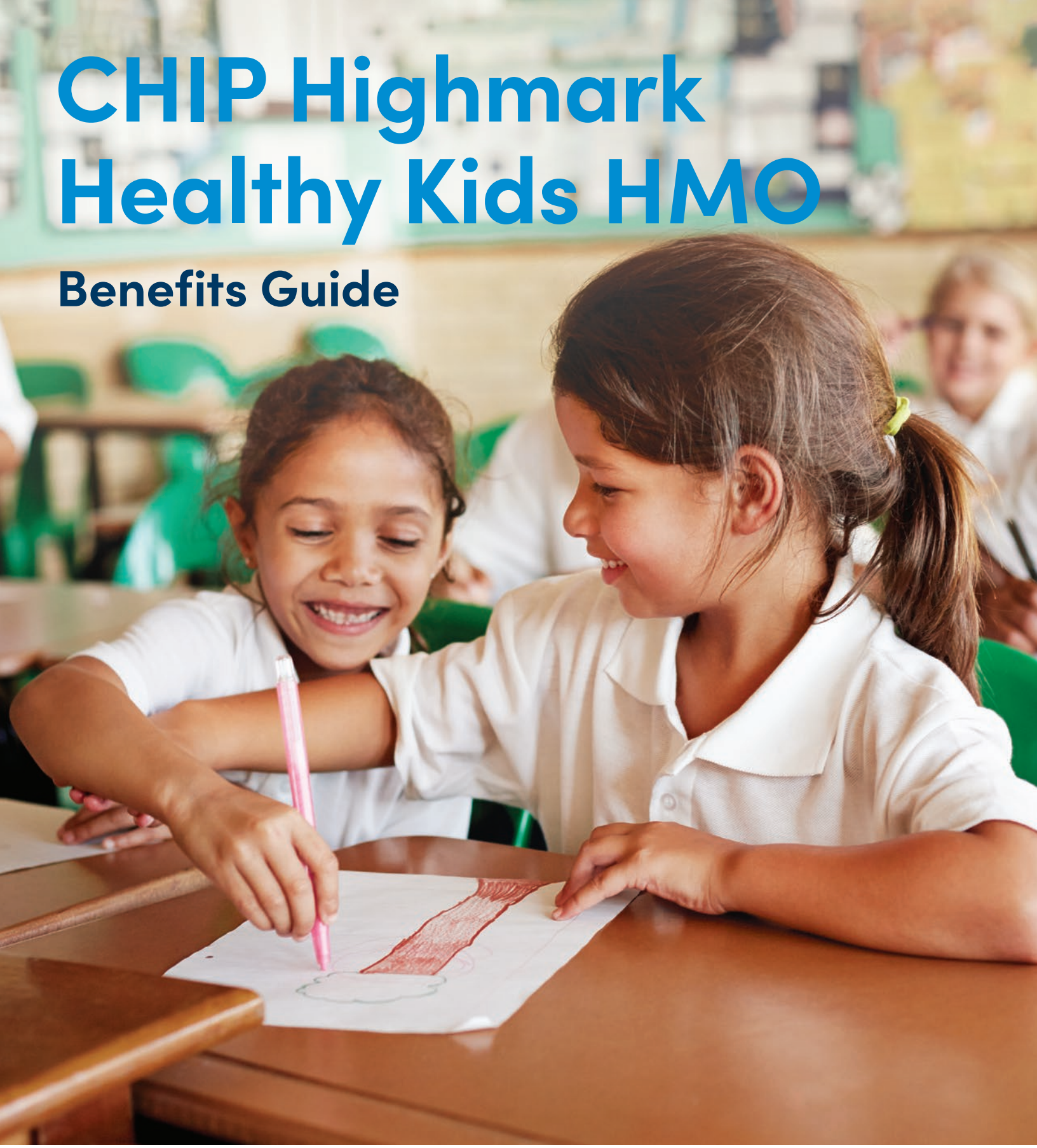
CHIP Highmark Healthy Kids HMO

Benefits Guide



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

HIGHMARK. CHOICE COMPANY
Highmark Healthy Kids

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you.
Call: 1-800-543-7105 (TTY 711)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-543-7105 (TTY 711)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-543-7105 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1-800-543-7105（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-543-7105 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-800-543-7105 (رقم هاتف الصم والبكم: 711).

ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-543-7105 (टिटिवाइ: 711) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-543-7105 (TTY: 711)번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-543-7105 (TTY: 711)។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-800-543-7105 (ATS : 711).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊
သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-543-7105 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-543-7105 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-800-543-7105 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারনে, তাহলে নিঃখরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন ১-800-543-7105 (TTY: 711)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.
Telefononi në 1-800-543-7105 (TTY: 711).

સૂચના: જો તમેગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષાસહાયસેવાઓતમારામાટેઉપલબ્ધછે.
ફોન કરો 1-800-543-7105 (TTY: 711).

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Introduction

Before you enroll in CHIP health care coverage, please carefully read this brochure. It gives you detailed information about the benefits and limitations of the program, as well as important information about the CHIP - Highmark Healthy Kids network and how to obtain care.

Using CHIP - Highmark Healthy Kids network providers

Highmark Healthy Kids members must use CHIP - Highmark Healthy Kids network providers that have a certified PROMISe ID number from the Pennsylvania Department of Human Services* to receive full reimbursement for covered services. There are no out-of-network benefits for members unless the plan authorizes services prior to a member receiving them or the service is provided for an emergency accident or medical condition.

Selecting a primary care provider (PCP)

Each enrolled member must select a primary care provider (PCP) to serve as their primary doctor for all medical care. The PCP must provide certain services, such as routine physicals, well baby/child visits, and routine immunizations. For all other services, members have the flexibility to go directly to any network provider without a referral from their PCP.

Though members don't need to contact their PCP to receive referrals for specialty care, we encourage members to develop a relationship with their PCP. The PCP can become familiar with a member's medical history, and members can enjoy the personal attention and trust that develops through a strong "family doctor" relationship. To select a network PCP, call Member Service at **1-800-543-7105 (TTY: 711)**.

Authorization for services

Certain covered services may require authorization and/or review by Highmark Choice Company. These services include, but are not limited to, inpatient hospital stays, certain outpatient procedures, services and equipment, and certain prescription drugs. Network providers are given complete information about services requiring preauthorization, concurrent review, retrospective review, and case management, and are responsible for obtaining authorization or providing information when appropriate.

*The Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) requires all CHIP professional providers to be certified with a PROMISe Identification number. This program requires every CHIP provider to enroll and receive a PROMISe ID to continue providing services to CHIP Members.

Summary of CHIP benefits, limits, and copayments

Benefits	Free	Low-cost	Full-cost
Benefit Period	Calendar Year		
Plan Payment Level *(Based on the Plan Allowance)*	100% Plan Allowance		
Lifetime Maximum *(per member)*	Unlimited		
Ambulance Service*	100% Plan Allowance. Preauthorization required for non-emergency services only.		
Autism Spectrum Disorders	100% Plan Allowance. Benefits for the diagnosis or treatment of autism spectrum disorders are subject to cost-sharing amounts as outlined below. Services will be paid according to the benefit category (e.g., speech therapy).		
Applied Behavioral Analysis	100% Plan Allowance, no copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment
Dental Services Related to Accidental Injury	100% Plan Allowance		
Diabetes Treatment	100% Plan Allowance		
Diagnostic Services	100% Plan Allowance – Inpatient Services and Outpatient Services		
*Advanced Imaging**	100% Plan Allowance		
Basic Diagnostic Services	100% Plan Allowance		
Durable Medical Equipment, Orthotics, and Prosthetics*	100% Plan Allowance		
Emergency Care Services	**100% Plan Allowance – Outpatient emergency care services** *(including medical/accident services and ER transportation)* **are not subject to preauthorization.**		
Emergency Room Facility Services	100% Plan Allowance, no copayment	100% after $25 copayment *(waived if admitted)*	100% after $50 copayment *(waived if admitted)*
Enteral (Medical) Foods*	100% Plan Allowance		
Family Planning Services	100% Plan Allowance		
Habilitative Therapy	Limits for occupational therapy, physical medicine, and speech therapy do not apply to habilitative visits for mental illness or substance abuse.		
Occupational Therapy	100% Plan Allowance – Limit: thirty (30) visits per benefit period		
Physical Medicine	100% Plan Allowance – Limit: thirty (30) visits per benefit period		
Speech Therapy	100% Plan Allowance – Limit: thirty (30) visits per benefit period		

*These services require preauthorization.

To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your account.

Benefits	Free	Low-cost	Full-cost
Hearing Care Services	100% Plan Allowance		
Audiometric Exam	100% Plan Allowance – One per benefit period		
Diagnostic Testing	100% Plan Allowance – One per benefit period		
Hearing Aid	Limit: One hearing aid or device per ear per two benefit periods. Specialist office visit copayments apply when hearing-aid-related services are rendered by a specialist.		
Home Health Care*	100% Plan Allowance		
Hospice Care*	100% Plan Allowance		
Hospital Services *Inpatient* and Outpatient*	100% Plan Allowance		
Maternity* *(Facility and professional services)*	100% Plan Allowance – required to notify Highmark Member Service for possible referral to Medicaid within the first 31 days		
Medical Care	100% Plan Allowance – *Includes inpatient visits and consultations.*		
Mental Health Care Services	100% Plan Allowance – *Inpatient* and outpatient services.* Members 14 years of age and older can self-refer.		
Office Visits			
Primary Care Provider and Retail Clinic Visit	100% Plan Allowance, no copayment	100% Plan Allowance after $5 copayment	100% Plan Allowance after $15 copayment
Specialist Physician & Specialist Virtual Visit	100% Plan Allowance, no copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment
Specialist Virtual Visit Originating Site Fee	100% Plan Allowance		
Urgent Care Visits	100% Plan Allowance, no copayment	100% Plan Allowance after $10 copayment	100% Plan Allowance after $25 copayment
*Telemedicine Services***	100% Plan Allowance		
Preventive Services			
Routine Physical Exam	100% Plan Allowance – When provided by the PCP		
Pediatric Immunizations	100% Plan Allowance – When provided by the PCP		
Routine Diagnostic Screening	100% Plan Allowance		
Mammograms	100% Plan Allowance		
Routine Gynecological Exams, including a Pap Test	100% Plan Allowance		
Vision Screening	100% Plan Allowance		
Lead Screening	100% Plan Allowance		
Allergy Testing and Treatment	100% Plan Allowance		

*These services require preauthorization.

To access telemedicine any time of the day or night, seven days a week, visit **Well360VirtualHealth.com and set up your account.

Benefits	Free	Low-cost	Full-cost
Private Duty Nursing*	100% Plan Allowance		
Skilled Nursing Facility Care*	100% Plan Allowance		
Substance Abuse Services	Members 14 years of age and older can self-refer.		
*Detoxification**	100% Plan Allowance		
*Inpatient Rehabilitation**	100% Plan Allowance		
Outpatient	100% Plan Allowance. *Includes full-session visits, equivalent partial visits or equivalent partial hospitalization services.*		
Surgical Expenses*	100% Plan Allowance. Includes assistant at surgery, anesthesia, second surgical opinion, and oral surgery.		
Therapy Services*			
Inpatient Rehabilitation	100% Plan Allowance		
Outpatient Services			
*Cardiac Rehabilitation**	100% Plan Allowance		
*Chemotherapy**	100% Plan Allowance		
*Dialysis Treatment**	100% Plan Allowance		
*Infusion Therapy**	100% Plan Allowance		
Occupational Therapy	100% Plan Allowance. Limit: Sixty (60) visits for rehabilitative services per benefit period.		
Physical Medicine	100% Plan Allowance. Limit: Sixty (60) visits for rehabilitative services per benefit period.		
*Radiation Therapy**	100% Plan Allowance		
*Respiratory Therapy**	100% Plan Allowance		
Speech Therapy	100% Plan Allowance. Limit: Sixty (60) visits for rehabilitative services per benefit period.		
Spinal Manipulations/Chiropractic Care	100% Plan Allowance. Limit: Twenty (20) visits per benefit period.		
Transplant Services*	100% Plan Allowance		
Generic Drugs	100% Provider's Allowable Price (PAP) after copayments below		
Up to 31-day supply	100% Plan Allowance, no copayment	$6 copayment or the PAP, whichever is less	$10 copayment or the PAP, whichever is less
Up to 60-day supply	100% Plan Allowance, no copayment	$12 copayment or the PAP, whichever is less	$20 copayment or the PAP, whichever is less
Maintenance Drugs – Up to 90-day supply	100% Plan Allowance, no copayment	$18 copayment or the PAP, whichever is less	$30 copayment or the PAP, whichever is less

Benefits	Free	Low-cost	Full-cost
Brand Drugs *(if medically necessary)*	100% Provider's Allowable Price (PAP) after copayments below		
Up to 31-day supply	100% Plan Allowance, no copayment	$9 copayment or the PAP, whichever is less	$18 copayment or the PAP, whichever is less
Up to 60-day supply	100% Plan Allowance, no copayment	$18 copayment or the PAP, whichever is less	$36 copayment or the PAP, whichever is less
Maintenance Drugs – Up to 90-day supply	100% Plan Allowance, no copayment	$27 copayment or the PAP, whichever is less	$54 copayment or the PAP, whichever is less

Prescription drug benefits

Benefits are available through the National Pharmacy Network only.

Prescription drugs are not covered out of network unless it's an emergency.

Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to this program.

Use of the formulary may result in restriction of drug availability.

Provider's Allowable Price (PAP): The amount at which a participating pharmacy has agreed with Highmark to provide prescription drugs to members under this plan.

No cost sharing will apply to self-administered chemotherapy medications, including oral chemotherapy medications.

Continuous glucose monitoring devices are covered at 100% of provider's allowable price.

Note: Certain covered preventive medications purchased at a Network Pharmacy are not subject to member cost sharing.

Prescription drug coverage

Highmark Healthy Kids covers all Federal Legend drugs. Prescription drugs for Highmark Healthy Kids members are covered when purchased through a National Network pharmacy. For Low-Cost and Full-Cost CHIP, you pay one copayment for generic drugs and a higher copayment for brand name drugs, and, if a generic drug is available, it will be dispensed. For a listing of network pharmacies, go to **HighmarkCHIP.com**, click on **Find Doctors** and then click on **Find a Pharmacy**. For a listing of covered drugs, go to **HighmarkCHIP.com** and click on **Find Doctors** and then click on **Find a Prescription Drug List**.

- Except in emergency situations, no coverage is provided for prescription drugs purchased at a non-participating pharmacy provider.
- Prescription drugs purchased from a participating pharmacy are available in a 31, 60, or 90-day supply. Commercially available packaging of some drug products may further limit the maximum days' supply.
- Quantity level limits may be imposed on certain prescription drugs by the plan. Such limits are based on the manufacturer's recommended daily dosage or as determined by the plan. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a prescription order or refill is dispensed, the participating pharmacy may limit the amount dispensed.
- The participating pharmacy provider will dispense generic drugs in accordance with state and federal laws, unless the prescribing physician specifically prohibits dispensing a generic drug and a brand drug must be dispensed, or a generic equivalent is not available. If the member will not accept a generic substitution when the prescription order permits and the

generic substitution is available, the member will be required to pay the difference between the price for a brand drug and any available generic equivalent for each separate prescription order or refill.

- The quantity level limit for each initial prescription order may be reduced, dependent upon the particular medication, to a quantity level necessary to establish that the member can tolerate the prescription drug. Consequently, the cost sharing and limitations will be prorated based upon the initial quantity dispensed. If the member is able to tolerate the prescription drug, the remainder of the available days supply for the initial prescription order will be filled and the member will be charged the balance of the amount applicable to the initial prescription order.
- Benefits are provided for selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are dispensed through an exclusive pharmacy provider:
  - Oncology-related therapies
  - Interferons
  - Agents for multiple sclerosis and neurological related therapies
  - Anti-arthritic therapies
  - Anti-coagulants
  - Hematinic agents
  - Immunomodulators
  - Growth hormone
  - Hemophilia-related therapies

Items excluded from drug coverage:

- Weight control drugs
- Drugs whose labeled indications are for cosmetic purposes only
- Charges for administration of prescription drugs and/or injectable insulin whether by a physician or other person
- Fertility drugs
- Drug therapy associated with nicotine cessation programs for members under age 18
- Impotency treatment drugs
- Antihemophilic drugs, unless purchased from an exclusive pharmacy provider
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes and those administered by the member or caregiver trained in self-administration of an IV
- Prescription drugs used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA)
- Any drug or medication which is otherwise excluded under the terms of the benefits

Highmark Healthy Kids medical coverage does not cover these services

No benefits will be provided for services, supplies, or charges as follows:

Abortion – For elective abortions, except those abortions necessary to avert the death of the member or to terminate pregnancies caused by rape or incest. This includes all related surgical procedures or prescription drugs provided for the purpose of terminating pregnancy.

Assisted fertilization – Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments.

Blood storage – For the storage of blood, except when done in preparation for a scheduled surgical procedure.

Comfort/convenience items – For personal or comfort/convenience items as defined in the member's subscription agreement.

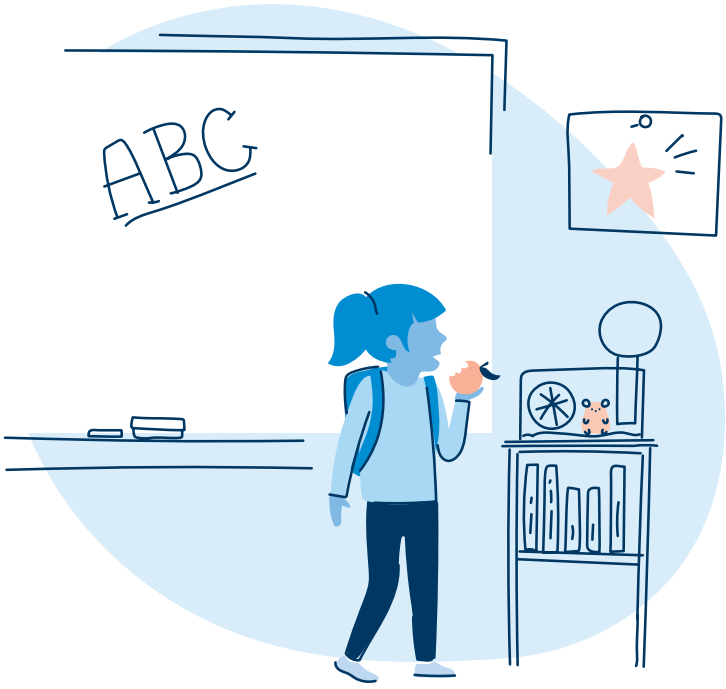
Complementary alternative medicine – For complementary alternative care services such as, but not limited to, acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments, and naturopathic services.

Cosmetic procedures – For a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body or performed for psychological or psychosocial reasons, and from which no improvement in physiological function can be expected, except: as otherwise required by law; when necessitated by a covered sickness or injury; when required to correct a condition directly resulting from an accident; or to correct a congenital birth defect.

Court-ordered services – For court-ordered services when not medically necessary and appropriate, as determined by the PCP and the plan or its designated agent.

Custodial care – For custodial care, domiciliary care, residential care, protective and supportive care, including educational services, rest cures, and convalescent care.

Dental care – Routine dental examinations and services are provided by United Concordia Companies, Inc.*



*Dental coverage and dental benefit administration is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company and does not provide Blue Cross and/or Blue Shield products. United Concordia Companies, Inc. is solely responsible for the products and services that each provides.

Effective date – Rendered prior to the member's effective date of coverage.

Experimental/investigative – Which are experimental/investigative in nature.

Foot care (routine) – For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

Hair – For hair growth stimulants, hair replacement surgery, or wigs.

Immunizations – For immunizations required for foreign travel or employment.

Infertility – For all services with the diagnosis of infertility, including counseling, testing, and treatment.

Legal obligation – For which a member would have no legal obligation to pay.

Maintenance therapy – For therapy services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

Maternity – For normal deliveries outside the service area which could have been foreseen and non-medical fees associated with maternity services.

Medically necessary and appropriate – Which are not medically necessary and appropriate.

Mental health – For any care that is provided for a condition which has no demonstrable organic origin or which extends beyond traditional medical management. This includes the following:

a) Services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting.

b) Neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing), except for specific evaluation purposes directly related to medical treatment.

c) Services provided for purposes of behavioral modification and/or training.

d) Services related to learning disorders or learning disabilities.

e) Services provided primarily for social or environmental change unrelated to medical treatment.

f) Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained.

g) Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.

Military service – To the extent benefits are provided to members of the armed forces or to patients in Veterans Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay.

Miscellaneous – For any medical or dental service or treatment, except as provided herein.

*The Pennsylvania Department of Human Services (DHS) and the Centers for Medicare and Medicaid Services (CMS) requires all CHIP professional providers to be certified with a PROMISe Identification number. This program requires every CHIP provider to enroll and receive a PROMISe ID to continue providing services to CHIP Members.

Motor vehicle accident – For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such medical treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

Nutritional counseling – For nutritional counseling, except for services noted on the Highmark Preventive Schedule and in the member handbook. (DPP for member over age 18 is part of Preventive Schedule, as well as nutritional counseling for obesity.)

Organ donation – Required by a member related to organ donation where the member serves as the organ donor. Expenses for donors donating organs to members are covered only as provided in this agreement. No payment will be made for human organs/tissue/blood which are sold rather than donated.

Physical examinations – For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports, or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.

Private duty nursing – For private duty nursing that is not considered medically necessary and appropriate.

Provider of service – Rendered by a provider who is a member of the patient's immediate family.

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

Sterilization, reversal of – For the reversal of voluntary sterilization.

Surrogate maternity – For services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments and prenatal/ delivery/postnatal services.

Termination date – Incurred after the date of termination of the member's coverage, except as provided herein.

Vision care – Routine vision examinations and services are provided by Davis Vision.**

Vision correction (radial keratotomy) – For the correction of myopia, hyperopia, or presbyopia, including, but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, and LASIK.

War – For any illness or injury suffered after the member's effective date as a result of any act of war.

Weight reduction – For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate. For bariatric surgery, including reversal, revision, repeat, and staged surgery, except for the treatment of sickness or injury resulting from such bariatric surgery, or unless required by law.

Workers' compensation – For any illness or injury eligible for or covered by any federal, state, or local government Workers' Compensation Act, Occupational Disease Law, or similar type legislation.

**Vision coverage and vision benefit administration is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company and does not provide Blue Cross and/or Blue Shield products. Davis Vision, Inc. is solely responsible for the products and services that each provides.

CHIP - Highmark Healthy Kids provider network

Highly qualified primary care providers (PCPs), leading medical specialists, and our network of hospitals assure members of receiving the professional excellence they demand for preventive, routine, and specialized care.

We establish high professional standards for our participating physicians and hospitals and carefully monitor them through regular screenings. As a result, when members require physician or hospital services, they can rest assured that they'll receive the most appropriate care they need.

Primary care providers

Members must select a primary care provider to coordinate their care. Primary care providers include family practitioners, general practitioners, internists, certified registered nurse practitioners, and pediatricians. To receive the best available care, members and their PCPs should establish a relationship based on honesty and mutual respect. Members need to take an active role in maintaining their own health care, talk openly and honestly with their PCP, ask questions, and follow their PCP's treatment and recommendations. While we encourage members to establish a long-term relationship with their PCP, they can change PCPs for any reason just by calling the Member Service number on their identification (ID) card.

Specialists

Highmark Healthy Kids members may go directly to a network specialist when they need care, without a referral from their PCP. CHIP - Highmark Healthy Kids network specialists represent some of the finest experts in their field.

Hospitals

CHIP - Highmark Healthy Kids hospitals include advanced teaching and research facilities as well as local community medical centers. Many of the area's finest, most renowned hospitals are part of the CHIP - Highmark Healthy Kids network.

Network hospitals offer a broad range of care, including general medical and surgical care, 24-hour emergency care, rehabilitation services,

women's care, skilled nursing care, and home health care. Many of the hospitals are recognized for their specialized services including cardiology, cancer, pediatric, obstetric, and trauma care.

CHIP - Highmark Healthy Kids provider directory

To locate a physician, specialist, hospital, pharmacy, or other facility that participates in the network, consult the online Provider Directory at **HighmarkCHIP.com.** Select **Find Doctors.**

The directory lists the provider's name, address, and phone numbers, and indicates whether a PCP is accepting new patients. However, members should always call a provider to verify that the provider is still participating and accepting new patients. Members may also call Member Service for assistance at **1-800-543-7105 (TTY: 711)**.

Health maintenance organization (HMO) coverage

Highmark Healthy Kids provides a comprehensive program of inpatient and outpatient health care benefits. If covered services are not available from a CHIP - Highmark Healthy Kids network provider, a preauthorization from Highmark Choice Company must be obtained to receive services from a provider outside the network. Several specific services are covered only when rendered by a primary care physician. Additionally, some covered services require preauthorization from Highmark Choice Company. Except for emergency care services, benefits are provided only for services performed by a network provider that has a certified PROMISe ID number from the Pennsylvania Department of Human Services,* and which are medically necessary and appropriate. Certain benefits are subject to cost sharing provisions such as copayment amounts.

Coverage also includes all reasonably necessary costs for emergency care services, including evaluation, testing and, if necessary, stabilization of the member's condition, whether provided within or outside the CHIP - Highmark Healthy Kids network service area. No preauthorization is required for emergency care services.

Transition/continuity of care

Transition of care

If a member is receiving medical care from a non-network provider at the time of their effective date of coverage, which is not otherwise covered by the member's prior coverage, the member may continue an ongoing course of treatment with that provider for a period of up to sixty (60) days from the member's effective date of coverage. Highmark Choice Company must be notified by the member to continue an ongoing course of treatment for the transition of care period. To request transition of care, call Member Service toll-free at **1-800-543-7105 (TTY: 711)**.

Continuity of care

If, at the time a member is receiving medical care from a network provider, notice is received from Highmark Choice Company that it intends to terminate or has terminated the contract of that network provider for reasons other than cause, the member may continue an ongoing course of treatment with that provider for a period of up to 60 days from the date of the notification of the termination or pending termination. If, however, the network provider is terminated for cause and the member continues to seek treatment from that provider, Highmark Choice Company will not be liable for payment for health care services provided to the member following the date of termination.

This transition/continuity of care period may be extended if determined to be medically necessary and appropriate by Highmark Choice Company following consultation with the member and the provider. In the case of a member who is in the second or third trimester of pregnancy on the effective date of coverage or at the time notice of the termination or pending termination is

received, care may continue with the provider through postpartum care related to delivery. Any services authorized under continuity of care will be covered in accordance with the same terms and conditions as applicable to network providers.

Coverage is provided for the following when a member is traveling outside the network service area:

- Medical care for an unexpected illness or injury that is not life-threatening but which cannot reasonably be postponed until the member returns home (urgent care)
- Medical care necessary to treat an illness or injury that originated in the Highmark Choice Company service area (follow-up care)

Determining care coverage

Healthcare Management Services (HMS), a division of Highmark, is responsible for ensuring that quality care is delivered to members within the proper setting, at the appropriate cost, and with the right outcome.

For benefits to be paid under Highmark Healthy Kids, services and supplies must be considered medically necessary and appropriate.

This means that services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease.
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate. If we denied coverage of a service or claim, you have the right to appeal the denial decision. More information about this process is included in the benefit booklet that you will receive after you enroll.

Care management process

Recognizing that each member has different needs at different times, care management represents an integrated, comprehensive approach to providing care support and assuring care is responsive and appropriate. Services listed below are part of a total care management program.

Preauthorization review

Preauthorization review begins once treatment information is received. The objectives of preauthorization are to:

- Verify member eligibility for services and benefits.
- Assess medical necessity and appropriateness of care.
- Establish that care is being rendered at an appropriate site by an appropriate provider.
- Initiate alternative levels of care when feasible.
- Identify members who will benefit from case management or condition management.

Concurrent review

Concurrent review may occur during the course of ongoing treatment. The objectives of the concurrent review are to:

- Evaluate a member's current medical status to determine need for service continuation.
- Evaluate appropriate level of care for treatment.
- Identify any potential quality of care concerns.

- Identify situations that require a physician consultation.
- Identify cases that may benefit from case management or condition management.
- Update and/or revise the discharge plan.

Discharge planning

Discharge planning is an integral part of the inpatient review process, often beginning prior to a scheduled admission and continuing throughout the course of treatment. The objectives of discharge planning are to:

- Promote, when appropriate, the use of alternative levels of care.
- Arrange for the provision of care in an appropriate setting.
- Provide early identification of members who may benefit from case management or condition management programs.
- Collaboratively develop and implement appropriate discharge plans.

Retrospective review

Retrospective review is the process of assessing the appropriateness of medical services after the services have been provided. The determination is based solely on the medical information available to the attending physician or ordering provider.

Case management

When a Highmark Healthy Kids member is injured, seriously ill, or considering certain types of surgery, case management may begin a collaborative process that involves case managers, the member, their family or significant others, physicians, and institutional providers. Case management assesses, plans, coordinates, monitors, and evaluates all of the options and services required to meet the member's health needs — always with the goal of educating the member to self-manage their care.

How we protect your right to confidentiality

At Highmark Choice Company, we have established policies and procedures to protect the privacy of our members' protected health information from unauthorized or improper use. We restrict access to our members' non-public personal information to only individuals who need to know that information to provide you health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to safeguard against unauthorized access, use, and disclosures. PHI may be oral, written, or electronic.

As permitted by law, Highmark Choice Company may use or disclose protected health information for treatment, payment, and health care operations, such as: claims management, certain types of routine audits by Highmark Choice Company group customers, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review, and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness, and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

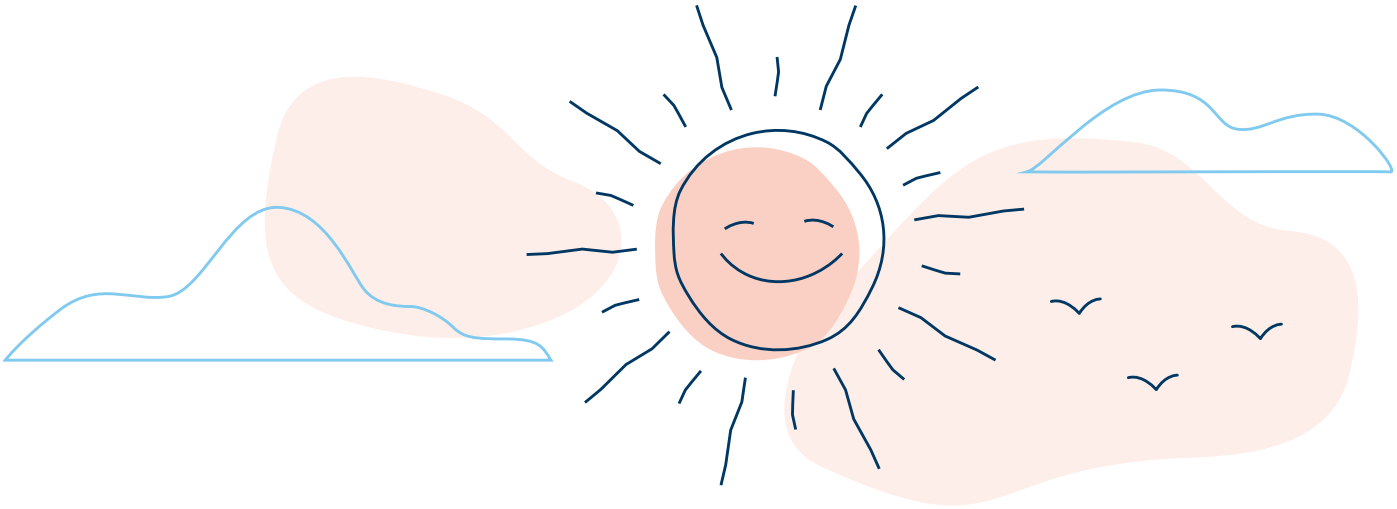
You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from many safeguards we have in place to protect the use of data and personal health information (PHI), including oral PHI,

that we maintain from unauthorized or improper use. This includes requiring Highmark employees to sign statements in which they agree to protect your confidentiality, not discussing PHI outside of our offices (i.e., in hallways or elevators), verifying your identity before we discuss PHI with you over the phone, using computer passwords to limit access to your PHI, and including confidential language in our contracts with doctors, hospitals, vendors, and other health care providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to doctors' offices. It's all part of safeguarding the confidentiality of your protected health information.



Take charge of your health

Because we fully support our members' efforts to lead healthy lives and want to make it easy to do so, we provide the tools you need. Our member support services include:

Blues On Call – Call 24 hours a day, seven days a week for health information and support at **1-888-258-3428**.

Member Service – Get answers to questions about your CHIP benefits by calling toll-free at **1-800-543-7105 (TTY: 711)**.

Website – Have 24-hour access to resources, health education tools, and coverage information at **HighmarkCHIP.com**.

Member Discounts – Get special savings from leading national companies in a wide range of categories.

Wellness Programs – Find out about online, community, and telephone-based wellness programs.

Baby BluePrints® – Understand and manage every stage of pregnancy and childbirth with this maternity education and support program.

For more information

Please call 1-800-543-7105, Monday through Friday, between 8:30 a.m. and 4:30 p.m. (TTY: 711)

Visit the Highmark Healthy Kids CHIP website at **HighmarkCHIP.com**.

Health benefits or health benefit administration may be provided by or through Highmark Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

Health care plans are subject to terms of the benefit agreement.

Blues On Call is a service mark of the Blue Cross Blue Shield Association.

Baby BluePrints is a registered mark of the Blue Cross Blue Shield Association.

Highmark Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-543-7105 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-543-7105 (телетайп: 711).