# Member Handbook

## KidzPartners

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

Health Partners Plans

# About CHIP

CHIP is the Children's Health Insurance Program. Funded by the Commonwealth of Pennsylvania and the federal government, CHIP provides important health benefits to children who do not have other health insurance coverage and who are ineligible to receive Medical Assistance in Pennsylvania.

Children who meet CHIP eligibility guidelines may receive CHIP health care benefits through KidzPartners.

# WELCOME

Welcome to KidzPartners, the Pennsylvania Children's Health Insurance Program (CHIP) from Health Partners Plans.

We want to be sure you get the most from your children's health coverage. This Member Handbook will help you understand all of the benefits, services and programs your children can use as KidzPartners members.

KidzPartners makes it very easy for you to get health care and services. If you ever have questions about your coverage or the care you are receiving, just call our Member Relations department at 1-888-888-1211. We're here 24 hours a day, seven days a week to help you!

No matter what language you speak, we can help. Through a special service, you have access to over 140 different languages to speak to us. Just call Member Relations for help.

If you are hearing impaired and are calling from a TTY phone, please call 711.

If you need help reading the information contained in this Member Handbook, please call us at the numbers above.

You may also visit our website at HealthPartnersPlans.com for more information about using KidzPartners to help keep your children healthy.

1-888-888-1211 (TTY 711)

# TABLE OF CONTENTS

# 1. GETTING STARTED

## Health Partners Plans and KidzPartners Basics

Health Partners Plans is the health plan that puts your needs first. We have been serving Delaware Valley families since 1985. We give you the healthcare benefits you need for you and your family, and the quality service you expect, all delivered with the respect you deserve. We work hard to earn your trust — and over the years, our members have told us they think we do a very good job.

Our KidzPartners program brings you all the benefits and services provided by Pennsylvania's Children's Health Insurance Program (CHIP), plus the excellence in customer service that our members have come to depend on. We are committed to constantly earning the trust you have placed in KidzPartners.

## Health Partners Plans' Pledge to Give You the Medical Care You Need

At Health Partners Plans, we want to keep your children healthy. That's why we pledge to give you the care you need, when you need it. Health Partners Plans does not directly or indirectly give financial rewards or incentives (a gift or something else that will make someone want to do something) to doctors or staff to limit or deny approvals for care. In this way Health Partners Plans makes sure that you get the care that is best for your children's medical needs.

## Quality Management Program

Health Partners Plans has a program to monitor and improve the care your children get as KidzPartners members. This includes the care your children receive from our participating providers, as well as our service to you. If you would like to know more about our Quality Management program, please call Member Relations at 1-888-888-1211 (TTY 711).

## Healthier YOU Programs

These programs help you manage your health care needs. We send out educational information concerning specific diseases and age-appropriate preventive screenings. In addition, care managers are available to work with your doctor and you to ensure you get the care you need.

Programs include:

- Asthma
- Diabetes
- Fit Kids (weight management)
- Baby Partners, our maternity care program (see page 20)

For more information about these programs, please call our Healthier YOU Helpline at 1-866-500-4571 (TTY 711) or visit our website at HealthPartnersPlans.com.

## Definition of Managed Care

At Health Partners Plans, we think of managed care as going back to the basics. This means that you pick a provider. Your children's personal doctor (or other health care professional) is known as a PCP, or primary care provider. Your children's PCP will keep all medical records, have their medical history and help you coordinate all their health care. It's that simple.

Remember, prevention is important in staying healthy. That means your children should get all the shots, regular checkups and screenings they need. This helps to prevent sickness and to keep everyone healthy. With KidzPartners, your children are covered for important well-child and preventive services, not just when they're sick. See "Well-Child Visits" in Section 5 for more about recommended preventive care.

## Membership ID Card

Your membership ID card lets everyone know that your children are KidzPartners members. The name and telephone number of their primary care provider (PCP) are on your card. Your card is important. You must show it when your children go for doctor and dentist visits, to get prescriptions filled and to get all other covered benefits and services. Do not let anyone else use your children's cards.

If you do not have your card, your children's provider can call us. We'll let him or her know that your children are KidzPartners members. If your card is ever lost or stolen, please call our Member Relations department at 1-888-888-1211 (TTY 711). Someone is available to help you 24 hours a day, seven days a week.

## Using KidzPartners Participating Providers for Your Children's Health Care Needs

As KidzPartners members, your children must use our participating providers — including doctors, hospitals and pharmacies — for all their health care (except for urgently needed care when you are out of the area, or for emergency care or family planning services). Our KidzPartners network of participating providers includes PCPs, specialists and many other types of health care providers.

We have carefully screened these doctors, hospitals and pharmacies to make sure they work together to give you the health care services that your children need. Your PCP will refer you to a participating specialist or hospital if needed. Remember, you can call your PCP at any time to follow up after a visit or hospital stay.

Your PCP is there to make sure your children get the medical care they need. He or she serves as your children's number one health care advocate and supports you in getting proper treatment and staying healthy.

Keep in mind that you must still use KidzPartners participating providers for the dental, vision and OB/GYN services. If you don't, we may not pay for these services and you may have to pay for them yourself.

If your children become sick when you are away from home and it is not an emergency, call your PCP. Your PCP will tell you what to do and if you need to seek care. If your PCP says your children need to see a doctor or other provider, KidzPartners will cover the visit, as long as it is for a covered service. Make sure you tell your children's PCP about any treatment that they receive when away from home. This way, your children's PCP can provide any needed follow-up care.

ALWAYS know that if it is an emergency, call 911 right away or go to the nearest emergency room.

## Choosing a Provider

When you enroll with KidzPartners, look in our KidzPartners Provider Directory and pick a PCP for each child in your family. You may also use the directory to find other participating providers, including specialists and ancillary providers.

If you need a copy of the directory, please contact Member Relations at 1-888-888-1211 (TTY 711). You can also use our online directory at HealthPartnersPlans.com to find participating providers. Both our print and online directories are marked to show which providers are accepting new patients.

You can select a PCP as part of your CHIP application process, or call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) to tell us the PCP you want. You can also call Member Relations for any help you need in choosing a PCP.

If we do not have your PCP selection, we will try to contact you. Ten days after your children's effective date, if you have not yet chosen a PCP, we will select one for you. We do this to be sure a doctor is ready to help when your children need care. If we assign a PCP, you can still choose another provider. See "Changing Your PCP" on page 7 for more details.

## The Benefit of Having a PCP

Think of your children's PCP as your family doctor. He or she is your advocate, the person you can count on to support you and help your children get the health care services they need. Your PCP may refer your children to specialists and other providers, and will coordinate all of your children's health care.

## Your PCP Is Part of a Bigger Picture

Your KidzPartners PCP is part of a network of hospitals, specialists and other health care providers. He or she will help your children get the care they need from the hospitals or specialists that he or she works closely with. This helps you get more personal care.

Keep in mind that this may mean that your PCP will make referrals only to other providers in the same hospital system, or otherwise limit referrals to only certain providers within the KidzPartners network. If you want your children to receive care from specific specialists or other providers, please consider the PCP's referral patterns when selecting your children's PCP.

We are proud that many of our participating doctors are teachers in medical schools. Some offices have resident doctors who see and treat patients under the supervision of a senior doctor. A resident doctor is someone who has finished medical school and may be learning a specialty, like treating heart conditions or skin problems.

Some KidzPartners participating practices have special staff, such as medical residents, certified nurse practitioners and physician assistants to help care for your children. These special staff members are always supervised by doctors who are responsible for all of your children's medical care.

## For More Information about Your PCP

If you want more information about your children's PCP — such as training, education or experience — please contact KidzPartners Member Relations at 1-888-888-1211 (TTY 711). A Member Relations representative can help you with this information.

## Changing Your PCP

If you want to change your children's PCP for any reason, here's how to do it:

1. Look at the list of PCPs in your KidzPartners Provider Directory or on the KidzPartners section of the website (HealthPartnersPlans.com). If you need a directory, just let us know and we will send you one.
2 Choose a new PCP.
3. Call KidzPartners Member Relations anytime at 1-888-888-1211 (TTY 711).
4. Tell the Member Relations representative that you want to change your children's PCP.

The representative will ask for needed information, including your reason for the change. In most cases, the change will be effective on the first of the following month (or the first of the second following month, if you make your request late in the month). This provides time for your new PCP to be notified and prepared to provide care for your children. In cases of urgent medical needs, Health Partners Plans will make special arrangements to make this change sooner.

Your Member Relations representative will provide you with the date when your children will start with their new PCP. You can make an appointment to see your children's new PCP any time after that date. (Before this date, please call your children's current KidzPartners PCP if health care services are needed.)

## Continuity of Care

If your provider ever leaves the KidzPartners network, or if you are being treated by a non-KidzPartners participating provider when you join KidzPartners, Health Partners Plans is responsible for working with you to make sure that you will be able to keep getting the care that you need. This is called continuity of care. Health Partners Plans follows certain guidelines when providing continuity of care. Those guidelines are outlined below.

If you are a new KidzPartners member receiving ongoing treatment for a specific health problem from a provider not in the KidzPartners network, you have the right to ask to continue seeing that provider for 60 days up to 90 days after you become a KidzPartners member.

If you are a new KidzPartners member, Health Partners Plans will continue to provide the same services that you received under your previous health plan, whether they needed prior authorization (pre-approved) or not, for 60 days up to 90 days after you become a KidzPartners member. (If these services are to be provided by a non-participating provider, however, prior authorization must be obtained from Health PartnersPlans.) If your new PCP decides that you need the services beyond the 60 days, Health Partners Plans will require a medical review by a medical director to continue these services.

If you are a new KidzPartners member who is pregnant and you are already under the care of an OB/GYN doctor not in the KidzPartners network, you may continue to receive services from that specialist throughout your pregnancy and after you have your baby. You can also decide to change to an OB/GYN doctor who is in the KidzPartners network.

Note: In most cases, members who become pregnant will qualify for Medical Assistance, and will be transitioned from CHIP to a Medical Assistance plan by the Pennsylvania Department of Human Services/County Assistance Office. In this situation, the new plan, rather than KidzPartners, will be responsible for services after the member is disenrolled from CHIP.

We will try to work with you to make sure you are able to be treated by the PCP, specialist or other provider that you want. However, there may be a situation where Health Partners Plans cannot honor your request for a particular provider. If a federal or state government agency decides that a provider cannot participate in a government program such as Medicaid or Medicare, that provider cannot be part of the KidzPartners network. Health Partners Plans will not cover the cost of any services given by that provider.

If your PCP ever leaves KidzPartners, we will notify you so that you can select a new PCP. You have the right to ask to continue seeing your PCP for 60 days up to 90 days from the date we notify you. We will permit this only if your PCP is willing to work with KidzPartners on a non-participating basis during this time period, and if your PCP has not been terminated from our network due to a quality issue. To ask to continue seeing your PCP for up to 60 days, call Member Relations at 1-888-888-1211 (TTY 711). If, in any case, ongoing care by your non-participating PCP is found by Health Partners Plans' Medical Director to be clinically appropriate, the 60-day transitional period may be extended.

If you have any questions about continuity of care, or if you would like to continue receiving services from a particular provider after you enroll in KidzPartners, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

## 24-Hour Access to Your PCP

Health Partners Plans believes that being able to see your PCP is a very important part of your care. For health concerns, you can contact your children's PCP 24 hours a day, seven days a week. It is part of our total commitment to you. If you have a medical problem or question, call your PCP.

## 24-Hour Teladoc Medical Assistance Line

You can also call Teladoc, 24 hours a day if you have a medical question and are not sure if you need to call your children's PCP. The board-certified doctors and pediatricians may be able to answer your health question and give you tips to care for the problem yourself. If you have a more serious health concern, they may suggest that you call your PCP. To reach Teladoc, call toll free, 1-800-Teladoc (835-2362). Remember, if your concern is life threatening or you need medical help right away, call 911 or go to the nearest emergency room.

## Appointment Standards

A PCP, OB/GYN doctor or other specialist in the KidzPartners network must meet these time frames for these appointments:

When you are waiting for a doctor to see your children, the average waiting time should be no more than twenty (20) minutes or no more than one (1) hour when the physician has another patient with an urgent medical condition or a difficult medical need.

| Appointment Type | Appointment Standard |
|---|---|
| New member appointment for your first examination: | Must be scheduled: |
| PCP – preventive health screening | Within 45 days of enrollment unless the member is already under the care of a PCP and is current with screens and immunizations |
| PCP – other routine care | Within three (3) weeks of enrollment |
| PCP or specialist – for members with HIV/AIDS | Within seven (7) days from the effective date of enrollment for any member known to be HIV positive or diagnosed with AIDS (such as self-identification), unless the member is already in active care with a PCP or specialist |
| PCP or specialist – for members who receive Supplemental Security Income (SSI) | Within 45 days of enrollment, unless the member is already in active care with a PCP or specialist |
| Members who are pregnant: | Must be scheduled: |
| OB/GYN – High-risk pregnancy visit | Within 24 hours of identification of high-risk pregnancy |
| OB/GYN – First trimester (pregnant 1-3 months) | Within 10 business days of being identified as pregnant |
| OB/GYN – Second trimester (pregnant 4-6 months) | Within five (5) business days of being identified as pregnant |
| OB/GYN – Third trimester (pregnant 7-9 months) | Within four (4) days of being identified as pregnant |
| Appointment with: | You must be seen: |
| PCP – Emergency medical condition | Immediately or referred to an emergency facility |
| PCP – Urgent medical condition | Within 24 hours |
| PCP – Routine appointment | Within 10 business days |
| PCP – Health assessment/general physical examination and first examination | Within three (3) weeks of enrollment |
| Specialist – Emergency medical condition | Immediately |
| Specialist – Urgent medical condition | Within 24 hours |
| Specialist – Routine appointment | Within 10 business days |

## Making an Appointment with Your Children's PCP

For regular checkups or for sick care, just call your children's PCP to make an appointment. All you have to do is:

1. Call your children's PCP office to find out when it is open.
2. Make an appointment. Your children's PCP name and telephone number are listed on your KidzPartners membership card.
3. Bring your membership card to the office visit. Please note that applicable copays are due at the time of receiving services.

If you need help making an appointment, please contact our Member Relations department at 1-888-888-1211 (TTY 711).

Remember, if you have a medical question, you can always call our 24-Hour Teladoc Medical Assistance Line, toll free, at 1-800-Teladoc (835-2362).

## Help if You Speak a Language Other than English

If you would like to request a Member Handbook or other KidzPartners information in another language, just call KidzPartners Member Relations at 1-888-888-1211 (TTY 711). Member Relations also has bilingual staff and access to a phone-based interpreter service, and can provide help for members who speak almost any language.

## Help in Alternative Formats

If you would like to request a Member Handbook or other KidzPartners information in an alternative format (such as audio tape, Braille or large print), at no cost, please call Member Relations at 1-888-888-1211 (TTY 711).

## Help if You Need an Interpreter or TTY Services

If you need an interpreter for any language, including sign language, or if you require TTY services for your health care needs, KidzPartners Member Relations can help you. Just call 1-888-888-1211 (TTY 711).

If you need a verbal interpreter and you call Member Relations, we have a phone-based interpreter service that can help you. This service provides over 140 languages and is available 24 hours a day, seven days a week. You will not have to make another telephone call to get this service. Member Relations will do this for you and will stay on the telephone with you. If you call the TTY line, you will be connected to a text telephone right away.

# 2. SEEING A SPECIALIST

## Definition of a Specialist

Specialists are doctors who treat specific problems. Examples of specialists include cardiologists (heart doctors), dermatologists (skin doctors) and oncologists (cancer doctors).

## When You Should See a Specialist

Your PCP may feel that your children have a sickness that needs to be treated by a doctor who has had special training so he or she can treat your children more effectively. If so, your PCP will give you a referral.

For a list of specialists, please look in our KidzPartners Provider Directory. To request a directory, please call Member Relations anytime at 1-888-888-1211 (TTY 711). Members can also find participating specialists on our website (HealthPartnersPlans.com) by using our online provider directory.

If a specialist ever leaves KidzPartners while your children are under his or her care, you have the right to request to continue seeing him or her for 60 days up to 90 days from the date we notify you. We will permit this only if your specialist is willing to work with KidzPartners on a non-participating basis during this time period, and if your specialist has not been terminated from our network due to a quality issue. Please call Member Relations to make such a request (please see “Continuity of Care” in Section 1 for more information).

Members with special needs can request that an appropriate specialist serve as their PCP. This is possible only if the specialist agrees to serve as a PCP, and if Health Partners Plans approves. In some situations, members with special needs may not qualify to have a specialist as their PCP. Call Member Relations at 1-888-888-1211 (TTY 711) to make this request.

## How to Get a Second Opinion

You may get a second opinion by asking your PCP to send your children to another participating specialist. KidzPartners covers the cost of the visit. Before going to another specialist for a second opinion, always check with your PCP.

# 3. OUT-OF-PLAN SERVICES

## What is an Out-of-Plan Provider?

An out-of-plan (or "non-participating") provider is a provider that does not have an agreement with Health Partners Plans to provide services to KidzPartners members.

## Out-of-Plan Facilities

An out-of-plan facility is a facility (such as a hospital or nursing home) that does not have an agreement with Health Partners Plans to provide services to KidzPartners members.

## Coverage of Out-of-Plan Services

If a participating KidzPartners hospital or other provider does not offer a service that your children need, KidzPartners will cover the out-of-plan services. When there are fewer than two specialists in the network that are trained to do the service, your PCP may choose to send your children to see an out-of-plan specialist. He or she can do this by asking for approval from Health Partners Plans. If Health Partners Plans denies this request, you may file a complaint or grievance. To file a complaint or grievance, call Member Relations at 1-888-888-1211 (TTY 711).

# 4. EMERGENCIES AND URGENT CARE

## Definition of an Emergency Service

For purposes of covering emergency care for KidzPartners members, Health Partners Plans will be guided by Pennsylvania Act 68, the Quality and Health Care Accountability Protection Act, which defines an emergency service as:

1. A health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:
   - Placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy
   - Serious impairment to bodily functions
   - Serious dysfunction of any bodily organ or part
2. Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described above.

## Get Care Right Away

In an emergency, get the care your child needs right away. If it is a life-threatening situation, call 911 for help immediately. Some examples of emergencies are:

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

If your child has an emergency, KidzPartners will cover any care he or she receives at the hospital. If your child is ever denied treatment at an emergency room, you should call your child's PCP or KidzPartners Member Relations right away. Your child's PCP telephone number is on their KidzPartners ID card. KidzPartners Member Relations can be reached 24 hours a day, seven days a week at 1-888-888-1211 (TTY 711).

After an emergency, always call your KidzPartners PCP within 24 hours or as soon as possible. Do not go back to the emergency room for follow-up care that is not an emergency, or this care may not be covered. Instead, make an appointment with your child's PCP. Remember, if you have a medical question, you can always call our 24-Hour Teladoc Medical Assistance Line, toll free, at 1-800-Teladoc (835-2362).

## Out-of-Plan Emergency Services

In an emergency, you should seek medical care from the nearest hospital or health care provider. This means your child may be admitted to a non-participating or "out-of-plan" hospital (especially if the emergency takes place while your child is outside of the KidzPartners service area). If this happens, your child might need to transfer to a participating hospital or provider. This transfer cannot take place until your child's condition is stable. Your KidzPartners PCP will discuss your child's condition with the doctor who is treating him or her. They will decide when your child can be moved.

Always call your child's PCP within 24 hours of getting emergency care, or as soon as possible, to arrange follow-up care. If you obtain non-emergency follow-up care from a non-participating provider, KidzPartners may not cover the costs of this care.

## Ambulance Services

Health Partners Plans covers all medically necessary emergency ambulance transportation. Remember: If it is a life-threatening situation, call 911 immediately.

## Urgent Care

Urgent care is care needed for an illness, pain or injury that, if left untreated, could become a crisis or emergency. If your child needs urgent care, your child's PCP will see him or her within 24 hours. You should call the PCP or have someone call for you. Remember, your child's PCP is available to you 24 hours a day, seven days a week. He or she is there to help your child, and will give you advice or direction. Taking this step could save you a trip to the emergency room! To learn more, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

If for some reason you are not able to reach your child's PCP or your PCP cannot see your child within 24 hours, you may also visit an Urgent Care Center. Urgent Care Centers are facilities that provide basic medical care for walk-in patients with illnesses or injuries that do not require emergency care, such as muscle sprains or minor cuts requiring stitches. To learn more about urgent care centers and the services they provide, please call Member Relations.

**KidzPartners is pleased to provide you with the following information on benefits, services and copays you have with KidzPartners, as well as what is not covered. Please call our Member Relations department anytime if you have any questions, at 1-888-888-1211 (TTY 711).**

# 5. BENEFITS, SERVICES AND COPAYMENTS

## Copays

Children are enrolled into "free," "low-cost" or "full-cost" CHIP based on family income and related information that you provide in your application. In the low-cost and full-cost programs, some of your KidzPartners benefits require a copayment or "copay" that you pay directly to the provider each time you get services, as described below.

### All members enrolled in KidzPartners:

There are no CHIP copays for preventive care services, including well-child visits and visits for immunizations, for members in any premium category.

### Members enrolled in "free" KidzPartners:

There are no CHIP copays for any services for any members enrolled in the free program.

### Members enrolled in "low-cost" KidzPartners pay the following CHIP copays:

- $5 for visits to your children's primary care physician, except for well-child visits
- $5 for visits to specialists
- $25 for visits to the emergency room. This copay is waived if your child is admitted.
- $9 for brand name formulary drugs and $6 for generics

The annual maximum you will pay for copays is five percent of your family income.

### Members enrolled in "full-cost" KidzPartners pay the following CHIP copays:

- $15 for visits to your children's primary care physician, except for well-child visits
- $15 for visits to any physician other than your PCP (specialist and behavioral health providers)
- $50 for visits to the emergency room. This copay is waived if your child is admitted.
- $18 for brand name formulary drugs and $10 for generics

## KidzPartners Benefits

The following chart provides an overview of your coverage with KidzPartners. Please also see "Non-Covered Services" at the end of this section and Special Needs Services (Section 7).

Note: Except in an emergency, ALL services from non-participating providers require prior authorization from Health Partners Plans.

| KidzPartners Benefit | How to Obtain This Benefit |
|---|---|
| Primary Care Services: Covered for both sick visits and well-child/preventive care. | You select your own primary care provider (PCP) from our network of participating providers and make your own appointments.* |
| Acupuncture: Up to 20 visits per year are covered for members 16 and older. | Select a provider from our acupuncture network. There is no copay. |
| Ambulance/Transportation Services: All modes of emergency transportation are covered. Non-emergent transport is not covered. Transportation between facilities/providers is covered if it's medically necessary, and not solely for convenience. | For emergencies, call 911. |
| Autism Services: Medically necessary services for the assessment/treatment of autism spectrum disorders are covered.<br><br>There is no annual dollar limit or maximum on services for the assessment/treatment of autism spectrum disorders. | Contact your PCP or treating specialist.<br><br>Prior authorization requirements are listed in this benefit grid. Some of the services used to assess and treat autism spectrum disorders may require prior authorization.<br><br>Services for the assessment/treatment of autism spectrum disorders will be subjected to copayments and any other general exclusions or limitations listed in this handbook. |
| Chiropractic Services: Up to 20 visits per year are covered. | Contact your PCP or treating specialist. |
| Consultations: By specialists, including second opinion consultations to determine the medical necessity of elective surgery, or when a member's family desires another opinion about medical treatment. | No prior authorization. |
| Dental Services: Emergency, preventive and routine dental cares are covered. Also see "Dental Care" in this section. | You may use any dentist listed in our provider directory.* Certain services require prior authorization. See Section 6 for information on prior authorization. |
| Diabetes Self-Monitoring Supplies: Formulary blood glucose meters, test strips, lancet devices and lancets, and glucose control solutions for checking test strip/ monitor accuracy are covered. | Members must use a participating pharmacy. Prescription required. Prior authorization may be required. Copays may apply. See also "Prescription Drugs" in this table. |
| Disease Management Programs: Programs are available to help you manage diabetes, pediatric obesity, and asthma. Smoking cessation counseling is also available to members enrolled in Disease Management programs. Covered in full. | Contact your PCP, or call our Disease Management department at 1-866-500-4571. |
| Drug and Alcohol Abuse – Inpatient Hospital Treatment: Covered. | No copays apply. No referral needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. See "Drug and Alcohol Treatment and Mental Health Services" in Section 7 for more information about Magellan. |
| Drug and Alcohol Abuse – Non-Hospital Residential Treatment: Covered. | No copays apply. No referral needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. |
| Drug and Alcohol Abuse – Outpatient Treatment: Covered. | No copays apply. No referral needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. |



*To find a KidzPartners participating provider, see the KidzPartners Provider Directory or our online directory at HealthPartnersPlans.com, or call Member Relations at 1-888-888-1211 (TTY 711).

| KidzPartners Benefit | How to Obtain This Benefit |
|---|---|
| Durable Medical Equipment (DME): Rental costs are covered for wheelchairs, or other equipment for home or school for therapeutic use, up to the total cost of purchase, or the purchase of durable medical equipment will be covered. | Provider prescription is required. Prior authorization is required for DME over $500 and all rentals. |
| Family Planning Services: Birth control pills, injectables, patches, and insertion and implantation of contraceptives, including devices, are covered. | Contact your PCP, gynecologist or family planning provider. |
| Fitness Program: Annual membership covered in participating facilities; participation requirements apply. | See "Fitness Program Membership" in this section. |
| Gynecological Services: Covered | Contact your PCP, gynecologist or any family planning provider. No prior authorization or referrals are required. |
| Habilitative Services – Outpatient Therapies: Covered up to 30 visits per therapy per year; for physical, speech, and occupational therapy. | Prior authorization is required after the first 8 visits of PT/OT combined. |
| Unlimited visits for chemotherapy, radiation therapy, respiratory therapy and dialysis. | Prior authorization required after the 8th visit of speech therapy. |
| Hearing: Emergency, preventive and routine hearing care, including audiologist visits when referred by the PCP, is covered. | Contact your PCP. No copay is required for services provided by the PCP. Specialist copay applies for audiologist visits. |
| Hearing Aids - One hearing aid per ear is covered every two years. | Contact your PCP. Prior authorization is required. |
| Home Health Care: This includes nursing services; physical, speech and occupational therapies; medical and surgical supplies; oxygen and its administration; home medical equipment. | Contact your PCP or your treating specialist. Prior authorization is required. |
| Home Infusion: Covered when medically necessary. | Contact your PCP or your treating specialist. Prior authorization is required. |
| Hospice Care – Inpatient and Outpatient: Covered when medically necessary. | Contact your primary care provider. Prior authorization and Certification of Terminal Illness are required. |
| Hospital Services – Inpatient: Acute hospital care, inpatient rehabilitation and behavioral health are covered when medically necessary. | Prior authorization is required for all physical health non-emergency admissions. Notification and authorization are required for emergent admissions. |
| Hospital Services – Outpatient: Medically necessary outpatient hospital services are covered. | Prior authorization is required for all outpatient surgery, and certain other services as noted elsewhere in this benefits chart. |

*To find a KidzPartners participating provider, see the KidzPartners Provider Directory or our online directory at HealthPartnersPlans.com, or call Member Relations at 1-888-888-1211 (TTY 711).

| KidzPartners Benefit | How to Obtain This Benefit |
|---|---|
| Injections and Medications: Provided in the physician office, a hospital, or freestanding ambulatory service center, including immunizations and anesthesia service when performed in connection with covered services | No copays apply.<br>Prior authorization may be required. |
| Laboratory and Radiology Services: Covered. | PCP prescription is required. Prior authorization is required for advanced radiology such as CT, MRI, PET scans, stress echocardiography, cardiac nuclear medicine imaging, and radiation therapy. |
| Mastectomy: Medical and surgical benefits with respect to mastectomy are covered when medically necessary. | Contact your PCP or treating specialist. |
| Mental Health Services – Inpatient: Covered when medically necessary. | No copays apply. No referral needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. |
| Mental Health Services – Outpatient: Covered. | No copays apply. No referral needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. |
| Mental Health Services – Partial Hospitalization: Covered when medically necessary. | No copays apply. No referral is needed. Members as young as 14 can self-refer.<br><br>Contact Magellan Behavioral Health of PA at 1-800-424-3701. |
| Newborn Care: Covered for a newborn child of member for 31 days following birth. | To ensure no lapse in access to health care for the newborn after the first 31 days, the member must contact Member Relations immediately after child is born to begin the process of getting the newborn his or her own health care coverage. |
| Obstetrical Services: Mothers and infants can remain in the hospital for 48 hours after a normal delivery or 96 hours after a cesarean delivery. Treatment for complications is also covered.<br><br>Well-mother/well-baby home visits: Members are covered for two maternity health care visits provided at their home following release from inpatient maternity site. Visits include parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary mother and baby assessments.<br><br>Our Baby Partners program is available to help you manage your health care while you are pregnant. Smoking cessation counseling is available. Covered in full. | No prior authorization or referrals are required for maternity hospital admissions.<br><br>Contact your PCP or your treating specialist. Prior authorization is not required for the first for two maternity health care visits provided at their home following release from inpatient maternity site.<br><br>Contact your PCP, or call our Baby Partners program for pregnant members at 1-866-500-4571 or 215-967-4690. |
| Oral Surgery: Covered | Specialist copay applies. Prior authorization is required when services are provided in a facility. |
| Organ Transplants: Covered for the member as recipient, when medically necessary and not experimental/ investigative. Formulary immunosuppresants are also covered. | Prior authorization is required. Donor transplant services covered only when the member is the transplant recipient, and when Health Partners Plans can verify that these services are not covered by the donor's insurance. |

*To find a KidzPartners participating provider, see the KidzPartners Provider Directory or our online directory at HealthPartnersPlans.com, or call Member Relations at 1-888-888-1211 (TTY 711).

| KidzPartners Benefit | How to Obtain This Benefit |
|---|---|
| Orthodontia: Medically necessary orthodontic treatment is covered by CHIP. Orthodontia is not covered for cosmetic reasons. | Medically necessary orthodontic services require prior approval. See "Orthodontics" in the Dental Care section. |
| Prescription Drugs: Formulary drugs are covered. Includes self-administered injectable medications and diabetes self-monitoring supplies. | Members must use a participating pharmacy.* Copays may apply. Prior authorization required for certain medications. |
| Preventive Care/Well-Child Care: All items or services, including preventative medications, recommended by the United States Preventive Services Task Force (USPSTF) A and B, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA) are covered. | Contact your PCP. No copays apply. |
| Private Duty Nursing – Inpatient: Covered when medically necessary. No limit. | Contact your PCP or your treating specialist.<br>Prior authorization required. |
| Prosthetics and Orthotics: Covers the purchase of prosthetic devices and supplies, including fittings and adjustments; replacements covered only when deemed medically necessary and appropriate. | Contact your PCP or your treating specialist.<br>Prior authorization is required for prosthetics and orthotics over $500. |
| Reconstructive Surgery: Covered when required to restore function following an accidental injury as a 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. | Contact your PCP or treating specialist. |
| ScriptSave: Special discount card for prescription drug/discount that can be used by entire family. | ScriptSave card will be mailed to you. |
| Skilled Nursing Facility Services: Covered when medically necessary. | Contact your PCP. Prior authorization is required. |
| Smoking Cessation Services: Covered. | Contact KidzPartners Member Relations at 1-888-888-1211. |
| Special Needs Unit (SNU) Services: The Special Needs Unit provides case management for members who may require extra assistance getting needed care for their illnesses, disabilities, or other special needs. Covered in full. | Contact your primary care provider or SNU at 1-866-500-4571. |
| Specialist Physician Services: Covered. | Contact your PCP. |
| Vision Care: Preventive and routine vision care are covered. This includes the cost of exams, corrective lenses, frames, and medically necessary contacts, not to exceed one routine eye exams and refraction including dilation a year and one pairs of eyeglasses (lenses and frames) or contact lenses a year. Discounts available for special lens treatments. See "Vision Care" in this section. | Contact any KidzPartners participating vision care provider for preventive/routine vision care services. |
| Weight Watchers®: Membership is covered when program requirements are met. See "Weight Watchers Benefit" in this section for more information. | Members pay a $2 weekly meeting fee. Contact KidzPartners Members Relations at 1-888-888-1211. |
| Well Women Preventative Care: Covered according to the Women's Preventative Services provisions of the Patient Protection and Affordable Care Act. | No copays apply. Prior authorization is not required. |

*To find a KidzPartners participating provider, see the KidzPartners Provider Directory or our online directory at HealthPartnersPlans.com, or call Member Relations at 1-888-888-1211 (TTY 711).

## Acupuncture

Acupuncture is an alternative to drugs and other treatments for headaches, back or neck pain and other health issues. All members 16 and older are covered for 20 visits annually and when visiting our specially credentialed acupuncture providers. When you go to the acupuncturist, he or she will make a treatment plan just for you. The provider then uses needles or other ways to stimulate specific points in the body to relieve pain. To find a licensed acupuncturist in our network, check our online provider directory at HealthPartnersPlans.com or call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

## Asthma Checkups

If your children have or you suspect they may have asthma, make sure they are on the right medication to help prevent asthma episodes. Checkups are covered as a primary care service. Call Member Relations at 1-888-888-1211 (TTY 711) for information on KidzPartners' Asthma Management program.

## Clinical Trials

If your children are eligible to participate in an approved clinical trial (according to trial protocol), with respect to treatment of cancer or other life-threatening disease or conditions, and either the referring provider is a participating provider who has concluded that participation in the trial would be appropriate, or you furnish medical and scientific information establishing that his or her participation in the trial would be appropriate, benefits shall be payable for routine patient costs for items and services furnished in connection with the trial. Health Partners Plans must be notified in advance of the member's participation in the qualifying clinical trial.

**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, KidzPartners 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 provider facility. If there is no comparable Qualifying Clinical Trial being performed by a participating professional provider, and in a participating provider facility, then KidzPartners 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 KidzPartners.

**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:

1. 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:

   a. The National Institutes of Health (NIH);

   b. The Centers for Disease Control and Prevention (CDC);

   c. The Agency for Healthcare Research and Quality (AHRQ);

d. The Centers for Medicare and Medicaid Services (CMS);

e. 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);

f. Any of the following, if the conditions For departments are met:

- The Department of Veterans Affairs (VA);
- The Department of Defense (DOD) and the Department of Energy (DOE), if for a study or investigation conducted by a Department, or that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) 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.

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

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application. The citation for reference is 42 U.S.C. §300gg-8. The statute requires the issuer to provide coverage for routine patient care costs for qualified individuals participating in approved clinical trials and issuer "may not deny the individual participation in the clinical trial."

In the absence of meeting the criteria listed above, the clinical trial must be approved by KidzPartners as a Qualifying Clinical Trial.

Routine patient costs associated with qualifying clinical trials 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.

## Covered Preventative Medications

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Member Services at 1-888-8880-1211 (TTY 711).

## Dental Care

Your children are covered for a broad range of routine dental services and preventive care. You can go to any of the general dentists or dental specialists listed in the Provider Directory. Just select a dentist from this list and call the office to make an appointment. Your children do not need a referral for a dental visit.

The plan covers Diagnostic and Treatment Services, Preventative Services, Palliative Treatment of Dental Pain, Minor Restorative Services, Endodontic Services, Periodontal Services, Prosthodontic Services, and Major Restorative Services. Covered dental services include:

- Anesthesia
- Checkups (two per year)
- Periodontal services
- Routine Prophylaxis (Cleanings, scaling and polishing of teeth), two per year, with the exception of pregnant women who shall be eligible for one additional prophylaxis during pregnancy.
- Root canals
- Crowns
- Sealants
- Dentures
- Dental surgical procedures
- Dental emergencies
- X-rays
- Extractions (tooth removal)
- Fillings
- Occlusal Guard by report
- Orthodontics (see next section)

For more information on your children's dental benefits, please call KidzPartners Member Relations anytime at 1-888-888-1211 (TTY 711).

## Orthodontics

**Medically Necessary**

Orthodontic treatment must be considered medically necessary and the only method to prevent irreversible damage and restore your children's teeth and supporting oral structures to health. All services require prior approval, a written plan of care, and must be performed by a participating provider. Braces for cosmetic reasons are not covered.

## Diabetes Checkups

If your children have or you suspect they may have diabetes, it is important they have a blood test called HbA1c, which will check the average amount of sugar in their blood over the past 2-3 months. It is also important to have a cholesterol test called an LDL. Diabetes checkups (including these tests) are covered as a primary care service. Diabetic children should also get dilated eye exams, which are covered under KidzPartners' vision benefit. Call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) for information on KidzPartners' Diabetes Management program.

## Family Planning Services

KidzPartners members can get family planning services through their PCP or any doctor or clinic of their choice including those not in KidzPartners' network. These services may include pregnancy testing, testing and treatment for sexually transmitted diseases, basic birth control supplies, and counseling.

## Fitness Program Membership

Exercise helps children stay healthy and feel good about themselves. That's why KidzPartners offers special memberships at participating YMCAs and other fitness centers. To qualify for a year-long membership at a participating center, members under 18 must complete six visits within the first three months. Members 18 and older must complete 12 visits during the introductory period, and pay a $2 copay for each visit.

After completing these visits, no copay is required for the rest of their one-year fitness membership period.

You must sign a fitness enrollment form during your children's first visit to the fitness center. For more information, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

## Formulary

KidzPartners has a formulary. A formulary is a list of medicines that a health plan approves for use. Your children's doctor uses our formulary when choosing medicines for them. The formulary contains two kinds of drugs: brand name drugs and generic drugs. Generic drugs contain the same active ingredients as brand name drugs. Since they work the same way as the brand name drugs, you can feel sure that these drugs are high quality and safe for you to take. The formulary also includes certain over-the-counter (non-prescription) drugs that doctors frequently recommend for children.

If the medicine your children's doctor wants to use is not part of the formulary, he or she can ask that Health Partners Plans approve the drug for you through the medical exception process. Your doctor will need to send a Letter of Medical Necessity (LOMN) to Health Partners Plans' Pharmacy department. This LOMN must explain why your children need the medicine and why formulary alternatives cannot be used, when applicable. Health Partners Plans will review your doctor's request and make a decision within 24 hours of receiving the request.

## 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.
- 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.
- Chiropractic Care – limit 20 visits per year
- Home Health Care: Care provided to a KidzPartners member who is homebound by a home health care provider in the KidzPartners member's home, if within the service area. This benefit is offered with no copayments and no limitations.

## Hearing Care Services

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

Benefits 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. No monetary limits apply.

## Home Health Care

If your child becomes sick or hurt, medical care may be available in your home. Your child's PCP will talk to you and, if appropriate, will then contact Health Partners Plans to request prior authorization for these services.

## Hospitalization

If your children need to be admitted to a hospital, your KidzPartners PCP will arrange for them to go to a KidzPartners participating hospital. Their PCP will continue to follow your children's care even if they need other doctors. Hospital admissions, except for emergencies, need prior authorization (pre-approved) by Health Partners Plans.

## 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 48 hours after discharge.

## Maternity Care

Prenatal care is the care you need when you find out you are pregnant. It is important for you and the health of your unborn child. When you find out that you are pregnant, call your obstetrician/gynecologist (OB/GYN) right away. If you do not have an OB/GYN, just call the Member Relations department or your PCP to pick one. It is important to your health and your baby's health to visit your OB/GYN the first three months of your pregnancy.

If you are newly enrolled in KidzPartners, schedule an appointment to see your OB/GYN immediately. During these visits, your OB/GYN will do important things to keep you and your baby healthy, like asking you questions about your medical history, giving you a physical exam and vitamins, and giving you tests to make sure you do not have any conditions like diabetes or high blood pressure.

KidzPartners covers all the OB/GYN visits you need before your baby is born, without copays. Regular checkups after the birth are also covered. It is important that you have checkups after you deliver your baby. You should see your doctor within three to six weeks after you have the baby or if you have any problems. If your OB/GYN ever leaves KidzPartners, or if you are a new enrollee and are seeing an OB/GYN who is not in KidzPartners' network, you have the right to request to continue seeing this doctor for your remaining prenatal care and follow-up care after the birth.

When you are pregnant, the covered care includes:

- Vitamins
- Hospital stays
- Hospital delivery and nursery
- Treatment for any maternity-related complications
- Smoking cessation
- Tests recommended or conducted by your OB/GYN

Through our Baby Partners program, KidzPartners provides all pregnant moms with important information about prenatal dental care. Moms who take good care of their teeth have healthier babies! Dental insurance covers routine prophylaxis (including clean, scaling and polishing of teeth) 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 prohpylaxis during pregnancy.

In addition, KidzPartners offers two home visits to every new mom and her newborn. Visits are usually scheduled within the first two weeks and the second two weeks following hospital discharge. Staying with KidzPartners throughout your pregnancy will help assure that you and your baby receive all necessary care.

KidzPartners offers its pregnant members additional assistance through our Baby Partners program. This includes talking to a case manager who can assist with questions you may have about your pregnancy and a welcome packet with important information on how to stay healthy while you are pregnant. For more information on our Baby Partners program, contact Member Relations at 1-888-888-1211 or the Baby Partners line at 1-866-500-4571 (TTY 711).

CHIP coverage will be extended to babies born to CHIP members for 31 days. It is important to apply for Medical Assistance or CHIP right after the birth of the child to provide continued coverage for the baby. Only one application needs to be completed to apply for both programs.

## 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 48 hours for a normal delivery and 96 hours for a cesarean 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.

## Member Education Classes

KidzPartners offers educational programs in many communities. Classes are available to help your children quit smoking, help you have a healthy baby, and help you become a better parent. KidzPartners also offers education to help members deal with special health problems, like asthma. Watch for information about these and other education sessions in your member newsletter. You can also call the Member Relations department for details about current classes 1-888-888-1211 (TTY 711).

## Outpatient Services

Outpatient services, such as X-rays and laboratory tests, are also covered. Your KidzPartners PCP will arrange for these services at a KidzPartners participating hospital or a participating outpatient center.

## Pediatric Preventive Care

Pediatric Preventive Care includes the following, with no cost-sharing or copays:

- Physical examination, routine history, routine diagnostic tests.
- Oral Health Risk Assessment, fluoride varnish for children ages 5 months to 5 years old (U.S. 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.

## Prescription Drug Benefits

If your children needs medicine, their PCP or specialist will write a prescription. Simply take it to one of the nearly 900 area pharmacies (drug stores) that fill KidzPartners prescriptions. Your prescription will be filled if your children are active KidzPartners members and the prescribed drug is on our formulary. Depending on your CHIP category, you may be charged a copayment for your prescription.

Sometimes you may be charged a copayment for a prescription by mistake. If you think you should not have to pay a copayment, please contact Member Relations or the pharmacy for assistance. If the pharmacist tries to charge you the wrong amount for a prescription, please ask him or her to contact Health Partners Plans.

If you need help finding a pharmacy, or would like a complete list of participating pharmacies, call our Member Relations department anytime at 1-888-888-1211 (TTY 711). You can also check the KidzPartners Provider Directory, or visit us online at HealthPartnersPlans.com to find participating pharmacies.

If your children's doctor makes his or her request for Health Partners Plans approval after you have already taken the prescription to the pharmacy, Health Partners Plans, while reviewing the request, will in most cases cover a 5-day supply of the medicine if your children have not already been taking the medicine and a 15-day supply if they have already been taking the medication.

We will let you and the doctor know whether we will approve the medicine for you. If we deny your children's doctor's request, you have the right to file a complaint or grievance. Since new drugs and treatments are put into use all the time, Health Partners Plans will make changes to the KidzPartners formulary as needed.

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 Relations at 1-888-888-1211 (TTY 711).

When a prescription drug is available as a generic, KidzPartners 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 KidzPartners.

When clinically appropriate, drugs are requested by the member, but are not covered by the health plan, the member should 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.

If you would like a copy of the KidzPartners formulary, please call our Member Relations department at 1-888-888-1211 (TTY 711) or visit our website at HealthPartnersPlans.com.

## Primary and Preventive Health Services

KidzPartners 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 cavities 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, breastfeeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, The Preventive Health Services are provided at no cost to the member.

## 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.

## Vision Care

Visits for routine eye exams and glasses or medically necessary contact lenses are covered. A participating vision provider must be used. 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, then a copayment may apply.

**Frames and lenses:** One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversized lenses, fashion and gradient tinting, oversized glass-gray #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items.

**Frequency of eye exam:** One routine examination and refraction every 12 months. The examination includes dilation, if professionally indicated. There is no Cost to member in network services. There is no coverage for out-of-network services.

**Frequency of lens and frame replacement:** One pair of eyeglasses every 12 months when medically necessary for vision correction.

**Lenses:** For in network, one pair is covered in full every calendar year. There is no coverage for out-of-network.*

There are no copayments for covered standard eyeglass lenses (Single Vision, Conventional [Lined] Bifocal, Conventional [Lined] Trifocal, Lenticular).

Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-gray #3 prescription sunglass lenses.

Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

All lenses include scratch-resistant coating.

There may be copayments for optional lens types and treatments:

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

**Frames:** Collection Frame – no cost to member. Non-Collection Frame – expenses in excess of $130 allowance payable by member. Additionally, a 20 percent discount applies to any amount over $130. There is no coverage for out-of-network services.

Replacement of lost, stolen or broken frames and lenses (one original and one replacement per calendar year) when deemed medically necessary.

**Contact lenses:** One prescription every year – in lieu of eyeglasses or 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 percent discount applies to any amount over $130.

Additional discounts may be available from participating providers.

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 his or her coverage area at time of eyeglass/contact replacement. If your 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.

Expenses in excess of $600 for medically necessary contact lenses, with pre-approval, include these conditions:

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.

KidzPartners covers routine vision exams. (Treatment of other eye problems may be covered as a medical benefit. Your children's PCP can refer you to an eye specialist if necessary.)

Your children's vision benefit includes two annual vision exams, and two pairs of eyeglasses or two pairs of prescription contact lenses per year. Additional replacement eyeglasses can be authorized if medically necessary.

When your children need a vision exam, just check your KidzPartners Provider Directory or call Member Relations at 1-888-888-1211 (TTY 711) for help finding a convenient vision care provider. When you call to make an appointment, be sure to tell the office your children are members of KidzPartners. Remember to bring your children's membership ID cards with you to the appointment.

Your children's vision benefit also includes one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five year period, with a maximum charge of $100 per visit.

Providers will obtain the necessary pre-authorization for these services. The benefit is not covered if performed by an out of network provider.

## Weight Watchers® Benefit

When children are overweight, those extra pounds can contribute to heart disease, high blood pressure and diabetes. And they can also cause problems with their confidence and self-image. That's why KidzPartners wants to help them with weight loss through Weight Watchers of Philadelphia, Inc.

You pay only a $2 weekly meeting fee when your children enroll in the KidzPartners Enhanced Benefit Weight Watchers program and meet program requirements.

To qualify, they must (1) attend 10 consecutive weekly meetings, and (2) lose at least one pound a month. If your children continue to meet the program requirements, their benefit will continue for successive 10-week periods.

Due to Weight Watchers requirements, participation is limited to members age 13 and older. Weight Watchers requires a doctor's note with a goal weight for children ages 13 – 17. For additional information about the program, call KidzPartners Member Relations anytime at 1-888-888-1211 (TTY 711).

## Well-Child Visits

You can make appointments with your children's PCP for well-child visits designed to keep them healthy. The primary and preventive care services children should have during these visits include:

**Regular checkups:** From the time they are born, it is very important for your children to visit their PCP regularly for well-child checkups, including routine blood pressure screening. Babies need checkups at 1, 2, 4, 6, 9, 12, 15 and 18 months; children need annual checkups starting at age two. In addition to providing a comprehensive physical exam, your children's PCP will arrange for any needed lab or other diagnostic testing. These visits help assure that your children stay healthy.

**Shots/immunizations:** Children should have many important shots before age two in order for the shots to have the most effect. Children should also continue to have shots, including boosters and flu shots, as necessary. Whenever your children see their PCP, be sure to check that their shots are up to date.

## Immunizations and Screenings

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, the 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/recs/schedules/index.htm.

**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.

**Health education:** Your children's PCP will provide information and advice on important health issues, including prevention/cessation of all types of tobacco use, and healthy eating habits.

**Developmental screening:** Checkups by your children's PCP will include screenings to check that your children's physical and learning development are on track.

**Allergy diagnosis and treatment:** For children exhibiting symptoms of possible allergies, preventive care includes diagnosis and treatment.

**BMI:** Ask your children's doctor about their Body Mass Index (BMI). This may help you determine whether your children are at risk for obesity.

**Young women's health screens:** As your daughters become young women, routine women's health care should include checkups, Pap tests and breast exams. Check with your children's PCP for more information.

## 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 sStandards 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 durable medical equipment (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.

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

## Reimbursement

Except for copays, you should never have to pay out of pocket for a covered service. If you do choose to pay for a service (for example, if you go to a new pharmacy and forget your KidzPartners ID card and pay for a prescription out of pocket), you can request that we repay you. We can send you a special form to help you give us all the information we need to make a decision about your request. If you have questions or would like to request a form, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711). If your request for reimbursement is approved, we will notify you and send you a reimbursement check.

## Non-Covered Services

There are some health care services that are not covered by KidzPartners. Except for certain "extra" benefits offered by KidzPartners, KidzPartners will not cover health care services that are not included in the Pennsylvania Children's Health Insurance Program.

## Some of the services and situations not covered by KidzPartners include the following:

- Services that are not medically necessary
- Administrative costs, such as charges for completing health forms or for missed appointments
- Alternative medicine, such as massage therapy and yoga
- Any service that is not provided or ordered by your KidzPartners PCP or specialist, except for emergency, mental health and substance abuse, and family planning services
- Consumable supplies
- Cosmetic surgery such as face lifts, tummy tucks, nose jobs or any surgery intended solely to improve appearance; only surgery considered to be reconstructive or restorative with prior authorization
- Food supplements
- Home modifications
- Infertility services
- Items for comfort or convenience, such as air conditioners and exercise equipment
- Mental retardation services
- Non-formulary drugs, unless pre-approved by Health Partners Plans
- Non-prescription eyeglasses or contact lenses
- Organ donation to non-members
- Paternity testing
- Physical exams performed primarily to meet third-party requirements, such as for school, camp, sports participation, or a driver's license
- Podiatry
- Respite care
- Services offered or covered by other programs, such as Medicare, Worker's Compensation, or Veterans Administration
- Services provided by non-participating providers, excluding emergencies
- Services provided outside the United States and its territories, with limited exceptions in Canada, Mexico and U.S. territorial waters
- Services requiring prior authorization if this authorization is not obtained
- Temporomandibular joint (TMJ) syndrome treatment
- Transportation provided for member convenience
- Weight reduction surgery

No health plan covers everything. This managed care plan may not cover all your health care expenses. If you are not sure if a particular service is covered by KidzPartners, it is important to check with your PCP or KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

# 6. COVERAGE GUIDELINES

## Prior Authorization

Sometimes, there are services or items that your PCP must ask Health Partners Plans to approve for you. This is known as prior authorization. These services include, but are not limited to:

- All non-emergency services performed by non-KidzPartners participating providers
- All scheduled (non-emergency) hospital admissions
- Ambulance services (non-emergency)
- Ambulatory Surgical Center/Short Procedure Unit procedures
- Certain durable medical equipment, such as wheelchairs and repairs
- Chemotherapy
- CT scans/PET scans/MRI
- Echocardiography
- Medicines not included in the KidzPartners formulary
- Occupational/Physical/Speech Therapy
- Other services as indicated on the "KidzPartners Benefits" chart in Section 5

When Health Partners Plans receives a complete request for prior authorization, we will contact you by phone within two business days from the date we received the request to tell you if we approved the service or item requested. A written decision notice will be mailed to you within two business days from the date of our decision.

If Health Partners Plans believes that we do not have all the information needed to make a decision, we will ask for the additional information needed from your children's provider within 48 hours of when we get the request. Health Partners Plans will let you know that we asked your provider for this additional information.

Health Partners Plans will contact you by phone and in writing with our decision within two business days after we get the additional information from your provider.

If your provider does not send the additional information within 14 calendar days of our request, then we will base our decision on the information available, will send you a written notice of our decision and will contact you verbally within two business days.

You have the right to appeal any prior authorization request that is denied. The written notice will tell you what you have to do to appeal.

Health Partners Plans follows set standards when making a decision about prior authorization or whether a procedure is medically necessary. These standards are called clinical criteria. Your provider can get a copy of these criteria by calling the provider helpline.

You may get a copy of the clinical criteria used in making a medical necessity decision by calling Member Relations at 1-888-888-1211 (TTY 711).

If your children's provider calls for an authorization for a service and it is not approved, Health Partners Plans will not pay for that service. However, you may still receive the service if you are willing to pay out of pocket. Your provider will have you sign a form saying you are aware you are responsible for paying for this unauthorized service.

Before your children receive any service requiring prior authorization, you have the right to check that authorization has been approved by calling Member Relations at 1-888-888-1211 (TTY 711).

## Payment Denials

When Health Partners Plans denies payment to a provider after your children have already received the service, we will send you a notice that tells you that payment was denied for one of the following reasons:

- The service(s)/item(s) were provided without prior authorization.
- The service(s)/item(s) were not a KidzPartners covered benefit.
- The admission or service was not medically necessary.

The purpose of these notices is to tell you of our decision to deny payment and to tell you whether the provider may or may not bill you for those services.

Before your children receive any service requiring prior authorization, you have the right to check that authorization has been approved by calling Member Relations at 1-888-888-1211 (TTY 711).

### Medical Necessity

In determining whether health care services for KidzPartners members are medically necessary and appropriate, Health Partners Plans considers the Pennsylvania Insurance Department definition as its standard. Satisfaction of this standard will result in coverage of the care or service, which is subject to benefit limitations.

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

1. In accordance with generally accepted standards of medical practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

## How We Cover New Services for KidzPartners Members

New advances in medicine can help us stay healthy. Before Health Partners Plans approves a new service or item, we want to make sure that these new advances are safe and helpful. That's why we are careful when we decide if we should cover a new service or item. Here's how we make our decision:

1. We receive a provider's request for a service or item.
2. We ask the provider to give us a letter that tells us all the details about the service or item and that also explains why the member needs the service or item.
3. We perform a web-based literature search to find out more details about the service or item. These details could include:
   - Whether the service or item was approved by the Food and Drug Administration;
   - If other providers have used the service or item and wrote about how it worked for them;
   - Whether the service or item is accepted as useful by other providers. If a literature search does not yield relevant information about the service or item, we contact medical experts directly to get details about the service or item.
4. After the details of the service or item are provided to us from either the literature search or the medical expert, one of our Medical Directors will review the details about the experimental service or item. After review, the Health Partners Plans Medical Director makes a decision about whether the service or item should be covered.

These steps help ensure that the service or item is both safe and helpful for your children. Experimental services or procedures are not covered under KidzPartners.

## If You Move or Change Your Phone Number

If you move or change your phone number, please notify us right away by calling KidzPartners Member Relations at 1-888-888-1211 (TTY 711). This is important so that we can provide your children's health care coverage smoothly. This is a KidzPartners member is responsibility.

As long as you move to an area within Bucks, Chester, Delaware, Montgomery or Philadelphia counties, your children can remain enrolled with KidzPartners. If you move outside the five-county area of Southeastern Pennsylvania, you will need to select a different CHIP provider.

## Family Size Changes

If your family size changes, call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

Note: CHIP coverage will be extended to babies born to CHIP members for 31 days. It is important to apply for Medical Assistance or CHIP right away to provide continued coverage for the baby. Only one application needs to be completed to apply for both programs.

# 7. SPECIAL NEEDS SERVICES

## Special Needs Unit

The Special Needs Unit at Health Partners Plans ensures that members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses and other special needs. We make sure that KidzPartners members receive the care they need. In addition to helping to coordinate KidzPartners services, the unit also works with various outside agencies to arrange for other necessary services in the community. If you would like the Special Needs Unit to help you and your children, please call 1-866-500-4571 (TTY 711) to discuss your needs.

## Services for Members with HIV/AIDS

A case manager in Health Partners Plans' Special Needs Unit works full-time to meet the special needs of members with HIV/AIDS. The case manager ensures that these members receive necessary medical care, arranges for needed social services, and helps coordinate their overall care. For information about how to get these services, please call 1-866-500-4571 (TTY 711).

## Well-Child and Preventive Services

In addition to covering your children's health care when they are sick, KidzPartners covers a broad range of well-child and preventive services. Your children's PCP gives complete care, including screening, testing and treatment for any condition to keep your child healthy.

We encourage all KidzPartners members to see their PCP regularly to get these screenings and immunizations. Please see your child's PCP, or call Member Relations for more information at 1-888-888-1211 (TTY 711).

Health screenings and services include but are not limited to:

- Anemia testing
- Growth measurements/Body Mass Index
- Hearing exams
- Immunizations (shots)
- Lead poisoning testing
- Physical examinations
- Routine dental care
- Sickle cell screening
- Vision exams and eyeglasses

## Drug and Alcohol Treatment and Mental Health Services

KidzPartners covers medically necessary drug and alcohol and mental health services. Both inpatient and outpatient services are covered, and are coordinated by a behavioral health company called Magellan Behavioral Health of PA, which has a contract with Health Partners Plans for these KidzPartners services.

Your PCP can contact Magellan to arrange care for your children. You can also contact Magellan directly at 1-800-424-3701 to arrange care. When Magellan is contacted, they will request information to help assess the type of care needed by your children, and will then direct you to a participating provider. No referral is necessary. Members as young as 14 years old can self-refer.

## WIC (Women, Infants and Children) Nutrition Program

WIC services provide healthy food, breastfeeding information and support and nutrition information to eligible women, infants and children.

WIC services are offered to:

- Pregnant women
- Mothers breastfeeding their babies
- Women who have given birth within the last six months

For children up to five years of age to receive WIC benefits, you must:

- Live in Pennsylvania
- Meet income guidelines
- Have a nutritional or medical need

WIC benefits will not change other benefits you receive.

For more information on the WIC program, please call 1-800-WIC-WINS (1-800-942-9467). You will receive information to see if you are eligible as well as the location of WIC sites in your area.

## Other Social Services Available to Members

Health Partners Plans can give you information about other social services that are available in the community. Health Partners Plans' Special Needs Unit can help identify and refer you to a social service agency that may be able to assist you with services not covered by KidzPartners.

Services that may be available include: mother/child service agencies, housing agencies, the Department of Human Services, the Women, Infants and Children (WIC) program, Head Start and Early Intervention Services.

If you would like additional information about any of these or other social service programs, please call our Special Needs Unit at 1-866-500-4571 (TTY 711).

# 8. MEMBER RIGHTS AND RESPONSIBILITIES

As a KidzPartners member, through Health Partners Plans, you have the right to know your Rights and Responsibilities. Exercising these rights will not negatively affect the way you are treated by Health Partners Plans, its participating providers or any state agencies.

When making your health care decisions, you have the right to feel that Health Partners Plans is not restraining, isolating, bullying, punishing or retaliating against you.

## Member Rights

As a KidzPartners member, you have many rights including:

1. You have the right to receive information about all the benefits and services offered by your plan in a manner that is easily understood. You have the right to know about policies that can affect your membership.
2. You have the right to make recommendations about KidzPartners' member rights and responsibilities.
3. You have the right to be a part of decisions made by Health Partners Plans and its participating doctors that affect your personal health care and your membership.
4. You have the right to be treated fairly, the right to respect and dignity, and the right to have your privacy protected.
5. You have the right to expect that information you provide to Health Partners Plans, your medical records and anything you discuss with your doctor will be treated confidentially and will not be released to others without your permission.
6. You have the right to request a specialist to help meet your special needs by serving as your primary care provider.

7. If a problem comes up, you have the right to question decisions made by Health Partners Plans or its participating providers.

8. You have the right to receive basic information about doctors and other providers who participate with KidzPartners. You have the right to choose from these providers, and to refuse care from specific doctors. You have the right to voice complaints and grievances about Health Partners Plans or care provided or denied.

9. You have the right to be present either in person or by telephone at the complaint or grievance hearing and to bring a family member, friend, lawyer or other person to help you.

10. You have the right to use an Advance Directive to say how you want your medical care handled. This written statement will be used if you are too sick to speak for yourself.

11. You have the right to have access to your medical records in accordance with Federal and State laws. If you would like a copy of your records, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) for help.

12. You have the right to talk openly with your doctor about all treatments that may be right for your health problem, whether or not KidzPartners covers them, and without regard to cost.

13. You have the right to receive information on available treatment options and alternatives. Your treatment options should be presented in a way that is clear to you. You also have the right to refuse treatment options from your doctor.

14. You have the right to request a copy of the clinica criteria used by Health Partners Plans in making a medical necessity decision.

15. You have the right to receive a "Certificate of Health Plan Coverage" if your membership has been terminated.

## Member Responsibilities

You have many duties as a KidzPartners member, including:

1. You have the duty to tell Health Partners Plans and its participating doctors about information that may affect your membership or your right to program benefits. For example, if you move to another address, you must call Health Partners Plans and your PCP and tell us your new address.

2. You have the responsibility to learn about your health problems and work with your doctor to develop a plan for your care.

3. You have the duty to help with your health care by following the membership rules. For example, you must call your PCP when you need urgent care, and after getting emergency care.

4. You have the duty to follow your PCP's instructions, such as taking medicine on schedule, once you have agreed to your PCP's treatment plan.

5. If you have children, you also have the duty to take them to the PCP for care. You have the duty to inform your doctor about your health history, and to sign a consent form so your doctor can receive a copy of your medical records and those records may be shared with other providers.

6. You have the duty to make and keep appointments, to be on time, and to call to cancel an appointment or to report that you will be late.

7. You have the duty to treat your PCP and other health care providers with respect and dignity.

8. You have the duty to use KidzPartners participating providers for all your health care needs. This includes PCPs, specialists, hospitals, pharmacies and other providers you use as a KidzPartners member.

## Patient Self-Determination Act

The Patient Self-Determination Act is a federal law. This law gives you the right to decide for the future which type of medical treatment you will accept, refuse or end if you become too sick to speak for yourself. Your medical wishes must be put in writing and given to your doctor or other health care providers before you get sick. This written document is called an Advance Directive.

In Pennsylvania, Act 169 went into effect in January of 2007, and it governs Advance Health Care Directives.

## Advance Directives

We all expect to stay healthy. And we hope you do for a long, long time. However, there may come a time when you are not healthy and can't make decisions about your health care. This is why it is important to have an Advance Directive.

Before writing an Advance Directive, you should think about the questions below. Discuss them with your family, friends and clergy.

- How important is it for you to die without a long period of pain and suffering?
- How important is it for you to follow your religious beliefs?
- How important is it to have your choices respected and followed?

There are two types of Advance Directives in Pennsylvania: Living Wills and Health Care Power of Attorney documents (these are also called Durable Power of Attorney documents).

## Living Wills

A Living Will is a document containing your wishes on how you would like to be treated if you have a terminal illness (illness resulting in death) or a very serious operation. If you are ill and cannot speak for yourself and/or make decisions for yourself, your Living Will document will tell your doctor what life-sustaining treatments (treatments to help keep you alive) you may want and which treatments you do not want.

Examples of life sustaining treatments are:

- Cardiopulmonary resuscitation (CPR) – a way to get your heart beating again
- Intravenous therapy (IV) – a way to keep you medicated when you can't take it by mouth
- Feeding tubes – a way to feed you if you can no longer feed yourself
- Respirators – a way to help you breathe if you can't breathe for yourself
- Dialysis – a way to purify your blood if your kidneys can't do it
- Pain relief – either requesting or refusing it

In order for your wishes to be carried out, your Living Will must be written before you become ill or have an operation; your doctor must have a copy of it; and, your doctor must determine, at the time the life-sustaining treatment decision is being made, that you are incompetent (in no condition to speak your wishes) and that your condition is either terminal (you will die) or that you are permanently unconscious (in a coma).

## Health Care Power of Attorney or Durable Power of Attorney

A Health Care or Durable Power of Attorney is a written statement that gives the name of a person (called a "proxy" or a "health care agent") who can make certain medical decisions for you if you are not able to express yourself physically or mentally (if you cannot think, make decisions, or speak). This written list of instructions is done before medical services are needed. Your doctor will follow these instructions if you cannot communicate these wishes for yourself.

Your proxy/health care agent can be an adult friend or family member and does not need to be a lawyer or medical professional. Some examples of the decisions or authority given to your proxy/health care agent through a Health Care/Durable Power of Attorney are:

- Admitting you to a hospital, residential or nursing facility
- Signing health care contracts for your medical services
- Authorizing medical or surgical procedures

Just like with the Living Will, you must write down your wishes in a Health Care/Durable Power of Attorney ahead of time and give them to your doctor and others who need to know your wishes, such as your proxy/health care agent. Under Pennsylvania law, you can change or end ("revoke") your Living Will or Health Care/Durable Power of Attorney at any time as long as you are competent.

Just be sure to let your doctor know if you are revoking it. If you make changes to your Living Will or Health Care/Durable Power of Attorney, be sure your doctor has a copy of the new document with your changes.

You can combine your Health Care Power of Attorney document with your Living Will, and have just one document which covers both topics (the Living Will and the Health Care Power of Attorney), or you can keep both documents separate.

To get help writing an Advance Directive, just call a lawyer, social worker, your doctor's office, or the State Attorney General's office. You can also call Health Partners Plans' Special Needs Unit at 1-866-500-4571 (TTY 711) for help.

## Will My Wishes Always be Followed?

The law does not ensure that a provider must follow your wishes in every case. However, it does say that if the doctor cannot in good conscience carry out your wishes, or if there are other policies that prevent the doctor from following your wishes, that the doctor must inform you. Your doctor must also help you locate another provider who is able to follow your wishes, if your wishes are permitted under Pennsylvania law. This is another reason why it is so important that you give your Advance Directive decisions to your doctor in writing ahead of time, so that if he or she is not able to carry out your wishes, you can be transferred to a doctor who can.

If you believe that your doctor or Health Partners Plans did not follow your Advance Directive, you have the right to file a complaint or a grievance. Please see "Complaints and Grievances" in Section 8 for a list of all of the steps that you can take to file a complaint or a grievance.

## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Health Partners Plans, we respect the confidentiality of your personal health information ("PHI," "Health Information" or "Information") and will protect your Information in a responsible and professional manner. We are required by law to maintain the privacy of your PHI and to send you this Notice. This Notice explains how we safeguard the privacy of your PHI and when we can share that information with others. It also informs you of your rights about your PHI and how you can exercise these rights.

When we talk about PHI or health information or information in this Notice, we mean the following:

- Information that identifies you (or could be used to identify you [e.g., your address, phone number, social security number, etc.]); and
- Any kind of information that relates to your physical health condition, the delivery of health care to you or the payment for that care (e.g., your claims, prescription and diagnosis information).

## How We Obtain, Use and Share PHI for General Purposes

Health Partners Plans engages in routine activities that result in the receipt or exchange of your health information from sources other than you. Where state or federal laws offer greater privacy protections, we will follow those more stringent requirements. We must comply with the rules governing the disclosure of Health Information related to HIV/AIDS testing and treatment, drug and alcohol abuse prevention or treatment, and mental health. In order to use or share PHI we must obtain your written authorization except as described below.

As your managed care plan, we may use or share health information about you to ensure that you obtain health services and to operate Health Partners Plans. We may use or share your health information for the following purposes:

***Treatment: Manage your health care***
We may use your health information so that we can manage your care. A doctor sends us Information about your diagnosis and treatment plan so we can arrange additional services.

We may disclose health information to professionals who are involved in your medical care. If you are in the hospital, we may give your hospital doctor access to your medical records sent to us by your doctor(s) who treated you in the past.

***Payment Disclosures: Pay for your health services***
We may use your health information to help pay for your health services submitted to us by doctors and hospitals for payment.

We may disclose your health information to determine your eligibility for one of our plans, and for reviewing services to determine medical necessity, performing utilization review, obtaining premiums, coordinating your benefits and collection activities.

***Health Care Operations: Operate Health Partners Plans***
We use health information about you to develop better services for you. For example, we may use and disclose Information to make sure the care you receive from a hospital or doctor's office is of the highest quality.

Using your health information, we may conduct medical reviews, review the qualifications and performance of the providers you visit, and resolve complaints and grievances.

***Administer Your Plan***
We may disclose your health information to your health plan sponsor for plan administration. A company may contract with us to provide health benefits, and we may provide that company with certain statistics to explain the premiums we charge.

***Health and Wellness Information***
We may use or share your health information to send you a reminder if you have an appointment with your doctor.

We may use or share your Information to inform you about alternative medical treatment and programs or about health-related products and services that may interest you, such as information about smoking cessation or weight-loss programs.

We may send materials to you if you meet certain age criteria to describe our products and an application form.

***Business Associates: Other organizations that help us***
We may share your health information with subcontractors, agents, and vendors, known as "Business Associates," who perform activities on our behalf, such as dental and vision practice managers, auditors and software support vendors. These business associates must agree to protect your health information.

## When We Share Your PHI For Special Purposes

Health Partners Plans is required or permitted to share your health information without your authorization in other ways – usually in ways that contribute to the public good, such as public health and research or as required by law. We have to meet many conditions under the law before we can share your information for these purposes. For more information, visit www.hhs.gov/ocr/ privacy/hipaa/understanding/consumers/index.html. For instance, we may share your Information for the following purposes:

***Public Health and Safety***
We may use or share your Health Information for certain types of public health or disaster relief efforts.

We may report your Health Information to state and federal agencies that regulate Health Partners Plans, such as the U.S. Department of Health and Human Services; the Centers for Medicare & Medicaid Services; the Pennsylvania Department of Health; the Pennsylvania Insurance Department; and the Pennsylvania Department of Human Services.

We may share your health information for public health activities. For example, we may report health information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.

We may report your health information to public health agencies if we believe there is a serious health or safety threat.

We may report your health information to a government authority regarding child abuse, neglect or domestic violence.

***Required By Law***
We must use or disclose your health information when we are required to do so by law, such as to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

***Legal Process, Law Enforcement, and Other Laws***
We may provide your health information to a court or administrative agency (for example, pursuant to a court or administrative order, search warrant or subpoena).

We may report your health information for law enforcement purposes. For example, we may give health information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.

We may report your health information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the president and others.

We may report information on job-related injuries because of the requirements of your state workers' compensation laws. We are permitted to use or share your health information about you for workers' compensation claims.

***Research, Death, and Organ Donation***
We may share your health information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law.

We may disclose a deceased member's PHI to family members, providers and others who were involved in the care or payment for care of the decedent prior to death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to us.

We may disclose your information to a personal representative such as a family member if the information pertains to that surviving family member's health. A decedent's health information is no longer considered protected under HIPAA starting 50 years after death. We may also share your health information with a funeral director as necessary to carry out his or her duties.

We may use or share your health information for banking or transplantation of organs, eyes or tissue.

Under certain circumstances, we may use and disclose health information for research. Before we use or disclose health information for research, the project will go through a special approval process. We also may permit researchers to look at records to help them identify patients who may be included in their research project as long as they do not remove or take a copy of any health information.

***With Your Authorization or at Your Direction***
We will share your PHI with your authorization. You can tell us your choices about what we share and how we share it. See the next section "What Are Your Rights?"

With your verbal or written permission, we may assist you in obtaining proof of immunization as required by a school for your child or minor for whom you have legal guardianship, or for yourself.

***Family and Friends***
We may share health information that is directly related to your treatment with your family, close friends, or others involved in payment for your care:

- When you are present prior to the use or disclosure and you agree; or
- When you are not present or competent. For example if you are unconscious, we may share your health information with family members if we believe it is in your best interest.

***Personal Representatives, Power of Attorney***
Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits, for example, an individual named in a durable power of attorney; a legal guardian for an incapacitated adult; or a parent or guardian of an unemancipated minor. A parent may also be a personal representative for a child who is a minor. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We may ask you or the individual you have designated to act for you to provide documentation. We will make sure the person has this authority and can act for you before we take any action.

***Communications to You***
We will communicate health information about you to the address, telephone number or email we have on record for the "subscriber" (the head of household, enrollee, responsible party) of your health benefits plan. For example, a newsletter may be mailed to the subscriber. We will not mail letters to separate addresses or change an address on file unless we are requested to do so and are able to agree to the request.

***Marketing, Sales and Fundraising (if applicable)***
The law permits us to market to you, such as to give you information on new products, except under certain circumstances. We may ask for your permission to market to you. In no case will we sell your health information. We may use PHI about you, including disclosure to a foundation or a business associate, to contact you for our fundraising purposes. You have the right to opt out of receiving such communications.

***Breach***
If your health information has been breached, meaning your health information has been accessed or received by someone who is not authorized to do so, we will notify you as required by law.

***Genetic Information***
We are prohibited from using or disclosing any PHI that is genetic information about you for underwriting purposes.

## What Are Your Rights?

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you would like to exercise the following rights, please contact KidzPartners at 1-888-888-1211 (TTY 711). You can also write to:

Information Services and Security
Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107 or
email us at HPHIPAAPrivacyOfficial@hpplans.com.

***You have the right to ask us to limit what we use or share.***
You may ask us not to use or share certain health information for treatment, payment, or our operations. You also have the right to ask us to restrict information that we have been asked to give family members or to others who are involved in your health care or payment for your health care. This request must be made in writing to Health Partners Plans.

Health Partners Plans has a standard form that can be requested. We are not required to agree to your request, and we may say "no" if it would negatively impact or affect your care.

***You have the right to ask your provider to restrict or limit your health information that you paid out of pocket.***
If you paid out-of-pocket (or in other words, your provider has not billed us) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to us for purposes of payment or health care operations.

***You have the right to request confidential communications.*** You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. For example, if you believe that you would be harmed if we send your Information to your current mailing address (in situations involving domestic disputes or violence), you can ask us to send the Information by alternative means (for example, by fax) or to a different or additional address. We may say "no" to your request, but we will tell you why in writing within 60 days. This request may be made verbally or in writing. Health Partners Plans has a standard form that can be requested by calling our Member Relations department at 1-888-888-1211 (TTY 711).

***You have the right to get a copy of your health and claims records.*** You may ask to see or get a copy of your health and claims records and other health information we have about you. The request must be made in writing and describe the information you would like to inspect. However, you do not have the right to access certain types of information and we may decide not to provide you with copies of the following Information:

- Contained in psychotherapy notes (we do not create or maintain psychotherapy notes here);
- Gathered for possible use for or in connection with a civil, criminal or administrative action or proceeding; and
- Subject to certain federal laws governing biological products and clinical laboratories.

***Additionally***, in certain other situations, we may deny your request to inspect or obtain a copy of your health information, such as when disclosure may not be in the best interest of your health. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

***You have the right to an electronic copy of Electronic Medical Records.*** If your health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is available in such form or format. If the health information is not available in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***You have the right to ask us to correct health and claims records.*** You may ask us to correct your health claims records if you think they are incorrect or incomplete. We may require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 60 days after we receive it.

We will notify you if there is a delay with respect to the date by which we will complete the action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your Health Information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to contest (argue) your statement. However, you have the right to request that your written request, our denial and your statement of disagreement be included with your information for any future disclosures.

***You have the right to get a list of those with whom we have shared health information.*** You can ask for a list (accounting) of when we have shared your health information for six (6) years prior to the date of your request, who we shared it with, and why. We will include all the disclosures except for:

- Information disclosed to be used for treatment, payment, and health care operations purposes;
- Information disclosed to you or pursuant to our authorization;
- Information that is incidental to a use or disclosure otherwise permitted;
- Information disclosed for a facility directory or to persons involved in your care;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; or
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We may require that your request be in writing. We will act on your request for an accounting within 60 days. We will provide one accounting within a 12 month period for free but will charge a reasonable, cost-based fee if you ask for another one within the 12 month period. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

## Effective Date of Notice

This Notice takes effect September 23, 2013. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to your health information.

## Right to Receive This Notice, Changes to This Notice

You have a right to receive a copy of this Notice upon request at any time. You may also view a copy of the Notice and other information supporting the protection of your health information on our website at HealthPartnersPlans.com. We reserve the right to change the terms of this Notice and to make the new Notice effective for all health information we maintain. Once revised, we will provide the new Notice to you by direct mail and post it on our website.

## Contact for Questions or Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting KidzPartners Member Relations at 1-888-888-1211 (TTY 711). You can also send us questions by mail to: HIPAA Official, Health Partners Plans, 901 Market Street, Suite 500, Philadelphia, PA 19107; by email to HPHIPAAPrivacyOfficial@hpplans.com; or by telephone at 1-800-553- 0784 (TTY 711).

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

# 9. HELP WITH PROBLEMS

At Health Partners Plans, we work very hard to keep you healthy, and to make sure that you are happy with the services we provide. Sometimes, however, you may have a concern about your health care or Health Partners Plans' services. We want to work out any concerns you have, and will work hard to resolve any problems you may have. Many times, our Member Relations department can help you with these questions or concerns. Member Relations representatives are available 24 hours a day, seven days a week, by calling 1-888-888-1211 (TTY 711).

## Complaints and Grievances

If a provider or Health Partners Plans does something that you are unhappy about or do not agree with, you can tell Health Partners Plans that you are unhappy about or that you disagree with what the provider or Health Partners Plans has done. This section describes what you can do and what will happen. Exercising your complaint and/or grievance rights will not negatively affect the way you are treated by Health Partners Plans, its participating providers or any state agencies.

## Complaints

***What is a complaint?***

A complaint is when you tell us you are unhappy with Health Partners Plans or your children's provider or do not agree with a decision by Health Partners Plans.

Some things you may complain about:

- You are unhappy with the care your children are receiving.
- You cannot get the service or item you want for your children because it is not a covered service or item.
- Your children have not received services that Health Partners Plans has approved.

## First Level Complaint

***What should I do if I have a complaint?***

To file a complaint, you can:

- Call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) and tell us your complaint.

Or

- Write down your complaint and send it to us at:
  Complaint & Grievance Unit
  Health Partners Plans
  901 Market Street, Suite 500
  Philadelphia, PA 19107

Or

- Have your children's provider or a designated representative file a complaint for you if you give the provider or representative your consent in writing to do so. This is called a first level complaint.

***When do I file a first level complaint?***

You must file a complaint within 45 days of getting a letter telling you that:

- Health Partners Plans has decided that your children cannot get a service or item you want because it is not a covered service or item.
- Health Partners Plans will not pay a provider for a service or item your children received.
- Health Partners Plans did not decide a complaint or grievance (that you told us about before) within 30 days.
- Health Partners Plans has decided that you cannot get a service you wanted because your children are over their benefit limit but you believe they are not over the benefit limit.

You must also file a complaint within 45 days of the date your children should have gotten a service or item if they did not get the service or item. The time by which you should have received a service or item is listed on the "Appointment Standard" chart in Section 1.

You may file all other complaints at any time.

***What happens after I file a first level complaint?***

After you file your complaint, you will get a letter from Health Partners Plans telling you that we have received your complaint, and about the first level complaint review process.

You may ask Health Partners Plans to see any information we have about your complaint. You may also send Health Partners Plans any information that may help with your complaint.

You may attend the complaint review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by video conference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A staff member of Health Partners Plans (or one of our subcontractors, if appropriate) who has not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

A letter will be mailed to you within five business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

## Second Level Complaint

***What if I don't like Health Partners Plans' decision?***

If you do not agree with our first level complaint decision, you may file a second level complaint with Health Partners Plans.

***When should I file a second level complaint?***

You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. Use the same address or phone number you used to file your first level complaint.

***What happens after I file a second level complaint?***
You will receive a letter from Health Partners Plans telling you that we have received your complaint and telling you about the second level complaint review process.

You may ask Health Partners Plans to see any information we have about your complaint. You may also send Health Partners Plans any information that may help with your complaint.

You may attend the complaint review for your scheduled hearing if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people who have not been involved in the issue you filed your complaint about, including at least one person not employed by Health Partners Plans, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A letter will be mailed to you within five business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

## External Complaint Review

***What can I do if I still don't like Health Partners Plans' decision?***
If you do not agree with Health Partners Plans' second level complaint decision, you may ask for an external review by either the Pennsylvania Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Health Partners Plans' policies and procedures.

You must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing. You must send your request for external review in writing to either:

Pennsylvania Department of Health Bureau
of Managed Care
Health & Welfare Bldg., Rm. 912 625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

Or

Pennsylvania Insurance Department Bureau
of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120-0024
Telephone Number: 1-877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from Health Partners Plans. You may also send them any other information that may help with the external review of your complaint. You may be represented by an attorney or another person during the external review.

A letter will be sent to you after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision

## Grievances

***What is a grievance?***
When Health Partners Plans denies, reduces or stops a service or item or approves a service or item different than the service or item you requested because it is not medically necessary, or because it is over your benefit limit and Health Partners Plans decides that you do not need an exception to the limit, you will get a letter (notice) telling you our decision.

A grievance is when you tell us you disagree with Health Partners Plans' decision.

## First Level Grievance

***What should I do if I have a grievance?***

To file a grievance, you can:

- Call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) and tell us your grievance.

Or

- Write down your grievance and send it to us at
  Complaint & Grievance Unit
  Health Partners Plans
  901 Market Street, Suite 500
  Philadelphia, PA 19107

Or

- Have your children's provider or designated representative file a grievance for you, if you give your provider or representative your consent in writing to do so.

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

***When should I file a first level grievance?***

You have 45 days from the date you receive the letter (notice) that tells you that Health Partners Plans denied, reduced or stopped a service or item or approved of a different service or item, to file your grievance.

***What happens after I file a first level grievance?***

After you file your grievance, you will get a letter from Health Partners Plans telling you that we have received your grievance and telling you about the first level grievance review process.

You may ask Health Partners Plans to see any information we have about your grievance. You may also send Health Partners Plans any information that may help with your grievance.

You may attend the grievance review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A licensed physician who has not been involved in the issue you filed your grievance about, in the same or similar specialty that usually manages or consults on the service/item in question, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we receive your grievance.

A letter will be mailed to you within five business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

## Second Level Grievance

***What if I don't like Health Partners Plans' decision?***

If you do not agree with our first level grievance decision, you may file a second level grievance with Health Partners Plans.

***When should I file a second level grievance?***

You must file your second level grievance within 45 days of the date you receive the first level grievance decision letter. Use the same address or phone number you used to file your first level grievance.

***What happens after I file a second level grievance?***

You will receive a letter from Health Partners Plans telling you that we have received your grievance, and telling you about the second level grievance review process.

You may ask Health Partners Plans to see any information we have about your grievance. You may also send Health Partners Plans any information that may help with your grievance.

You may attend the grievance review the day of your pre-scheduled hearing if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by video conference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of three or more people who have not been involved in the issue you filed your grievance about, including a licensed physician in the same or similar specialty that usually manages or consults on the service/item in question and at least one person not employed by Health Partners Plans, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A letter will be mailed to you within five business days after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

## External Grievance Review

***What can I do if I still don't like Health Partners Plans' decision?***

If you do not agree with Health Partners Plans' second level grievance decision, you may ask for an external grievance review.

You must call or send a letter to Health Partners Plans asking for an external grievance review within 15 days of the date you receive the second level grievance decision letter. Use the same address and phone number you used to file your first level grievance. We will then send your request to the Department of Health.

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

Health Partners Plans will send your grievance file to the reviewer. You may send the reviewer any additional information that may help with the external review of your grievance, within 15 days of filing the request for an external grievance review.

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

## Expedited Complaint and Grievance and Expedited External Review

***What can I do if my children's health is at immediate risk?***

If your children's doctor or dentist believes that the usual time frames for deciding your complaint or grievance will harm your children's health, you or your children's doctor or dentist can call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) and ask that your complaint or grievance be decided more quickly. This is called an expedited complaint or an expedited grievance. You will need to have a letter from your children's doctor or dentist faxed to 215-991-4105 explaining how the usual time frame for deciding your complaint or grievance will harm your children's health.

If your children's doctor or dentist does not fax Health Partners Plans this letter within 48 hours of your request for expedited (faster) review, your complaint or grievance will be decided within the usual time frames.

***What happens after I file an expedited complaint or grievance?***

A committee of three or more people, including a licensed physician and at least one person not employed by Health Partners Plans, will review your complaint or grievance. The licensed physician will decide your expedited complaint or grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your complaint or grievance about.

Health Partners Plans will call you within 48 hours of when we receive your request for an expedited (faster) complaint or grievance, accompanied by a doctor's letter, to tell you our decision. We will also send you a letter within two days telling you all of the reasons for the decision and what you can do if you don't like the decision.

If you are not satisfied with the decision of the expedited complaint, you can file an expedited external complaint with the Pennsylvania Insurance Department or the Pennsylvania Department of Health (see External Complaint Review) within two business days from the date you get the expedited complaint decision letter.

If you want to ask for an expedited external grievance by the Department of Health, you must call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) within two business days from the date you get the expedited grievance decision letter. Health Partners Plans will send your request to the Department of Health within 24 hours after receiving it.

You may not ask for an expedited review after Health Partners Plans has made a second level grievance decision on the same issue.

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

You may call KidzPartners Member Relations at 1-888-888-1211 (TTY 711) if you need help or have questions about complaints and grievances. If you need help filing your complaint or grievance, a staff member of Health Partners Plans will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

At any time during the complaint or grievance process, you can have someone you know (which may include your children's provider) represent you or act on your behalf. If you decide to have someone represent or act for you, tell Health Partners Plans, in writing, the name of that person and how we can reach him or her.

This person can also help you if you decide you want to appear at the complaint or grievance review. If you want legal assistance, you can contact your local legal aid office or the Pennsylvania Health Law Project at 1-800-274-3258.

***Persons Who Speak a Language Other Than English***

If you ask for language interpreter services, Health Partners Plans will provide the services at no cost to you. Please contact KidzPartners Member Relations at 1-888-888-1211 (TTY 711) for more information.

## Persons with Disabilities

If needed, Health Partners Plans will help persons with disabilities in presenting complaints or grievances at no cost. This help includes:

- Providing sign language interpreters;
- Giving you information that Health Partners Plans will submit at the complaint or grievance review in an alternative format, before the review; and
- Providing someone to help copy and present information.

## What to Do If You Receive a Bill

There may be times when you are billed for services you receive. You may be billed for unpaid copay amounts, or for services not covered by KidzPartners. Participating providers cannot bill you unless they tell you that you will have to pay for the service before you get the service.

Sometimes, you may also receive a bill from your hospital or doctor by mistake.

If you do receive a bill:

1. Open it right away.
2. If the bill is for services that you believe are covered by KidzPartners, do not pay it. Just write "KidzPartners" and your child's KidzPartners identification number from his or her ID card on the bill.
3. Mail the bill back to the office that sent it to you. Or,
4. Call the "billing questions" phone number shown on the bill, and give them your child's KidzPartners ID number.

If you follow these steps right away, you should not receive any more bills for your children's health care (except for unpaid copay amounts) as long as you are going to KidzPartners participating doctors, hospitals, pharmacies and other providers. If you do get another bill for your children's health care, or if you have questions about what to do when you get a bill, call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

## Special Investigations Unit

Health Partners Plans' Special Investigations Unit (SIU) looks into the actions and behaviors of KidzPartners doctors and other providers, KidzPartners members, and Health Partners Plans employees.

The SIU checks to see if these people act in a way that is not legal or is not ethical (wrong).

Members who believe that providers, other members or Health Partners Plans employees have acted in a way that is not legal or is not ethical should call our SIU Hotline at 1-866-477-4848. This hotline is for reporting the suspected actions or behaviors of members, providers and employees. You do not need to tell us your name or phone number when you call our hotline — just share with us what you would like to about the actions that you think may be wrong. Some examples of behavior that is not legal or is not ethical include:

- Providers who submit claims for services they did not provide
- Providers who submit a bill for a more expensive service than the one they actually did
- A provider who pays a member to see him or her
- Providers who submit more than one bill for the same service
- Providers who perform services that are not necessary
- Providers who abuse a patient physically, mentally, emotionally or sexually
- Providers who offer a member free services, equipment or supplies in exchange for the member's ID number and then use that ID number to bill Health Partners Plans for services never provided
- A pharmacist who pays providers for referrals
- A pharmacist who gives generic drugs but bills for brand name drugs
- Members who sell their membership cards or ID numbers
- Members who sell medicines they receive through KidzPartners

## Tips for Recognizing "Fraud" and "Abuse" Issues

***When Receiving Services at a Provider's Office***

When a medical procedure is recommended, make sure the doctor explains to you why your child needs the procedure.

***When Filling Prescriptions***

Ask the pharmacist how many pills are in the bottle to make sure that it is the same number that the doctor prescribed.

When asking someone to take your child's prescription to the pharmacy to get it filled for you, make sure that you know and trust that person.

***When Attending a Gym or Physical Therapy Facility***

Make sure you initial or sign gym cards ONLY for completed visits. Do not allow someone to have you initial or sign for any visits that you are planning to complete but have not yet completed.

## Safeguards to Protect Your KidzPartners Member Identification Card

Keep your children's KidzPartners member identification cards in a safe place. Check them often to make sure that your children's cards are not missing.

Show your children's KidzPartners member identification cards or provide their identification numbers only to your children's health care providers or administrators and pharmacists.

Do not leave any documents showing your children's KidzPartners member identification numbers in public places.

When receiving your health care services, Health Partners Plans recommends that you:

- Be cautious. Be alert. Be safe.
- If you see or hear about any wrongdoing, please make a note of what you think is wrong and call our SIU Hotline at 1-866-477-4848 (TTY 711). You can use our hotline number to report any suspected wrongdoing about KidzPartners participating doctors or other providers, members and/or Health Partners Plans employees. An easy way to remember the hotline number is 1-866-HP-SIU-4U.

## For More Information

If you have any questions or need more information about your KidzPartners benefits or services, call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

You can also ask for more written information about Health Partners Plans and its policies. This information includes:

- A list of names, addresses and titles of members of Health Partners Plans' Board of Directors
- A description of the plan's confidentiality policy
- A description of the provider credentialing process for reviewing providers who want to participate in the KidzPartners network
- A list of participating providers affiliated with anticipating hospitals
- A list of participating PCPs, specialists, pharmacies and providers of ancillary services in an appropriate alternate format
- A copy of the plan's medical guidelines (utilization criteria) used in reviewing your request for care
- Whether a specific drug is covered
- A summary of how Health Partners Plans pays KidzPartners providers for their services
- A description of the plan's Quality Management program

# 10. ELIGIBILITY AND ENROLLMENT

## Who Is Eligible for CHIP?

Children must meet the following basic requirements to be eligible for CHIP:

- Pennsylvania resident
- U.S. citizen or permanent status alien
- Under age 19
- Not covered by any other health insurance plan, and not eligible for Medical Assistance

Please note that enrollment is also subject to Commonwealth of Pennsylvania funding availability. Should funding be unavailable, applicants may be placed on a waiting list. When funding is again available, enrollment would be offered to new members in the order that complete applications were received.

If eligible for CHIP, family income will determine whether a child may be enrolled on a free, low-cost or full-cost basis. If your children are enrolled for low-cost or full-cost coverage, you will be required to pay monthly premiums for this coverage, and copays for services received.

There are no copays in the free CHIP program. There are no copays for preventive health services for low-cost or full-cost CHIP members

## How Long Does Coverage Last?

If your children are enrolled into CHIP, their coverage will be effective for 12 calendar months.

## How Is Coverage Renewed?

CHIP rules require that children's eligibility for CHIP be reviewed yearly. Every year, three months before your children's anniversary date in the program, we will send you a renewal form. (The anniversary date is the date your children were originally enrolled in the program.)

To keep your children's coverage in force, you must fully complete and return the form to us before your children's anniversary date. Or, you may renew by using the COMPASS online application: Go to www.compass.state.pa.us click on "Renew your benefits" and follow the instructions there. Your children's CHIP coverage will end if all renewal information is not received when due.

## What Happens if Premium Payments Are Not Made, or Not Made on Time?

If your children are enrolled in KidzPartners low-cost or full-cost coverage, and you do not pay applicable premiums by the due date, coverage will stop. Coverage will end automatically on the last day of the month that coverage has been paid for.

Health Partners Plans provides flexible payment options, including check and money order payments and recurring credit card and debit payments, to help make paying premiums convenient for you. Premium rate changes are subject to prior review and approval by the Pennsylvania Insurance Department.

## What Is Eligibility Review?

If you have any questions about a KidzPartners eligibility determination, please call Member Relations anytime at 1-888-888-1211 (TTY 711). You should also keep in mind that if your child's circumstances (including family income) change, you can reapply for CHIP coverage or for different CHIP coverage.

You have the right to request an impartial review of Health Partners Plans' determination. (You may also ask us for a copy of the procedures that our eligibility decision was based on). If you request a review, the Pennsylvania Insurance Department (PID) will complete it.

An interview with you, a representative of Health Partners Plans and a representative of the PID will be conducted to consider the information used to determine that your children were not eligible, or that they were eligible for low-cost or full-cost rather than free coverage. You may submit information to the PID review officer to explain why you think the decision made was not correct. You may also choose to have someone act as your children's representative.

To request a review, you must send a letter explaining the reason(s) you are requesting a review and a copy of the KidzPartners notice (the denial or disenrollment notice, or letter approving low-cost or full-cost coverage). You must send your request within 30 days of the date on the KidzPartners notice to:

Eligibility Review Committee
Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107

If we cannot resolve your issue, we will forward your written request and any additional information to the Pennsylvania Insurance Department.

The Pennsylvania Insurance Department will contact you with detailed information, including the date and time when the interview is scheduled. Reviews are usually done by phone, but you may request an interview in person.

## Loss of Coverage

In addition to the issues discussed above (failure to pay applicable premiums when due and failure to fully comply with renewal requests), there are other reasons why KidzPartners coverage may be ended. These include but are not limited to:

- Aging out: CHIP coverage generally ends on the last day of the month of the member's 19th birthday. If the member is hospitalized or receiving other inpatient care at this time, however, coverage will be extended until the member is discharged from the facility.

- Moving out of the KidzPartners service area (if you move elsewhere in Pennsylvania, you will need to choose another CHIP program)
- Willful misrepresentation or fraud in applying for your children's KidzPartners coverage
- Violation of the material terms of the application
- Misuse of your children's ID cards, including allowing use of the cards by anyone other than your enrolled children (if the subscriber is responsible for the misuse, all of the subscriber's enrolled children are subject to loss of coverage)
- Failure of the member and PCP to establish a satisfactory patient-doctor relationship, if the plan has provided the member an opportunity to select another PCP in good faith; the member has repeatedly refused to follow the doctor's treatment plan; and the plan has notified the member in writing at least 30 days in advance that it considers the patient-doctor relationship to be unsatisfactory, and specific changes are necessary to avoid disenrollment, subject to the plan's grievance procedure. (Disenrollment of the member's entire family will not result unless the member is the subscriber.)
- Another reason approved by the Commissioner of Insurance

If Health Partners Plans intends to end your children's coverage for one of the reasons listed, you will be notified in writing at least 15 days in advance. The notice will include the reason for disenrollment, and information about your rights. If any member is an inpatient in a hospital or skilled nursing facility when coverage is due to be ended, coverage will be extended until the member is discharged (or at least until the member's benefit limit has been reached, if this date is earlier.)

Your children will never lose their coverage based on their health status. Nor will they lose their coverage as a result of your filing a complaint or grievance with the plan.

You can choose to disenroll your children for any reason. If you decide to leave KidzPartners, you can choose any other CHIP program that serves your county. However, we value having your children as KidzPartners members and hope that you will call Member Relations first if you are thinking about leaving. This way, you can give us the chance to help fix any problems you may be having. You and your children are important to us!

# 11. TERMS YOU MAY NOT KNOW

Certain language used in this Member Handbook is specific to health care, managed care or the Commonwealth's CHIP program. The following are brief definitions of some words you may not know.

**Advance Directives** – Legal documents used to spell out what medical treatment you will accept, refuse or end if you are too sick to speak for yourself. See page 39 for more details.

**Ancillary Providers** – Non-physician health care professionals/agencies that provide any of a number of specialized health services, such as home health care, durable medical equipment and radiology studies (x-rays). Ancillary providers that participate with KidzPartners are included in both the printed and online KidzPartners provider directories.

**Case Manager** – A health care professional who works with members to ensure that they receive needed services and extra help that they may need to access these services. Case Managers help KidzPartners members in areas including disease management, special needs and maternity care.

**Complaint** – When you tell us that you are unhappy with Health Partners Plans, a decision we've made, or a participating provider. See pages 47 – 52 for more details.

**Copayment** – The part of covered healthcare costs that is your responsibility to pay. The "copay" amount depends on your membership category and on the type of health care service. See page 15 for more details.

**Eligibility Review** – Examination of a plan's decision regarding CHIP eligibility. The Pennsylvania Insurance Department conducts these examinations, if requested, when the member or prospective member disagrees with the decision made. See page 56 for more details.

**Formulary** – List of medicines approved for use by KidzPartners members. Non-formulary medicines will not be covered without prior approval by the plan. See page 23 for more details.

**Grievance** – When you tell us that you disagree with our decision to deny, reduce or stop a service or item you requested, or to approve a different service or item in its place. See pages 47 – 52 for more details.

**Managed Care** – A type of health insurance that takes an active role in overseeing the member's health care, generally requiring the use of plan-specified doctors and other providers and the prior approval of certain services by the plan. Health Partners Plans is a managed care organization.

**Medical Assistance** – A state/federal-funded health program that provides coverage to residents who meet income and other requirements. Pennsylvania residents eligible for Medical Assistance (also known as Medicaid) cannot enroll in CHIP.

**Medically Necessary/Medical Necessity** – Basis for determining the need for and appropriateness of health care services. See page 33 for more details.

**Participating Provider** – A provider contracted with the plan to provide care/services to its members. With very limited exceptions, all services provided to KidzPartners members must be provided by participating providers. Services provided by non-participating providers without prior plan approval will not be covered. See page 6 for more details.

**Premium** – The monthly cost for CHIP coverage for those members enrolled in the low-cost or full-cost programs. Premiums are billed monthly by the plan.

**Primary Care Provider (PCP)** – Doctor or other health care professional who provides or coordinates a member's basic health care needs.

**Prior Authorization** – Approval by the plan required before some types of health care services are performed. Prior authorization should be obtained by the provider on behalf of the member for such services, and can be confirmed by contacting Member Relations. See page 32 for more details.

**Special Needs Unit** — Department that provides extra help to members with physical or behavioral disabilities, complex or chronic health issues or other special needs. See page 35 for more details.

**Well-child/Well-adolescent Visits** – PCP and other visits for screenings, immunizations and other preventive health services. KidzPartners members in all premium categories are covered for preventive services with no copays. See page 35 for more details.

# KidzPartners Quick Reference

**Member Relations**
Call 1-888-888-1211
Available 24 hours, every day, for questions about coverage and help with plan services.

**TTY users**
Call 711
For deaf and hearing/speech-impaired members with access to special telephone equipment.

**Teladoc Medical Assistance Line**
Call 1-800-Teladoc (835-2362)
Available 24 hours, every day, to answer health questions. (Not for emergency situations. Call 911 in an emergency.)

**Office Address**
901 Market Street, Suite 500
Philadelphia, PA 19107
Office Hours: Monday – Friday, 9 a.m. to 5 p.m.

**Enrollment Mailing**
PO Box 1420
Philadelphia, PA 19105-1420
For mailing applications/supporting materials ONLY.

**Payment Mailing**
PO Box 42971
Philadelphia, PA 19101-2971
For mailing premium payments ONLY.

**Email**
dspencer@hpplans.com
Send KidzPartners an email message at your convenience.

**Website**
HealthPartnersPlans.com
Learn more about KidzPartners, find participating doctors, health information and more.

**Community Outreach Office**
826 E. Allegheny Avenue
Philadelphia, PA 19134
Call 215-426-4372
Our Member Relations satellite location, available Monday – Friday, 8 a.m. to 4:30 p.m.

**SIU Fraud & Abuse Hotline:**
Call 1-866-477-4848
Available 24 hours, every day, to leave messages or anonymous tips about suspected wrongdoing.

Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107
1-888-888-1211
Visit us at HealthPartnersPlans.com

For additional help, around the clock, please call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

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

Health Partners Plans

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