# CHIP

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WELCOME TO CHIP, BROUGHT TO YOU BY FIRST PRIORITY HEALTH

CHIP, brought to you by First Priority Health, helps keep your child healthy through regular preventive checkups and immunizations, and gives you access to quality health care when your child is ill. Take control of your child’s well-being and make the right choices to start healthy habits.

Getting started on a healthy future is easy and Blue Health Solutions℠ can help. With this program, you have access to a wide choice of health management tools, resources and personal support for your child. It’s another way we help make better health easier for you and your family.

This handbook contains information about accessing the benefits and services your child can enjoy as a CHIP member. It’s important to know how to use the preventive and wellness services we offer, as well as the benefits you need if your child is sick. Please take the time to read this handbook and save it for reference.

PLEASE PAY YOUR PREMIUM ON TIME

The state of Pennsylvania requires that, if you fail to pay your premium for Low-Cost or Full-Cost CHIP as required by applicable insurance laws, your child will lose CHIP coverage. If you have any questions about this requirement, please call 1-800-543-7199
Section I

A. GENERAL INFORMATION FOR CHIP MEMBERS

Here is important information that you’ll need for quick reference.

Contact Information

Office: 19 North Main Street
         Wilkes-Barre, PA

Parking: Available directly across the street from our building. Handicapped parking is available in the lot next to the building.

Lobby hours: 8 a.m. to 5 p.m., weekdays. The lobby is wheelchair accessible.

Mailing address: All mail should be sent to our corporate headquarters at:

First Priority Health
Attn: CHIP
19 North Main Street
Wilkes-Barre, PA 18711-0302

Website:  www.bcnepa.com

1.800.543.7199 (1.800.KIDS.199)
1.800.413.1112 (TTY)

Hours: Representatives are available from 8 a.m. to 5 p.m., Monday through Friday. After hours, voice mail is available.

Visit www.bcnepa.com to:
- Learn more about your child’s benefits and how to use his/her coverage
- Find a list of participating doctors and health care providers
- Compare cost and quality information on doctors and hospitals
- Change to a different primary care physician (PCP)
- Find information on prescription drug services, and health and wellness tools
- View benefits and claims information
- View our Notice of Privacy Practices and Rights

and Responsibilities
- Find health care facilities/hospitals in the First Priority Health provider network
- Request a new ID card for your child
- Email your questions to our private and secure message center anytime

Call First Priority Health Service Representatives to:
- Tell us about a concern or make a suggestion
- Ask us to change your address or phone number
- Ask questions about a bill from a doctor or Other health care provider or facility
- Ask questions, if your child has been denied coverage for a service or benefit
- Ask questions about CHIP eligibility
- Tell us of a change in your family income or size
- Tell us if your child enrolls in a private insurance plan and/or Medical Assistance
- Ask for a copy of our Notice of Privacy Practices or Rights and Responsibilities

Call Your Child’s PCP to:
- Establish your child as a patient
- Schedule a routine physical or preventive care appointment
- Get care whenever your child is sick or injured
- Receive follow-up care after your child receives emergency care
- Obtain prior authorization (approval) before getting covered services outside the First Priority Health network
- Get medical advice if your child will be traveling out of the First Priority Health service area
Let us help make it easier for you to make the right choices and get the support you need for your child’s good health with Blue Health Solutions.

Support when you need it. Health coaches are registered nurses and dietitians who can work one-on-one with you, over the phone, to help you and your child develop and achieve personalized health goals. They are your partners in good health and will answer your health questions, offer tips, provide information and even help develop a wellness plan.

Help after hours. Need help after hours or when your health coach is not available? 24/7 Nurse Now gives you 24-hour/7-day-a-week access to registered nurses. Talk to the nurses anytime, on a variety of health topics, from chronic conditions to common health issues to urgent care issues that impact your child. Just call 1.866.442.2583. Rather chat online? You can email a nurse through our “Self-Service” site on www.bcnepa.com.

Health and wellness programs and tools. Health management programs offer support for asthma and diabetes. Wellness programs include tobacco cessation, weight management and maternity care. Participation is completely voluntary—you decide what is right for you and your child. You can simply call a health coach and chat. Or request more help and receive educational materials and online health management tools. Health coaches can even provide support between office visits and with the coordination of a doctor’s treatment plan. To reach a health coach, call 1.866.262.4764 or (TTY) 1.877.720.7771, weekdays, between 8 a.m. and 8 p.m.

Care management. For those hospitalized or facing a serious medical condition, care management programs can help. Care management programs include catastrophic case management, transition of care, intermediate care management and behavioral health care management. Care coordinators provide support as your medical care advocates and can help with coordinating many aspects of the treatment plan recommended by your child’s doctor. If you think a care coordinator can help, call 1.800.346.6149 or (TTY) 1.877.720.7771, weekdays, between 8 a.m. and 8 p.m.

Online resources. Fast, simple, whenever you need it. Our Health & Wellness website is an easy-to-use wellness resource that is customizable and provides the latest health information and interactive tools. Use the health assessment to learn ways to improve your child’s health; try the health calculator to figure out body mass index and track sleep habits. You can even keep a personal health record and so much more! Check out all of the online tools at www.bcnepa.com to help support a healthy lifestyle. Click on “Health & Wellness,” then choose “MyHealth Solution.”

Value-added discounts. Discounts on wellness products and services are available with Blue365® through the Blue Cross and Blue Shield Association. CHIP members can take advantage of discounts for fitness centers, weight management programs and alternative health services, locally and nationally. Just show your child’s ID card to take advantage of valuable discounts. Visit www.bcnepa.com, click on “Health & Wellness” and select “Discounts on Health & Wellness Services” to see our list of participating vendors and discounts, or call a service representative at the number on the back of your child’s ID card.

Your child’s health is important to us and we know privacy is important to you. Rest assured that information shared on the health assessment and with health coaches and care coordinators is kept private and confidential. We will not share personal information with anyone else (unless required by law). We use the information you share through our health management programs only to help you meet your goals for better health and a healthier lifestyle!
C. **Understanding Health Coverage Terms**

To help you better understand the information contained in this handbook, here are some general health care definitions.

**Claim**—An itemized statement of costs for health care services and/or supplies provided by a facility, doctor or other health care provider.

**Copayment**—If applicable, the payment that you make at the time of each office visit, emergency room visit or filling of a prescription.

**Drug Formulary**—A listing of prescription drugs and supplies covered by First Priority Health®. The list is reviewed regularly and subject to change.

**Participating Provider**—A hospital, facility, doctor or other professional provider that has an agreement with First Priority Health to accept our payment in full, less any copayments, if applicable.

**Premium**—If applicable, the amount of money you pay on a regular basis to keep your CHIP coverage active.

**Primary Care Physician (PCP)**—A doctor who supervises, coordinates and provides initial basic care and medical services. A PCP can be a general practitioner, internist or pediatrician.

**Prior Authorization**—The process by which certain covered services are approved before the date of service.

Your child’s PCP or participating provider will coordinate this for you in most cases.

**Renewal**—The process that takes place once a year, on the anniversary date of your child’s enrollment, when we review your child’s eligibility for CHIP coverage.

**Service Area**—The 13 counties serviced by First Priority Health: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.
D. **WHAT’S IMPORTANT AT FIRST PRIORITY HEALTH**

1. **Preventive Care**

   It’s important that you take advantage of the preventive care benefits that we offer so you can keep your child healthy. Take an active role in your child’s health care by participating in these recommended preventive screenings and immunizations. Check with the PCP to find out if your child is up-to-date on his/her routine visits and immunizations.

   This HMO periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force (USPSTF), (all items or services with a rate of A or B in the current recommendations), The American Cancer Society and the Health Resources and Services Administration (HRSA).

   Examples of covered “USPSTF A” recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, and tobacco use counseling and interventions.

   Examples of covered “USPSTF B” recommendations are dental cavity prevention for preschool children, healthy diet counseling, oral fluoride supplementation/rinses and vitamins, BRCA risk assessment and genetic counseling and testing, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women, and sexually transmitted infections counseling.

   Examples of covered HRSA required benefits include all Food and Drug Administration approved contraceptive methods, sterilization procedures, breast feeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, The Preventive Services are provided at no cost to the Member.

   **Pediatric Preventive Care**

   Pediatric Preventive Care includes the following, with no cost-sharing or co-pays: Physical Examination, Routine History, Routine Diagnostic Tests. Oral Health Risk Assessment, Fluoride varnish for children ages 5 months – 5 years old (US Preventative Task Force Recommendation). Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling. Blood Lead Screening and Lead Testing. This blood test detects elevated lead levels in the blood. Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.

   **Well Woman Preventive Care**

   There is no cost sharing for preventative services under the services of Family Planning, Women’s health, and Contraceptives.

   Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:

   Routine Gynecological Exam, Pap Smear: Female Members are covered for one (1) routine gynecological exam each Benefit Period. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.

   Mammograms: Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography...
service Provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.

Breastfeeding: Comprehensive support and counseling from trained Providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother’s Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member.

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

2. Recommended Exam Schedule
   a. Newborn to 1 year: 7 times per year (e.g., 3–5 days, 1, 2, 4, 6, 9, 12 months)
   b. Ages 1 to 3 years: 4 visits (e.g., 15, 18, 24, 30 months)

3. Recommended Immunizations
   a. Diphtheria, Tetanus, Pertussis
   b. Haemophilus Influenzae, type B
   c. Hepatitis A
   d. Hepatitis B
   e. Human Papillomavirus
   f. Influenza
   g. Meningococcal
   h. Measles, Mumps and Rubella
   i. Pneumococcal Conjugate
   j. Polio
   k. Rotavirus
   l. Varicella

Note: Benefits provided for immunizations are determined by the Pennsylvania Department of Health as recommended by the Advisory Committee on Immunization Practices. The recommended immunizations and exam schedule are subject to change.

4. MATERNITY SERVICES
   - A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the member’s pregnancy or delivery, are covered.
   - Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
   - Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the CHIP member is released prior to forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn’s authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care Provider whose scope of practice includes postpartum care must make such home health care visits. At the mother’s sole
discretion, the home health care visit may occur at the facility of the Provider. Home health care visits following an Inpatient stay for maternity services are not subject to Copayments, Deductibles, or Coinsurance, if otherwise applicable to this coverage.

5. Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

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

6. Immunizations

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric and adult Immunization ACIP schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/schedules/index.html.

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

Service

We value you and care about your concerns. That is why we do everything we can to simplify your child’s health care experience, respond quickly to your questions and help you with your health care needs. Our knowledgeable service representatives are here to help you when you have questions.

Simplicity

First Priority Health works hard so you don’t have to. Just show your child’s ID card to your child’s participating provider and pay the applicable copayment, if any. That’s it!

Quality

First Priority Health works closely with the doctors and specialists in our network to make sure the services your child receives are appropriate and cost effective. We are partners in providing your child with the best care possible.

Respect

At First Priority Health, we respect your child as an individual. You can be assured of professionalism and confidentiality with your child’s medical matters. We do everything possible to ensure that your child receives all the rights to which he/she is entitled.

Covered Kids

Covered Kids is our CHIP member newsletter, with important information about how to use your child’s plan and get the most from his/her benefits. Special features will give you ideas about how to keep your child healthy and will keep you informed about changes in benefits and other important information. You can find the newsletter online at www.bcnepa.com under “Member Newsletters”.

Covered Kids
A. **YOUR CHILD’S FIRST PRIORITY HEALTH ID CARD**

You need to show your child’s ID card to the doctor or hospital when he or she receives care, so you should carry it with you at all times. The card shows your child’s name, ID number, PCP’s name and phone number and copayments, if applicable. This information is needed for the claim that the participating provider or hospital will send to us.

You are responsible for any copayments at the time of service. With Free CHIP, there are no copayments. With Low-Cost and Full-Cost CHIP, copayments apply to primary and specialist care, emergency room visits and prescription drugs. Specific amounts are listed on your child’s benefit summary and ID card.

We ask that you review your child’s ID card. If any information is wrong, or if the card is lost or stolen, please call our First Priority Health Service Representatives at 1.800.543.7199 or (TTY) 1.800.413.1112.

Your child’s ID card includes the following information:

- Your child's name
- Your child’s identification number
- Your child's group number
- Copayment amounts
- The pharmacy network logos
- The toll-free Member Service phone number for questions about your coverage
- A number to call when receiving services out of the network
- Address for submitting claims that are either out of the network or out of the 13 counties

**PROTECT YOUR CARD**

If it is lost or stolen, please call Member Services immediately at 1-800-547-7199.

It is illegal to lend your child’s identification card to any person who is not eligible to use your benefits.
Section III

A. Your Child’s First Priority Health Primary Care Physician

With First Priority Health, you are required to select a PCP. With his or her advice, your child will have access to a wide range of quality medical services available from our participating specialists and facilities.

1. Choosing a PCP
When enrolling, you received a directory of participating health care providers from which to choose your child’s PCP. You can choose any participating provider except those practices that are no longer accepting new patients. These practices are marked “not available for selection.” Once you have selected a PCP, First Priority Health encourages you to schedule an appointment to discuss your child’s medical history and current conditions. This helps build a strong patient–doctor relationship and ensures that your child’s doctor has access to all of your child’s medical records. You should talk with the PCP about any medical questions you have.

If you do not choose a PCP upon your child’s enrollment, we will assign one on your behalf. However, you are able to choose a new PCP at any time. A PCP usually specializes in internal medicine, family medicine or pediatrics. Your child’s PCP will provide primary health care services, such as annual physicals and medical tests, oversee care when your child is ill or injured and treat any chronic health problems or diseases.

2. Changing a PCP
While First Priority Health encourages our CHIP members and PCPs to build and maintain lasting relationships, you may change your child’s PCP and select another at any time. Our website, www.bcnepa.com, provides an updated list of participating doctors as well as other information (office locations, hospital affiliations, etc.) you will need to select a new PCP. You can also compare cost and quality data on up to 3 doctors and hospitals at a time. Just click on “Find a Doctor/Hospital.” Or simply call a First Priority Health Service Representative at 1.800.543.7199 or (TTY) 1.800.413.1112 for help.

3. Access to OB/GYNs
A female member can use her PCP or choose a participating obstetrician/gynecologist (OB/GYN) for obstetrical and gynecological care. Your child’s OB/GYN may treat any gynecological or obstetrical condition; however, your child still needs a PCP, who will coordinate other primary care needs.

4. Establishing a Relationship with Your Child’s PCP
You should call your child’s PCP’s office to make an appointment for an initial health assessment to establish your child as a patient. It’s best to do this even if your child is in good health. It’s a good way for you, your child and the PCP to get to know one another.

You always have the right to refuse treatment, as allowed by law. If you refuse recommended treatment, First Priority Health is not responsible for medical expenses that result from your decision.

Continuity of care means keeping everyone on your child’s health care provider team informed. This helps to ensure your child’s safety and to avoid duplication of services. Because we want to help the health care provider team in protecting your child’s health and safety, there may be times when it is necessary for First Priority Health to inform your child’s PCP periodically about services, including but not limited to tests, procedures and office visits your child has received from other health care providers. Communication is important so that the health care provider team has the most updated information about your child’s health and can help to ensure the best outcomes.

To have the most effective relationship with your child’s PCP:
- Keep and be on time for appointments. Call ahead to schedule appointments and, when necessary, call to cancel your child’s appointment at least 24 hours before the scheduled time. It’s also important to let the PCP’s office know if you’ll be late. Your child’s PCP’s office provides coverage arrangements 24 hours a day, 7 days a week, including weekends and holidays.
- Follow the doctor’s advice. You can help make sure the care your child receives is effective by following the doctor’s instructions.
- Participate in decisions regarding your child’s health care. Any time you are not sure about a medical procedure or don’t understand the treatment your child’s doctor recommends, ask questions. The same thing is true for questions about medication.

- Share information. Give your child’s doctor or health care provider an honest description of your child’s current symptoms, effects of medication and results of treatment. Provide your child’s medical history and any relevant medical records, including X-rays and other diagnostic tests.

Often it helps to make a list of questions to ask the doctor. You may also want to have a family member or friend with you—to take part in the discussion, to take notes or just to listen.

5. Transitioning Care
If your child is a new CHIP member, he/she may continue ongoing care with a non-participating provider for a period of up to 90 days from your child’s first day of coverage. Call a First Priority Health Service Representative to arrange coverage for this care.

If First Priority Health ends its contract with a participating provider from whom your child receives care, we will let you know and ask you to select another provider. Your child can continue care for 90 days, if the terminated provider agrees to the arrangement.

6. Transitioning Care When Pregnant
If a new enrollee is in the second or third trimester of pregnancy, the transitional period will last through postpartum care related to the delivery. Call a First Priority Health Service Representative to arrange coverage for this care at 1.800.543.7199 or (TTY) 1.800.413.1112.

Covered services will be provided under the same terms and conditions that apply to participating providers.

7. When Provider Contracts Terminate
First Priority Health cannot guarantee continued access during the term of your child’s enrollment with any participating PCP, specialist, hospital or other provider. If your child is being treated by a provider who no longer participates with First Priority Health, we will provide access to other participating providers with similar training and experience.

If First Priority Health ends a contract with a participating provider for cause, including breach of contract, fraud, criminal activity or posing a danger to a child or the health, safety or welfare of the public, First Priority Health will not be responsible for any health care services provided to your child following the date of termination. If First Priority Health ends a contract with a PCP, every member served by that doctor will be notified of the termination and we will ask that you select another PCP for your child.

8. Specialist Services
Your child’s PCP will, in most cases, provide the care that your child needs. However, your child may need care from a specialist physician. The PCP can suggest a participating specialist or facility to best meet your child’s medical needs, or you may choose one on your own.

9. Prior Authorization
Some services require prior authorization (approval) from First Priority Health before they are performed. Your child’s PCP or participating provider will coordinate this for you in most cases. However, if your child receives care not properly authorized, not covered or from a non-participating provider, you will have to pay for all of the charges.

10. Non-Participating Provider Services
When your child needs covered services that cannot be provided by a specialist or facility within the First Priority Health network, your child’s PCP or specialist will still need to complete and send an outpatient nonparticipating provider request form to First Priority Health for approval before your child obtains covered services outside the First Priority Health network.

If you’re not sure the provider participates with First Priority Health, click on Find a Doctor/Hospital at bcnepa.com/FindDoctorHospital.aspx, or call a service representative at 1.800.543.7199 or (TTY) 1.800.413.1112 for help.
Section IV

A. CHIP BENEFITS AND SERVICES

1. Medical Benefits

A Member Child is entitled only to the benefits as described in this Section, subject to the conditions, exclusions and limitations set forth herein.

A new enrollee may continue an ongoing course of treatment with a Non-Participating Provider for a transitional period of up to ninety (90) days from the Member Child’s Effective Date of Coverage. First Priority Health, in consultation with the Member Child’s Parent or Guardian and the Provider may extend this transitional period, if determined by First Priority Health, to be clinically appropriate. For a new enrollee in the second or third trimester of pregnancy on the Effective Date of coverage, the transitional period shall extend through post-partum care related to the delivery.

Covered Services rendered during the above-referenced transitional period provided to such new enrollees will be provided under the same terms and conditions as applicable for Participating Providers. The Non-Participating Provider who agrees to continue to provide care to a new enrollee, in order to receive payment from First Priority Health, must agree to accept the terms applicable to Participating Providers, including, but not limited to, prohibition on balance billing, and must agree to hold the Member Child’s Parent or Guardian harmless for moneys which may be owed by First Priority Health to the Provider.

a. Primary Care Physician Benefits

Except in an emergency as described in Section IV.i., the following Covered Services will be provided to a Member Child when Medically Necessary and at or through the Member Child’s Primary Care Physician’s office of record, or at other Participating specialist without Prior Authorization by the Member Child’s Primary Care Physician. Copays may apply. Prior Authorization for a diabetic eye examination once per calendar year is not required for a Member Child diagnosed with diabetes. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon non-participating Prior Authorization by the Member Child’s Primary Care Physician or treating Participating Physician and First Priority Health.

A Member Child with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation by First Priority Health, and if approved will be permitted to receive (a) a specialist with clinical expertise in treating the disease or condition or (b) the designation of a specialist to provide and coordinate the Member Child’s primary and specialty care.

The designation of a specialist shall be pursuant to a treatment plan approved by First Priority Health, in consultation with the Primary Care Physician, the Member Child and, as appropriate, the Specialist Physician. The Specialist Physician must be a Participating Professional Provider, except as described above. Covered Services from the Primary Care Physician include:

1) Office visits during office hours, and during non-office hours when Medically Necessary.

2) Home visits by the Member Child's Primary Care Physician, if the Member Child's Primary Care Physician deems it Medically Necessary.
3) Well child care from birth.

4) Routine physical examinations, once per Calendar Year, and additional examinations when Medically Necessary.

5) Laboratory and X-ray services, EKG’s and other diagnostic services.

6) Casts.

7) Emergency coverage arrangements through the Member Child’s Primary Care Physician’s office which are available twenty-four (24) hours a day, seven (7) days a week.

8) Follow-up care after Emergency Services.

9) Obstetrical services.

A female Member Child may select a Participating Professional Provider for maternity and gynecological services, including Medically Necessary follow-up care and diagnostic testing relating to maternity and gynecological care without Prior Authorization. Routine neonatal circumcision is covered. Such health care services shall be within the scope of practice of the selected Participating Professional Provider, who is responsible for keeping the Member Child’s Primary Care Physician informed of all health care services provided.

Coverage will be provided for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of care following caesarean delivery. A shorter length of stay may be justified when the treating or attending Physician determines in consultation with the mother that she and the newborn meet medical criteria for safe discharge in accordance with guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Those guidelines determine appropriate length of stay based upon, but not limited to, the following: the evaluation of the antepartum, intrapartum and postpartum course of the mother and infant; the gestational stage, birth weight and clinical condition of the infant; the demonstrated ability of the mother to care for the infant post-discharge; and the availability of the post-discharge follow-up care to verify the condition of the infant and mother within forty-eight (48) hours after discharge.

When a discharge occurs within forty-eight (48) hours following a Hospital admission for a normal vaginal delivery or within ninety-six (96) hours following a Hospital admission for Caesarean delivery, benefits will be provided for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Home health care visits shall include parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments. The post-partum home health visit is exempt from any deductibles or Copayments.

10) Therapeutic drugs, medications, and injectables, only when deemed a critical part of the therapeutic Covered Service being rendered by the Primary Care Physician during an office visit, and when Medically Necessary. Coverage is limited to the amount of therapeutic drug, medication, or injectable administered during the office visit. First Priority Health has the right to require prior authorization for certain drugs administered in the Physician’s office, as they deem necessary. A list of specific drugs which require prior authorization is available upon request from First Priority Health.
b. Outpatient Benefits

Except in an emergency as described in Section IV.i., the following Covered Services will be provided to a Member Child when Medically Necessary and at or through the Member Child's Primary Care Physician's office of record, or at other Participating specialists. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon non-participating Prior Authorization by the Member Child's Primary Care Physician and/or participating treating specialist and First Priority Health. Outpatient Covered Services include:

1) Ambulance service: Benefits are payable for Medically Necessary ambulance services by land, air or water, Advanced Life Support (ALS) or Basic Life Support (BLS) for local transportation. The ambulance must be transporting the member:
   a) from home or from the scene of an accident or Medical Emergency, to the nearest Hospital;
   b) between Hospitals;
   c) between a Hospital and Skilled Nursing Facility;
   d) from a Hospital or Skilled Nursing Facility to the Member's home;
   e) from the Member’s home or from a Facility Provider to an Outpatient treatment site; or
   f) from an Outpatient treatment site to the nearest Hospital.

   If there is no facility in the local area that can provide Covered Services for the Member's condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service. If the Member chooses to go to another facility that is farther away, payment will be based on the Allowable Charge for transportation to the closest facility that can provide the necessary services. All non-emergency transport by Providers who are not part of the First Priority Health Network will require Prior Authorization.

2) Ambulatory surgery, (i.e. surgery performed in an acute-care Hospital's short procedure unit or a free-standing surgical facility) with Prior Authorization of selected procedures by First Priority Health.

3) Laboratory and X-ray services, EKGs and other diagnostic services.

4) Outpatient surgery, (i.e., surgery performed in a Physician’s office or in an acute-care Hospital’s Outpatient department) with Prior Authorization of selected procedures.

5) Medical social services and other health services to include:
   a) Pre- and post-hospital planning;
   b) Facilitation of or coordination of care (but not payment for) to community health and social welfare agency services;
   c) Facilitation of or coordination of care (but not payment for) to related family counseling services except as specified in Section IV.f.; and
   d) Facilitation of or coordination of care to and payment for services of appropriate family planning, including birth control.

6) Home health services upon Prior Authorization by First Priority Health. When a discharge occurs within forty-eight (48) hours following a Hospital admission for a mastectomy, benefits will be provided for one (1) home health care visit within forty-eight (48) hours of the Hospital discharge. Prior Authorization will not be required for this visit.

Care provided to a CHIP member who is homebound by a home health care provider in the
CHIP member’s home, if within the service area. This benefit is offered with no co-payments and no limitations.

7) Home Infusion Therapy. Benefits will be provided for the following services provided to a Member Child by a Home Infusion Therapy Agency:
   a) Total parenteral nutrition*;
   b) Enteral nutrition*;
   c) Intravenous therapy;
   d) Chemotherapy and cancer hormone treatment;
   e) Anti-infective therapy (*Lyme Disease);
   f) Pain management (continuous and epidural analgesics);
   g) Enzyme replacement;
   h) Immune globulin therapy*.

The Home Infusion Therapy Agency shall supply all items used directly with Home Infusion Therapy to achieve therapeutic benefits and to assure proper functioning of the system, including, but not limited to: catheters, concentrated nutrients, dressings, enteral nutrition preparation, extension tubing, filters, heparin sodium (parenteral only), infusion bottles, IV pole, liquid diet (for catheter administration), needles, pumps, tape and volumetric monitors.

All therapies are subject to prospective, concurrent and/or retrospective utilization review by health care professionals, and further may require Prior Authorization to determine if a therapy is Medically Necessary and Appropriate. Before prescribing the therapy, a Participating Home Infusion Therapy Agency will advise the Member if Prior Authorization is required.

*Therapies that generally require Prior Authorization are noted with an asterisk above. Any therapy or Drug, the use of which is not FDA approved may be considered Experimental/Investigative and, therefore, must be Prior Authorized.

Failure to obtain Prior Authorization for any services which require it shall result in a denial of benefits.

Home Infusion Therapy benefits will not be provided for:
   i. A Member Child who is receiving benefits under the Hospice Care program;
   ii. Blood and blood products therapy; and
   iii. Any injectable drugs covered under any other benefit section of this Benefits Booklet.

8) Hospice Care with Prior Authorization by First Priority Health. When the Member Child’s Primary Care Physician requests Prior Authorization from First Priority Health stating that the Member Child has a terminal illness and when the Member Child or responsible party on behalf of the Member Child, elects in writing to receive care primarily in the home to relieve pain and to enable the Member Child to remain at home rather than to receive other types of care, the Member Child shall be eligible for Hospice Care benefits.

If the Member Child or the Member Child’s responsible party elects to institute curative treatment to sustain life, the Member Child will not be eligible to receive further Hospice Care benefits until the cessation of such curative treatment.
Coverage will be provided for services based on four (4) levels of care: 1.) routine; 2.) respite; 3.) continuous; and 4.) inpatient.

The Hospice Care benefit will include, coverage for continuous care consisting of nursing care for up to twenty-four (24) hours per day necessary to maintain the patient at home or acute Inpatient care for a period of crisis when Medically Necessary and not solely for comfort measures. Respite Care on a short-term inpatient basis in a Hospital or Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient's home. Respite Care is available at First Priority Health's discretion.

Benefits will be provided for palliative and supportive services at each level of care to a terminally ill Member Child by a Hospice Care program in accordance with a treatment plan approved and periodically reviewed by First Priority Health. The following services provided to a Homebound Member Child by an approved Hospice responsible for the patient's overall care will be eligible for coverage:

a. Hospice Medical Director;
b. Nursing care provided by or under the supervision of a registered nurse;
c. Pain management;
d. Palliative chemotherapy and/or radiation therapy;
e. Pharmaceuticals;
f. Laboratory services;
g. Medical and surgical supplies and durable medical equipment;
h. Palliative parenteral or enteral nutrition therapy;
i. Oxygen and its administration;
j. Medical social services provided by a social worker;
k. Counseling services provided to the Member Child and/or family members related to the patient's terminal condition;
l. Home health aide and homemaker services;
m. Physical therapy, occupational therapy and speech therapy;
n. Dietitian services;
o. Bereavement counseling.

9) Dialysis Treatment includes hemodialysis and peritoneal dialysis

10) Oxygen and the initial equipment necessary to utilize oxygen, when Medically Necessary. Replacement of the initial oxygen equipment is not covered.

11) Therapeutic Drugs that are not self-administerable.

Benefits are provided for all FDA-approved therapeutic drugs, including cancer Chemotherapy and cancer hormone treatment, that are not self-administerable required in the treatment of an illness or injury.
12) Metabolic Formulas for infants and children only for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria. This benefit does not include coverage for normal food products used in the dietary management of rare genetic metabolic disorders. Benefits for Metabolic Formulas are exempt from any deductible requirements.

13) Radiation Therapy.

14) Diabetes education services. Covered services include participation in a diabetes self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet, prescribed by a licensed physician, includes:

a. Visits medically necessary upon the diagnosis of diabetes;

b. Visits under circumstances whereby a physician identifies or diagnoses a significant change in the patient’s symptoms or conditions that necessitate changes in a patient’s self-management and when a new medication or therapeutic process relating to the patient’s treatment and/or management of diabetes has been identified as Medically Necessary by a licensed physician.

Services will be covered only when provided by a Participating Provider subject to the criteria of First Priority Health. These criteria are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association.

15) Equipment and supplies for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items.

Equipment and supplies must be prescribed by a licensed Provider and are limited to those which are preferred for use by First Priority Health, unless other equipment and supplies have been authorized as an exception, based on, and supported by, medical justification from the prescriber. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and Orthoses.

The Benefits are provided for equipment and supplies and pharmacological agents for the treatment of diabetes, in accordance with Pennsylvania Law, Section 633, Act 98 of 1998.

16) Observation Room. Those services furnished on a Hospital’s premises, including use of a bed and periodic monitoring by hospital’s nursing or other staff, which are reasonable and necessary to evaluate an Outpatient’s condition or determine the need for a possible admission to the Hospital as an Inpatient requires Prior Authorization at some facilities.

c. **Specialist Physician Benefits**

Except in an emergency as described in Section IV.i. of this Contract, Covered Services will be provided to a Member Child by a Participating Specialist Physician when Medically Necessary. Copays may apply. Prior Authorization for a diabetic eye examination once per Calendar Year is not required for Member Children diagnosed with diabetes. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon prior approval by the Member Child’s Primary Care Physician and/or Participating Treating Specialist and First Priority Health.
1) Allergy care (except routine injections, which should be administered by the Member Child’s Primary Care Physician).

2) Anesthesia.

3) Cardiology.

4) Endocrinology.

5) Gynecology and Obstetrics.
   a. A Member Child or a Member Child’s Parent, on behalf of a female Member Child, may select a Participating Professional Provider for maternity and gynecological services, including Medically Necessary follow-up care and Referrals and necessary Prior Authorizations for diagnostic testing relating to maternity and gynecological care, without prior approval from the Member Child’s Primary Care Physician. Such health care services shall be within the scope of practice of the selected Participating Professional Provider, who is responsible for keeping the Member Child’s Primary Care Physician informed of all health care services provided.

6) Internal Medicine.

7) Neurology.

8) Oncology.

9) Ophthalmology. Coverage will be provided for vision care when Medically Necessary to diagnose and treat a disease process involving the anatomy of the eye.

10) Oral Surgery for
   a. any condition which is a result of trauma or disease;
   b. dental services directly associated with early childhood caries (ECC) prior to age four (4), once per lifetime
   c. for the removal of bony impacted wisdom teeth and related anesthesia.

11) Coverage for the removal of partially or totally bony impacted wisdom teeth, when performed by a Participating Provider (a provider within the First Priority Health Network of Providers) in other than a Hospital or Ambulatory Surgical Facility, will be covered. When such surgery cannot be safely or adequately performed in other than a Hospital or Ambulatory Surgical Facility and if authorized by First Priority Health’s Medical Director, the surgery may occur in a Hospital or Ambulatory Surgical Facility for Member Children with complex medical conditions.

   Local anesthesia and conscious sedation in conjunction with the removal of partially or totally bony impacted wisdom teeth are covered when performed by a Participating Provider.

   General anesthesia charges in an office setting in conjunction with the removal of partially or totally bony impacted wisdom teeth are covered when performed by a Participating Provider without prior authorization. General anesthesia administered in a Hospital or Ambulatory Surgical Facility in conjunction with the removal of partially or totally bony impacted wisdom teeth is covered for Member Children with complex medical conditions if authorized by First Priority Health’s Medical Director.

12) Otolaryngology.

13) Pathology.

14) Pediatrics.
15) Radiology (dental x-rays are not covered unless related to Covered Services).

16) Surgery.
Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider in a Physician’s office or in a short procedure unit, Hospital, Outpatient department, or Freestanding Outpatient Facility for the treatment of disease or injury. Separate payment will not be made for Inpatient pre-operative care or all post-operative care normally provided by the surgeon as part of the surgical procedure.

For questions concerning Prior Authorization, a Member Child’s Parent or Guardian should contact the Plan by calling a BlueCare Service Representative prior to the service being rendered. Ambulatory Surgery (i.e., Surgery performed in an acute-care Hospital’s short procedure unit or a free-standing surgical facility) and Outpatient Surgery (i.e., Surgery performed in a Physician’s office or in an acute-care Hospital’s Outpatient department) require Prior Authorization by First Priority Health for certain procedures performed in Participating Provider facilities. Prior Authorization is required for all ambulatory Surgery and Outpatient Surgery performed in Provider facilities that are not part of the FPH Network.

Covered surgical procedures shall also include routine neonatal circumcision and any voluntary surgical procedure for sterilization (tubal) regardless of Medical Necessity. Surgery performed for the reversal of sterilization is not covered.

17) Urology.
a. Emergency - In an emergency as described in Section IV.i., the Covered Services listed above will be covered without Prior Authorization, subject to all conditions and requirements set forth in Section IV.i.

d. **Inpatient Hospital Facility Benefits**

A Member Child who is hospitalized by a Participating Physician, if Medically Necessary and upon Prior Authorization from First Priority Health, is entitled to the following Covered Services only at Participating Hospitals and Participating Skilled Nursing Facilities. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon Prior Authorization by First Priority Health.

Covered Services in Skilled Nursing Facilities are limited to those services which are Medically Necessary and which constitute Skilled Inpatient Care. Inpatient Hospital and Skilled Nursing Facility Covered Services include:

1) Semi-private room and board accommodations.

2) Private accommodations when Medically Necessary and upon Prior Authorization by the Member Child's Primary Care Physician and First Priority Health’s Medical Director. A Member Child who occupies a private room without such authorization shall be directly liable to the Participating Hospital or Participating Skilled Nursing Facility for the difference between payment by First Priority Health to the Participating Hospital or Participating Skilled Nursing Facility of the per-diem or other agreed-upon rate established between First Priority Health and the Participating Hospital or the Participating Skilled Nursing Facility and the private room rate.

3) General nursing care.

4) Private duty nursing care.

5) Use of intensive or special care facilities when Medically Necessary.

6) Diagnostic and therapeutic radiological procedures, except as specifically excluded in
Section IV.
7) Use of operating room and related facilities.
8) Drugs, medications and biologicals, when Medically Necessary.
9) Laboratory testing and services.
10) Pre- and post-operative care.
11) Special tests when Medically Necessary.
12) Therapy Services.
13) Oxygen.
14) Anesthesia and anesthesia services.
15) Unreplaced blood and blood components and the administration and processing of whole blood, blood plasma and blood derivatives.
16) Intravenous injections and solutions.
17) Dialysis Treatment, including hemodialysis and peritoneal dialysis.
18) Surgical, medical and obstetric services provided by a Participating Hospital.
19) Transplant Procedures

If a human organ or tissue transplant is provided from a human donor to a human transplant recipient:

a. When both the recipient and the donor are Member Childs, each is entitled to the benefits of this Contract.

b. When only the recipient is a Member Child, both the donor and the recipient are entitled to the benefits of this Contract. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to: other insurance coverage, or coverage by First Priority Health or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this Contract to the extent benefits remain and are available under the Contract after the benefits of the recipient have been paid.

c. When only the donor is a Member Child, the donor is entitled to the benefits of this Contract. The benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by First Priority Health or any government program available to the recipient. No benefits will be provided to the non-Member Child transplant recipient.

d. If any organ or tissue is sold rather than donated to the Member Child recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Member Child recipient's Contract limit.

e. If the Member Child's coverage includes Prescription Drug coverage, immunosuppressant drugs in connection with covered transplants will be covered under the Mail Order Prescription Drug benefit and the cost of these drugs.

Facilities nationwide have been selected to participate in the Blue Cross and Blue Shield Association Blue Distinction Program for Transplants. Blue Distinction Centers for Transplants provide a range of services for transplants, including but not limited to:

- Heart
- Lung (deceased and living donor)
- Combination heart bilateral lung
- Liver (deceased and living donor)
- Simultaneous pancreas kidney (SPK)
- Pancreas (PAK/PTA)
- Kidney-only in conjunction with SPK/PAK
- Bone marrow/stem cell (autologous and allogeneic)

Blue Distinction Centers for Transplants have been contracted on a transplant specific basis. In order for benefits to be provided at the level of coverage as if the Member Child had been able to obtain services from a Provider within the First Priority Health Network of Providers, a Member Child must utilize a Blue Distinction Transplant facility that has been specifically designated by Blue Cross and Blue Shield companies for the specific transplant type.

There is no coverage for services provided by a Non-Participating Provider or at a Blue Distinction Transplant facility that has not been specifically designated by Blue Cross and Blue Shield companies for the specific transplant type unless approved by a Medical Director of First Priority Health. In the case of a transplant as a result of an Emergency Medical Condition, approval by a Medical Director of First Priority Health is required within forty-eight hours of the emergency admission or as soon as reasonably possible.

**Prior Authorization for Transplant Procedures.**

Providers must contact BCNEPA Utilization Management at the time the Member Child is referred for a transplant consultation/evaluation. Providers within the FPH Network and Participating Providers of a Host Blue PPO Network are responsible for obtaining the Pre-Certification on behalf of a Member Child. The Member Child is responsible to confirm with a BlueCare Service Representative that their Provider obtained Pre-Certification prior to the service(s) rendered.

20) Therapeutic Drugs that are not self-administerable.

Benefits are provided for all FDA-approved therapeutic drugs, including cancer Chemotherapy and cancer hormone treatment, that are not self-administerable and required in the treatment of an illness or injury.

21) Length of stay following a mastectomy that the treating physician determines is necessary to meet generally accepted criteria for safe discharge.

22) Surgical procedure for mastectomy, including prosthetic devices and Reconstructive Surgery incident to any mastectomy. Covered services will be provided for prosthetic devices inserted during Reconstructive Surgery and Reconstructive Surgery for all physical complications of all stages of mastectomy including lymphedemas.

23) Inpatient rehabilitation therapy is limited to forty-five (45) days per Calendar Year for treatment of CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain surgery.

24) Inpatient rehabilitation therapy

Emergency - In an emergency as described in Section IV.i., the Covered Services listed above will be covered without Prior Authorization, subject to all the conditions and requirements.
e. **Alcohol and/or Drug Abuse Treatment Benefits**

Alcohol and/or Drug Abuse Covered Services include:

1) **Outpatient** -

Covered Services involve diagnosis, detoxification, medical treatment and medical referral services. Covered Services also include: (1) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; (5) drugs, medicines, equipment use and supplies.

Member Child out-of-area students may receive Outpatient Alcohol and/or Drug Abuse treatment out of the First Priority Health service area. If Inpatient treatment is required, the Member Child must return to the First Priority Health service area to utilize coverage.

2) **Inpatient Detoxification** – A Member Child is eligible for Inpatient Detoxification benefits in either a Participating Hospital or an Inpatient Non-Hospital Residential Facility.

The following services shall be covered under Inpatient Detoxification treatment: (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic X-ray; (4) psychiatric, psychological and medical laboratory tests; (5) drugs, medicines, equipment use and supplies.

3) **Inpatient Non-Hospital Residential Care** – A Member Child is eligible for Inpatient Non-Hospital Residential Care in an Inpatient Non-Hospital Residential Facility. Inpatient Non-Hospital Residential Care Covered Services include: (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) rehabilitation therapy and counseling; (4) family counseling and intervention; (5) psychiatric, psychological and medical laboratory tests; (6) drugs, medicines, equipment use and supplies.

f. **Mental Health Care Services**

1) **Outpatient Mental Health Care Services**:

Each Member Child may see a psychiatrist, clinical psychologist, or psychiatric social worker in individual, group, family therapy or electroconvulsive therapy (ECT) sessions. A Member Child who is an out-of-area student may receive Outpatient Mental Health treatment out of the First Priority Health service. If Inpatient treatment is required, the Member Child must return to the First Priority Health service area to utilize coverage.

Services include outpatient professional visits and outpatient partial hospitalization days.

2) **Inpatient Mental Health Care Services**:

The following Covered Services are provided for Inpatient treatment:

a. Individual psychotherapy;

b. Group psychotherapy;

c. Psychological testing;

d. Family counseling - counseling with family members to assist in the Member Child’s diagnosis and treatment; and

e. Electroconvulsive therapy treatment - electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same
Provider.

The necessity for Behavioral Health Acute Care in an Inpatient setting is determined by the presence of a mental or substance abuse disorder and the presence of any of the following five (5) associated clinical factors:

a. Danger to self;
b. Danger to others;
c. Inability to care for self;
d. Life-threatening danger associated with substance detoxification; and
e. Life-threatening danger stemming from co-existing medical factors.

g. Mastectomy and Breast Reconstruction

Benefits are provided for a mastectomy performed on an inpatient or outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a Mastectomy; and
- Physical complications of all stages of Mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the Member’s physician, received within forty-eight (48) hours after discharge.

h. 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 order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a Mastectomy.

i. Emergency care Benefits Within and Outside the First Priority Health Service Area

Emergency care benefits include treatment and services in the Outpatient department of a Hospital.

- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of bodily injury resulting from an accident shall be covered.
- Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of a medical condition with acute symptoms, which would result in requiring immediate Medical Care, shall be covered.

If accident services are classified as Surgery (e.g., suturing, fracture care, etc.), payment to a Professional Provider will be made as a surgical benefit. Visits performed in the Outpatient department of a Hospital that are follow-up to emergency accident care and medical Emergency Services are classified and payable as Outpatient benefits.
First Priority Health will reimburse the Provider or Member Child for the reasonable cost of emergency accident services or a medical Emergency Service (less appropriate Copayments) performed within or outside the First Priority Health Network (including out of the country), regardless of Provider.

Reimbursement – First Priority Health may limit reimbursement for emergency accident services, or a medical Emergency Service by a Non-Participating Provider, located either within or outside the First Priority Health Network, to those expenses which are incurred up to the time the Member Child is determined to be medically able to travel or to be transported to a First Priority Health Participating Provider. Reimbursement will be subject to payment by the Member Child of all appropriate Copayments, deductibles and coinsurance. Once a Member Child is stabilized, to continue coverage First Priority Health reserves the right to transfer a Member Child’s care from a Non-Participating Provider to a Participating Provider. When processing the claim for reimbursement, First Priority Health shall consider both the presenting symptoms and the services provided. A Non-Participating Provider may bill a Member Child for the difference between the amount First Priority Health reimburses the Provider and the billed charges. The Member Child is responsible for a Copayment for Emergency Service provided by a Non-Participating Provider plus the difference between the amounts First Priority Health reimburses the Provider and the billed charges. If the Member Child is admitted to the Hospital from the emergency room, the emergency room Copayment is waived.

The Member Child is responsible for a Copayment for each emergency visit to a Physician's office and a Copayment for each emergency visit to a Hospital Outpatient department or emergency room.

j. Out-of-Area Care Benefits for Unexpected Condition (URGENT CARE)

1) Urgent Care - For Urgent Care outside the First Priority Health Service Area, the Member Child can receive coverage through the BlueCard Program. Prior to receiving Urgent Care, the Member Child’s Parent or Guardian must call the toll-free number listed on the identification card for instructions on availing themselves of this coverage. Appropriate copayments may apply.

2) Referred Care (Follow-Up Care) – A Member Child who is currently receiving ongoing treatment for an illness or injury and plans to travel outside First Priority Health’s Service Area can receive coverage through the BlueCard Program. Prior to receiving Referred Care, the Member Child’s Parent or Guardian must call the toll-free number listed on the identification card for instructions on availing themselves of this coverage and to request a Transfer of Medical Information Form. Appropriate Copayments may apply.

k. Rehabilitative/Habilitative Outpatient Services

The following Covered Services will be provided to a Member Child when Medically Necessary and at or through the Member Child’s Primary Care Physician’s office of record, or at other Participating Providers for selected services. Payment will be made for Covered Services provided by a Non-Participating Provider if Medically Necessary and upon Prior Authorization by First Priority Health. Rehabilitative services include:

1) Cardiac Rehabilitation - Member Child may receive up to thirty-six (36) visits per benefit period.

2) Outpatient Occupational, Physical, and Speech Therapy - Member Child may receive benefits for up to thirty (30) visits per therapy during a calendar year if the Member Child’s Primary Care Physician certifies that the treatment will result in an improvement of the Member Child’s condition.
3) Pulmonary Rehabilitation - Member Child may receive up to eighteen (18) Outpatient visits in a Calendar Year.

4) Respiratory Therapy Unlimited

5) Habilitative Services - Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of outpatient settings. Covered services are limited to 30 visits per calendar year for Physical Therapy; 30 visits per calendar year for Occupational Therapy; and 30 visits per calendar year for Speech Therapy, for a combined visit limit of 90 days per calendar year. Visit limits under this benefit are combined with visit limits described under Outpatient Rehabilitation Therapy.

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

I. Chiropractic Manipulative Benefits

Chiropractic Manipulative Treatments, consultations, and Adjunctive Procedures are limited to a combined Maximum of twenty (20) visits per Benefit Period, if Medically Necessary.

m. Durable Medical Equipment, Prosthetics, Orthotics

Durable Medical Equipment, the initial provision of Prosthetics and the initial provision of Orthotics if Medically Necessary and approved by the Member Child's Primary Care Physician. Instructions regarding appropriate use of the item are covered. Replacements are not included, except as certified Medically Necessary for children due to normal growth. Covered Durable Medical Equipment includes, but is not limited to, the following:

1) Hospital beds and related equipment (bed rails, mattresses);
2) Equipment to increase mobility (walkers, wheelchairs);
3) Commodes (elevated seats, portable bedside commodes);
4) Breathing apparatus (positive and intermittent positive pressure breathing machines, suction machines);
5) Therapeutic equipment (infusion equipment, I.V. stands and equipment);
6) Apnea monitors;
7) Jobst pressure garments used in burn treatment;
8) Unna boots and air casts; and

Covered Prosthetics and Orthotics include, but are not limited to, the following:

a. Artificial limbs;
b. Knee braces, not made of elastic or fabric support;
c. Splints (acrimo-clavicular or zimmer, carpal tunnel, clavicle or “figure-8”, finger, Pavlik harness and wrist);
d. Immobilizers;
e. Corrective shoes, shoe inserts and supports, or other foot orthoses;
f. Supportive back braces with metal stays;
n. Preventive Care

Coverage will be provided for the preventive care services provided for under the Patient Protection and Affordable Care Act and Health Resources and Services Administration’s (HRSA) Women’s Preventive Services: Required Health Plan Coverage Guidelines. The frequency and eligibility of services are subject to change to conform to the guidelines and recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Center for Disease Control, and the Health Resources and Services Administration. Preventive care services include, but are not limited to, the following:

1) Immunizations

Coverage will be provided for pediatric immunizations, including immunizing agents, which, as determined by the Department of Health, conform to the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric immunizations are available until the Member Child attains age twenty-one (21). Pediatric and adult immunizations which are provided by participating providers are exempt from Copayments.

2) Routine Gynecological Examinations and Pap Smears

Female Member Child is covered for one (1) gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine Pap smear per Benefit Period in accordance with the recommendations of the American College of Obstetricians. Female members have "direct access" to care by an obstetrician or gynecologist. There is no PCP referral needed. Benefits are exempt from all Copayments when provided by participating providers.

3) Screening and Diagnostic Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service Provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit. Benefits are exempt from Copayments when provided by participating providers.

4) Colorectal Cancer Screening

Coverage for colorectal cancer screening is provided for covered individuals. Coverage for non-symptomatic covered individuals shall include, but is not limited to:

a. One (1) fecal occult blood test per Benefit Period.

b. Sigmoidoscopy, screening barium enema, colonoscopy, or a test consistent with approved medical standards and practices to detect colon cancer, at a frequency determined by the covered individuals Physician.

Coverage for symptomatic covered individuals shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.

Screenings for colorectal cancer for non-symptomatic individuals exempt copayments when provided by participating providers.

5) Prostate Cancer Screening

Coverage is provided for one (1) prostate specific antigen (PSA) and/or one (1) digital rectal
exam per Benefit Period. Benefits are exempt Copayments when provided by participating providers.

6) Preventive Drugs

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Member Services at 1.800.543.7199.

Select Over-the-Counter (OTC) products may be covered if mandated by the Patient Protection and Affordable Care Act (PPACA). If the member has a prescription for the over-the-counter medication, the medication is listed in the formulary, and the member has been diagnosed with certain medical conditions, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call Member Services at 1.800.543.7199.

When a Prescription Drug is available as a Generic, the HMO/PPO will only provide benefits for that Prescription Drug at the Generic Drug level. If the prescribing Physician indicates that the Brand Name Drug is medically necessary and should be dispensed, the brand name drug is covered at the generic cost-share amount by the contractor.

When clinically appropriate drugs are requested by the Member, but are not covered by the health plan, the Member shall call Customer Service at the telephone number on the back of the Member's Identification Card to obtain information for the process required to obtain the prescription drugs.

Benefits are provided for those generic-equivalent preventive drugs with a prescription, which as determined by the U.S. Preventive Services Task Force have a rating of A or B, in accordance with the Affordable Care Act of 2010. Generic equivalent preventive drugs with a prescription are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a participating pharmacy.

Benefits are also provided for certain generic FDA-approved prescription contraceptives for a female Member Child with a prescription, in accordance with the Health Resources and Services Administration’s (HRSA) Women’s Preventive Services: Required Health Plan Coverage Guidelines.

These generic preventive drugs are exempt from Deductibles, Copayments, and Coinsurance, when dispensed by a participating pharmacy.

In order to receive benefits, the Member Child must present the Prescription and First Priority Health Identification Card to a participating pharmacy and the claim must be filed by a participating pharmacy.

7) Nutritional Therapy

Nutritional Therapy to promote a healthy diet is available to the Member Child when provided by a licensed healthcare professional. Benefits are exempt from all Copayments, when provided by a Participating Provider.

Diabetes Outpatient self-management training and education as provided in Subsection B of this Medical Benefits Section and Nutritional Therapy provided to a Homebound Member Child under Subsection B of this Medical Benefits Section is exempt from this Benefit Maximum.
Coverage for dependent children, who are covered under this Contract, will be provided as follows:

a. Dependent children, ages two (2) through twelve (12), when accompanied by a parent.

b. Dependent children, ages thirteen (13) through seventeen (17), with parental consent. No coverage is provided for dependent children under the age of two (2).

o. **Urgent Care Center Benefit**

Benefits are provided for visits rendered and billed by a Participating Provider in an Urgent Care Center to a Member Child who is an Outpatient. Benefits are provided for treatment of illness or injury.

Outpatient covered services rendered by a provider not in an Urgent Care Center will be processed in accordance with the terms and conditions of the respective Outpatient Hospital and/or Professional Provider benefits.

p. **Autism Spectrum Disorders**

For a Member Child under age 19, coverage will be provided for the diagnostic assessment and treatment of Autism Spectrum Disorders.

Once a Member Child is identified as having Autism Spectrum Disorder, First Priority Health will work closely with the Department of Human Services (DHS) to see if they can better meet the Member Child’s health care needs.

q. **Retail Clinic Care**

Benefits are provided for Retail Clinic Care visits and consultations rendered and billed by a Professional Provider to a Member Child who is an Outpatient. Benefits are provided for the examination, diagnosis, and treatment of common minor ailments. A primary care office visit copayment applies per visit.

r. **Clinical Trials**

**Routine Patient Costs Associated With Qualifying Clinical Trials:**

Benefits are provided for routine patient costs associated with participation in a qualifying Clinical Trial. To ensure coverage and appropriate claims processing, the HMO must be notified in advance of the Member’s participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional Provider, and conducted in a Participating Facility Provider facility. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider facility, then the (HMO/PPO) will consider the services by a Non-Participating Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by the HMO.

**QUALIFYING CLINICAL TRIALS** – a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following:

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

1) The National Institutes of Health (NIH);
2) The Centers for Disease Control and Prevention (CDC);
3) The Agency for Healthcare Research and Quality (AHRQ);
4) The Centers for Medicare and Medicaid Services (CMS);
5) Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
6) Any of the following, if the Conditions For Departments are met:
   a. The Department of Veterans Affairs (VA);
   b. The Department of Defense (DOD); or
   c. The Department of Energy (DOE), if for a study or investigation conducted by a Department, is that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
   c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
   d. The citation for reference is 42 U.S.C. § 300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer “may not deny the individual participation in the clinical trial.”
   e. In the absence of meeting the criteria listed above, the clinical trial must be approved by the HMO/PPO as a Qualifying Clinical Trial.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS - Routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

s. How to Receive Hearing Benefits

Routine hearing examinations should be provided by the Member Child’s Primary Care Physician. If the Primary Care Physician recommends that the Member Child have an audiometric examination, the Member Child will need to see an audiologist or otolaryngologist.

When using a Participating Professional Provider, present the Member Child’s First Priority Health Identification Card at the time services are provided. The Provider will handle all the paperwork.

Payment for Covered Services performed by a Participating Professional Provider will be made to the Provider.

HEARING BENEFITS

The Member Child is entitled to the following services performed by a licensed Professional Provider or Otolaryngologist or contracting Audiologist or contracting Hearing Aid Supplier, subject to Exclusions, as listed in Section IV, and what is not covered, in this section.
HEARING EVALUATION

Such services, performed by a licensed Professional Provider, or a contracting Audiologist, or Otolaryngologist, or contracting Hearing Aid Supplier:

1. Basic comprehensive case history to determine loss of hearing acuity and whether the loss can be compensated for by a hearing aid if needed.

2. Audiometric Examination to measure hearing acuity including relating to air conduction, bone conduction, speech reception threshold and speech discrimination; summary and findings.

3. Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary.

Benefit Limits: One routine hearing examination and one audiometric examination per 12 months; one hearing aid or device per ear every 24 months. Batteries for hearing aids and devices are not covered.

Hearing Benefits are limited as follows:

1. Payment for one Hearing Evaluation is limited to once every calendar year for each Member Child.

2. Payment for one Audiometric exam is limited to once every calendar year for each Member Child.

3. Payment is limited to not more than one hearing aid per ear in any two calendar years.

B. WHAT IS NOT COVERED

In addition to the Medical Benefit Exclusions as listed in Section IV, the following also apply:

1. Replacement batteries are not covered;

2. Charges for hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature;

3. Replacement of hearing aids that are lost, broken or stolen;

4. Replacement parts for the repair of hearing aids; and

5. All other expenses incurred in connection with hearing aids not specifically mentioned in the Hearing Aid Section are not covered under the Hearing Benefit.
C. MEDICAL BENEFIT EXCLUSIONS

1. Services which are not Medically Necessary, except those that are provided within the Contract for preventive services or those mandated by law.

2. Any service in connection with or required by a non-covered procedure or benefit.

3. Services in excess of any benefit maximum as stated in Section IV.

4. Charges for services or supplies incurred prior to the Member Child’s Effective Date.

5. Charges for services or supplies incurred after the date of termination of the Member Child’s coverage.

6. Services or supplies, obtained by or on behalf of a Member Child without required Prior Authorization, except as described in Section IV.

7. All non-Emergency Services rendered in or performed by a Non-Participating Provider without non-participating Prior Authorization from the Member Child’s Primary Care Physician and/or Participating Treating Specialist and First Priority Health prior to services being rendered.

8. Services which are not prescribed performed or directed by a Provider licensed to do so.

9. Payment for any Covered Services as secondary carrier, unless the required written Prior Authorizations are obtained.

10. Coverage for a Member Child who is on active military duty or for services received as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country, when the Member Child is legally entitled to other coverage and facilities are reasonably available to the Member.

11. Treatment or services received as a result of participating in a riot or insurrection.

12. Services as a result of injuries sustained during the commission of or attempt to commit a felony.

13. Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from surgery.

14. The following procedures are not covered: removal of skin tags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy and panniculectomy; otoplasty; rhytidectomy; blepharoplasty; actinic changes; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following surgery for breast disease; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.
15. All dental services including preventive dental care, regardless where or by whom performed, related to the care, filling, removal or replacement of natural teeth, dentures or bridges and treatment of diseases of the teeth or gums, including, but not limited to: treatment of dental cavities, periodontics, endodontics, apicoectmies, orthodontics, soft tissue impactions, and orthognathic surgery, except as required for correction of a condition caused by accidental injury, for hospital and anesthesia charges associated with Medically Necessary dental procedures requiring sedation, other than the removal of bony impacted wisdom teeth, which cannot be safely or adequately performed on an Outpatient basis for Member Children upon authorization of First Priority Health’s Medical Director.

Treatment of TMJ is excluded except for surgical treatment for the total reconstruction or replacement of a completely degenerated joint.

16. Routine and cosmetic foot care, except for care provided as a result of diabetes.

17. The repair and replacement of Prosthetics and Orthoses, except if the Prosthetic or Orthosis was provided as a result of diabetes and for children due to normal growth.

18. Inpatient Hospital & Skilled Nursing Facility Benefits for the treatment of Morbid Obesity, services and associated expenses related to the non-surgical medical treatment of obesity, including, but not limited to, dietary supplements or programs for weight reduction. Treatment of obesity, including surgical intervention, to prevent related secondary illnesses, such as, but not limited to, diabetes mellitus, hypertension, hyperlipidemia, arteriosclerotic cardiovascular disease and arthritis is also excluded from coverage.

Treatment in connection with transsexual surgery, except for treatment resulting from a complication of such transsexual surgery.

20. Assisted fertilization techniques such as, but not limited to, In Vitro Fertilization (IVF) of any kind, including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment; embryo acquisition, storage and transport; human chorionotropin; urofollitropin; menatropins or derivatives; donor ovum and semen and related costs, including collection, preparation, preservation or storage.


22. The reversal of sterilization.

23. Charges in connection with penile implants.

24. Abortions, except services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.

25. The purchase of organs which are sold rather than donated to transplant recipients, transplants involving mechanical organs or non-human organs and charges for organ donor searches are also excluded from coverage.


27. Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.

28. Corneal surgery to change the shape of the cornea to correct vision problems, except for trauma or medically necessary conditions resulting from corneal surgery.
29. Except as provided in Primary Care Physician Benefits and in Specialist Physician Benefits, routine eye examinations, except diabetic eye examinations once per Calendar Year; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntongics, optometric therapy, vision augmentation devices and vision enhancement systems.

30. Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.

31. Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a physician, such as but not limited to, allergen filtration systems including allergy products.

32. Provision or replacement of the following items, including, but not limited to:
   (a) motor driven or deluxe equipment of any sort, or equipment which has been otherwise determined by First Priority Health to be non-standard; (b) items, which are primarily for personal comfort or convenience, including, but not limited to: bed boards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, ostomy supplies, or self-administered catheters or prosthetic socks, except when administered by a home health agency as part of the home health benefit; (d) exercise equipment; (e) self-help devices including, but not limited to: elevators, lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or piece of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) dental services or appliances of any sort, including, but not limited to: dentures, bridges, dental implants, or intra-oral Prostheses; (j) eyeglasses or contact lenses; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) pro-glide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; (v) modification or customization of any Durable Medical Equipment.

33. Examinations for the fitting or adjustment of hearing aids.

34. Charges for telephone calls or consultations, except telephone calls or consultations provided by a Primary Care Physician; failure to keep a scheduled visit; completion of forms, transfer or copying of records or generation of correspondence.

35. Travel or transportation expenses, even though prescribed by a physician, except ambulance service as described.

36. Charges for a private room when a semi-private room is available.

37. Inpatient services that could safely and adequately be performed in a home, Provider’s office or at any other level of institutional care.

38. Long-Term Residential Care.

39. Custodial care, domiciliary care, convalescent care, or rest cures, outpatient Private Duty Nursing or specialized nursing care.

40. Therapy or rehabilitation, including, but not limited to cognitive therapy, except as described.

41. Pulmonary rehabilitative therapy on an Inpatient basis.

42. Therapy and devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.

43. Vitamin, mineral and electrolyte supplements, food, special diets, and feedings for children and infants except those providing at least thirty-five (35) percent of daily caloric requirements given
enterally through an in-dwelling gastrointestinal tract tube necessitated by the inability to take
nutrition by mouth, or in conditions of gastrointestinal tract impairment, parenterally through an
intravenous catheter. Infant formulas including those prescribed for reasons of fat malabsorption,
lactose intolerance, milk protein intolerance and/or milk allergies. Metabolic formulas except those
that are mandated to be covered by law for the therapeutic treatment of phenylketonuria (PKU),
branched-chain ketonuria, galactosemia and homocystinuria.

44. Treatment of pervasive developmental disorders such as mental retardation, defects, deficiencies
and learning disabilities. This exclusion does not apply to medical treatment of such Members in
accordance with the benefits provided in this handbook.

45. Services for the treatment of insomnia and other sleep disorders, delirium, dementia, neurological
disorders and other mental disorders with a known physical basis or due to a general medical
condition.

46. Services for the treatment of anti-social personality, conduct disorders and paraphilias.

47. Methadone or methadone-like equivalents(except for Suboxone equivalents and Subutex
equivalents).


49. Charges to the extent payment has been made under Medicare when Medicare is the primary
carrier or by any other federal, state or local government program.

50. Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation
Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's
Compensation Act and first party valid and collectible claims covered by a motor vehicle policy
issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law or any
applicable federal or state law. This exclusion applies regardless of whether the Member claims the
benefit compensation.

51. Alternative and complementary medicine, except as provided in Section IV. Benefits.

52. Services performed by a Provider with the same legal residence as a Member or who is a family
member, including spouse, brother, sister, parent or child.

53. Charges for services, use of facilities, or supplies that any covered person has no legal obligation to
pay and for which no charge would have been made in the absence of insurance.

54. Separate charges by interns, residents and other health care professionals who do not have a
Participating Provider Agreement with First Priority Health, who are directly, or indirectly, employed
by Hospital or Facility Other Provider which is a Participating Facility Provider with First Priority
Health and makes their services available.

55. Educational classes, support groups and disease management programs unless sponsored or
provided by First Priority Health, except as required for diabetes education services.

56. Charges for any Prescription Drug or supply, which is not Medically Necessary and appropriate
based on one (1) or more of the following reasons:
   a. The indication and/or use is of a cosmetic nature or to enhance physical appearance; to
      enhance athletic performance; or for weight loss.
   b. Based on the Pharmacist's professional judgment, the Prescription should not be dispensed.
   c. The Prescription Drug or supply is subject to Prior Authorization and has not been authorized as
      an exception, (based on, and supported by, medical justification from the Prescriber) for the
      following reason:
         i. The use of the Prescription Drug or supply is contraindicated due to: overutilization, drug-
            drug interaction, drug-disease interaction, therapeutic duplication, adverse reaction, or
The following are excluded:

(1) drugs which do not require a prescription; (2) drugs which cannot be self-administered; (3) medical supplies; devices and equipment, (4) test agents and devices, except those used for diabetes; (5) smoking-cessation aids, including nicotine patches, gums and nasal sprays, except Prescription Drugs specifically designated by First Priority Health which are covered for one treatment period per lifetime; (6) the additional charge for a brand-name drug for which there is a Generic Equivalent Drug available, unless the Brand Name Drug is requested by the physician and deemed to be medically necessary; (7) allergy extracts for allergen immunotherapy; (8) administration or injection of any drugs; (9) replacement of lost, stolen or damaged drugs.

57. Copayments, Deductibles, Coinsurance or penalties applied.

58. Physical, psychiatric or psychological examinations, testing, reports, vaccinations, immunizations or treatments, when such services are:

a. for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption;

b. relating to judicial or administrative proceedings or orders;

c. conducted for purposes of medical research; or

d. to obtain or maintain a license of any type.

59. Unattended services, with the exception of at-home sleep studies.
Section V

A. PHARMACY BENEFITS

Benefits will be provided for covered Prescription Drugs dispensed by a Participating Pharmacy in the amounts specified in the Schedule of Benefits, as follows (copays may apply):

1. Covered drugs/supplies include: (a) Prescription Drugs which can be self-administered, (b) insulin, (c) disposable syringes/needles for the administration of covered Prescription Drugs and insulin, (d) lancets, (e) glucose test strips, (f) spacer devices for use with metered-dose inhalers, (g) peak flow meters, (h) other drugs/supplies which may be specifically designated by First Priority Health, (i) the covered pharmaceutical services necessary to make such drugs available, not including, however, any drug or group of drugs specifically excluded in this benefits booklet and (j) oral contraceptives, injectibles, transdermals (patches) and contraceptive devices, including the insertion and implantation of those devices.

2. a. Each Prescription Drug is limited to a thirty (30) day supply based on the Prescriber’s directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature and/or quantity limits allowed by the Plan.

   b. Each Maintenance Prescription Drug is limited to a ninety (90) day supply based on the Prescriber’s directions for use and further subject to the quantity limits authorized by the Prescriber on the Prescription order, maximum daily dosages as indicated in the drug information literature and/or quantity limits allowed by the Plan.

3. Prescriptions are refillable for a period not in excess of one (1) year from the date written and further subject to refill limitations as set forth in federal and/or state law or by the Prescriber.

4. Unless the Prescriber or Pharmacist has requested and received Prior Authorization for an early refill, the claim will be denied if a refill is requested before the time seventy-five (75) percent of the days’ supply of medication has passed. An early refill Prior Authorization can be granted for an additional supply for reasons such as vacation or business travel. A Participating Pharmacy may receive authorization by telephone to fill the prescription early on a one-time-only basis any time before the next regular refill due-date.

5. In order to receive benefits, the Member Child’s Parent or Guardian must present the First Priority Health Identification Card to a Participating Pharmacy and the claim must be filed by a Participating Pharmacy, except in special circumstances and such other situations as deemed appropriate by First Priority Health.

6. Special Circumstances - In special circumstances, such as when a Member Child needs an unexpected Prescription when beyond a reasonable distance from a Participating Pharmacy, while vacationing or traveling out of area, inaccessibility to a Participating Pharmacy, inaccessibility of the First Priority Health electronic claims/eligibility systems, or for urgent or emergency needs, the Member Child’s Parent or Guardian may request reimbursement for purchased Prescriptions from First Priority Health. Reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for the Generic Equivalent Drug. If there is no Generic Equivalent Drug, reimbursement will not be in excess of the amount which would otherwise have been payable to a Participating Pharmacy for a Preferred Prescription Drug. Such requests are subject to a filing limit of one (1) year from the date of purchase.
7. All Prescription Drug claims are subject to prospective, concurrent and/or retrospective drug utilization review by health care professionals, and further may require Prior Authorization to determine if a Prescription Drug is Medically Necessary. Before prescribing the Prescription Drug, a Participating Prescriber will advise the Member Child’s Parent or Guardian if Prior Authorization is required. Should a Prescription Drug which requires Prior Authorization be presented to a Participating Pharmacy without Prior Authorization, the Participating Pharmacy will advise the Member Child’s Parent or Guardian that Prior Authorization is required for coverage of the Prescription Drug.

No benefits will be provided for a Prescription Drug by First Priority Health when the Member Child’s Parent or Guardian elects not to obtain or fails to obtain Prior Authorization or the Member Child’s Parent or Guardian seeks reimbursement for a Prescription Drug which is subsequently determined not to be Medically Necessary.

8. Women’s Preventive Services - Certain generic FDA-approved prescription contraceptives are covered for female Member Child with a prescription, in accordance with the Health Resources and Services Administration’s (HRSA) Women’s Preventive Services: Required Health Plan Coverage Guidelines.

If the Member Child is unable to use the covered products that are available at no cost share, the Member Child’s provider must submit a prior authorization addressing items such as why the covered products are insufficient as well as the covered products that were tried by the Member Child. A coverage determination will be made after receipt and review of this information. If the outcome results in an approval, the prior authorization will allow for the requested product to process at no cost share to the Member Child.

If the outcome results in a denial of “no cost share” coverage, or if a prior authorization is not requested the tier 3 copayment will be assessed for coverage of a Non-Preferred Prescription Drug for requests for such branded products that do not have generic equivalents.
Section VI

A. PAYING FOR CHIP COVERAGE

CHIP is a program for which state and federal funds are available. For many families, CHIP is free, including American Indians and Alaskan Natives. Families with higher incomes that do not qualify them for Free CHIP are responsible for monthly premiums.

1. PAYMENT DUE DATES

Premiums must be paid on or before the 15th of each month for members enrolled in Low-Cost or Full-Cost CHIP. Premiums must be received on or before the 15th of the month in which they are due. If the 15th of a month falls on a weekend or holiday, the premium must be received on the next business day after the 15th.

We strongly recommend that you mail your child’s premium payment on or before the 10th of each month.

2. PAYMENT OPTIONS

After your child is enrolled, you may elect to pay your premium monthly, quarterly, semi-annually or annually. Payments may be made by personal check or money order. You must remit your child’s payment with the invoice slip provided, and you should note your child’s account number on the “note” line of your check or money order. Send your payment to:

First Priority Health CHIP
19 North Main St. Wilkes Barre, PA 18711

3. LATE PAYMENTS

If your child has Low-Cost or Full-Cost CHIP and you fail to make timely payments of your premium, your child’s coverage may terminate at the end of the last month for which payment was made. After 31 days of delinquency, the member’s account will be cancelled retroactively to the end of the last month for which the premium was due. Once delinquent, we require two months’ payment of premium to reinstate the account and another months’ payment for the upcoming month, for a total of three months’ payment.

Any and all claims for service incurred after the cancellation date will become the member’s responsibility.

4. PREMIUM INCREASES

The monthly amount may be adjusted in the event of a rate change. Members will be notified of any change to the monthly premium due at least 30 days in advance of the change.

5. RECEIVING A BILL FOR SERVICES

If your child uses participating providers in the networks servicing CHIP members and receives care for covered services under CHIP, you should not receive a bill for any portion of the charges.

If you receive a bill for a service, check it over carefully. Sometimes bills do not include correct insurance information and/ or some might have been filed incorrectly. Make sure your child’s
member identification number is correct (found on your child’s identification card). Correct the spelling of the patient’s name that appears on the bill, if necessary. If you feel you have received a bill in error, please contact the appropriate company to see if they received a claim for the service in question. A Member Service representative will investigate the claim for you, answer any questions you may have about it, and keep you informed of its status. The Member Service numbers are:

- **First Priority Health** 1-800-543-7199
- **Davis Vision** 1-800-999-5431
- **United Concordia** 1-800-332-0366

B. **HOW AND WHEN TO FILE A CLAIM**

A claim is an itemized statement of costs for health care services and/or supplies provided by a facility, doctor or other health care provider.

1. **Copayments**
   
   With the Low-Cost and Full-Cost CHIP Programs, copayments are required for some services. PCP, specialist and emergency room copayments are listed on your child’s ID card. Prescription drug copayments are listed on your child’s benefit summary. See the benefit summary for a complete list of your copayment responsibilities.

2. **First Priority Health claims**
   
   When your child receives services provided by a participating facility, doctor or other health care provider, the provider will send the claim directly to us. We will process the claim according to your child’s benefits and pay the provider.

   However, if you should ever receive a claim directly from a participating provider and it is for an amount other than that for which you are responsible, please send the claim to:

   **First Priority Health Claims Department**
   19 North Main Street
   Wilkes-Barre, PA 18711-0302

   All claims must include the following:
   - Patient’s full name, date of birth and address
   - First Priority Health member ID number (as shown on patient’s ID card)
   - Date each service or supply was provided
   - A description and/or procedure code for each service
   - Diagnosis, illness or injury for each service
   - Amount charged for each service
   - Number of units for each service
   - Name and address of provider (on provider’s official bill or letterhead)
   - Location where services were provided, if other than the doctor’s office

   Certain services require additional information, such as medical notes from the provider, payment or rejection notices from other insurance carriers (including Workers’ Compensation, other health plans, Medicare, auto insurance, etc.), origin and destination points for ambulance transfers or accident information. Delays in submitting this special information, when required, may result in a claim processing delay.
Claims must be sent to us within one year from the date the service was rendered in order to be considered for payment.

First Priority Health will notify you of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. We may extend this period for up to 15 days, one time only, provided we determine that an extension is necessary due to matters beyond our control. If an extension is necessary, we will notify you, before the end of the initial 30-day period, of both the circumstances requiring the extension of time and the date when First Priority Health expects to make a decision.

If the extension is needed because you did not send the information necessary to decide the claim, the notice of extension must specifically describe the required information. You will be given at least 45 days from receipt of the notice to provide the specified information.

3. **Dental or vision claims**
   Your child may receive services from an out-of-network provider, although you will receive the maximum benefit level if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then send a claim for reimbursement to the appropriate address:

   **Dental claims:**
   Dental Claims  
   P.O. Box 69421  
   Harrisburg, PA 17106-9421

   To request a dental claim form, visit the United Concordia website at www.UCCI.com or call 1.800.332.0366.

   **Vision claims:**
   Vision Care Processing Unit  
   P.O. Box 1525  
   Latham, NY 12110
Section VII

A. YOUR RIGHTS AND RESPONSIBILITIES FOR YOUR CHILD’S CARE

1. Member Rights

As the parent or guardian of a CHIP member, you have the right to:

- Receive information about your child’s rights and responsibilities
- Receive information about all the benefits, services and programs offered by CHIP, brought to you by First Priority Health
- Know about policies that can affect your child’s membership
- Basic information about doctors and other providers who participate with First Priority Health
- Choose from First Priority Health’s network of participating providers and to refuse care from specific doctors
- Request a specialist to serve as your child’s primary care provider, if your child has certain special medical needs or diagnoses
- Be treated with respect and due consideration for your child’s dignity and privacy
- Expect that information you provide to First Priority Health and anything you, or your child, discuss with your child’s doctor will be treated confidentially, and will not be released to others without your permission
- Have all records pertaining to your child’s medical care treated as confidential unless sharing them is required to make coverage decisions or is otherwise required by law
- See your child’s medical records, unless access is specifically restricted by reason of law or by the attending physician for medical reasons, to keep copies for yourself and to ask to have corrections made, if needed
- Receive clear and complete information from your child’s doctor about your child’s health condition and treatment, including what choices you have and what risks are involved
- Receive information about available treatment options and alternatives, regardless of cost or benefit coverage
- Be a part of any decisions made about your child’s health
- Refuse to have your child receive any drugs, treatment or other procedure offered by First Priority Health or its providers, to the extent permitted by law
- Be informed by a physician about what may happen if drugs, treatments or procedures are refused
- Refuse to allow your child to participate in medical research projects
- Give informed consent before the start of any procedure or treatment
- Ensure your child receives timely care in the case of an emergency
- Question decisions made by First Priority Health or its participating providers, and to file a complaint or grievance regarding any medical or administrative decisions you disagree with
- Make recommendations regarding First Priority Health’s members’ Rights and Responsibilities policy
- Exercise your rights without adversely affecting the way First Priority Health, its providers and state agencies may treat you
2. Member Responsibilities

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

- Understand how CHIP, brought to you by First Priority Health, 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 health care services appropriately
- Inform First Priority Health 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 becomes covered under
- Supply up-to-date medical information to First Priority Health and its providers so they can provide your child 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
- Contact First Priority Health if your child is admitted to the hospital or in an emergency room, within 24 hours or as soon as possible;
- Use your child’s member ID card to access care
- Pay any applicable fees
Section VIII

A. ENSURING THAT YOUR CHILD RECEIVES QUALITY CARE

1. Complaint and Grievance Procedure

At First Priority Health, we do everything possible to ensure your child receives quality health care and outstanding service. Occasionally, however, a child’s parent may want to share a concern with us. Our complaint and grievance procedures assure that you receive fair and confidential treatment. A complaint is a dispute or objection regarding a participating provider; a coverage issue, including contract exclusions, limitations and non-covered benefits; and the operations and management policies of First Priority Health. A grievance is a request for a review of the denial of a health care service based on medical necessity and appropriateness.

If you have a concern, we suggest you call a First Priority Health Service Representative to see if the issue can be resolved informally. If the issue cannot be resolved to your satisfaction, the procedure to file a complaint or grievance is in your child’s First Priority Health benefits booklet enclosed with this Member Handbook. There you will find an explanation of how you can file a complaint or grievance, your right to appeal a decision and how to designate a representative to help you. All disputes involving denial of payment for a health care service will be made by qualified personnel with experience in the same or similar scope of practice, and all notices of decisions will include information about the basis for the determination.

The procedure for filing a complaint or grievance regarding dental or vision benefits is in your child’s dental or vision benefits booklet.

If you have questions about the procedure for filing a complaint or grievance, see your child’s benefits booklet, or if we can help, please call our First Priority Health Service Representatives at 1.800.543.7199 or (TTY) 1.800.413.1112, weekdays, between 8 a.m. and 5 p.m.

2. New Technology

Whenever there are advances in health care, such as new treatment techniques, medication or medical equipment, First Priority Health has a process for reviewing each new option for safety and effectiveness. We work with a nationally recognized, independent organization that specializes in reviewing and evaluating new medical technology. The organization asks the following questions in each review:

- Is the technology approved by the appropriate governmental regulatory agency?
- Is there scientific proof that this technology is likely to be effective?
- Does this technology work as well as or better than current treatment?
- Does scientific research show the effect of this technology on health outcomes?
- Does this technology improve health outcomes outside research settings?

After the organization reviews new medical technology, it gives a report that is evaluated by a committee of First Priority Health participating doctors. The committee meets several times a year to consider the quality of each review, how much research was done and the medical value of the new technology.

3. Utilization Management (Review)

Blue Cross of Northeastern Pennsylvania reviews your child’s care to be sure it is medically necessary and appropriate before, during and/or after receiving care. This ensures that your child receives quality care in the most appropriate setting.

Our staff, who review your child’s care and make the decision to approve or deny coverage, are professionals with unrestricted licenses in their fields from the Commonwealth of Pennsylvania. Only a licensed doctor can make the decision to deny payment for any services. Decisions are based on
appropriateness of care and service and if your child has coverage for the service. Blue Cross of Northeastern Pennsylvania does not reward anyone or offer financial incentives for denying any coverage for care or services.

All decisions to approve or deny coverage will be shared with you in writing. If we do not cover your child’s care, we will tell you the reason and clinical rationale for the decision.

Blue Cross of Northeastern Pennsylvania will keep written records of all denials for at least 7 years. And it is important to note that, when we ask for information about your child from a health care provider, proper ID is always provided to keep all information confidential.

If you have questions about the utilization management process, call the Utilization Management department at 1.800.962.5353 or (TTY) 1.888.444.7018 weekdays, between 8 a.m. and 5 p.m.

For utilization management questions related to behavioral health/substance abuse, call 1.800.599.2428, or for TTY, use the Pennsylvania Relay 7–1–1 Service. Language assistance is also available to discuss the utilization management process at the telephone numbers listed above.

**The Utilization Management Department Provides Prior Authorization/Precertification**

(prospective utilization review)

Before your child receives care or is admitted to a facility, we review the doctor’s plan for care and decide to approve or deny payment for the health care service. This review looks at how appropriate the care is and if the facility is the right place to have the service, based on nationally recognized and/or our corporate guidelines. If we approve coverage, the approval still does not guarantee we will pay for the services. Payment is based on specific benefits and eligibility at the time of the service.

**Admission Certification**

If your child is admitted to a hospital or facility, we review the services received, based on nationally recognized criteria. This makes sure your child receives care in the most appropriate setting.

**Concurrent Utilization Review**

When your child is admitted to a hospital or has an ongoing course of treatment, we review his/her care during the treatment, based on the ongoing treatment plan. We then decide to approve or deny payment for the health care service. This ensures that your child’s treatment is medically necessary and/or provided in the most appropriate setting.

**Retrospective Utilization Review**

This is a review of care after your child receives it to decide if we will approve or deny payment for the health care service.

**Discharge Planning**

Starting on the first day of an inpatient admission to a facility or hospital, we help the facility to develop a discharge plan. The professional reviewer may also refer your child’s case for follow-up and assistance.
4. Business Matters

Who Is Covered?
The child named on the ID card is covered by CHIP. Coverage is provided by First Priority Health. Only the child named on the card is eligible to receive the benefits of this program.

Eligibility
Your child must meet the following requirements to be enrolled in CHIP. He/she:

• Must live within Blue Cross of Northeastern Pennsylvania’s 13-county service area.
• Must continue to meet all income requirements
• Must not be covered by any health insurance plan, self-insured plan or self-funded plan and/or not be eligible for or covered by Medical Assistance offered through the Department of Human Services
• Must be under age 19
• Must meet the citizenship requirements according to federal guidelines

Note: Depending on income levels, children may be eligible for either Free, Low-Cost or Full-Cost insurance. If eligible for Low-Cost or Full-Cost insurance, families will be required to pay a monthly premium and copayments for their children’s health insurance.

How Long Is My Child Covered?
Your child is covered for 12 calendar months, beginning with the first calendar month in which coverage is effective. Then we review your child’s eligibility for renewal each year.

What Is Renewal?
We will periodically review your child’s eligibility for health care coverage in the CHIP program. This is known as “renewal.” Renewal will occur each year on the anniversary of the date your child was originally enrolled in CHIP.

Each year, 90 days before your child’s anniversary date, we will send you a renewal form to complete and mail back to us. We must get this form before the anniversary date or your child’s insurance will be canceled.

CHIP Low-Cost and Full-Cost Premium and Payment Information
If the family of a child enrolled in Low-Cost or Full-Cost CHIP does not make payment under the CHIP agreement by the due date, coverage will automatically end on the last day of the month for which payment has been made.

Confidentiality and Privacy
As part of our normal business operations, we will have access to member records that contain private information. We will use this information to provide benefits, to ensure and improve quality and to identify health care needs. Keeping this information confidential is very important. We have implemented policies and procedures to ensure the confidentiality of member information and records. Information in medical records and received from doctors, other network health care practitioners, hospitals or health professionals instrumental in the doctor/patient relationship will be kept confidential. The information may be released for use for bona fide medical research and education, as required by law or to compile aggregate statistical data. Any additional release of information, outside of treatment, payment or health care operations, requires your authorization.

We have implemented a Statement of Corporate Ethics and Code of Business Conduct that is distributed yearly to our employees to address the confidentiality of all member information. Additionally, all employees receive yearly HIPAA Privacy and Security training and are required to confirm their understanding of the importance of safeguarding member information.

Finally, in accordance with HIPAA, we have implemented a number of physical, administrative and technical safeguards for protection of our members’ oral, written and electronic protected health information. This includes, but is not limited to:
• The securing of all physical facilities
• The securing of the systems that maintain member information
• The execution of confidentiality and business associate agreements with vendors that we may share member information with
• Encryption of information sent electronically
• Verification procedures to ensure information is only released to individuals who have the authority to receive member information
Section IX

A. YOUR CHILD’S CHIP VISION BENEFITS

Vision care benefits are provided through the vision care administrator, Davis Vision. A Davis Vision Participating Professional Provider (“Participating Professional Provider”) will accept the allowance as payment in full for Covered Services. Present your Child’s First Priority Health Identification Card to the Participating Professional Provider at the time services are provided.

The Participating Professional Provider will handle all the paperwork for your Child and payment will be made directly to the Participating Professional Provider. You are not responsible for any portion of the bill.

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.

Please note: Benefits include routine eye examinations, spectacle lenses (or contact lenses, when medically necessary).

If you choose to go to a Provider who does not participate with Davis Vision, you will be responsible for paying any difference between the allowance for Covered Services and the Non-Participating Provider’s charge.

A list of participating Davis Vision Participating Providers in your area is included in your participating provider directory. Since the participating status of providers can change over the course of time,

BEFORE SCHEDULING AN APPOINTMENT, ASK THE DOCTOR OR STAFF, “ARE YOU A PARTICIPATING DAVIS VISION PROVIDER?”

1. Vision Care Benefits

Your Child is entitled to the following services rendered by a Participating Optician, Optometrist, and/or Ophthalmologist, subject to Exclusions and What Is Not Covered.

a. Eye Examination and Refractive Services
   1) Case history;
   2) Visual acuity, near and far;
   3) External examination, including biomicroscopy or other magnified evaluation of the anterior chamber;
   4) Objective, subjective and ophthalmoscopic examinations;
   5) Binocular measure; and
   6) Summary, findings and recommendations

b. Post-Refractive Services
   Post-Refractive Services consist of one set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch
resistance coating and low vision items. The plan also provides a listing of optional types of lenses that involve copays. See list below;

<table>
<thead>
<tr>
<th>Lenses</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultraviolet Protective Coating</td>
<td>No Copay</td>
</tr>
<tr>
<td>Polycarbonate Lenses (if not child, monocular or prescription +/-6.00 diopters)</td>
<td>$30</td>
</tr>
<tr>
<td>Blended Segment Lenses</td>
<td>$20</td>
</tr>
<tr>
<td>Intermediate Vision Lenses</td>
<td>$30</td>
</tr>
<tr>
<td>Standard Progressives</td>
<td>$50</td>
</tr>
<tr>
<td>Premium Progressives (Varilux®, etc.)</td>
<td>$90</td>
</tr>
<tr>
<td>Photochromic Glass Lenses</td>
<td>$20</td>
</tr>
<tr>
<td>Plastic Photosensitive Lenses (Transitions)</td>
<td>$65</td>
</tr>
<tr>
<td>Polarized Lenses</td>
<td>$75</td>
</tr>
<tr>
<td>Standard Anti-Reflective (AR) Coating</td>
<td>$35</td>
</tr>
<tr>
<td>Premium AR Coating</td>
<td>$48</td>
</tr>
<tr>
<td>Ultra AR Coating</td>
<td>$60</td>
</tr>
<tr>
<td>Hi-Index Lenses</td>
<td>$55</td>
</tr>
</tbody>
</table>

Facial measurements, lenticular formula, any other specifications, cost of the materials, verification of the completed prescription upon return from the laboratory, adjustment of the completed eyeglasses to the Child's face and the subsequent servicing (e.g., refitting, readjusting, tightening) for a period not to exceed 90 days.

2. **Vision Care Benefits are limited as follows:**

a. Payment for any eye examination and refraction is limited to one routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No Cost to member in network. Out-of-Network – no coverage.

b. Payment for spectacle lenses (or contact lenses when medically necessary) is limited to once every six months for each Member Child. Eligibility will be determined from the date of the last previous refraction.

c. Frequency of lens and frame replacement: One pair of eyeglasses every 12 months-calendar year, when medically necessary for vision correction.


e. Frames: Collection Frame – no cost to member**. Non-collection frame: Expenses in excess of $130 allowance payable by member Additionally, a 20% discount applies to any amount over $130**. Out-of-network – No coverage.*

f. In cases involving services in which the provider and the Member Child or the Member Child’s family elect to utilize light-sensitive lenses, the program will provide benefits, but will not provide any additional allowance in excess of those delineated in the Benefits Booklet, provided the Member Child qualifies for such benefits.

g. Payment for frames and spectacle lenses not supplied by a Participating Professional Provider will be made only if prescribed by a professional provider and in such case will be made to the Member Child or the Member Child’s family.

h. Contact Lenses: One prescription every year – in lieu of eyeglasses, when medically necessary for vision correction.
Expenses in excess of a $130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount 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. Should this occur 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).

Out of Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g. vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.

**Note: Additional discounts may be available from participating providers.

Expenses in excess of $600 for medically necessary contact lenses, with prior-authorization. These medically necessary 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.

i. Davis will repair or replace lost, stolen, broken frames and lenses, (one original and one replacement per calendar year, when deemed medically necessary).

j. 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-powered 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.

3. **What is Not Covered**

In addition to Exclusions, no vision care benefits will be paid for services, supplies or changes for:

a. Examinations or materials, which are not listed as Covered Services or items of supply;

b. Any spectacle lenses which do not require a prescription;

c. The cost of any insurance premiums indemnifying the Member Child against losses for spectacle lenses, frame, or contact lenses;

d. Industrial safety glasses and safety goggles;

e. Medical or surgical treatment of the eye;

f. Diagnostic services, such as diagnostic X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;

g. Drugs or any other medications;

h. Procedures determined by the Plan to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, and tonography; and

i. Eye examinations or materials necessitated by the Member Child’s employment or furnished as a condition of employment.
B. **Your Child’s CHIP Dental Benefits**

A Member Child who has CHIP covered dental benefits provided by a United Concordia (UCD) CHIP Participating Provider will have no out of pocket costs. A Member Child can, however receive dental benefits from any dentist. If the Member Child chooses to go to a dentist who is not a CHIP Participating Provider, the Member Child will be responsible for paying the difference between the Non-Participating dentist’s charge and the allowance for covered services.

Present your child’s UCD identification card to the participating dentist at the time services are provided.

The participating dentist will handle all the paperwork for you and United Concordia will send the payment directly to the participating dentist. The participating dentist will accept UCD’s allowance as payment in full for covered services.

**A list of participating dentists in your area is included in your participating provider directory.** Since the participating status of providers can change over the course of time, **BEFORE SCHEDULING AN APPOINTMENT, ASK THE DOCTOR OR STAFF, “ARE YOU A PARTICIPATING PROVIDER?”**

1. **Dental Care Benefits**

Your Child is entitled to the following services rendered by a Dentist subject to Exclusions, listed in Section IX and What Is Not Covered, listed in this Section.

**a. Diagnostic Services**

1) Routine oral examinations, but not more than once in any period of 6 consecutive months.

2) Dental X-rays:
   i. Full-mouth X-rays, 1 in 3 years
   ii. Bitewing X-rays, but not more than one per 6 months

3) Routine prophylaxis (including removal of plaque, calculus and stains) – once every 6 months, with the exception of a Member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy.

4) Topical fluoride application, but not more than 2 every 12 months

5) Space maintainers for premature loss of primary posterior molars or permanent first molars

6) Sealants for Children under age 19 years on permanent molars, 1 per 3 year period.

**b. Minor Restorations**

1) Amalgam (silver) and resin based composite (white) restorations for all permanent teeth and deciduous teeth.

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

3) Resin, porcelain and full cast single crowns are eligible for permanent teeth; replacement is limited to once in a five-year period when the crown is not serviceable and cannot be made serviceable. Payment will be made for a single crown only if the tooth cannot be restored with another material such as amalgam. If the tooth can be restored with another material, an allowance will be made for an alternate material. A preoperative X-ray is required for review prior to approval; crowns are reviewed for necessity and prognosis; alternative benefits such as a basic restoration are applicable.

c. General Services

1) Palliative emergency treatment of an acute condition requiring immediate care.

2) Simple extractions.

3) Surgical extractions – surgical removal of an erupted tooth requiring elevation of micoperiosteal flap and removal of bone and section of tooth (not related to removal of wisdom teeth.).

4) Pulpotomies for deciduous teeth.

5) Endodontic (Root Canal) Therapy for permanent teeth

6) Periodontics (non-surgical and surgical treatment of diseases of the gums and bone supporting the teeth)
   Scaling and root planing - one per quadrant per 24 months.
   Periodontal maintenance (prophylaxis) – four in 12 months combined with adult prophylaxis after the completion of active periodontal therapy.
   Debridement (full mouth) to enable comprehensive evaluation and diagnosis – once per lifetime
   Occlusal Guard by report – 1 in 12 months for patients 13 and older
   Gingivectomy & Gingivoplasty – one per surgical area per every 36 months
   Osseous Surgery - one per surgical area per every 36 months
   Guided Tissue Regeneration – once per site per lifetime
   Soft Tissue Grafts – once per 36 months
   Gingival Flap Procedures - – one per surgical area per every 36 months
   Distal or Proximal Wedge (when not performed in conjunction with surgical procedures in same anatomical region – one per surgical area per 36 months.
   Crown Lengthening.
   Implantology and related services – 1 per tooth in 60 months
   Pulpal Therapy – one per tooth per 2 year limit
   Dentures – One per 5 year period limit
   Partial Dentures - One per 5 year period limit

7) Administration of anesthesia including intravenous sedation in conjunction with a Covered Service when rendered by the operating surgeon/Dentist, assistant surgeon or attending Dentist.

8) Consultations, limited to one consultation per consultant during any one period of hospitalization when your Child is an Inpatient and the dental condition requires such consultation.
2. **Dental Care Benefits are further limited as follows:**

   a. If a Member Child transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist performs Covered Services for one dental procedure, UCCI shall be liable for not more than the amount that it would have been liable for had but one Dentist performed the Covered Service.

   b. In all cases involving Covered Services in which the Dentist and a Member Child or the Member Child’s Parents select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this benefit will be based on the charge allowance for the lesser procedure.

   c. A contract between a Member Child or the Member Child’s Parents, and Dentist, prior to the effective date of coverage is not invalidated by a subsequent agreement made between UCCI and/or the Member Child or the Member Child’s Parents and/or Dentist. The Member Child or the Member Child’s Parents will be liable for any difference due to the Dentist after the UCCI liability has been satisfied.

   d. Any additional treatment that is necessitated by lack of Member Child’s or Member Child’s Parents cooperation with the Dentist or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member Child or the Member Child’s Parents.

3. **What is Not Covered**

   In addition to the Exclusions, the following also apply:

   a. Labial veneers and laminates done for cosmetic purposes;

   b. Duplicate and temporary devices, appliances, and services;

   c. Plaque control programs and for oral hygiene and dietary instruction;

   d. Alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth;

   e. Local anesthesia when billed for separately by a Dentist;

   f. Gold foil restorations;

   g. Services submitted by another Professional Provider and Dentist, which is the same services performed on the same dates for the same patient;

   h. Prosthetics; and

   i. Orthodontics other than that determined to meet medically necessary criteria.
C. **EXCLUSIONS—DENTAL AND VISION**

1. For any illness or injury suffered after the Member Child’s Effective Date of coverage as a result of any act of war.

2. For charges to the extent payment has been made under Medicare or would have been made if the Member Child had applied for Medicare and claimed Medicare benefits.

3. For care conditions that state or local law requires to be treated in a public facility.

4. For personal convenience items or services such as barber services, guest meals, radio and television rentals, and other like items and services.

5. For special medical reports, unless directly related to treatment of a Member Child.

6. Payment for services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by state law.

7. For costs related to any court appearance, proceeding or hearing.

8. For charges for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers compensation, occupational disease or similar type legislation. This exclusion applies regardless of whether the Member Child claims the benefits or compensation.

9. Orthoptics (a technique of eye exercise designed to correct the visual axes of eyes not properly coordinated for binocular vision).

10. Services or supplies received from a dental or medical department established primarily for treatment or employees or members and maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

11. Charges Incurred prior to the member’s effective date or during an Inpatient admission that commenced prior to the Member Child’s effective date.

12. Charges Incurred after the date of termination of the Member Child’s coverage.

13. For telephone consultation, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

14. Charges for which the Member Child has no legal obligation to pay.

15. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary and Appropriate.

16. For any oral surgery.

17. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services.

18. For equipment costs related to services performed on high-cost technological equipment as defined by the Plan, such as, but not limited to, computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or the Plan.
19. For treatment or services for injuries resulting from the maintenance or use of motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

20. For local infiltration anesthetic.

21. For benefits paid or payable under another health plan or program; which are provided by a Federal Government Hospital or institution, except where otherwise required by law to provide benefits.

22. For any services which are not medically necessary or medically appropriate as determined by the Plan.

23. For services rendered by other than a facility, hospital or professional provider.
D. **GENERAL PROVISIONS – DENTAL AND VISION**

1. **Benefits to Which Member Children are Entitled:**
   a. The liability of the Plan is limited to the benefits provided.
   b. No person other than a Member Child is entitled to receive benefits. Such right to benefits and coverage is not transferable.
   c. Benefits for Covered Services will be provided only for services and supplies that are rendered by a Professional Provider specified in the Definitions Section herein and regularly included in such Professional Provider’s charges.

2. **Termination of Member Child Coverage:**
   a. When a Member Child ceases to be an Eligible Child, or the required payment is not made, the Member Child’s coverage will terminate at the end of the last month for which payment was made.
   b. Termination of coverage automatically terminates all the Member Child’s coverage. It is the responsibility of First Priority Health to notify, in writing, the Member Child of the termination of the coverage.
   c. The Member Child’s coverage may be terminated if it is proven that the Child’s Parents obtained or tried to obtain:
      1) Coverage by supplying materially incorrect or misleading enrollment eligibility information with respect to the Member Child; or
      2) Benefits on behalf of the Member child through material misrepresentation or fraud.
      First Priority Health will give the Parents written notice prior to terminating the Member Child’s coverage.

3. **Benefits after Termination of Coverage**
   a. If the Member Child is an Inpatient on the day coverage terminates, the benefits shall be provided:
      1) Until the maximum amount of benefits has been paid; or
      2) Until the Inpatient stay ends, whichever occurs first.

4. **Notice of Claim**
   a. The Plan will not be liable unless proper notice is furnished by a Provider of services to the Plan that Covered Services have been rendered to a Member Child. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for the Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered by a Provider of services.
   b. Failure to give notice to the Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Plan be required to accept notice more than 60 days after Covered Services are rendered.

5. **Release of Information**
   Any person or entity having information relating to an illness or injury for which benefits are claimed may furnish to the Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Plan may furnish similar information to other entities providing similar benefits at their request.
The Plan shall provide to First Priority Health, at First Priority Health’s request, any and all information regarding claims and charges submitted to the Plan by Providers. The Parties understand that any information provided to First Priority Health will be sanitized by the Plan to prevent the disclosure of the identity of any Member Child or other patient treated by said providers.

The Plan may also furnish other Plans or Plan-sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

6. Disclosure

The Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, (the “Association”) permitting the Plan to use the Blue Cross and Blue Shield Service Mark in the Service Area, and the Plan is not contracting as an agent of the Association. The Commonwealth, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this agreement based upon representations by any other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the Commonwealth for any of the Plan’s obligations to the Commonwealth. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

7. Limitations

No legal action may be taken to recover benefits within 30 days after Notice of Claim has been given as specified above, and no such action may be taken later than one year after the date Covered Services are rendered.

8. Payment of Benefits

1) The Plan is authorized by the Member Child or the Member Child’s Parents to make payments directly to Participating Professional Providers furnishing Covered Services for which benefits are provided. However, the Plan reserves the right to make the payments directly to the Member Child or the Member Child’s Parents.

The right of a Member Child to receive payment is not assignable, nor may benefits be transferred, either before or after Covered Services is rendered.

2) Once Covered Services are rendered by a Professional Provider, the Plan will not honor requests from the Member Child or the Member Child’s Parents not to pay the claims submitted by the Professional Provider. The Plan will have no liability to any person because of its rejection of the request.

9. Member Child/Provider Relationship

1) The choice of a Professional Provider is solely that of the Member Child or the Member Child’s Parents.

2) The Plan does not furnish Covered Services, but only makes payment for Covered Services received by Member Children. The Plan is not liable for any act or omission of any Professional Provider. The Plan has no responsibility for a Professional Provider’s failure or refusal to render Covered Services to a Member Child.

3) The use or non-use of an adjective such as Participating or Non-Participating in modifying any Professional Provider is not a statement as to the ability of the Professional Provider.

10. Identification Cards

UCCI and First Priority Health will provide identification cards to Member Children.

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11. Notice

Any notice required must be in writing. Notice given to a Member Child will be sent to the Member Child’s address as it appears on the Records of the Plan or in care of First Priority Health. First Priority Health, the Plan, a Member Child or the Member Child’s Parents may, by written notice, indicate a new address for giving notice.

12. Facility of Payment

Whenever payments should have been made in accordance with these provisions, but the payments have been made under any other Plan, a Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid and to the extent of the payments for Covered Services; the Plan shall be fully discharged from liability.

13. Right of Recovery

1) Whenever payments have been made by a Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan shall have the right to recover the excess from among the following, as the Plan shall determine any person to or for whom such payments were made, any insurance company, or any other organization.

2) The Member Child or the Member Child’s Parents, personally and on behalf of family members, shall, upon request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the Plan’s rights to recover the excess payments.

14. Subrogation

1) To the extent that benefits for Covered Services are provided or paid, the Plan shall be subrogated and succeed to any rights of recovery of a Member Child for expenses Incurred against any person or organization except insurers on policies of health insurance issued to and in the name of the Member Child or where specifically prohibited by law.

2) The Member Child or the Member Child’s Parents shall pay the Plan all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid, to the extent permitted by law.

3) The Member Child or the Member Child’s Parents shall take such action, furnish such information and assistance, and execute such papers as the Plan may reasonably require to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interests of the Plan.

15. Participating and Non-Participating Professional Provider Reimbursement

1) Participating Professional Provider: Benefit amounts, as specified in the Schedule of Benefits, refer to Covered Services rendered by a Participating Professional Provider which are regularly included in such Professional Provider’s charges and are billed by and payable to such Professional Provider.

2) Non-Participating Professional Provider: The allowance for Covered Services rendered by a Non-Participating Professional Provider which are regularly included in such Provider’s charges and are billed by and payable to such provider is the same as for a Participating Professional Provider.

3) When Covered Services are performed by a Non-Participating Professional Provider, the Plan reserves the right to make payment to the Member Child. Any difference between the Non-Participating Professional Provider’s charge and the Plan payment shall be the personal responsibility of the Member Child or the Member Child’s Parents.
16. **Service Benefits Provision**

Service benefits apply to Member Children who meet the eligibility requirements for this program and utilize Participating Professional Providers. Participating Professional Providers have agreed to accept the Provider’s Reasonable Allowance as payment in full for Covered Services, except in the case of certain Deductibles, Co-insurance, Copayment or amounts exceeding the maximum. Such Deductibles and Co-insurance amounts must be paid to the Participating Professional Provider by the Member Child within 60 days of the date in which the Plan finalizes such services.

17. **Out-of-State-Benefits**

When Covered Services are rendered outside of Pennsylvania by a Professional Provider, the Plan reserves the right to determine a reasonable fee for such Covered Services.

18. **Limitations of Plan Liability**

The Plan shall not be liable for injuries or damage resulting from acts or omissions of any Plan officer or employee or of any Professional Provider or other person furnishing services or supplies to the Member Child; nor shall the Plan be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

19. **Termination by Incorrect Information or Misrepresentation**

As a material inducement for the issuance of coverage, it is represented by the applicant that all statements made and information shown in the application are true and complete, and are correctly recorded and noted in the Application. Any misrepresentation therein is material to the risk, and will, at the option of the Plan and subject to the paragraph below, render the coverage void from inception, and will forfeit any charges theretofore paid to the extent of any liability Incurred by the Plan.

After two years from the date of issue of the coverage, no misstatements, except fraudulent misstatements made by the Applicant in the application, shall be used to void the coverage, or to deny benefits for a claim Incurred commencing after the expiration of such two-year period.

20. **Termination of Participating Hospital or Participating Facility Provider Contracts**

A contract between the Plan and a Participating Facility Provider may be terminated, without notice to the Member Child, in accordance with the provision thereof. In the event of such termination, benefits shall be provided in accordance with the terms so specified.

21. **Determination of Service**

The Plan’s determination of the benefit provisions applicable for services rendered to a Member Child hereunder shall be conclusive.

22. **Benefits from Another Plan**

If any benefits to which a Member Child is entitled are also provided in full or in part by another agreement issued by another Blue Cross or Blue Shield Plan, or any private or government group or individual health care plan or program, coverage shall be automatically void with respect to such Member Child and without effect beginning on the date his/her coverage became effective.

23. **Complaint and Grievance Procedure**

For dental services, the Member Child will receive a written notice concerning these services called an Explanation of Benefits (EOB). The EOB for dental services will be provided separately by United Concordia. If you have questions or concerns on these services or if a service is rejected and you disagree, please call the number on the EOB for further clarification and resolution of the concern or question.
For vision services, the Member Child will receive a written notice concerning these services called an Explanation of Benefits (EOB). The EOB for vision services will be provided separately by Davis Vision. If you have questions or concerns on these services or if a service is rejected and you disagree, please call the number on the EOB for further clarification and resolution of the concern or question.

If you have done this and still disagree with the decision regarding the service, you have the right to appeal. If you wish to appeal a claim decision, please send or call your appeal to the following:

**First Priority Health**

19 North Main Street  
Wilkes-Barre, PA 18711  
1-800-543-7199

Please have your Member Child’s EOB or other information with you when you call or send copies along with a written appeal.

If you believe that your child may suffer serious medical consequences within the next seven to 10 days because of a denial of coverage for certain services, please do the following:

- Request an expedited (faster) review.
- Include your concerns and your expedited review with your appeal letter or phone call.
- Refer to Section IX, subsection 23 for more detailed Complaint and Grievance Procedures.

The Pennsylvania Insurance Department oversees the CHIP program. If you have filed an appeal and feel your appeal is not being treated adequately, you may contact them at the following address:

Pennsylvania Insurance Department  
Bureau of Consumer Services  
1321 Strawberry Square  
Harrisburg, PA 17120