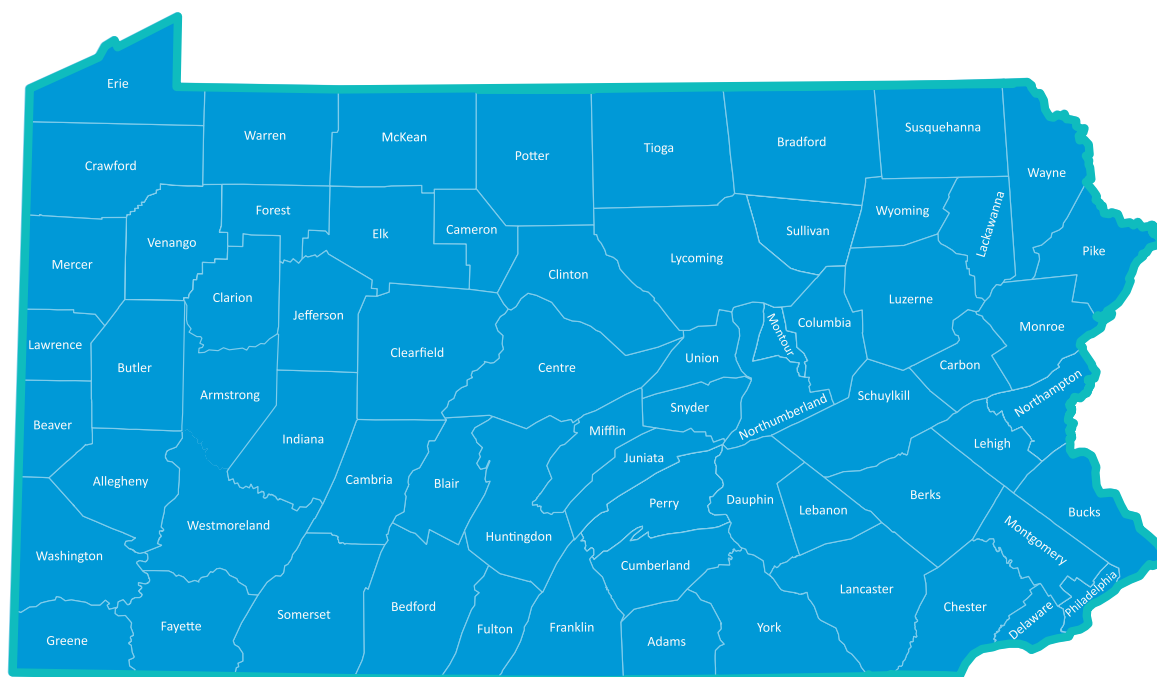
GHP Kids customer care telephone number is [866-621-5235](tel:866-621-5235) (PA Relay 711). You may also visit our website at ghpkids.com for additional information about your CHIP benefits, or you may write us at:

[Geisinger Health Plan](#)

M.C. 3220

100 N. Academy Ave., Danville, PA 17822

Geisinger service area



GHP Kids provides coverage in all 67 Pennsylvania counties.

Enrollee identification cards

If you haven't received your child's GHP Kids identification (ID) card in the mail, it will arrive shortly. Each child enrolled receives their own ID card. This card entitles your child to all the benefits explained in this handbook. The card will include:

- Your child's name
- Enrollee identification number
- Primary care physician's (PCP) name and phone number
- Phone numbers for your health plan's customer service, dental services, behavioral health services and vision care services

Your child's card is for their use only. Never let anyone else use your child's ID card. You will need to present this ID card when your child receives care. You'll also need to take the card to the pharmacy when picking up prescriptions for your child.

If you don't receive your child's ID card within the next two weeks, or if your child's card is lost or stolen, contact GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711). We will send you a new one. Or if your child has changes to his or her CHIP enrollment, you may receive a new card in the mail. You should destroy the old ID card and use only the new one. The services that your child is receiving will continue to be available while you wait for the new card to arrive.

Emergencies

An emergency medical condition is a severe injury or illness that a reasonable person with no medical training would feel that there is an immediate risk to a person's life or long-term health.

If your child needs emergency care, call 911 or go to the nearest emergency room. See section G in this handbook for more information about emergency services.

Language and communication assistance needs

GHP Kids can provide this handbook and other information you need in languages other than English at no cost to you. GHP Kids can also provide your handbook and other information you need in other formats such as compact disc, braille, large print, DVD, electronic communication and other formats if you need them at no cost to you. Call GHP Kids customer care at **866-621-5235** (PA Relay 711) to ask for any help you need. Depending on the information you need, it may take up to five days for GHP Kids to send you the information.

GHP Kids will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing.

These services are available at no cost to you. If you need an interpreter, call GHP Kids customer care at **866-621-5235** (PA Relay 711) and we will connect you with the interpreter service that meets your needs.

If your primary care provider (PCP) or other provider cannot provide an interpreter for your appointment, GHP Kids will provide one for you. Call GHP Kids customer care at **866-621-5235** (PA Relay 711) if you need an interpreter for an appointment.



C. Eligibility and enrollment

Who is eligible for CHIP?

In order to qualify for health insurance coverage under the CHIP program, your child must be:

- Under 19 years of age
- A resident of Pennsylvania
- A U.S. citizen, U.S. national or lawfully present immigrant
- Uninsured (not have any other health insurance coverage)
- Not eligible for Medical Assistance (Medicaid)

You must meet the guidelines based on household size and income. Click the following link for income/family size information: pa.gov/en/agencies/dhs/resources/chip/eligibility-and-benefits.html. Most families can receive CHIP coverage for free. Others can get the same benefits at a low cost, depending on household size and income. There are three main categories of CHIP coverage:

- **Free CHIP** – There are no required monthly premium payments and no copayments for covered services.
- **Low-cost CHIP** – Payment of a modest monthly premium that is a portion of the total cost of health insurance coverage is required, and there are copayments for some covered services.
- **Full-cost CHIP** – Payment of a monthly premium that covers the total cost of health insurance coverage is required, and there are copayments for some covered services

Your child cannot be denied coverage based on a pre-existing condition if you meet the eligibility requirements for CHIP. However, if your child has a documented serious illness or disability, they may be eligible for Medical Assistance rather than for CHIP. GHP Kids and your doctor will be able to assist you in obtaining the appropriate coverage in this situation.

How can I check on the enrollment or eligibility status of my child?

You can find answers to your questions about eligibility and application processing by visiting dhs.pa.gov/COMPASS or using the myCOMPASS PA mobile app. Or you can call the statewide customer service center at **877-395-8930** or **215-560-7226** in Philadelphia.

What changes do I need to report during the benefit period?

Be sure to immediately report any changes in your family's circumstances after your child has been enrolled. If you do not report changes promptly, you may lose coverage. These changes may include:

- A change in household size
- A change in address
- A change in phone number
- A change in household income
- Coverage under a private or employer sponsored plan or Medical Assistance

May I transfer my child's CHIP coverage to a different CHIP insurance company?

Yes. To transfer your child's CHIP coverage to a different CHIP insurance company, call **800-986-KIDS (5437)** and request a voluntary transfer. Before you request the transfer, be sure to verify that the insurance company you would like to switch to participates in CHIP in your area and that your doctor participates with that insurance company. The customer service representative will tell you the effective date of change and you'll receive a letter confirming this information. Until that date, your child must continue to use their CHIP benefits through GHP Kids.

May I request a reassessment of eligibility during a CHIP enrollment period?

You may visit dhs.pa.gov/COMPASS, use the myCOMPASS PA mobile app or call the statewide customer service center at **877-395-8930** or **215-560-7226** in Philadelphia for eligibility reassessment.

How can I add another child to CHIP coverage?

If your family already has one child enrolled in CHIP, you may add another child in the family by visiting dhs.pa.gov/COMPASS, using the myCOMPASS PA mobile app or calling the statewide customer service center at **877-395-8930** or **215-560-7226** in Philadelphia. Once eligibility is determined, the child will be enrolled.

Will a pregnant CHIP enrollee stay on CHIP?

If a CHIP enrollee becomes pregnant, they will remain in CHIP for the duration of their pregnancy and through the completion of the 12-month postpartum period. The CHIP enrollee must contact the Department of Human Services (DHS) after the birth of their baby so eligibility can be determined for the newborn. DHS can be contacted by visiting dhs.pa.gov/COMPASS, using the myCOMPASS PA mobile app or calling the statewide customer service center at **877-395-8930** or **215-560-7226** in Philadelphia.

How can a CHIP enrollee's newborn be added to CHIP coverage?

A baby born to a CHIP enrollee is automatically eligible for Medical Assistance or CHIP beginning with their date of birth. A new application is not required. You will need to contact the Department of Human Services (DHS) by visiting dhs.pa.gov/COMPASS, using the myCOMPASS PA mobile app or calling the statewide customer service center at **877-395-8930** or **215-560-7226** in Philadelphia immediately after the child is born to report the change in circumstance and have the newborn added and determined eligible for either Medical Assistance or CHIP.

How long does my child's CHIP coverage last?

Your child's CHIP coverage will run for a full calendar year (12 months) from the first day of your child's enrollment unless eligibility changes due to non-financial reasons (e.g., move out of state, reach age 19, enroll in Medicaid, etc.). This time period is called the enrollment period. At the end of the enrollment period, you must renew your child's CHIP coverage or their coverage will end.

How do I renew my child's CHIP coverage?

You can submit your renewal in several ways:

- Online at dhs.pa.gov/COMPASS
- Over the phone by calling **866-550-4355** Monday through Friday between 8 a.m. and 5 p.m.
- Mail, fax or drop it off in person to your local County Assistance Office (CAO)

The easiest way to complete your healthcare renewal is online at dhs.pa.gov/COMPASS. You can even submit required verification documents on the COMPASS website or through the myCOMPASS PA mobile app. You can download the myCOMPASS app for free from the Apple App Store or the Google Play Store.

It is possible that your child's CHIP category will change upon the annual renewal.

What may cause my child's CHIP coverage to end?

You will receive written notice from the Department of Human Services (DHS) in the mail before your child's coverage ends. The letter will include the date that your child's CHIP coverage will end and the reason why it is ending. The following reasons will result in the termination of your child's CHIP coverage:

- Your child is no longer eligible for CHIP due to your household income being too low.
- You do not respond to any renewal notices.
- You do not provide all the requested information needed for DHS to complete the renewal process.
- Your child is covered by Medical Assistance or becomes eligible for Medical Assistance.
- Your child becomes covered under a private health insurance. If this happens, CHIP will end when you renew. **Note:** If you do not cancel CHIP coverage, benefits will continue and you will continue to be billed for CHIP.
- Nonpayment of the initial premium in low-cost or full-cost CHIP
- Nonpayment of the monthly premium in full-cost CHIP
- Voluntary termination.
- Your child turns 19 years of age.
- Your child is deceased.
- Your child moves out of state.
- Your child is a prison inmate or a patient in a public institution for behavioral diseases.
- Misinformation was provided at the time of application or renewal that would have resulted in a determination of ineligibility.
- Misuse of your children's ID cards.

What can I do if I disagree with the results of the eligibility determination or if my child's CHIP coverage ends?

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

hearing form is included with your eligibility notice.

What does an eligibility notice include?

An eligibility notice is sent when DHS has made an eligibility determination, and it will tell you if you are eligible to receive CHIP benefits. The notice includes the following:

- Income used to make an eligibility and premium determination
- Household information like family size and relationships
- Date benefits begin or end
- Next review date
- Hearing and appeal information

What if I don't agree with an eligibility decision at application or renewal or during my eligibility period?

During the reconsideration period, you can provide any information/verification to have your eligibility determined with updated material.

- At application: An individual can request a reconsideration without a new application if requested verification is provided or a new application is requested within 60 days of denial date.
- At renewal: An individual can request a reconsideration if requested verification/renewal packet is provided or a new application is requested within 90 days of closure date of benefits.
- During eligibility period: An individual can request a reconsideration without a new application if requested verification is provided or a new application is requested within 60 days of the date benefits were closed.

What if I still don't agree with an eligibility decision and have sent the necessary information to the CAO for a reconsideration?

If you do not agree with the outcome of your reconsideration or any other eligibility decision, you may request a fair hearing via written or verbal request

How do I find information on how to request/complete an appeal?

Appeal information is provided with each eligibility notice that you receive. This includes the form to complete to request a hearing along with instructions on where to provide the form or how to call to make a verbal request.



D. Enrollee rights and responsibilities

Enrollee rights

As the parent or guardian of a CHIP enrollee, or as a CHIP enrollee, you have the right:

- To receive information about your rights and responsibilities
- To be treated with respect and recognition of your dignity and need for privacy
- To be provided with information about GHP Kids, its services, the practitioners providing care, and enrollees' rights and responsibilities
- To know about policies that can affect your child's enrollment
- To be able to choose providers, within the limits of the GHP Kids network, including the right to refuse treatment from specific practitioners
- To request a specialist to serve as your child's primary care physician if your child has certain special healthcare needs or diagnoses
- To participate in decision-making regarding your child's healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
- To have a healthcare provider, acting within the lawful scope of practice, discuss medically necessary care and advise or advocate appropriate care with you or on your behalf including; information regarding the nature of treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from GHP Kids

- Be informed by a physician about what may happen if drugs, treatments or procedures are refused
- Give informed consent before the start of any procedure or treatment
- Refuse to participate in medical research projects
- Question decisions made by GHP Kids or its network providers, and to file a complaint or grievance regarding any medical or administrative decisions you disagree with
- File a grievance about GHP Kids or care provided and to file a CHIP review appeal with the Department
- Have access to your medical records in accordance with applicable federal and state laws and the right to request that they be amended or corrected
- Expect information that you provide to GHP Kids and anything you or your child discuss with the healthcare provider will be treated confidentially, and will not be released to others without your permission
- Make recommendations regarding GHP Kids' enrollees' "rights and responsibilities" policy
- Exercise your rights without adversely affecting the way GHP Kids, its providers and state agencies may treat you
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation

Enrollee responsibilities

As the parent or guardian of a CHIP enrollee or as a CHIP enrollee, you have a duty to:

- Understand how CHIP, brought to you by GHP Kids, works by reading this handbook and other information made available to you
- Follow the guidelines set forth in this handbook and in other information made available to you, and ask questions about how to access healthcare services appropriately
- Inform GHP Kids and your child's providers about any information that may affect your child's membership or right to program benefits, including other health insurance policies your child/you becomes covered under
- Supply up-to-date medical information to GHP Kids and its providers so they can provide your child/you with appropriate care
- Be sure that your primary care provider has all of your child's medical records, including those from other doctors
- Contact your child's primary care provider first for all medical care except in the case of a true emergency
- Consent to the proper use of your child's health information
- Treat your child's providers with dignity and respect, which includes being on time for appointments and calling ahead if you need to cancel an appointment
- Provide a safe environment for services administered in your home
- Learn about your child's health problems and work with providers to develop a plan for your child's care
- Follow the instructions or guidelines you receive from the provider, such as taking prescriptions as directed and attending follow up appointments
- Take full responsibility for any consequences of your decision to refuse treatment on your child's behalf



E. Primary care providers

What role does a primary care provider play in your child's healthcare?

A primary care provider (PCP) is your child's regular doctor. PCPs provide well-child exams and preventive services and also see your child when he or she is sick. A PCP helps coordinate care if your child needs tests, if they need to see a specialist or if he or she has to go to the hospital.

Pediatricians, internists, family medicine practitioners and certified registered nurse practitioners are examples of different types of PCPs you can choose from. Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP. Some of these providers may be physician assistants, medical residents or certified nurse-midwives.

How do I select my child's PCP?

All enrolled children must have a PCP. You have 10 days from the receipt of your notice of enrollment letter to select a PCP. If you do not select a PCP, GHP Kids will assign a PCP for your child.

You may use the provider directory to help you find a PCP that participates with GHP Kids. The provider directory is located online at ghpkids.com. You may call GHP Kids customer care at **866-621-5235** (PA Relay 711) to ask that a copy of the provider directory be sent to you. The provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The credentials and services offered by providers
- Whether or not the provider speaks languages other than English and if so, which languages
- Whether or not the provider locations are wheelchair-accessible

If you choose a PCP who isn't already treating your child, you'll need to contact the PCP you have selected, and make sure they are taking new patients. You can reach the PCP at the telephone number listed in the provider directory. If the PCP agrees to take your child as a patient, notify GHP Kids customer care at **866-621-5235** (PA Relay 711).

If you have trouble finding a PCP who is accepting new patients, contact GHP Kids customer care at **866-621-5235** (PA Relay 711) for help.

How do I change my child's PCP?

You may choose a new PCP for your child at any time as long as you follow the established procedure for requesting a change in PCP:

- Select your new PCP from the list of network providers in the provider directory.
- Make sure the PCP you select is taking new patients.
- Call GHP Kids customer care at **866-621-5235** (PA Relay 711) and tell the representative that you want to change your child's PCP.

In most cases, the change will become effective the day of your request. The representative will tell you the date when your child may begin seeing their new PCP. Your child may not receive services from their new PCP until the date the change officially becomes effective. If your child receives services from the new PCP before they are recognized as your child's official PCP by GHP Kids, you may be responsible for paying bills for those services. Your child will receive a new ID card in the mail that lists the new PCP.

What if your child's current PCP is not a network provider?

If your child is a new GHP Kids enrollee, and your child is currently being treated by a PCP who doesn't participate with GHP Kids, you must notify GHP Kids immediately. In order to promote continuity of care, GHP Kids will allow your child to continue seeing that provider for up to 60 days if the provider is willing to work with GHP Kids on an out-of-network basis. During this time, GHP Kids will work with you to find a PCP who is a network provider to take over the care of your child. Under certain circumstances, GHP Kids may not be able to honor your request for a particular provider. If a provider has been removed from the GHP Kids network for quality issues, or if the federal or state government agency decides a provider cannot participate in a government program, that provider's services cannot be covered by GHP Kids.

After-hours care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call healthcare professionals will help you with any care and treatment you need.

GHP Kids has a toll-free nurse hotline (Tel-A-Nurse) at **877-543-5061** that you can also call 24 hours a day, 7 days a week. A nurse will talk with you about your urgent health matters.

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.

Appointment standards

GHP Kids providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment
- You should not have to wait for routine care more than 30 minutes, or no more than 1 hour when the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency facility.
- A physical and behavioral health assessment, general physical examination and first examination are scheduled within 3 weeks of enrollment.
- If you are HIV positive or diagnosed with AIDS, your PCP or specialist should see you within 7 business days from the effective date of enrollment, unless you are already in active care with a PCP or specialist.
- Appointments with the following specialty provider types for routine care should occur within 15 business days: otolaryngology, orthopaedic surgery, dermatology, pediatric dentist, allergy & immunology, pediatric endocrinology, pediatric gastroenterology, pediatric general surgery, pediatric infectious diseases, pediatric nephrology, pediatric neurology, pediatric oncology, pediatric pulmonology, pediatric rehab medicine, pediatric rheumatology and pediatric urology.
 - Appointments for routine care with all other specialty provider types not listed above should be scheduled within 10 business days of the referral.
- If you are pregnant and:
 - In your first trimester, your provider must see you within 10 business days of GHP Kids learning you are pregnant
 - In your second trimester, your provider must see you within 5 business days of GHP Kids learning you are pregnant
 - In your third trimester, your provider must see you within 4 business days of GHP Kids learning you are pregnant
 - Have a high-risk pregnancy, your provider must see you within 24 hours of GHP Kids learning you are pregnant



F. Specialist providers

If your PCP believes that your child has an illness or other type of condition that requires the services of a specialist, they will refer you to a specialist provider. You need to be sure that the specialist that your PCP refers you to is in the GHP Kids network. You may find out by asking your PCP or calling the specialist's office and asking them if they participate with your plan.

What do I do if I think my child needs to see a specialist?

If your child has an illness or other condition that needs to be treated by a specialist, you should discuss this with your PCP. You don't need a referral to see a specialist. However, your PCP can help you decide what type of specialist can best help your child. Some services a specialist could provide may need a prior authorization. Your PCP can help you to obtain the prior authorization.

Can a specialist serve as my child's PCP?

Enrollees with special healthcare needs or certain diagnoses may request that an appropriate in-network specialist serve as his or her PCP. This is possible only if the specialist agrees to act as your child's PCP and if GHP Kids approves of the arrangement. For example, a pregnant enrollee might select an OB-GYN as their PCP. Call GHP Kids customer care at **866-621-5235** (PA Relay 711) to determine if your child is eligible to have a specialist serve as his or her PCP.

What if my child is referred to an out-of-network specialist?

If your child gets a referral for a specialist who is an out-of-network provider, you must get prior authorization from GHP Kids to see the specialist. If the requested service can be provided by a specialist who is a network provider, you must go to the network specialist in order for services to be covered.

What if my child's current specialist is an out-of-network provider?

If your child is a new GHP Kids enrollee and is currently being treated by a specialist who does not participate with GHP Kids, notify GHP Kids immediately. In order to promote continuity of care, under most circumstances, GHP Kids will allow your child to continue seeing that provider for up to 60 days if they are actively continuing a course of treatment and if the specialist is willing to work with GHP Kids on an out-of-network basis. During this time, GHP Kids will work with you to find a specialist who is a network provider to take over the care of your child.

What if my child is pregnant and their OB-GYN is not a network provider?

If your child is a new GHP Kids enrollee, is in the second or third trimester of their pregnancy, and is already under the care of an OB-GYN not in the GHP Kids network, under most circumstances, your child may continue to receive services from that specialist throughout the pregnancy, for the delivery of the baby, and for postpartum-related care.

An enrollee in their first trimester will be required to select a new OB-GYN provider that participates with GHP Kids. If you need help finding a network OB-GYN provider who is accepting new patients, call GHP Kids customer care at **866-621-5235** (PA Relay 711).

How can my child get a second opinion?

Your child is entitled to get a second opinion regarding the medical necessity of surgery or any other recommended medical treatment.

If there are fewer than two specialists in GHP Kid's network trained to provide a particular service, your PCP will need to send your child to an out-of-network specialist provider for the second opinion. Your PCP will need to contact GHP Kids to receive special approval for your child to receive services from an out-of-network provider. GHP Kids will provide for a second opinion from a network provider or arrange for your child to see an out-of-network provider at no cost to you.



G. Emergency services, urgent care, after-hours care and out-of-network services

Emergency care

Emergency care consists of services provided to an enrollee after the sudden onset of a medical condition accompanied by rapidly progressing symptoms of sufficient severity or severe pain that the average person could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- The health of the enrollee would be jeopardized
- If the enrollee is pregnant, the health of the unborn child would be jeopardized
- The enrollee would suffer serious impairment of bodily functions
- The enrollee would suffer serious dysfunction of any body organ or part

Emergency care includes covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services to evaluate or stabilize an emergency medical condition. Emergency care also includes transportation and related emergency services provided by a licensed ambulance service if the condition meets the above criteria.

Where should I go to receive emergency services?

In an emergency, you should seek medical care from the nearest hospital or healthcare provider. This could mean your child may need to be treated by an out-of-network or out of plan hospital (especially if the emergency occurs out of the GHP Kids service area). If this happens, your child might need to transfer to a network hospital or provider. This transfer cannot take place until your child's condition has been stabilized. GHP Kids will discuss your child's condition with the provider who is treating him or her, and the doctor will let GHP Kids know when your child can be transferred.

What should I do if I think my child needs emergency care?

In an emergency, get the care your child needs right away. If you are out of the service area, go immediately to the nearest emergency room. You will not be charged any additional amounts for using an out-of-network provider or facility. Prior authorization is not required for your child to receive emergency care.

If you are not sure if your child's condition qualifies as an emergency, call your child's PCP for advice.

It is important to remember that an emergency services provider does not replace your child's PCP. Your child's PCP knows them best, and if your child does not require emergency services, taking your child for a sick visit to his or her PCP will provide your child with the best continuity of care.

If your child has a life-threatening situation, call 911 for help immediately.

Some examples of life-threatening emergencies are:

- Poisoning
- Choking
- Heavy bleeding
- Chest pain
- Trouble breathing
- Sudden inability to move or talk
- Serious cuts or burns
- Drug overdose
- Blackouts
- Broken bones

Some examples of non-emergency conditions include:

- Sore throat
- Backache
- Vomiting
- Earache
- Cold or flu
- Bruises, swelling, or small cuts

Call GHP Kids customer care at **866-621-5235** (PA Relay 711) by the next business day to notify GHP Kids of the emergency services provided to your child.

Call your child's PCP by the next business day to notify them of the emergency services provided to your child.

Any medically necessary follow-up care your child receives is not considered an emergency service. If the follow-up care is provided by a doctor other than your child's PCP, you should:

- Contact your child's PCP with the name of the provider who will be providing the follow-up care.
- If required, obtain prior authorization before taking your child to see the provider.
- If your child received emergency services from an out-of-network specialist provider, your PCP and GHP Kids will help you establish a relationship with a network specialist provider who can provide your child's follow-up care.

Urgent care

What is an urgent care center?

Urgent care centers are facilities that provide basic medical care for walk-in patients with illnesses or injuries that do not require emergency care, such as sprains or cuts requiring stitches. If you need to find a network urgent care center in your service area, you can call GHP Kids customer care at **866-621-5235** (PA Relay 711).

If you're out of the service area and your child needs urgent care, in order to be covered, the care must be in response to a sudden and unexpected condition or injury that needs care that cannot wait until you return to the service area.

Urgent care is not intended for illnesses or conditions that require emergency care. Urgent care is any service provided to an enrollee with a condition or injury that needs to be treated within 24 hours. Usually your child's PCP can provide urgent care services for your child. If you are not able to reach your child's PCP, or your PCP cannot see your child within 24 hours, you may also visit an urgent care center.

If you are not sure if your child's condition qualifies as an urgent care situation, call your child's PCP for advice.

Remember that an urgent care center does not replace your child's PCP. Your child's PCP knows them best, so if your child doesn't need urgent care, take them for a sick visit to their PCP to have the best continuity of care.

After-hours care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call healthcare professionals will assist in providing you with the necessary care and treatment you need.

Out-of-network services

What is an out-of-network provider?

An out-of-network provider is a provider that does not have an agreement with GHP Kids to provide services to CHIP enrollees.

What is an out-of-network facility?

An out-of-network facility is a facility (such as a hospital or diagnostic test facility) that does not have an agreement with GHP Kids to provide services to CHIP enrollees.

How can my child access out-of-network services?

If medically necessary, your child's PCP can request that your child receive services from a provider or facility that is not part of GHP Kids' network. If these services are available from providers within the network, your child will need to receive services from a network provider or facility. Unless prior authorization is received, you may be responsible for payment of any out-of-network services your child receives.

What if my child is outside the GHP Kids service area?

If you are outside the GHP Kids service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get prior approval from GHP Kids to seek care. For non-emergency conditions that require care within 24 hours, go to the nearest urgent care center. If you need to be admitted to the hospital, you should notify your PCP. If you need care for a non-emergency condition while outside of the service area, call your PCP or customer care, who will assist you in accessing the most appropriate care.

What if my child is traveling outside the United States?

Your child is not covered if they receive medical services while outside of the United States.

How are claims paid for out-of-network services?

If your child receives a service from an out-of-network provider or facility that was either authorized by GHP Kids or was an emergency or urgent care service, you must submit the claim from the provider to GHP Kids.

To file a claim, call GHP Kids customer care at **866-621-5235** (PA Relay 711) and request that a claim form be mailed to you. Fill out the claim form and submit it along with the bill from the provider that lists all the services received to the following address:

Geisinger Health Plan

P.O. Box 853910

Richardson, TX 75085-3910

You have one year from the date of service to send the bill to GHP Kids.

If GHP Kids sends you a check to settle a claim you have submitted for payment, you will be responsible for ensuring that the provider's claim is paid in full.



H. Your costs for covered services

What are premiums and when do I pay them?

Premiums are the regularly scheduled monthly payments that you pay to GHP Kids for CHIP coverage. There are no premiums for enrollees with free CHIP coverage. If your child is enrolled in low-cost or full-cost CHIP, each month you will receive a bill for the following month's premium. You will receive notice from GHP Kids of any change.

What are copayments and when do I pay them?

Copayments are out-of-pocket costs you pay to the provider at the time of the appointment or when the service is rendered. You must pay the copayment each time your child gets a service from a provider if the service is one that requires a copayment. Copayments are given on the table below. There are no copayments for free CHIP.

When can I be billed by a provider?

Out-of-network providers are not allowed to bill enrollees except under certain circumstances. There are certain situations when you may get a bill from a provider that you will be responsible to pay.

These situations are:

- If your child goes over a benefit limit on a service
- If your child receives a medical service that is not a covered benefit
- If your child receives a covered service from a healthcare provider who is an out-of-network provider without first receiving prior authorization from GHP Kids
- If a provider told you before you received the service that the service would not be covered

and you agreed to pay for the service

- If your child received a service from a provider who is not enrolled with the commonwealth
- Unpaid copayment amounts

Out-of-network providers are not allowed to bill enrollees for services above and beyond GHP Kids' agreed upon reimbursement rate. This means that other than the above circumstances you should not receive a bill from an out-of-network provider. If you do receive a bill from an out-of-network provider, call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711) immediately so the situation can be resolved as soon as possible.

Providers in GHP Kids' network may not bill you for services that GHP Kids covers. Even if your provider has not received payment or the full amount of his or her charge from GHP Kids, the provider may not bill you. This is called balance billing.

What do I do if I get a bill?

If you get a bill from a GHP Kids network provider and you think the provider should not have billed you, you can call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711).

If you get a bill from provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.



I. Summary of copayments for CHIP

| Medical benefit | Free CHIP | Low-cost CHIP | Full-cost CHIP |
|--|-----------|------------------------------|------------------------------|
| Well-child PCP visit | \$0 | \$0 | \$0 |
| Other PCP visit | \$0 | \$5 | \$15 |
| Specialist visit | \$0 | \$10 | \$25 |
| Routine gynecology visit | \$0 | \$0 | \$0 |
| Other gynecology visit | \$0 | \$10 | \$25 |
| Obstetrical (maternity visit) | \$0 | \$0 | \$0 |
| Outpatient occupational, physical, or speech therapy visit | \$0 | \$10 | \$25 |
| Emergency department | \$0 | \$25 (waived if admitted) | \$50 (waived if admitted) |
| Urgent care visits | \$0 | \$10 | \$25 |
| Out-of-area urgent care visit | \$0 | \$10 | \$25 |
| Pharmacy, including diabetic supplies: | | | |
| Generic drug | \$0 | \$6 | \$10 |
| Brand-name drug | \$0 | \$9 | \$18 |
| Substance use services | \$0 | \$0 | \$0 |
| Behavioral health services | \$0 | \$0 | \$0 |

If you believe a provider charged you the wrong amount for a copayment or for a copayment you believe you not should have to pay, you can file a complaint with GHP Kids. See section AA, *Complaints and grievances*. For information on how to file a complaint, call GHP Kids customer care at **866-621-5235** (PA Relay 711).



J. Subrogation

Subrogation is the process of seeking recovery of healthcare expenses from other parties who may be responsible for an injury. The process saves healthcare dollars by making sure that the responsible party or his or her insurer pays the expenses.

For instance, when an injury occurs because of an accident in which someone other than your child is at fault, the insurance carrier of the other individual may be responsible for the payment of your child's medical treatment. In those cases, GHP Kids may be entitled to recover from the other carrier payments for services it provided for your child. If you receive money from a lawsuit, settlement or other third party or his or her insurer, you may be responsible, to the extent permitted by law, to reimburse GHP Kids for expenses paid out relating to the injury.

If you have questions about subrogation, call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711).



K. Coordination of benefits

Occasionally there are times when some of your child's healthcare bills may be covered by a different policy other than CHIP. An example of when this might happen is when an enrollee is involved in a motor vehicle accident and some of the cost of his or her medical care is covered by the automobile insurance policy.

Coordination of benefits is a provision that is intended to help insurance companies avoid duplication of claims and delays in payments. It is often used in cases where two or more separate insurance companies are involved in the payment of services. It avoids claims payment problems by establishing the order in which insurance companies pay their claims and by providing the authority for the orderly transfer of information needed to pay claims properly.

If any of the benefits to which your child is entitled are also provided in full or in part by another agreement issued by another insurance plan or program, your child's CHIP insurance should be billed secondary to any such additional coverage(s).

If you have questions about coordination of benefits, call GHP Kids customer care at **866-621-5235** (PA Relay 711).



L. Obtaining a certificate of creditable coverage (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that GHP Kids issue a Certificate of Creditable Coverage (certificate) to you when your child's coverage under this program ends. This certificate is proof that your child was covered under this program and the length of that coverage.

If your child's coverage under this program ends and your child subsequently enrolls under a group health plan, that plan may impose a pre-existing condition limitation period. HIPAA requires, under certain circumstances, that the new group health plan reduce the pre-existing condition limitation period by the period of time during which there was previous healthcare coverage. You should cooperate with your new plan's administrator in order to determine whether your child will receive such credit for their past coverage. You should submit the certificate that GHP Kids mails you and any other certificates or proof of prior healthcare coverage that you have for your child to your new plan's administrator. HIPAA requires that your new plan's administrator determine how much credit, based on your child's past coverage, your child will be given.

If your child's coverage under this program ends and you subsequently choose to enroll your child in an individual health insurance plan, your child's prior coverage may entitle you to select from certain additional coverage options required by HIPAA. You should ask the insurer whose coverage you wish to purchase whether they offer such choices for your child. If it does, you may ask the insurer whether you are eligible to purchase that coverage. In order to make that determination, the insurer will need evidence of your child's prior healthcare coverage. You should submit the certificate that GHP Kids gives you for your child and any other certificates or proof of prior healthcare coverage you have for your child to the insurer. HIPAA requires that the insurer then determine whether you qualify for those special coverage options if it sells them.



M. Medical benefits

This section lists the services covered by your child's CHIP insurance. The services in this section are listed in alphabetical order. Under each covered service listing you will find a brief description of the benefit provided and any limits or restrictions that may apply.

Except under very specific circumstances, such as in the case of an emergency, all services described in this section are covered only if provided by a network provider. Except in the case of an emergency, prior authorization by GHP Kids, or other specialized documentation or certifications required for a particular benefit must be obtained before your child receives the service in order for the claim to be covered.

Services are only covered up to the specified benefit limits. Once your child has reached the available benefit limit, your child will either need to stop receiving those particular services, or you will be responsible for paying for the services directly.

If you have any questions about your child's medical benefits, please call GHP Kids customer care at **866-621-5235** (PA Relay 711). Your customer care representative can tell you if a particular service is covered, if there are any benefit limits, what providers your child may see for a service, and what you may need to pay out of pocket for a service.

Autism-related services: Covers medically necessary services included on an autism treatment plan developed by a physician or licensed psychologist. Coverage includes evaluations and tests performed to diagnose autism disorder; services of a psychologist/psychiatrist; rehabilitative care including applied behavioral analysis; speech/language, occupational and physical therapy; and prescription and over-the-counter drug coverage. Enrollees are eligible to use the expedited appeals process defined in Act 62 for autism related complaints and grievances.

In order to provide your child with the best possible autism-related services, you should contact GHP Kids customer care at **866-621-5235** (PA Relay 711) and ask to speak with a case manager. You may also visit the Department of Human Services Autism website at PAAutism.org for more information about autism and Act 62.

Behavioral health: GHP Kids provides an array of services to help your child, including inpatient and outpatient behavioral health services, non-hospital residential treatment, and inpatient and outpatient treatment substance use treatment.

Behavioral health services are described more fully in section N of this handbook.

Chiropractic care: Includes manipulation of the spine or other body parts as treatment of diagnosed musculoskeletal conditions for which treatment is expected to restore a level of functioning due to this condition. Consultations and X-rays are included.

Preauthorization may be required. Limit of 20 visits per year applies.

Dental care (emergency, preventive and routine): Includes medically necessary diagnostic, restorative, endodontic, periodontics, prosthodontic, oral surgery, orthodontic and adjunctive services as identified in the CHIP dental benefit package. Does not include cosmetic dental services.

Dental services are described more fully in section R of this handbook.

Diabetic treatment, equipment and supplies: Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics and outpatient self-management training and education, including information on proper diets (see Act 1998-98, as amended (40 P.S. §764e)).

Diagnostic, laboratory and X-ray services: Includes all laboratory and radiology services, EKGs, EEGs, allergy testing and other diagnostic services and materials related to the diagnosis and treatment of sickness and injury provided on an inpatient or outpatient basis when ordered by a network provider or referred specialist and/or facility provider. Some services may require preauthorization.

Disposable medical supplies: Includes ostomy supplies and urological supplies deemed medically necessary. No limits apply.

Durable medical equipment: Includes rental or the purchase, delivery and installation of durable medical equipment (DME), which is designed to serve a medical purpose for a medical condition due to an illness or injury, is intended for repeated use, is not disposable and is appropriate for home or school use. Replacement or repair is covered for normal wear and tear when medically necessary due to the normal growth of the child. Coverage of DME may require preauthorization.

Emergency medical and accident services (including emergency transportation): Services are provided in cases of a sudden onset of a medical condition that is accompanied by rapidly progressing symptoms such that the enrollee would suffer serious impairment or loss of function of a body part or organ, or whose life or life of a fetus would be in danger. Emergency transportation by land, air or water ambulance is covered when medically necessary.

Emergency care services are described more fully in section G of this handbook.

Gender transition: Federal Final Rule “Nondiscrimination in Health Programs and Activities” prohibits discrimination on the basis of sex in health-related insurance and other health-related coverage. Coverage related to gender-affirming services that otherwise fall within the beneficiary’s scope of covered CHIP benefits (e.g., physician’s services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies) will be compensable under the CHIP program when deemed medically necessary. Medical necessity is to be determined utilizing the World Professional Association for Transgender Health (wpath.org) Standard of Care guidelines and any successor WPATH guidelines. Sex-specific healthcare cannot be denied or limited because the person seeking services identifies as belonging to another gender. For example, a provider may not deny a patient gynecological services such as Pap smears based on identification as a transgender male.

Hearing care: Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary. Payment limited to one routine hearing examination and one audiometric examination per calendar year.

Includes the cost of examinations and one hearing aid or device per ear every two benefit years.

Home healthcare: Covered for a child who is homebound. A child is considered homebound if her/his medical condition prevents them from leaving home without a great deal of effort. This includes medically necessary benefits such as nursing services; home health aide services; physical, speech and occupational therapies; medical and surgical supplies; oxygen and its administration; home medical equipment; and home infusion therapy, except for blood and blood products. Private duty nursing and custodial services are not covered. This benefit is offered with no copayments and no visit limitations. Coverage of home health may require preauthorization.

Hospice care: Covered services include palliative and supportive services provided through a hospice program by a network hospice provider for a terminally ill child.

Services require preauthorization and physician certification that the child has a terminal illness. Respite care is also included. A child receiving hospice care may still receive care for other illness or conditions. Hospice care benefits are provided until death or discharge from hospice.

Immunizations: Coverage will be provided for pediatric immunizations (except those required for employment of travel), including immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Pediatric and adult immunization schedules are at cdc.gov/vaccines/hcp/imz-schedules/index.html.

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

Injections and medications: Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital, or freestanding ambulatory service center. Includes immunizations as described in this benefits package and anesthesia services when performed in conjunction with covered services, including emergency services.

Inpatient hospitalization: Includes pre-admission testing, semi-private room and board accommodations; private accommodations when medically necessary; general nursing care; use of intensive or special care facilities when medically necessary; diagnostic and therapeutic radiological procedures; use of operating room and related facilities; drugs, medications and biologicals; laboratory testing and services; blood bank services; pre-operative and post-operative care; special tests when medically necessary; therapy services, oxygen, anesthesia and anesthesia services; and any other services normally provided relating to inpatient hospitalization and skilled nursing inpatient care. No day limits apply. Preauthorization may be required for non-emergency services.

Inpatient rehabilitation stays are covered when an enrollee requires skilled rehabilitation on a daily basis. Requires a physician's prescription. No day limits apply.

Medical foods: Includes medical foods and prescribed nutritional formulas used to treat phenylketonuria (PKU) and related disorders given orally or by tube feeding. (See Act 1996-191(40 P.S. §§ 3901-3909)). No limits apply.

Organ transplants: Includes transplants that are medically necessary and not considered to be experimental or investigative for a recipient who is an enrollee and services related to inpatient care related to the transplant. This benefit also includes immunosuppressants.

Orthotic devices: Includes the purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid device designed to support, align or correct bone and muscle injuries or deformities. Replacements are covered only when the replacement is deemed medically necessary and appropriate and due to the normal growth of the child.

Outpatient habilitation services: Healthcare 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.

Outpatient hospital services: Includes medical services, nursing, counseling or therapeutic treatment, or supplies received from an approved healthcare facility while not an inpatient. Outpatient physical health services related to ambulatory surgery, outpatient hospitalization, specialist office visits, follow-up visits or sick visits with a PCP are not limited.

Outpatient medical services: Includes chemotherapy, dialysis, radiation treatments and respiratory therapy when the enrollee has a documented diagnosis which necessitates the prescribed therapy. There is no limit on number of visits.

Outpatient rehabilitative therapy services: Speech, occupational and physical therapy to regain lost skills. Enrollees must have a documented diagnosis that indicates the prescribed therapy is medically necessary. There is no limit on number of visits.

Pharmacy services: GHP Kids provides coverage for a broad range of prescription drugs. Our formulary provides a list of drugs that we cover. The formulary can be found at ghpkids.com.

Pharmacy services are described more fully in section Q of this handbook.

Prosthetic devices: Includes the purchase of prosthetic devices and supplies required as a result of injury or illness to replace all or part of an absent body part or to restore function to permanently malfunctioning body organs. The benefit extends to the purchase, fitting and necessary adjustment of prosthetic devices. Replacements are covered only when the replacement is deemed medically necessary and appropriate due to the normal growth of the child.

Qualifying clinical trials: Benefits are provided for routine patient costs associated with participation by qualified individuals in an approved qualifying clinical trial (42 § 300gg-8). Routine patient costs include all items and services consistent with the coverage provided under the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. To ensure coverage and appropriate claims payment, the enrollee must contact their insurance contractor before beginning the trial.

Benefits are payable if the qualifying clinical trial is conducted by a network professional provider and conducted in a network facility provider facility. If there is no comparable qualifying clinical trial being performed by a network professional provider, and in a network facility provider facility, then the contractor will consider the services by an out-of-network provider, network in the clinical trial, as covered if the clinical trial is deemed a qualifying clinical trial.

Skilled nursing facility services: Medically necessary skilled nursing and related services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services but not requiring confinement in a hospital. No day limits apply.

Urgent care services: Covers care at walk-in medical facilities for conditions that do not require emergency care but that need to be treated within 24 hours.

Urgent care services are described more fully in section G of this handbook.

Vision care: Includes the cost of exams, corrective lenses, frames or contacts in lieu of glasses or when medically necessary. Limited to one exam every 12 months unless an additional exam is medically necessary.

Vision care services are described more fully in section S of this handbook.



N. Behavioral health services

Behavioral health disorders or conditions and substance use disorders can significantly impact a child's physical and behavioral health. If you think your child has a behavioral health issue or a drug or alcohol problem, don't delay getting them the help they need. GHP Kids provides an array of services to help your child, including inpatient and outpatient behavioral health services, non-hospital residential treatment, and inpatient and outpatient treatment substance use treatment. If you have questions about behavioral health benefits, call the GHP Behavioral Healthcare Connector Team at **888-839-7972**.

Who can my child receive behavioral health or substance use disorder services from?

Except in the case of an emergency, behavioral health or substance use disorder services must be provided by network providers and facilities unless the use of an out-of-network provider or facility is preauthorized by GHP Kids.

Does my child need a referral to visit a behavioral health specialist?

Your child does not need a referral from a PCP to see a network behavioral health or substance use disorder provider. An enrollee (14 years of age or older) or a parent or guardian may self-refer.

If you need self-referral assistance, require help finding a network provider in your area, are having difficulty getting an appointment scheduled with a network provider, or have questions about behavioral health benefits, call the GHP Behavioral Healthcare Connector Team at **888-839-7972**.

Does my child need prior authorization to receive behavioral health services?

Prior authorization is required for all inpatient behavioral health services and some non-routine outpatient services. Non-routine services are treatments that go beyond regular checkups and provider visits. For behavioral health services, non-routine services include but are not limited to partial hospitalization, intensive outpatient programming, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation. If you have questions about prior authorization for behavioral health services, call the GHP Behavioral Healthcare Connector Team at **888-839-7972**.

What if my child has a behavioral health or substance use disorder emergency?

A behavioral health emergency is the sudden onset of a potentially life-threatening condition where you believe that your child is at risk of injury to themselves or others if immediate medical attention is not given. A substance use crisis is when your child is considered in imminent, potentially life-threatening physical danger with a need for immediate detoxification for chemical dependency.

If your child is in a behavioral health or substance use crisis or emergency situation, call **911** or go to the nearest emergency room. You will be connected with a behavioral health professional who will help you assess the seriousness of the situation.

The initial treatment for a behavioral health emergency or substance use crisis is covered even when provided by out-of-network behavioral health providers or rendered at an out-of-network facility.

What types of behavioral health services does GHP cover?

GHP Kids coverage includes the behavioral health services described below when provided by in-network providers:

- **Inpatient behavioral health services:** Includes services furnished in a behavioral health hospital, residential facility or other 24-hour therapeutically structured services. Covers physician services including psychiatric visits and consultations, nursing care, group and individual counseling and related inpatient therapeutic services. Enrollees 14 years of age or older may self-refer. No day limits or copayments apply.
- **Outpatient behavioral health services:** Includes outpatient services furnished at a behavioral health facility and community-based services. Includes partial hospitalization programs, intensive outpatient programs, and office-based outpatient behavioral health services. Covered services include psychological testing; visits with outpatient behavioral health providers; individual, group and family counseling; therapeutic services; targeted behavioral health case management; and medication management. There are no limits for behavioral health outpatient visits per benefit year. No copayments apply.
- **Inpatient substance use disorder services:** Services provided in a hospital or an inpatient non-hospital facility that meets the requirements established by the Department of Health and is licensed as an alcohol/drug addiction treatment program. Covers detoxification stays, services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy and interventions, equipment use, medication management and services normally provided to inpatients. No day limits or copayments apply.
- **Outpatient substance use disorder services:** Services provided in a facility licensed by the Department of Health as an alcohol/drug treatment program. Includes treatment in a partial hospitalization program, intensive outpatient program treatment, and outpatient behavioral health treatment services. Covers services of physicians, psychologist, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy, and medication management. Tobacco use cessation is covered. There are no limits for substance use services visits per benefit year. No copayments apply.



O. Surgical services

Surgery performed for the treatment of disease or injury is covered on an inpatient or outpatient basis. Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident) is not covered.

Includes anesthesia administered by or under the supervision of a specialist other than the surgeon, assistant surgeon or other attending specialist. Includes general anesthesia and hospitalization and other expenses normally incurred with administration of general anesthesia.

- **Consultations for a second opinion:** Consultations to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment. No referral is needed.
- **Mastectomy and breast reconstruction:** Benefits are provided for a mastectomy performed on an inpatient or outpatient basis. Benefits include all stages of reconstruction on the breast on which the mastectomy has been performed, surgery to reestablish symmetry or alleviate functional impairment, including but not limited to augmentation, mammoplasty, reduction mammoplasty, mastopexy and surgery on the other breast to produce a symmetrical appearance. Covers surgery for initial and subsequent insertion or removal prosthetic devices to replace to removed breast or portions of the breast, and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is also provided for at least one home healthcare visit, as determined by the enrollee's physician, received within 48 hours after discharge.
- **Oral surgery:** Oral surgery may be performed at an inpatient or outpatient facility, depending on the nature of the surgery and medical necessity. Examples of covered services include removal of partially or fully impacted third molars (wisdom teeth); non-dental treatments of the mouth relating to medically diagnosed congenital defects; birth abnormalities; surgical removal of tumors, cysts and infections; surgical correction of dislocated or completely degenerated temporomandibular joints; and baby bottle syndrome.
- **Reconstructive surgery:** Reconstructive surgery will only be covered when required to restore function following accidental injury; result of a birth defect, infection or malignant disease; in relation to gender transition surgery deemed medically necessary in order 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; or breast reconstruction following a mastectomy.



P. Women's health services

Women's health services covers those services described under the Women's Preventive Services provision of the Affordable Care Act. There are no copayments for preventive services. Covered services include, but are not limited to:

Routine gynecological services: Includes one routine annual gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per benefit year. Also includes counseling, education and related services to prevent and address the consequences of at-risk behaviors related to sexually transmitted diseases (STDs) and pregnancy. Each enrollee may use a primary care physician or may directly choose any network professional provider delivering gynecological services without referral.

Mammograms: Screening and diagnostic mammograms are covered when performed by a qualified mammography service provided who is certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. There are no copayments for this service.

Breastfeeding: Comprehensive support and counseling from trained providers, access to breastfeeding supplies, including coverage for renting of hospital-grade breast pumps under DME and 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 or nursing mothers with no cost sharing to the enrollee.

Osteoporosis screening: 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 the architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items under the law.

Obstetrical services: Includes prenatal, intrapartum and postpartum care, including care related to complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician or gynecologist, a certified nurse-midwife or a PCP. Services provided by a network hospital or birthing center are covered. Mothers and infants can remain in the hospital for 48 hours after a normal vaginal delivery or 96 hours after a cesarean delivery. A shorter stay may be covered if the attending provider (physician, nurse-midwife or physician assistant), in consultation with the mother, discharges the mother and infant earlier.

Newborn care: A baby born to a CHIP enrollee is automatically eligible for Medical Assistance or CHIP beginning with their date of birth. A new application is not required. Contact DHS immediately after the child is born to report the change in circumstance and have the newborn added and determined eligible for either Medical Assistance or CHIP. Includes routine nursery care, prematurity services, preventive/well-child healthcare services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Maternity home healthcare visit: Enrollees are covered for at least one maternity home healthcare visit provided at their home when the CHIP enrollee is released prior to: 48 hours of inpatient care following a normal vaginal delivery or 96 hours of inpatient care following a cesarean delivery, or in the case of a newborn, in consultation with the mother of the newborn's authorized representative. Home healthcare visits include but are not limited to parent education, assistance and training in breastfeeding and bottle feeding; infant screening and clinical tests; and the performance of any necessary maternal and neonatal physical assessments. A licensed healthcare provider whose scope of practice includes postpartum care must make such home healthcare visit. 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.

Family planning services: Includes but is not limited to birth control pills, injectable contraceptives, transdermal (patches) and insertions and implantation of contraceptive devices approved by the Federal Food and Drug Administration, voluntary male and female sterilization, artificial insemination and counseling. Abortifacient drugs are not covered. There are no copayments when services are provided by a network provider.

Abortions: Abortions will only be covered if a physician has certified the abortion is medically necessary to save the life of the mother or if the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. The incident of rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the enrollee is physically or psychologically unable to comply with the reporting requirement.



Q. Pharmacy services

GHP Kids provides coverage for a broad range of prescription drugs. Our formulary is a continually updated list of drugs that we cover. The formulary can be found at ghpkids.com. Generally, we do not cover drugs that are not listed in the formulary. The plan recognizes that in some situations, you may not respond well to a given formulary medication or you may have an allergy or other condition that warrants the use of a non-formulary medication. An exception process exists for these special instances. You or your doctor can call the number on the back of your identification card to obtain information for the process required to obtain a non-formulary drug.

Prescription drugs: Includes any substance taken by mouth; injected into a muscle, the skin, a blood vessel or a cavity of the body; or applied topically to treat or prevent a disease or condition, dispensed by order of a healthcare provider with applicable prescriptive authority. Generic drugs will be automatically substituted for a brand-name drug whenever a generic formulation is available unless your doctor indicates that the brand-name drug is medically necessary. Copayments may apply.

GHP Kids has mail-order for your maintenance prescriptions or you can continue with a retail pharmacy. For more information on mail-order pharmacy, contact GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711).

Over-the-counter drugs: Covered when the drug is a part of the formulary, the enrollee has a prescription for the drug and a documented medical condition that indicates the drug is medically necessary. Copayments may apply.

Preventive medications: Select medications such as contraceptives, iron supplements, fluoride supplements, folic acid supplements, vitamins, aspirin, smoking deterrents, breast cancer preventatives, HIV pre-exposure prophylaxis and vaccinations are considered preventive medications and are covered at no cost to the enrollee when filled at a network pharmacy with a valid prescription. Enrollees can call GHP Kids customer care regarding questions on coverage.



R. Dental benefits

CHIP covers dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions. There are no copayments for dental services, and no referrals are needed from your PCP to make an appointment, so making sure your child gets high-quality dental care couldn't be easier.

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

Who can my child see for dental care?

You can make an appointment with any GHP Kids network dentist. Find a list of GHP Kids network providers at ghpkids.com or by calling GHP Kids customer care at **866-621-5235** (PA Relay 711)

If you need help getting an appointment, call GHP Kids customer care at **866-621-5235** (PA Relay 711) for help.

How much does dental care cost?

Except in the case of an emergency, in order for a dental benefit to be completely covered by CHIP, dental care must be provided by a dentist who is a network GHP Kids provider. Covered dental benefits provided by a network provider and approved by GHP Kids will have no out-of-pocket costs.

Some out-of-network dental providers will expect payment in full for services at the time of the visit. In this case, it will be your responsibility to pay the bill, and then submit the bill to Skygen, our dental benefit administrator. To request reimbursement, mail your dental claim to Skygen's address on the back of your enrollee ID card. You will be sent a check for the allowed amount of the covered services your child received. This check may be less than the amount you paid the out-of-network dentist.

In a case involving a covered service in which the dentist, the enrollee or the enrollee's parent selects a more expensive course of treatment than is customarily provided for the dental condition, payment under this benefit will be based on the charge allowance for the lesser procedure. In this case, the parent is responsible to pay the difference between the charge of the actual service rendered and the amount received from Skygen.

What dental services are covered by CHIP?

GHP Kids covers many dental services, including preventive care and other services. A participating dentist must be used. Your child does not need a referral from a PCP to see a dentist. Some dental services must have prior authorization. Your GHP Kids dentist will contact us to get the approval before the services are provided. There are no copayments for routine dental services. If any dental service is provided under the medical benefit, a copayment may apply.

If you are unable to locate a participating dentist in your area or are unable to schedule an appointment for your child within a reasonable period of time due to a limited number of participating dentists in your area, GHP Kids might cover the dental service at the in-network rate from a provider who is not in your network at no additional cost.

Covered dental services

Preventive and diagnostic services:

- Two routine exams per year, including prophylaxis (cleaning of teeth), one checkup every six months, with the exception of an enrollee under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy
- Two topical fluoride treatments per year (one treatment every six months)
- Two topical applications of fluoride varnish per year; services can be provided by either a dental provider or a PCP
- Sealants for enrollees younger than 19 years old for permanent molars free from caries and/or restoration; one sealant per tooth every three years except when visible evidence of clinical failure is apparent
- Dental X-rays
 - Full-mouth X-rays limited to once in a three-year period
 - Bitewing X-rays limited to once in a six-month period
 - Space maintainers

Other services:

- Anesthesia when done with a covered service
- Bridges
- Crowns (some crowns must have prior authorization from GHP Kids)
- Dentures (limited to one set per 60 months)
- Emergency temporary treatment of an acute dental condition requiring immediate care
- Fillings – amalgam and resin-based composite restorations
- Major restorative services
- Minor restorative services
- Occlusal guard by report (one per 12 months)
- Pedicle soft tissue grafts
- Periodontal services
- Prosthodontic services
- Pulpotomies
- Removal of impacted teeth (soft tissue, partial and bony impactions)
- Root canals
- Simple extractions

Orthodontia (braces):

Not for cosmetic reasons, only when medically necessary. Prior authorization is required.

- Evaluations for braces:
 - Only covered as a separate service if the enrollee is determined to be ineligible for other orthodontic services
- Placement of braces, adjustments and removal
- Retainers limited to one; replacement retainers are not covered



S. Vision services

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. If you need help finding a vision provider or getting an appointment, call GHP Kids customer care at **866-621-5235** (PA Relay 711).

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.

What vision benefits are covered?

- Lenses
- Contact lenses are covered if medically necessary in lieu of a set of glasses
- Frames

Other vision services that are included, with no copayments, when medically necessary:

- Coverage of glass or plastic lenses, including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items.
- Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.
- Eye examination and refractive services – Includes up to one routine eye examination and refractive test per benefit year, unless a second eye examination and refractive test is medically necessary. This includes dilation if professionally indicated. No cost to enrollee in network. Out-of-network – no coverage.
- Lenses: In network – One pair covered in full every calendar year. Out-of-network – no coverage.
- Frames: In network – No cost to enrollee. Expenses in excess of \$130 allowance payable by enrollee. Additionally, a 20% discount applies to any amount over \$130. Out-of-network – no coverage.
- Contact lenses: One prescription every year – in lieu of eyeglasses, or when medically necessary for vision correction.
- Expenses in excess of \$600 for medically necessary contact lenses, with pre-approval. These conditions include aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction. One replacement of medically necessary broken, lost or scratched corrective lenses, frames and contact lenses (one original and one replacement, not to exceed two per benefit year).

Copayments for optional lens types and treatments:

| | |
|--|--------------|
| Ultraviolet protective coating | No copayment |
| Polycarbonate lenses (if not child, monocular or prescription >+/-6.00 diopters) | \$30 |
| Blended segment lenses | \$20 |
| Standard progressives. | \$50 |
| Premium progressives (Varilux®, etc.) | \$50 |
| 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 |



Contact lenses: Expenses in excess of a \$130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). A 15% discount also applies to any amount over \$130.

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).

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.



T. Additional medical benefits brought to you by GHP Kids

GHP Kids may offer additional services and care options as added benefits to its enrollees. These benefits are not sponsored by CHIP and are provided solely by GHP Kids. If you have questions about the added benefits provided by GHP Kids, call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711).

- **Incentive program:** Earn rewards just for keeping your child up to date on routine vaccines, dental visits and health screenings. Once your child completes these healthy activities, you'll earn a gift card. To learn more about our member rewards or if you have questions, call GHP Kids Member Rewards customer care at [866-847-1216](tel:866-847-1216) (PA Relay 711) and someone will assist you.
- **Certified health coaches:** Coaches (for age 18 only) help participants build healthy habits and manage a variety of conditions with unlimited coaching sessions on topics such as maintaining a healthy weight, practicing mindfulness, nutrition, physical activity, and tobacco use.
- **Online education:** Enjoy a personalized wellness experience for 13+ years of age through our online wellness portal where your child can participate in educational resources. Geisinger has fun, interactive resources designed for your family with access to nutritional tips, exercise ideas and ways to create healthy habits. You can also sync activity trackers and have mobile app and device integration.
- **Health programs:** Age-specific, hands-on interactive programs are fun for kids and motivate them to improve their health.
- **Challenges:** Kids learn healthy habits through individual and team challenges based on exercise, nutrition, sleep and more.
- **Presentations:** Virtual presentations offer families 20- to 30-minute sessions on a variety of health, safety and wellness topics.
- **Neighborly:** Get connected to free and reduced-cost programs and services through an online platform and app that address a variety of social needs like food, transportation, support networks, childcare, housing, health education, financial assistance and more. For resources available in your community, visit neighborlypa.com.
- **Tel-A-Nurse hotline:** Call the toll-free hotline at [877-543-5061](tel:877-543-5061) 24/7 to talk to a nurse about your non-emergency health issues.



U. Services not covered

Not all services, supplies or charges are covered by GHP Kids, and some services may have limitations. Except as specifically provided in the summary of CHIP benefits recognized in this handbook, or specifically identified in this handbook as a GHP Kids enhanced benefit, no benefits will be provided for the following services, supplies and charges, including but not limited to:

- Alternative medicine, such as acupuncture and massage therapy
- Comfort and convenience items
- Cosmetic surgery, except post-mastectomy breast reconstruction
- Certain drugs:
 - Drug Efficacy Study Implementation (DESI) drugs
 - Experimental drugs
 - Weight loss drugs
 - Infertility agents
 - Drugs used for cosmetic purposes
 - Anabolic steroids
 - Drugs labeled for investigational use
 - Drugs used for hair growth
 - Impotency drugs
- Charges for completion of any specialized report, form, insurance form or copying of medical records.
- Experimental and investigational procedures, treatment, equipment, drugs and devices
- Experimental or investigative transplants/organ donations
- Immunizations and drugs used for prevention of disease when required solely for employment or traveling outside of the United States.
- Medically unnecessary services or supplies
- Nonemergency transportation
- Nonprescription glasses or contact lenses
- Out-of-country care (emergency and routine care provided outside the United States)
- Physical evaluations and examinations primarily to meet a requirement of schools, sports, camps or driver's license
- Services provided without the required prior authorization
- Services by nonparticipating providers unless prior authorization was obtained from GHP Kids
- Services to treat temporomandibular joint syndromes (TMJ), with the exception of surgery for temporomandibular joint disease
- Weight-reduction surgery



V. Continuity of care

What is continuity of care?

Continuity of care refers to the ongoing committed relationship between an enrollee and their provider. Promoting continuity of care allows providers to act as advisors and patient advocates as the enrollee moves through various stages of the healthcare system.

How does GHP Kids promote continuity of care for my child?

If your provider ever leaves the GHP Kids network, or if you are being treated by an out-of-network provider when you join GHP Kids, GHP Kids is responsible for working with you to make sure that your child will be able to keep getting the healthcare that he or she needs.

Under most circumstances, if a provider an enrollee is seeing stops participating with GHP Kids, the enrollee may continue an ongoing course of treatment with that provider for a 60-day transitional period. This includes pregnant enrollees in their second or third trimester who, except under certain circumstances, may continue to seek treatment from their OB-GYN for both their current pregnancy and postpartum care.

A new enrollee may also continue a course of treatment with an out-of-network provider for a 60-day transitional period under most circumstances. This includes both an enrollee's primary care physician and specialists that are actively treating the enrollee at the time CHIP coverage with GHP Kids begins.

If you have questions about continuity of care, call GHP Kids customer care at **866-621-5235** (PA Relay 711).

Under what circumstances would a provider not be allowed to care for my child under the continuity of care policy?

Under certain circumstances, GHP Kids may not be able to cover services provided by a certain provider. Some examples of these situations include, but are not limited to:

- Your current provider refuses to accept payment from GHP Kids.
- Your current provider has been excluded from the GHP Kids network for cause.
- Your current provider is prohibited from receiving monies from a government-funded program.



W. Case management, disease management, and quality improvement

Case management

If you have special healthcare needs and medical conditions, GHP Kids has case management nurses and social workers who can help you get the services you need. They can help you and your healthcare provider design a plan to get you the care you need.

Your membership in the case management program is voluntary. You can opt in or opt out at any time. Call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711) for help.

Disease management

Disease management programs are programs that provide specific information and communications to enrollees with certain health conditions. They are used to provide specialized support and education to assist enrollees who are diagnosed with certain conditions that require specific self-care efforts. Disease management helps improve an enrollee's quality of life by preventing or minimizing the effects of a disease or condition, and also helps to reduce healthcare costs. Disease management programs are free of charge to CHIP enrollees who are eligible.

What disease management programs are available?

CHIP enrollees are eligible to participate in any of the following disease management programs:

- Asthma
- Diabetes
- Obesity
- Tobacco cessation

Call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711) to find out more about the disease management programs available to your child.

How can I enroll my child in a disease management program?

GHP Kids may automatically enroll your child in a disease management program if your child has certain diagnoses. Your child's PCP may also enroll your child in one of GHP Kids' disease management programs.

If your child is not enrolled in a program and you think they would benefit from disease management services, call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711).

Utilization management

Utilization management is a process that GHP Kids uses to manage the use of medical services to ensure that your child receives necessary, appropriate, high-quality care in a cost-effective manner.

You can get more information about the utilization process and decisions on authorization by calling GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711). You'll be referred to a member of the utilization management staff, who can tell you why a certain decision was made and the criteria used to make that decision.

Quality improvement program

GHP Kids has a program in place to monitor and improve the care your child receives as a CHIP enrollee. This includes care your child receives from network providers as well as services and other programs made available to you and your child.

GHP Kids works with network providers to follow the guidelines, standards, and regulations of regulatory agencies and accrediting bodies including the Pennsylvania Departments of Health, Insurance, and Human Services; the federal Centers for Medicare and Medicaid Services; and the National Committee for Quality Assurance.

Some of the areas we monitor as part of our quality improvement program include:

- Credentialing and recredentialing of doctors and other providers
- Preventive healthcare and opportunities to improve enrollee wellness
- Access to and satisfaction with care
- Utilization management

If you'd like more information about the GHP Kids quality improvement program, call GHP Kids customer care at [866-621-5235](tel:866-621-5235) (PA Relay 711). GHP Kids can provide you with a description of the program and an update on how GHP Kids is doing in meeting any established goals.

Visit chipcoverspakids.com to view CHIP annual performance reports.



X. Evaluation of new treatments and technology

Enrollee access to safe and effective care is important to us. We routinely evaluate new healthcare services, procedures, devices and drug treatments to determine if they should be included as a CHIP benefit for our enrollees. To be considered for coverage, the new treatment or technology must:

- Have final approval from the appropriate government regulatory bodies such as the Food and Drug Administration (FDA)
- Be supported by published scientific evidence that the treatment or technology has therapeutic value
- Have helpful effects on health outcomes or health risks
- Provide a benefit that is the same as or greater than any current alternative

We are committed to evaluating all new treatments and technologies that are requested by your child's doctor for your child's care. GHP Kids medical directors, who consider new medical and scientific information as well as any applicable government requirements, review these requests. Any medically necessary treatment that is not considered experimental will be reviewed upon request. You and your child's doctor will be notified of GHP Kids' decision.



Y. Privacy and confidentiality

GHP Kids is required to protect the privacy of your protected health information (PHI). GHP Kids must provide you with information on how your PHI may be used or shared with others. This may include being shared with providers for the purpose of coordinating care or making payments. It may also include sharing your information with DHS to demonstrate compliance with federal and state laws related to privacy. This information is included in our Notice of Privacy Practices. You will receive a copy of the privacy notice when your child enrolls with GHP Kids. You may also request a copy of GHP Kids' Notice of Privacy Practices by calling GHP Kids customer care at **866-621-5235** (PA Relay 711) or visiting ghpkids.com.

What privacy and confidentiality rights does my child have?

Your child has the right to have all of his or her health information and records safeguarded and kept private and confidential. This includes both existing and former enrollees of GHP Kids.

CHIP and GHP Kids follow all the regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law protects the privacy of a person's medical records and health information. CHIP and GHP Kids also follow all other state and federal regulations regarding the privacy of medical records and health information.

What kind of information is covered by the privacy and confidentiality policies of GHP Kids?

Protected health information includes but is not limited to data such as your child's:

- Name
- Address
- Social security number
- Birth date
- Healthcare services received
- Premiums paid
- Medical record

Under what circumstances may GHP Kids legally disclose my child's PHI?

GHP Kids may release your child's protected health information under the following circumstances:

- As required by law or court order
- When you provide written authorization to release the information
- In connection with any of the following actions by GHP Kids
 - To verify an enrollee's coverage
 - To arrange for healthcare treatment and services for your child
 - To provide payment for healthcare treatment and services your child received
 - To coordinate benefits, care and claims payments between two insurers
 - To gather demographic data and other statistical information for use in GHP Kids' quality improvement and utilization management programs
 - To share information as required by law in connection with an enrollee's complaint or grievance
 - For internal and external audits
 - To perform routine business operations necessary to provide your child with quality healthcare coverage

What should I do if I think my child's privacy rights have been violated?

If you think that your child's privacy rights have been violated, you may file a written complaint directly with GHP Kids Privacy Officer at:

Geisinger System Privacy Office

M.C. 28-74

100 N. Academy Ave.

Danville, PA 17822

Email: systemprivacyoffice@geisinger.edu

Phone: 570-271-7360

or by calling GHP Kids customer care at 866-621-5235 (PA Relay 711)

If you prefer, you may file a formal written complaint with the Secretary of the U.S. Department of Health and Human Services at the address given below. Your complaint must be in written form and must include your name and your child's name.

Anonymous complaints will not be accepted.

Office of Civil Rights

Secretary of the U.S. Department of Health and Human Services

150 South Independence Mall West – Suite 372

Philadelphia, PA 19106-3499

How may I learn more about HIPAA and my child's privacy rights?

If you'd like to know more about HIPAA and your child's privacy rights, call GHP Kids customer care at 866-621-5235 (PA Relay 711).

You may also learn more by visiting any of the following websites:

- ghpkids.com
- pa.gov/content/dam/copapwp-pagov/en/dhs/documents/chip/chip-resources/documents/privacy_notice.pdf
- hhs.gov/ocr
- health.pa.gov/topics/administrative/pages/hipaa



Z. Fraud and abuse

GHP Kids has a hotline number that may be used to report a medical provider, facility or business for suspected fraud or abuse. The hotline number is **800-292-1627** (TTY: 711). Or email us at fa@thehealthplan.com.

Some common examples of fraud and abuse are:

- Billing or charging you for services that were not provided to your child
- Offering you gifts or money to receive treatment or services
- Offering you free services, equipment or supplies in exchange for your ID card number
- Providing services that your child doesn't really need
- Physical, behavioral or sexual abuse by medical staff

How do you report enrollee fraud or abuse?

If you think someone is using your or another enrollee's GHP Kids card to get services, equipment or medicines; is forging or changing their prescriptions; or is getting services they do not need, call the GHP Kids Fraud and Abuse Hotline at **800-292-1627** (TTY: 711) or email fa@thehealthplan.com to report it. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 844-DHS-TIPS (844-347-8477).

How do you report provider fraud or abuse?

Provider fraud is when a provider bills for services, equipment or medicines you did not get or bills for a different service than the one you received. Billing for the same service more than once or changing the date of the service are also provider fraud. To report provider fraud, call the GHP Kids Fraud and Abuse Hotline at **800-292-1627** (TTY: 711) or email fa@thehealthplan.com. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 844-DHS-TIPS (844-347-8477).



AA. Complaints and grievances

What is a complaint?

A complaint is when you tell GHP Kids you are unhappy with GHP Kids or your provider, or you do not agree with a decision by GHP Kids.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that GHP Kids has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

What should I do if I have a complaint?

To file a complaint, you can do any of the following:

- Call GHP Kids at **866-621-5235** (PA Relay 711) and tell us your complaint.
- Write down your complaint and send it to us by mail or fax.

GHP Kids

Fax: **570-271-7225**

ATTN: Appeals Department
100 N. Academy Ave.
Danville, PA 17822-3220

- Your provider can file a complaint for you if you give the provider your consent in writing to do so.

First level complaint

When should I file a first level complaint?

You must file a complaint within 60 days of getting a notice telling you about:

- a denial because the service or item is not a covered service;
- the failure of the MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in CHIP;
- a denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the enrollee; or
- a denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

You must file a complaint within 60 days of the date you should have gotten a service, item or written notice of a decision if you did not get a service or item.

You may file all other complaints at any time.

What happens after I file a first level complaint?

After you file your complaint, you or your authorized representative will get a letter from GHP Kids telling you that we have received your complaint, and about the first level complaint review process.

You may ask GHP Kids to see any relevant information we have about your complaint. You may also send information that may help with your complaint to GHP Kids.

You or your authorized representative may attend the complaint review if you or your authorized representative want to attend it. GHP Kids will tell you or your authorized representative the location, date and time of the complaint review at least seven days before the day of the complaint review. You or your authorized representative may appear at the complaint review in person, by phone or by video conference. If you decide that you do not want to attend the complaint review, it will not affect the decision.

A committee of one or more GHP Kids staff who were not involved in and do not work for someone who was involved in the issue you filed your complaint about will meet to decide about your complaint. GHP Kids will mail you a notice within 30 days from the date you filed your first level complaint to tell you the decision on your first level complaint. The notice will also tell you what you can do if you do not like the decision.

What if I don't like GHP Kids' decision?

If you don't agree with our first level complaint decision, you may ask GHP Kids to do one of the following:

If the complaint is about one of the following, you may ask for an external review:

- GHP Kids' decision that you cannot get a service or item you want because it is not a covered service or item
- GHP Kids' decision to not pay a provider for a service or item you got
- GHP Kids' failure to decide a complaint or grievance you told GHP Kids about within 30 days from when GHP Kids got your complaint or grievance
- You not getting a service or item within the time frame you were supposed to
- GHP Kids' decision to deny your request to disagree with GHP Kids' decision that you must pay your provider

You must ask for an external review of the complaint within 15 days of the date you got the first level complaint decision notice.

For all other complaints, you may file a second level complaint within 45 days of the date you got the complaint decision notice.

Second level complaint

When should I file a second level complaint?

You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter.

To file a second level complaint, you can do any of the following:

- Call GHP Kids at **866-577-7733**, option 3 (PA Relay 711), and tell GHP Kids your second level complaint.
- Write down your second level complaint and send it to GHP Kids by mail or fax.
- Fill out the complaint request form included in your complaint decision notice and send it to GHP Kids by mail or fax.

GHP Kids address and fax number for second level complaints:

GHP Kids

Fax: **570-271-7225**

ATTN: Appeals Department
100 N. Academy Ave.
Danville, PA 17822-3220

What happens after I file a second level complaint?

After you file your second level complaint, you will get a letter from GHP Kids telling you that GHP Kids has received your complaint, and about the second level complaint review process.

You may ask GHP Kids to see any information GHP Kids has about the issue you filed your complaint about at no cost to you. You may also send information that you have about your

complaint to GHP Kids.

You or your authorized representative may attend the complaint review if you want to attend it. GHP Kids will tell you the location, date and time of the complaint review at least 15 days before the complaint review. You or your authorized representative may appear at the complaint review in person, by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect the decision.

A committee of three or more people, including at least one person who does not work for GHP Kids, will meet to decide your second level complaint. The GHP Kids staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your complaint about. GHP Kids will mail you a notice within 45 days from the date your second level complaint was received to tell you the decision on your second level complaint. The letter will also tell you what you can do if you do not like the decision.

What if I don't like GHP Kids' decision on my second level complaint?

Appeal of a complaint:

- If the subject of the complaint is an objection regarding a participating healthcare provider or the coverage, operations or management policies, an enrollee or the enrollee's authorized representative shall have 15 days from receipt of the notice of decision to appeal the decision to the department.
- If a second level review was completed, an enrollee, or the enrollee's authorized representative, shall have 15 days from receipt of the notice of the decision from the second level review committee to appeal the decision to the department.

Records from the internal process for the complaint shall be transmitted to the department in the manner prescribed. The enrollee or enrollee's authorized representative, the healthcare provider or the CHIP managed care plan may submit additional materials related to the complaint.

Grievances

What is a grievance?

When GHP Kids denies, decreases or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a letter (notice) telling you GHP Kids' decision.

A grievance is when you tell us you disagree with GHP Kids' decision.

What should I do if I have a grievance?

To file a grievance, you or your authorized representative can:

- Call GHP Kids at **866-621-5235** (PA Relay 711) and tell us your grievance, or
- Write down your grievance and send it to GHP Kids by mail or fax, or
- Fill out the complaint/grievance request form included in the denial notice you got from GHP Kids and send it to GHP Kids by mail or fax.

GHP Kids address and fax number for grievances:

GHP Kids

Fax: **570-271-7225**

ATTN: Appeals Department

100 N. Academy Ave.

Danville, PA 17822-3220

Your provider can file a grievance for you if you give the provider your consent in writing to do so. If

your provider files a grievance for you, you cannot file a separate grievance on your own.

When should I file a grievance?

You, your authorized representative or the healthcare provider have 60 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item to file your grievance.

What happens after I file a grievance?

After you file your grievance, you will get a letter from GHP Kids telling you that we have received your grievance, and about the internal grievance review process.

You, your authorized representative or the healthcare provider may ask GHP Kids to see any relevant information we have about your grievance. You, your authorized representative or the healthcare provider may also send information that may help with your grievance to GHP Kids.

You, your authorized representative or the healthcare provider may attend the grievance review if you want to attend it. GHP Kids will tell you the location, date and time of the grievance review at least 15 days before the day of the grievance review. You may appear at the grievance review in person, by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect the decision.

A committee of three or more people, including a licensed doctor, will meet to decide your grievance. The GHP Kids staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your grievance about. GHP Kids will mail you a notice within 30 days from the date your grievance was received to tell you the decision on your grievance. The notice will also tell you what you can do if you do not like the decision.

What if I don't like GHP Kids' decision?

You may ask for an external grievance review. An external grievance review is a review by an independent review organization consisting of a committee of one or more licensed physicians, licensed psychologists or licensed dentists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the healthcare service being reviewed.

You must ask for an external grievance review within 15 days of the date you got the grievance decision notice.

External grievance review

How do I ask for an external grievance review?

To ask for an external grievance review:

- Call GHP Kids at **866-577-7733** (PA Relay 711), and tell GHP Kids your grievance, or
- Write down your grievance and send it to GHP Kids by mail to:

GHP Kids
ATTN: Appeals Department
100 N. Academy Ave.
Danville, PA 17822-3220

GHP Kids will send your request for external grievance review to the Bureau of Managed Care (BMC).

What happens after I ask for an external grievance review?

The BMC will notify you of the external grievance reviewer's name, address and phone number. You will also be given information about the external grievance review process.

GHP Kids will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the reviewer within 15 days of filing the request for an external grievance review.

You will receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you don't like the decision.

You may call GHP Kids' toll-free telephone number at [866-577-7733](tel:866-577-7733) if you need help or have questions about complaints and grievances, you can contact your local legal aid office at Legal Aid Network [800-322-7572](tel:800-322-7572) or call the Pennsylvania Health Law Project at [800-274-3258](tel:800-274-3258).

Expedited grievances

What can I do if my health is at immediate risk?

If your doctor or dentist believes that waiting 30 days to get a decision about your grievance could harm your health, you or your doctor or dentist may ask that your grievance be decided more quickly. For your grievance to be decided more quickly:

- You must ask GHP Kids for an early decision by calling GHP Kids at [866-577-7733](tel:866-577-7733) (PA Relay 711) or faxing a letter or the grievance request form to [570-271-7225](tel:570-271-7225).
- Your doctor or dentist should fax a signed letter to [570-271-7225](tel:570-271-7225) within 72 hours of your request for an early decision that explains why GHP Kids taking 30 days to tell you the decision about your grievance could harm your health.

If GHP Kids does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your grievance could harm your health, GHP Kids will decide your grievance in the usual time frame of 30 days from when GHP Kids first got your grievance.

Expedited grievance and expedited external grievance

A committee of three or more people, including a licensed doctor, will meet to decide your grievance. The GHP Kids staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your grievance about.

You may attend the expedited grievance review if you want to attend it. You can attend the grievance review in person but may have to appear by phone or by videoconference because GHP Kids has a short amount of time to decide the expedited grievance. If you decide that you do not want to attend the grievance review, it will not affect our decision.

GHP Kids will tell you the decision about your grievance within 48 hours of when GHP Kids gets your doctor's or dentist's letter explaining why the usual time frame for deciding your grievance will harm your health or within 72 hours from when GHP Kids gets your request for an early decision, whichever is sooner, unless you ask GHP Kids to take more time to decide your grievance. You can ask GHP Kids to take up to 14 more days to decide your grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited grievance decision, you may ask for an expedited external grievance review by the BMC.

You must ask for expedited external grievance review by the BMC within two business days from the date you get the expedited grievance decision notice. To ask for expedited external review of a grievance:

- Call GHP Kids at [866-577-7733](tel:866-577-7733) (PA Relay 711), and tell GHP Kids your grievance, or

- Write down your grievance and send it to GHP Kids by mail or fax:

GHP Kids

Fax: **570-271-7225**

ATTN: Appeals Department
100 N. Academy Ave.
Danville, PA 17822-3220

GHP Kids will send your request to the BMC within 24 hours after receiving it.

What kind of help can I have with the complaint and grievance processes?

If you need help filing your complaint or grievance, a staff member of GHP Kids will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review.

At any time during the complaint or grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell GHP Kids in writing the name of that person and how GHP Kids can reach him or her.

You or the person you choose to represent you may ask GHP Kids to see any information GHP Kids has about the issue you filed your complaint or grievance about at no cost to you.

You may call GHP Kids' toll-free telephone number at **866-577-7733** (PA Relay 711), if you need help or have questions about complaints and grievances. You can contact your local legal aid office or call the Pennsylvania Health Law Project at **800-274-3258**.

Persons whose primary language is not English

If you ask for language interpreter services, GHP Kids will provide the services at no cost to you.

Persons with disabilities

GHP Kids will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- Providing sign language interpreters
- Providing information submitted by GHP Kids at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review
- Providing someone to help copy and present information





BB. Helpful definitions

Appeal: A request for your health insurance company to review a decision that denies a benefit or to review a grievance again.

Authorization: An approval for a service.

Benefit period: The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by GHP Kids. A charge is considered incurred on the date the service or supply was provided to the enrollee. Benefit limits may be calculated based on either a calendar year or a policy year (that is the one-year period that begins with your child's enrollment in CHIP).

Benefits: Services, procedures and medications GHP Kids will cover.

Calendar year: A one-year period that begins on Jan. 1 and ends on Dec. 31.

Case management: One-on-one help made available by GHP Kids to provide education and coordination of benefits tailored to your child's individual needs.

Child: A person under 19 years of age.

Concurrent care: Services rendered in an inpatient setting by a provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions.

Contract: An agreement between GHP Kids and the Children's Health Insurance Program that allows GHP Kids to administer CHIP in the GHP Kids service area.

Copayment: A fixed amount (example, \$15) you pay to the provider for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Cosmetic procedure: A medical or surgical procedure which is performed to improve the appearance of any portion of the body and from which no improvement in physiologic function may be expected.

Covered service: A service or supply specified in this handbook for which benefits will be provided.

Custodial care: Services to assist a person in the activities of daily living, such as walking, bathing, dressing and feeding. It typically involves personal care that does not require continued attention of skilled, trained medical personnel.

Disenrollment: Stopping your membership in GHP Kids CHIP.

Drug formulary: A listing of preferred prescription drugs and supplies covered by GHP Kids. The GHP Kids drug formulary is available upon request.

Effective date: The date an enrollee's coverage begins as shown on the records of GHP Kids.

Fraud: A dishonest (i.e., knowingly or intentionally false, misleading or incomplete) statement or act.

Home infusion therapy: The administration of parenteral, enteral and intravenous solutions which are provided in the home setting.

Informed consent: Consent you give to allow medical treatment, made with complete knowledge of all relevant facts, including any risks involved and any available alternatives.

Limitations: The maximum frequency or age restrictions or monetary caps associated with a covered service.

Medical necessity: Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine, are clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and are not primarily for the convenience of the patient, physician or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Enrollee: A child who meets eligibility requirements for CHIP and is enrolled in GHP Kids.

Network provider: A provider of covered services who has entered into a contractual agreement with GHP Kids in order to provide care or supplies to enrollees.

Newborn: An infant from birth to 1 month of age.

Out-of-network provider: A provider of covered services who has not entered into a contractual agreement with GHP Kids. Except in the case of an emergency, prior authorization from GHP Kids may be required before an enrollee receives services from an out-of-network provider regardless of the type of service rendered.

Palliative care: Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay or reverse progression of the disease itself or provide a cure. The goal is to prevent and relieve pain and suffering.

Partial hospitalization: The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility licensed as a behavioral health or alcohol and/or drug abuse treatment program by the Pennsylvania Department of Health, designed for an enrollee who would benefit from more intensive services than are offered in outpatient treatment but does not require inpatient care.

PCP: Primary care physician or primary care provider.

Plan: GHP Kids.

Pre-existing condition: A condition (whether physical or behavioral) for which medical advice, diagnosis, care or treatment was recommended or has been received prior to the effective date of coverage.

Primary care physician: A physician who supervises, coordinates and provides initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician to an enrollee. Under certain circumstances, a specialist may act as enrollee's PCP if the enrollee child has significant special needs or certain diagnoses.

Provider: A medical professional such as a doctor, nurse, counselor or physical therapist.

Provider directory: A list of providers who participate with GHP Kids to help take care of enrollees' healthcare needs.

Prior authorization: The process by which services are approved by GHP Kids prior to the enrollee receiving a covered service or treatment by certain specialists or out-of-network providers. If prior authorization is required, typically, except in the case of a medical or dental emergency, claims for these services will not be paid for unless the prior authorization is obtained before the date of service.

Reconstructive procedure/surgery: Procedures, including surgical procedures, performed on a structure of the body to restore or establish satisfactory bodily function or correct a functionally significant deformity resulting from disease, trauma or a previous therapeutic process.

Referral: A special form of prior authorization used to allow the enrollee to seek services from a specialist.

Respite care: Palliative care given in a setting outside the enrollee's home in order to provide a brief interval of relief for the enrollee's primary caregiver, which is usually a family member.

Self-referred services: Services not provided by an enrollee's PCP, but that do not require prior authorization or a referral in order to receive them.

Service area: The geographic region that an enrollee must live in to be enrolled in CHIP with GHP Kids.

Specialist: A doctor or other healthcare provider that has specific, detailed training in a specialized medical field.

Substance use disorder: Any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency as evidenced by physical tolerance or withdrawal.

Surgery: The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures.

Terminally ill: An incurable and irreversible medical condition in an advanced state that will, in the opinion of a physician, ultimately result in an enrollee's death regardless of any medical treatments provided.

Treatment: The care an enrollee receives from providers.



CC. County Assistance Office (CAO) contact information

To find the County Assistance Office (CAO) contact information for a specific county, refer to pa.gov/agencies/dhs/contact/cao-information.

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, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@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, phone or email 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).
OCRMail@hhs.gov

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

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-447-4000 (PA RELAY 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-447-4000 (PA RELAY 711) o hable con su proveedor.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-447-4000 (PA RELAY 711)或咨询您的服务提供商。

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-447-4000 (PA RELAY 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-447-4000 (PA RELAY 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (1-800-447-4000 (PA RELAY 711) أو تحدث إلى مقدم الخدمة".

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplèman tè apwopriye pou bay enfòmasyon nan fòm akse sib yo disponib gratis tou. Rele nan 1-800-447-4000 (PA RELAY 711) oswa pale avèk founisè w la.

LU'U Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-447-4000 (PA RELAY 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-447-4000 (PA RELAY 711) або зверніться до свого постачальника».

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-447-4000 (PA RELAY 711)或與您的提供者討論。」

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-447-4000 (PA RELAY 711) ou fale com seu provedor.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-447-4000 (PA RELAY 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-447-4000 (PA RELAY 711) ou parlez à votre fournisseur. »

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-447-4000 (PA RELAY 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-447-4000 (PA RELAY 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-447-4000 (PA RELAY 711) પર ફોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Geisinger Health Plan may not cover all your healthcare expenses. Read your GHP Kids Enrollee Handbook carefully to determine which healthcare services are covered. For questions, contact Customer Care at 866-621-5235.



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

Geisinger
HEALTH PLAN

ghpkids.com