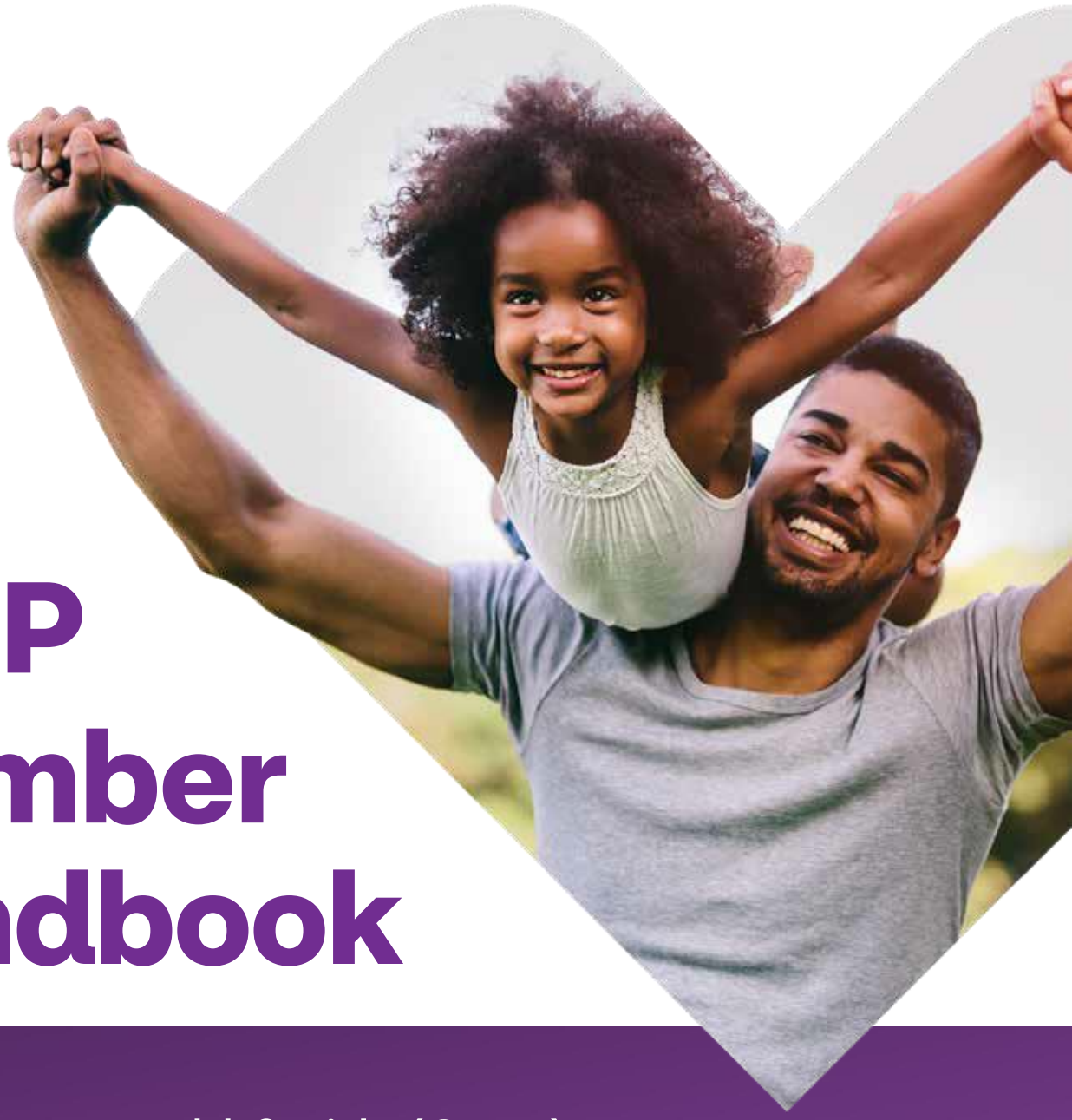

CHIP Member Handbook

Aetna Better Health® Kids (CHIP)

Learn about your health care benefits

Healthier happens together™

AetnaBetterHealthKidsPA.com

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

aetna®

PA-25-10-10 (Rev 2/2026)

Write important numbers here!

Your child's member ID number

_____

Your other child's member ID number

_____

Your child's Primary Care provider (PCP)

_____

Your other child's Primary Care provider (PCP)

_____

Pharmacy

_____

Poison control center

_____

In case of emergency, call 911 or your local emergency hotline.

Any questions? Call Member Services at **1-800-822-2447(toll-free) or TTY:711 (hearing impaired only)**.

Visit our website at **www.AetnaBetterHealth.com/Pennsylvania**

If you need this material translated into another language, call Member Services at **1-800-822-2447(TTY:711)**.
Si usted necesita este material en otro lenguaje, llame a Servicios al Miembre al **1- 800-822-2447(TTY:711)**.

This managed care plan may not cover all of your child's health care expenses. Read the plan contract carefully to determine which health care services are covered. To contact the plan, call **1-800-822-2447 (TTY:711)**.

Aetna Better Health® Kids Member Handbook

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

Children's Health Insurance Program

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Welcome!

Thank you for enrolling your child in the Children's Health Insurance Program (CHIP) brought to you by Aetna Better Health Kids. Your child has a wide range of benefits available to them through the CHIP program. These include, but are not limited to:

- Doctor's visits
- Prescriptions
- Checkups
- Dental care
- Vision care
- Emergency room visits
- Behavioral health care
- Hospital stays
- Tests and x-rays

CHIP is a state and federally funded program that provides health insurance for uninsured children up to age 19, who are not eligible for Medical Assistance. We provide CHIP coverage through a contract with the Pennsylvania Department of Human Services Offices of Medical Assistance Programs Bureau of Children's Health Insurance Program (CHIP). Every CHIP member must renew benefits annually (subject to program funding availability and continued eligibility). The renewal process is simple and described in this handbook.

This handbook will help you understand your child's CHIP benefits, how to access care, and how to get in touch with us. It also provides information on members' rights and responsibilities.

If you haven't received your child's Aetna Better Health Kids member identification card (ID) in the mail, it will arrive shortly. Each child enrolled receives his or her own ID card. You'll need to use this ID card when your child gets care. You'll also need to take the card to the pharmacy when picking up prescriptions for your child.

If you have any problems reading or understanding this information, have questions about your child's coverage or the care your child is receiving, or don't get your child's ID card, call us at **1-800-822-2447 (TTY: 711)**.

Welcome to CHIP, brought to you by Aetna Better Health Kids! We're glad you're a member and look forward to serving you.

2. Eligibility and Enrollment

Who is eligible for CHIP?
To qualify and enroll in CHIP, your child must be:
- Under the age of 19
- A U.S. citizen, a U.S. National or a qualified alien
- A resident of Pennsylvania
- Uninsured
- Not eligible for medical assistance

How can I check on the enrollment or eligibility status of my child?
You can check on your child's enrollment, the benefits they have available to them and find participating providers in your area by calling Member Services at **1-800-822-2447 (TTY: 711)**. You can check your eligibility status by checking your COMPASS account or contacting the County Assistance Office (CAO).

What CHIP options are available?
Depending on your family size and income, your child may qualify for free, low-cost, or full-cost CHIP coverage. Free coverage doesn't require monthly premium payments or co-payments. Low-cost and full-cost coverage requires a monthly premium payment and copayments for certain services. If your child qualifies for low-cost or full-cost coverage, you'll receive detailed instructions and a monthly bill that must be returned with your payment in order for your child to remain enrolled in CHIP. Your child may lose coverage if the monthly premium isn't paid by the due date on the invoice.

What changes do I need to report during the benefit year?
All changes in your family's circumstances after your child has been enrolled, need to be reported to COMPASS or the County Assistance Office (CAO). If you don't report changes promptly, you may lose coverage. These changes can include:
- Family size
- Address
- Phone number
- Household income or employment status
- Coverage under a private or employer sponsored plan or Medical Assistance

When will I get my child's member ID card?
You'll get your child's Aetna Better Health Kids identification (ID) card(s) in the mail within 5 to 7 business days of enrolling. The card(s) entitles your child to all of the CHIP benefits explained in the benefit portion of this handbook (including medical, dental, vision, behavioral health, etc.). The card(s) will include:
- Your child's name
- Member identification number
- PCP name and phone number
- Phone numbers for Member Services, dental services, behavioral health services and eye care services
- Your child's ID card(s) is for his or her use only. Never let anyone else use your child's ID card(s).

When does my child need to use an Identification card?
You'll need to show your child's ID card to providers whenever your child needs to get any covered services.

What do I do if my child's ID card is lost?
Call Member Services at **1-800-822-2447 (TTY: 711)** immediately if your child's ID card is lost. We'll send you a new ID card in the mail.

Can I transfer my child's CHIP coverage to a different CHIP insurance company?
Yes. To transfer your child's CHIP coverage to a different CHIP insurance company, contact the CHIP Bureau at **1-800-986-KIDS (5437)** and request the transfer. Before you request the transfer, check that the insurance company you want to switch to participates in CHIP in your area and that your doctor participates with that insurance company. The change will take place shortly after you call us. There will be no lapse in CHIP coverage. You'll be told the effective date of change. You'll also get a letter confirming this information. Until that date, your child must continue to use their CHIP benefits through Aetna Better Health Kids.

Can I request a re-assessment of eligibility during a CHIP benefit year?
Yes, you can request a re-assessment through your CAO or through COMPASS of your child's eligibility during the CHIP benefit year to see if they might qualify for a less expensive CHIP option. The CAO will re-assess your child's eligibility based on any changes in the size of your family or income. The CAO will let you know if the changes would or wouldn't result in a change of CHIP options. You don't have to change options while in the middle of a benefit year.

How can I add another child to CHIP coverage?
If your family already has one child enrolled in CHIP, you can add another child in the family by calling the PA County Assistance Office at **1-800-692-7462** or you can use the COMPASS website to apply online or to find your local county office details.

Will a pregnant CHIP member stay on CHIP?
A CHIP member who becomes pregnant during their 12-month term of CHIP eligibility will remain in CHIP for the duration of the 12-month term (and 12 months postpartum). When the baby is born, they must contact the CAO immediately so the CAO can screen the newborn for CHIP or Medical Assistance eligibility. The CAO will determine which program the newborn is eligible for using the right information on income and family size in the member's original application.

How can a CHIP member's newborn be added to CHIP coverage?
If a CHIP member has a newborn baby while enrolled in CHIP, the newborn is automatically covered by CHIP for the first 31 days of life. You'll need to call the PA County Assistance Office at **1-800-692-7462** or use the COMPASS website to apply online or to find your local county office details immediately after the child is born to start the enrollment process. This is necessary for the newborn to get their own health care coverage after the 31-day period ends.

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

How do I renew my child's CHIP coverage?
You'll get a letter and renewal form from the CAO 90 days before the end of the benefit year. The renewal letter and renewal form will tell you what information you need to provide

for the annual review.

You can renew online at **www.compass.state.pa.us** or by paper. Go to our website for a full list of instructions on how to renew online at **AetnaBetterHealth.com/Pennsylvania**. If you want to renew by paper, make sure you complete the form and return it with all required information before the deadline. If you don't, your child's CHIP coverage will end on the date stated in the letter. It's possible that your child's health care coverage will change upon yearly renewal. We must review your family's income every year. Within 15 days of getting your renewal form and any requested documents, you'll get a letter telling you whether your child continues to be eligible for CHIP. It'll also explain any changes in coverage for the new benefit year.

If your child isn't eligible for CHIP, the CAO will determine if your child is eligible for Medical Assistance and will send you a letter of their decision. If your child isn't eligible for CHIP or Medical Assistance, you'll get a letter explaining why your renewal application was denied, along with information on how to appeal the decision if you disagree with it.

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

You'll receive written notice from the CAO in the mail before your child's coverage ends. The letter will include the date that your child's CHIP coverage will end and the reason it is ending.

The following reasons will result in the termination of your child's CHIP coverage:

- Your child is no longer eligible for CHIP due to your family income being too low. If your child is no longer eligible for CHIP due to your family income being too low, your child's CHIP coverage will end on the renewal date. The CAO will determine if your child is eligible for Medical Assistance. During the period of review with Medical Assistance, your child will not have a lapse in coverage.
- You don't respond to renewal notices. If you don't respond to any renewal notices, then your child's coverage will end. You must renew health coverage for your child(ren) every year, so if you don't respond, their coverage will end.
- You don't provide all the requested information needed for the CAP to complete the renewal process. You must provide the required information listed on your renewal form or the renewal cannot be completed, and your child's CHIP coverage may end.
- If you are a Full-cost CHIP member and your child is covered under a private health insurance policy or Medical Assistance. Your child's CHIP coverage will end going back to the first day of the month the other coverage was reported. Your child will not suffer a lapse in coverage. You'll also receive a refund for any premiums paid to Aetna Better Health Kids after the termination date.
- Non-payment of the premium in Full-cost CHIP. If your child is enrolled in the Full-cost CHIP programs, and you don't pay the premium by the due date, you'll get a letter 30 days before the end date letting you know that you have 30 days to pay the premium or your child's CHIP coverage may end.
- Voluntary termination. You can end your child's CHIP coverage at any time by calling PA County Assistance at **1-800-692-7462** or use the COMPASS website to find your local county office detail.
- Your child turns 19 years of age. A child is eligible for CHIP up to age 19. Coverage ends on the last day of the calendar month when the child turns 19.
- Your child moves out of state. CHIP only covers Pennsylvania residents. Your child's coverage will end retroactive to the first of the month immediately following his or her relocation to a different state.
- Your child is a prison inmate or a patient in a public institution for mental disorders. Your child's eligibility will be re-evaluated if he or she is a prison inmate or a patient in a public institution for mental disorders. Once your child is no longer in prison or a public mental institution, and meets the other eligibility requirements, he or she will become eligible for

CHIP again.

- Misinformation was provided at the time of application or renewal that would have resulted in a determination of ineligibility. If we determine that you used incorrect or fraudulent information in applying for or renewing CHIP coverage for your child, your child's coverage will be terminated.

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

If you don't agree with CHIP eligibility decision, you will be able to appeal the decision and request a reconsideration through the Department of Human Services. Appeal information is provided with each eligibility notice that you will receive from the Department of Human Services.

The CHIP Bureau does this review. If you request a review, it will be done with you and a representative from the CHIP Bureau. The CHIP Bureau will consider the information that was used to make the decision that your child isn't eligible for CHIP or of the decision to terminate your child's current CHIP coverage. You may send information to the review officer that explains why you think the decision was incorrect. You can choose someone to act as your representative.

3. Member Rights and Responsibilities

Member rights

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

- Get information about your child's rights and responsibilities
- Get information about all the benefits, services and programs offered by CHIP, brought to you by Aetna Better Health Kids
- Know about policies that can affect your child's membership
- Basic information about doctors and other providers who participate with Aetna Better Health Kids
- Choose from Aetna Better Health Kids' network of participating providers and refuse care from specific doctors
- Request that a specialist serve as your child's primary care provider if your child has certain special medical needs or diagnoses
- Be treated with respect and due consideration for your child's dignity and privacy
- Expect that information you give to Aetna Better Health Kids and anything you or your child discuss with your child's doctor will be treated confidentially, and will not be released to others without your permission
- Have all records pertaining to your child's medical care treated as confidential unless sharing them is required to make coverage decisions or is otherwise required by law
- See your child's medical records unless access is specifically restricted by reason of law or by the attending physician for medical reasons, to keep copies for yourself and to ask to have corrections made if needed
- Get clear and complete information from your child's doctor about your child's health condition and treatment including what choices you have and what risks are involved
- Get information about available treatment options and alternatives, regardless of cost or benefit coverage
- Be a part of any decisions made about your child's health
- Refuse to have your child receive any drugs, treatment, or other procedure by Aetna Better Health Kids or offered by its providers to the extent permitted by law
- Be informed by a physician about what may happen if you refuse drugs, treatments

or procedures
- Refuse to allow your child to participate in medical research projects
- Give informed consent before the start of any procedure or treatment
- Ensure your child receives timely care in case of an emergency
- Question decisions made by Aetna Better Health Kids or its participating providers, and to file a complaint or grievance regarding any medical necessity or administrative decisions you disagree with
- Make recommendations regarding Aetna Better Health Kids' members' "rights and responsibilities" policy
- Exercise your rights without adversely affecting the way Aetna Better Health Kids, its providers and state agencies may treat you

Member responsibilities

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

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

3. Member Services

Member Services is ready to help you with any questions about your child's coverage or the care your child receives. Your member ID card has the Member Services toll-free number. You can reach Member Services by calling **1-800-822-2447 (TTY: 711)**. For your convenience, Member Services is available 24 hours a day, 7 days a week.

You may also visit our website at **AetnaBetterHealth.com/Pennsylvania** for more information about your child's CHIP benefits. You can also write us at:

Aetna Better Health Kids
PO Box 818047
Cleveland, OH 44181-8047

Can Member Services help me if I speak a foreign language?

Yes. No matter what language you speak, we can help. Call us at **1-800-822-2447** and let us know what language you speak and that you'll require special assistance. You can also request a member Handbook or other Aetna Better Health Kids information in print or another language or format, at no cost. What number do I call if I am hearing impaired? Call **1-800-628-3323** if you're hearing impaired and are calling from a TTY phone.

How can Member Services help me if I am visually impaired?

Call Member Services at **1-800-822-2447 (TTY: 711)** if you're visually impaired and would like to request a member Handbook or other Aetna Better Health Kids information in an alternative format such as audio tape, Braille or large print, at no cost.

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-385-4104 (TTY/PA RELAY: 711) or speak to your provider.

ATENCIÓN: Si habla otro idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia linguística. También, están disponibles sin cargo ayudas y servicios auxiliares apropiados para brindarle información en formatos accesibles. Llame al 1-800-385-4104 (TTY/PA RELAY: 711) o hable con su proveedor.

注意：如果您使用简体中文，您可以免费获得语言援助服务。您还可以免费获得以无障碍格式提供信息的适当辅助设备和服务。请致电 1-800-385-4104 (TTY/PA RELAY: 711) 或咨询您的医疗服务提供者。

ध्यान दिनुहोस्: यदि तपाईं अंग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने, नि:शुल्क भाषा सहायता सेवाहरू तपाईंको लागि उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायता र सेवाहरू पनि नि:शुल्क उपलब्ध छन्। 1-800-385-4104 (TTY/PA RELAY: 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ВНИМАНИЕ: Если вы говорите на языке, отличном от английского, то вам доступны бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также доступны для вас бесплатно. Звоните по номеру 1-800-385-4104 (TTY/PA RELAY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة بالمجان. تتوفر أيضًا مساعدات وخدمات مساعدة مناسبة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالرقم 1-800-385-4104. (TTY/PA RELAY: 711) أو تحدث إلى مقدم الخدمة الخاص بك.

ATANSYON: Si lang ou pale a se pa anglè li ye, gen sèvis èd pou lang ki disponib gratis pou ou. Èd ak sèvis konplemantè pou founi enfòmasyon nan yon fòma ki aksesib, disponib pou ou tou gratis. Rele 1-800-385-4104 (TTY/PA RELAY: 771) oswa pale ansanm avèk founisè ou an.

CHÚ Ý: Nếu quý vị nói ngôn ngữ không phải tiếng Anh, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi số 1-800-385-4104 (TTY/PA RELAY: 711) hoặc nói chuyện với nhà cung cấp của quý vị.

УВАГА: Якщо ви розмовляєте мовою, відмінною від англійської, то вам доступні безкоштовні послуги мовної допомоги. Відповідні допоміжні засоби та послуги з надання інформації в доступних форматах також доступні для вас безкоштовно. Телефонуйте за номером 1-800-385-4104 (TTY/PA RELAY: 711) або зверніться до свого постачальника послуг.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
您還可以免費獲得以無障礙格式提供資訊的適當輔助設備和服務。請致電
1-800-385-4104 (TTY/PA RELAY: 711) 或諮詢您的醫療服務提供者。

ATENÇÃO: se você fala um idioma diferente do inglês, encontram-se disponíveis serviços linguísticos gratuitos. Auxílios e serviços auxiliares para fornecer informações em formatos acessíveis estão disponíveis gratuitamente. Ligue para 1-800-385-4104 (TTY/PA RELAY: 711) ou fale com seu provedor.

লক্ষ্য করুন: যদি আপনি ইংরেজি ছাড়া অন্য কোনো ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। প্রবেশযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবাও বিনামূল্যে পাওয়া যায়। অনুগ্রহ করে 1-800-385-4104 নম্বরে ফোন করুন (TTY/PA RELAY: 711) অথবা আপনার সেবা প্রদানকারীর সঙ্গে যোগাযোগ করুন।

ATTENTION : Si vous parlez une langue autre que l’anglais, des services d’aide linguistique vous sont proposés gratuitement. Des aides et services complémentaires appropriés visant à fournir des informations dans des formats accessibles vous sont également proposés gratuitement. Appelez le 1-800-385-4104 (TTY/PA RELAY: 711) ou adressez-vous à votre prestataire.

សូមចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស
សេវាជំនួយផ្នែកភាសាមានផ្តល់ជូនអ្នកដោយឥតគិតថ្លៃ។ ឧបករណ៍ជំនួយ
និងសេវាកម្មបន្ថែមដែលសមស្របសម្រាប់ផ្តល់ព័ត៌មានក្នុងទ្រង់ទ្រាយដែលអាចចូលដំណើរការបាន
ក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-800-385-4104
(TTY/PA RELAY: 711) ឬពិគ្រោះជាមួយអ្នកផ្តល់សេវារបស់អ្នក។

주의: 영어가 아닌 다른 언어 사용자인 경우 무료 언어 지원 서비스를 사용할 수 있습니다.
접근 가능한 형식으로 정보를 제공하는 적절한 보조 도구 및 서비스도 무료로 제공됩니다.
1-800-385- 4104 (TTY/PA RELAY: 711) 번으로 전화하거나 제공자에게
문의하십시오.

ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની ભાષા બોલો છો, તો તમારા માટે મફત ભાષા સહાય
સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને
સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-385-4104 (TTY/PA RELAY: 711) પર
કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

4. Primary Care Provider

What role does a primary care provider (PCP) play in my child's health care?
A PCP is your child's regular doctor. Pediatricians, internists and family medicine practitioners are examples of different types of PCPs. Your child may have a specialist serve as his or her PCP if he or she has special needs or certain diagnoses. This is possible only if the specialist agrees to act as your child's PCP and if Aetna Better Health Kids approves the arrangement.

An example of such an instance would be a pregnant member selecting an OB-GYN as her PCP.

PCPs provide well-child exams and preventive services. They also see your child when he or she is sick. PCPs help coordinate care if your child needs tests, needs to see a specialist or has to go to the hospital.

Your child's PCP will have someone available 24 hours a day, 7 days a week to help with your child's health care.

If your child requires care after your PCP's normal office hours, call your child's PCP. Either your PCP or another health care provider will instruct you where to take your child to get care if the problem cannot wait until the PCP's normal office hours.

What if my child's current PCP is not a participating provider?
You must tell us immediately if your child is a new Aetna Better Health Kids member and is currently being treated by a PCP who isn't in our network. In order to promote continuity of care, Aetna Better Health Kids will allow your child to keep seeing that provider for up to 90 days if the provider is willing to work with Aetna Better Health Kids on a non-participating basis. During this time, Aetna Better Health Kids will help you find a PCP who is in our network to take over the care of your child.

Under certain circumstances, we may not be able to honor your request for a certain provider. If a provider has been removed from the Aetna Better Health Kids network for quality issues, or if the federal or state government agency decides that a provider cannot participate in a government program, we cannot cover that provider's services.

How do I select my child's PCP?
All enrolled children must have a PCP. You can use the provider search feature on our website to help you find a participating PCP. If you don't have a computer or access to the internet, call us at **1-800-822-2447 (TTY: 711)**. We'll help you find a doctor. You have ten calendar days from the receipt of your notice of enrollment letter to select a PCP. We'll assign a PCP for your child if you don't select a PCP.

If you choose a PCP who isn't already treating your child, call the PCP and make sure they're taking new patients. You can reach the PCP at the telephone number listed in the provider directory. If the PCP agrees to take your child as a patient, notify us by calling **1-800-822-2447 (TTY: 711)**. Call us for help if you have difficulty finding a PCP who is accepting new patients.

How do I change my child's PCP?

You can choose a new PCP for your child at any time if you follow these steps:

- Select your new PCP from the list of participating providers in the provider directory found on our website at **AetnaBetterHealth.com/Pennsylvania**. The online provider directory lists information of all network providers, including names, addresses, phone numbers, specialties and qualifications, board certification status and more. You can also search our providers on the **HealthGrades.com** website to get more information, such as medical school attended and residency completion.
- Make sure the PCP takes new patients. Call Member Services at **1-800-822-2447 (TTY: 711)** and tell us that you want to change your child's PCP.
- In most cases, the change becomes effective immediately at the time you request the change, and the provider's availability to accept new patients is established. We'll tell you the date your child can start seeing his or her new PCP. Your child may not get services from his or her new PCP until the date the change officially becomes effective. You may be responsible for paying bills for those services if your child gets services from the new PCP before then. Your child will get a new ID card in the mail that lists the new PCP.

5. Specialist Providers

Specialists have training, education and a board certification or license in a specialized area of health care. A specialist is usually not your PCP unless your child has special needs or certain diagnoses.

If your PCP thinks that your child has an illness or condition that requires the services of a specialist, they'll send you to a specialist provider.

Make sure that your specialist is in our network. You can find out by calling the specialist's office and asking if they participate with Aetna Better Health Kids.

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

If you think your child has an illness or condition that needs to be treated by a specialist, you should discuss this with your PCP. Your PCP will help you decide what type of specialist can best help your child.

How do I find an in-network specialist provider?

Your PCP can help to refer you to a specialist, you can call Member Services at **1-800-822-2447 (TTY: 711)** , or look online at the provider directory at **AetnaBetterHealth.com/Pennsylvania**. Our provider directory has a list of all types of in-network providers and their names, addresses, phone numbers and languages.

You can request to see a specialist that is not in our network if we:

- Determine we do not have a provider in our network that can cover your necessary treatments in a timely manner
- Only have one of a certain type of specialist in our network

All you have to do is call us to ask to see a provider that's not in our network. The provider that's not in our network must request prior authorization. If we deny the request for you to see a provider that's not in our network, you can file a complaint or grievance. We'll cover these services out-of-network for as long as we're unable to cover the services in network.

What if my child's current specialist is a non-participating provider?

If your child is a new Aetna Better Health Kids member and gets treatment from a specialist who is not in the Aetna Better Health Kids network, you must notify Aetna Better Health Kids

immediately. In order to promote continuity of care, under most circumstances, we'll allow your child to keep seeing that provider for up to 90 days. In order for this to happen:

- Your child must be actively continuing a course of treatment
- The specialist must be willing to work with Aetna Better Health Kids on a non-participating basis
- During this time, we will help you find a specialist who is in our network to take over the care of your child

What if my child is pregnant and her current OB-GYN isn't a participating provider?
Under most circumstances, your daughter can continue to get services from her current OB-GYN throughout her pregnancy, at the time of her delivery and for post-partum care. A member may continue with her current provider if not in our network or can select a new OB-GYN provider that participates with Aetna Better Health Kids. If you need help finding a participating OB-GYN provider accepting new patients, call Member Services at **1-800-822-2447 (TTY: 711)**.

How can my child get a second opinion?
Your child can get a second opinion regarding the medical necessity of surgery or any other recommended medical treatment. If there's only one specialist in our network trained to provide a particular service, your PCP can send your child to an out-of-network specialist provider for a second opinion.

Your PCP will need to contact Aetna Better Health Kids to get special approval for your child to receive services from an out-of-network provider.

Can a specialist serve as my child's PCP?
Members with special needs or certain diagnoses may request that an appropriate in network specialist serve as his or her PCP. This is possible only if the specialist agrees to act as your child's PCP and if Aetna Better Health Kids approves the arrangement. An example would be a pregnant member selecting an OB-GYN as her PCP. Call Member Services at **1-800-822-2447 (TTY: 711)** to determine if your child is eligible to have a specialist serve as his or her PCP. You have the right to get some services without asking your PCP or getting a prior authorization. This is called direct access.

Members have direct access and can self-refer to Aetna Better Health providers for the following covered services:

- Vision exams
- Dental services
- First visit with a chiropractor (other visits must be authorized). Up to twenty (20) visits per year.
- First visit with a physical therapist (other visits must be authorized)
- Emergency care
- Routine and preventive care
- Inpatient/Outpatient Substance Use Disorder and Mental Health rehab services (this includes treatment in a residential setting). Members as young as 14 years old can self-refer.
- Women's health care services including:
  - Gynecological and obstetrical providers
  - Preventive health care
  - Mammograms/breast exams
  - Pap tests (cervical cancer screenings)
  - Routine family planning services (birth control)

What is continuity of care?
Continuity of care refers to the ongoing committed relationship between a member and his or her provider. Promoting continuity of care allows providers to act as advisors and patient advocates as the member moves through various stages of the health care system.

How does Aetna Better Health Kids promote continuity of care for my child?
If your provider ever leaves the Aetna Better Health Kids network or if you get treatment from a non-participating provider when you join Aetna Better Health Kids, we're responsible for working with you to make sure your child will be able to keep getting the health care that he or she needs. Under most circumstances, if a provider you see stops participating with Aetna Better Health Kids, you can continue an ongoing course of treatment with that provider for a transitional period.

A new member may also continue a course of treatment with a non-participating provider for a transitional period under most circumstances. This includes both a member's primary care physician and specialists that are actively treating the member at the time CHIP coverage with Aetna Better Health Kids begins.

Under what circumstances would a provider not be allowed to provide care to my child under the continuity of care policy?
Under certain circumstances, Aetna Better Health Kids may not cover services provided by a certain provider. Some examples of these situations include, but are not limited to:
- Your current provider refuses to accept payment from Aetna Better Health Kids
- Your current provider has been excluded from the Aetna Better Health Kids network for cause
- Your current provider is prohibited from receiving monies from a government funded program

6. Appointment Standards

Aetna Better Health Kids is required to have a network with enough providers to ensure enrollees have timely access to covered services.

Network providers agree to provide Aetna Better Health Kids enrollees with appointments within the timeframes listed below. If a network provider tells you that you must wait longer than these timeframes, please call Member Services at **1-800-822-8447 (TTY:711).**

Appointment Availability Standards

Condition	Member	Provider	Standard
Emergency	CHIP	PCP or specialist	Members must be seen immediately or referred to an emergency facility
Behavioral health emergency	CHIP	PCP or specialist	Immediately seen or referred to emergency room
Urgent medical condition	CHIP	PCP or specialist	Appointments must be scheduled within 24 hours

Behavioral health non-life threatening	CHIP	PCP or specialist	Appointments must be scheduled within 6 hours
Behavioral health urgent – no immediate danger	CHIP	PCP or specialist	Appointments must be scheduled within 48 hours
Routine (physical and CHIP behavioral)	CHIP	PCP	Appointments must be scheduled within 10 business days, with wait time less than 30 minutes
Specialists		Specialist: • Pediatric Dentist • Dermatology • Orthopedic surgery • Otolaryngology • Pediatric allergy and immunology • Pediatric endocrinology • Pediatric gastroenterology • Pediatric general surgery • Pediatric hematology • Pediatric infectious disease • Pediatric nephrology • Pediatric neurology • Pediatric oncology • Pediatric pulmonology • Pediatric rehab medicine • Pediatric rheumatology • Pediatric urology	Appointments must be scheduled within 15 business days
All other specialty pediatric general surgery		Specialist	Appointments must be scheduled within 10 business days

Health assessment	CHIP	PCP	Appointments must be scheduled within 3 weeks of enrollment
General physical examination	CHIP	PCP	Appointments must be scheduled within 3 weeks of enrollment
First physical examination	CHIP	PCP	Appointments must be scheduled within 3 weeks of enrollment

Appointment Availability Standards (Obstetrics)

Condition	Members	Provider Types	Standards
Prenatal:			
	Initial visit in first trimester	OB/GYN or certified nurse midwife	Appointments must be scheduled within 10 business days of the member being identified as pregnant
	Second trimester	OB/GYN or certified nurse midwife	Appointments must be scheduled 5 business days of member being identified
	Third trimester	OB/GYN or certified nurse midwife	Appointments must be scheduled 4 business days of being identified
	High-risk pregnancy	OB/GYN or certified nurse midwife	Appointments must be scheduled within 24 hours of identification or immediately if an emergency exists

7. Emergency Care

What is an emergency?

The definition for emergency medical condition is a "medical condition manifesting itself by acute symptoms of sufficient severity, (including 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 immediate danger or death."

In an emergency:

- Call **911** for help or
- Go to the nearest emergency room or
- Call an ambulance to take you to the emergency room

If you feel like you or your child's life is in danger or health is at serious risk, you should get medical help immediately. You don't need pre-approval for emergency services. Examples of emergency conditions include:

- Sharp chest pains
- Placing the health of the individual, (or 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
- Passing out

- Poisoning
- Medicine or drug overdose
- Bleeding that will not stop
- Severe burns
- Broken bones
- Choking
- Danger of losing a limb
- Life threatening condition
- Hard to breathe
- Not able to move
- Seizures

How to get emergency medical care

Remember, only use an emergency room when you have an emergency. If you do have an emergency, go to the nearest emergency room. You don't need pre-approval for emergency ambulance transportation or emergency care in the hospital. The hospital must treat you if you have a medical emergency.

Emergency transportation is covered in emergencies. Call an ambulance or call **911** for help.

Once you're at the hospital, remember that you can say no to treatment. You can also ask for another hospital or refuse to go to another hospital.

Don't use the emergency room for follow-up care. Instead, call your PCP for follow-up care. Only go back to the emergency room if your PCP tells you to. We may not cover follow-up care in the emergency room. You may get a bill.

What is urgent care?

The definition for urgent medical condition is "any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency medical condition." Call your PCP if your child has any of these:

- Sore throats
- Colds
- Vomiting
- Rashes
- Bruises
- Sprains
- Diarrhea
- Earaches
- Stomach aches (not usually emergencies)

What is an urgent care center?

Urgent care centers are facilities that provide basic medical care for walk-in patients with illnesses or injuries that don't require emergency care, such as sprains or cuts requiring stitches. You can call Member Services at **1-800-822-2447 (TTY: 711)** if you need to find a participating urgent care center in your service area or you can click **https://www.aetnabetterhealth.com/pennsylvania/find-provider** to find a provider.

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

After-hours care (non-emergency)
Call your PCP if you don't need emergency care. Your PCP or an on-call provider is available 24 hours a day, 7 days a week. On-call health care professionals such as medical residents, nurse practitioners and physician assistants may assist in providing you with the necessary care and treatment. Your doctor or on-call health professional will tell you what to do.

You also have access to a virtual option for your urgent care needs. Please go to our website, **AetnaBetterHealth.com/Pennsylvania** or call Member Services at **1-800-822-2447 (TTY: 711)** for more information.

8. Out of Network Providers

What is an out-of-network provider?
An out-of-network provider is a provider that doesn't have an agreement or contract with Aetna Better Health Kids. To see a current list of providers in the Aetna Better Health Kids network, go to our website at **AetnaBetterHealth.com/Pennsylvania**.

What is an out-of-network facility?
An out-of-network facility is a hospital or a diagnostic test facility that doesn't have an agreement or contract with Aetna Better Health Kids.

How can my child access out-of-network services?
If medically necessary, your child's PCP can request that your child get services from a provider or facility that's not part of the Aetna Better Health Kids network. If these services are available from providers within the network, your child will need to receive services from a contracted provider or facility. Unless you get prior authorization, you may be responsible for payment of any out-of-network services your child receives.

How are claims paid for out-of-network services?
In the case of an emergency, you may see any Medicaid provider. You may go to a provider not in our network only if:
- The care is needed
- There are no Aetna Better Health Kids providers to give the care in a timely manner
- Aetna Better Health Kids has approved the care in non-emergencies.

If your PCP wants you to see a provider who is not in Aetna Better Health Kids' provider network, they must send us a written request. We have the right to choose where you can get services when there is not an Aetna Better Health Kids provider available to give the care you need. The provider that is not in our network, who plans to give you care, should request prior authorization to provide services. Call Member Services at **1-800-822-2447 (TTY: 711)** with any questions.

9. Your Costs for Covered Services

Your family's size and income determine which CHIP coverage option is available for your child. You may be able to get free CHIP coverage, Low-cost coverage, or Full-cost coverage. Depending on your child's type of coverage, you may be required to pay certain out-of-pocket costs in order for your child to receive services.

What are premiums and when do I pay them?
Premiums are the regularly scheduled monthly payments that you pay to Aetna Better Health

Kids for CHIP coverage. **There are no premiums for members with free CHIP coverage.** If your child has Low-cost or Full-cost CHIP, you'll receive a monthly bill for the upcoming month's coverage (example: you'd receive a bill in April for May coverage). You are able to pay your premium a variety of ways. You can pay at local retail stores like CVS Pharmacy, Walgreens and Family Dollar by having the bar code scanned that is on the bottom of your invoice. You can pay by mail with a check or money order by sending your payment to:
Aetna Better Health® Kids
PO Box 785656
Philadelphia, PA 19178-5656

You can pay online with a credit or debit card by accessing the Aetna Payment System at this link: **https://secure.directbiller.com/db-payer-ui/#/login** or you can call **1-877-222-2004** and pay by phone. Please be sure to have your member ID and invoice number ready when you call. To learn more details, visit our Understanding CHIP Costs page at **AetnaBetterHealth.com/Pennsylvania/members/chip/costs.**

If a premium amount changes during the benefit year, you'll receive notice from Aetna Better Health Kids of the change, and the change will be effective upon notification from the CHIP Bureau.

What are copayments and when do I pay them?
Copayments are out-of-pocket costs that you must pay at the time of service if your child has Low-cost or Full-cost CHIP. There are no copayments for members with free CHIP coverage. You pay copayments to the provider at the time of the appointment or when you get the services. You must pay the copayment each time your child gets a service from a provider if the service is one which requires a copayment. Copayments can be found in the Summary of Benefits, beginning on page 22 of this handbook.

There are no copayments for the following:
- Preventive or well-child visits. A preventive visit is one where your child gets a service to prevent a future disease or condition.
- Routine preventive or diagnostic dental and vision services.
- Preventive Medications: Contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, HIV Pre-exposure prophylaxis (PrEP) medications, tamoxifen, and raloxifene are considered preventative medications and are covered at no cost to you when filled at a participating pharmacy with a valid prescription and when certain criteria are met.

When can I be billed by a provider?
Participating providers aren't allowed to bill members except under certain circumstances. But there are certain situations when you may get a bill from a provider and will be responsible to pay. These situations are:
- If your child goes over a benefit limit on a service
- If your child gets a medical service that isn't a covered benefit
- If your child gets a covered service from a health care provider who isn't an Aetna Better Health Kids participating provider, without first receiving prior authorization
- If your child gets services that aren't medically necessary
- If you didn't pay your copay

Participating providers aren't allowed to bill members for services above and beyond Aetna Better Health Kids agreed upon reimbursement rate. This means that other than the above

circumstances, you shouldn't get a bill from a participating provider. If you do receive a bill from a participating provider, call us at **1-800-822-2447 (TTY: 711)** immediately so we can resolve the situation as soon as possible.

10. Coordination of Benefits

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

CHIP members aren't allowed to have any other medical insurance coverage in addition to CHIP. Occasionally some of your child's health care bills may be covered by a different policy other than CHIP. An example of this is if your child gets into a motor vehicle accident. The automobile insurance policy may cover some of the cost of his or her medical care.

If another insurance plan or program agreement provides any of the benefits to which your child is entitled, your child's CHIP insurance should be billed secondary to any such additional coverage(s).

If you have questions about coordination of benefits, call us at **1-800-822-2447 (TTY: 711)**.

11. Subrogation

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

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

If you have questions about subrogation, call us at **1-800-822-2447 (TTY: 711)**.

12. Summary of Benefits

Medical benefits	Limits	Copayment amounts		
		Free	Low Cost	Full Cost
Autism spectrum disorder related services	None.	$0	Copayments based on the type of service the member receives.	
Diagnostic services	None.	$0	$0	$0
Durable medical equipment	None.	$0	$0	$0
Emergency services	None.	$0	$25	$50
Emergency transportation	Transportation outside of the service area will only be covered if medically necessary.	$0	$0	$0
Family planning services – OB -GYN	None.	$0	$10	$25
Family planning services – PCP	None.	$0	$5	$15
Gender transition services when medically necessary (i.e., physician's services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, etc.)	None. Medical necessity will be determined based upon the World Professional Association for Transgender Health (WPATH) Standard of Care.	$0	Copayments may apply to medications and physician office visits.	
Hearing care services	One routine hearing exam per year One hearing aid or device per ear, per year	$0	$10 Copayment apply when services are rendered by a specialist provider.	$25 Copayment apply when services are rendered by a specialist provider.
Home health services	None.	$0	$0	$0
Hospice services	None.	$0	$0	$0
Inpatient hospital and skilled nursing facility stays	None.	$0	$0	$0
Inpatient rehabilitation stays	None.	$0	$0	$0
Maternity care services	None.	$0	$0	$0
Medical foods	None.	$0	$0	$0
Oral Surgery	None.	$0	$10	$25

Medical benefits	Limits	Copayment amounts		
		Free	Low Cost	Full Cost
Outpatient medical therapy services (chemotherapy, dialysis, radiation treatments, and respiratory therapy)	None.	$0	$0	$0
Outpatient rehabilitation services (occupational, physical, and speech therapy)	30 visits per therapy per benefit year.	$0	$10	$25
Outpatient surgical services	None.	$0	$0	$0
PCP office visits	None. *No copayment required for annual exam.	$0	$5*	$15*
Specialist office visits	None.	$0	$10	$25
Urgent care services	None.	$0	$25	$25
Women's health services - OB-GYN	One annual gynecological examination and associated services per benefit year. *No copayment required for annual exam.	$0	$10*	$25*
Women's health services* - PCP	One annual gynecological examination and associated services per benefit year. *No copayment required for annual exam.	$0	$5*	$15*
Brand-name drug	Limits defined in the formulary	$0	$9	$18
Generic drug	Limits defined in the formulary	$0	$6	$10
Select Preventive Medications (Contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, HIV Pre-exposure prophylaxis (PrEP) medications, tamoxifen, and raloxifene)	Limits defined in the formulary	$0	$0	$0

13. Medical Benefits

This section lists the medical services covered by your child's CHIP insurance. All services must be medically necessary. The services in this section are in alphabetical order. Under each covered service listing you will find a brief description of the benefit provided and any limits or restrictions that may apply. We reserve the right to restrict benefit coverage of medical equipment purchases to certain manufacturers and specific product types. Call Member Services at **1-800-822-2447 (TTY: 711)** for more information about medical equipment purchasing restrictions.

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

We only cover services up to the specified benefit limits. Once your child has reached the available benefit limit, your child will need to stop receiving those particular services or you'll be responsible for paying for the services directly.

Please call Member Services at **1-800-822-2447 (TTY: 711)** if you have any questions about your child's medical benefits. Your Member Services representative can tell you if a particular service is covered, if there are any benefit limits, what providers your child may see for a service, and what you may need to pay out of pocket for a service. Your Member Services representative can also tell you how much money or how many visits you have remaining for any service.

Autism Spectrum Disorder and related services

In accordance with the Pennsylvania Autism Insurance Act (Act 62), the following services, when medically necessary for the assessment, diagnosis, and treatment of Autism Spectrum Disorders are covered:

- Prescription drug coverage including over-the-counter (OTC) medications, vitamins and aspirin
- Services of a psychiatrist and/or psychologist
- Rehabilitative and therapeutic care

Benefit limits: None. Coverage under this section is subject to copayments as identified elsewhere in this handbook.

Treatment of autism spectrum disorders must be:

- Medically necessary and prescribed by a physician or other independently licensed health care professional with prescribing authority
- Identified in a treatment plan
- Provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, licensed behavior specialist (a person licensed in Pennsylvania to provide applied behavioral analysis), or certified registered nurse practitioner
- Provided by an autism service provider or a person, entity or group that works under the direction of an autism service provider

Act 62 of the Pennsylvania code requires private insurance companies to permit expedited internal and external review processes to review grievances for a child who has been denied

or partially denied coverage for treatment of autism spectrum disorder. You may start this process by calling Member Services at **1-800-822-2447 (TTY: 711)**. Make sure that we have all of the information we need from your child's treating professionals to support your Service coverage request.

If you have further questions about autism spectrum disorder benefits or need assistance finding participating providers who treat autism spectrum disorder in your area, call Member Services at **1-800-822-2447 (TTY: 711).** You may also visit the Department of Human Services Bureau of Autism's website at **www.autisminpa.org** for more information about autism spectrum disorder and Act 62.

Diabetic services[1]

Medically necessary diabetic treatment, equipment, medications and supplies as follows:

- Diabetic medical equipment, monitoring supplies and prescription medications
- Outpatient diabetic training and education
- Diabetic eye examinations
- Laboratory screening tests
- Routine diabetic foot care and orthotics
- Aetna Better Health Kids diabetic disease management program
- Aetna Better Health Kids Enhanced Member Services Unit care coordination and care management can reached by calling **1-855-346-9828**.

Benefit limits: Payment is limited to one routine diabetic eye exam per benefit year. Batteries for diabetic medical equipment are not covered. Services identified above are subject to the same benefit limits noted elsewhere in this handbook.

Diagnostic, laboratory, and radiology services

Medically necessary diagnostic tests, services and materials related to the diagnosis and treatment of sickness and injury in both inpatient and outpatient settings. Benefit limits: Certain services may require prior authorization in order to be covered.

Durable medical equipment

Medically necessary durable medical equipment (DME) coverage applies to equipment designed to serve a medical purpose such as:

- They have an illness or an injury
- It is able to stand repeated use
- It is not disposable or for a single patient use
- It is required for use in the home or school environment. This benefit covers the cost of DME rental (or purchase if purchase is cheaper than renting the DME over an extended period of time), delivery and installation.

We only cover the repair or replacement of DME as required with normal wear and tear when medically necessary.

DME may require prior authorization. Any DME request over $500 may require review by our Medical Director.

[1] In order to provide your child with the best care possible, if your child has a diagnosis of diabetes, you should contact the Enhanced Member Services Unit at **1-855-346-9828** and request that your child be enrolled in the Aetna Better Health Kids diabetes disease management program.

Emergency care services

As described in the emergency care section of this handbook (see section VI).

Benefit limits: None.

Emergency transportation services

Transportation services by land, air or water ambulance are covered only when medically necessary. Services must be rendered in the following situations:

- In response to an emergency
- For the purpose of transporting an inpatient member between facilities

When a homebound member is discharged from the hospital and for medical reasons cannot be transported by other means

Family planning services

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

Benefit limits: None.

Gender transition services

The CHIP Program and Aetna Better Health Kids covers gender transition services such as physician's services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, etc. when deemed medically necessary* and appropriate.

Benefit limits: None. *Medical necessity will be determined based upon the World Professional Association for Transgender Health (WPATH) Standard of Care.

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 benefit year for Physical Therapy; 30 visits per benefit year for Occupational Therapy; and 30 visits per benefit year for Speech Therapy, for a combined visit limit of 90 days per benefit 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 a post-operative brain surgery.

Hearing care services

Your child's PCP should provide routine and preventive hearing examinations. If your PCP recommends that your child have a specialist perform an audiometric examination, your child does not need a referral to see an audiologist or otolaryngologist if you use a provider who participates in the Aetna Better Health Kids network. If medically necessary, hearing aids and devices, and the fitting and adjustment of such devices, are covered.

Benefit limits: One routine hearing exam and an audiometric exam per 12 months. One

hearing aid or device per year every 12 months. Batteries are not covered. No dollar limits apply.

Home health care services

Home health care is only covered if your child is homebound. Your child is considered homebound when his or her medical condition prevents them from leaving home without a great deal of effort. Home health care services include medically necessary:

- Physician services
- Physical, speech, and occupational therapy services
- Medical and surgical supplies and equipment, including oxygen
- Home infusion therapy (not including blood or blood products)

Benefit limits: Home health services may require prior authorization by Aetna Better Health Kids. There are no copayments and no limitations.

Hospice services

Hospice is a special kind of care that is available to members who suffer from a terminal illness. This care will be concurrent with care related to the treatment of the condition for which the diagnosis of terminal illness was made. Members getting hospice and palliative care services may still receive Aetna Better Health Kids covered services for other illnesses or conditions as well.

Hospice services must be prior authorized by Aetna Better Health Kids and require a certification by a physician stating that the member has a terminal illness. Aetna Better Health Kids must be provided with a written request for hospice services by either the member, if they're of legal age, or by the member child's legal guardian.

Hospital services: inpatient, outpatient and ambulatory surgical center services

Hospital benefits may be provided by a participating facility on either an inpatient or outpatient basis and must be medically necessary. These services may be provided at participating facilities, such as an acute care hospital, skilled nursing facility or an ambulatory surgical center.

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation, and skilled nursing services are not limited.

Inpatient medically related rehabilitation therapy is not limited.

Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits, and follow-up appointments or sick visits with a member's PCP are not limited. Benefit limits: Hospitalization related services may require prior authorization except in the case of an emergency.

Mastectomy and breast cancer reconstructive surgery services

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

- Surgery to re-establish 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

There of; due to a mastectomy; and

- Physical complications of all stages of mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the

member's physician, received within forty-eight (48) hours after discharge.

Benefit limits: Mastectomy services may require prior authorization.

Maternity services

A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Except in the case of an emergency or in accordance with the continuity of care policy, participating providers must provide maternity services at participating facilities. Providers of maternity care services may include:

- Physicians
- Nurse practitioners
- Certified nurse midwives
- Facilities may include both acute care hospitals and free-standing birthing centers

Hospital and physician care services relating to antepartum, intrapartum and postpartum care, including complications resulting from the member's pregnancy or delivery are covered. If the member's eligibility changes when they are in the second or third trimester of the pregnancy, they may remain through the postpartum stage with the same physician or practitioner.

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 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.

Members can also receive one home health care visit following an inpatient release for maternity care if the member is released prior to 48 hours for a normal delivery or prior to 96 for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health 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.

If a pregnant member joins Aetna Better Health in their second or third trimester, and their provider is out-of-network, they may continue to see that provider through the pregnancy and postpartum period.

In the same way, if we end our contract with a pregnant member's doctor and the member is in their second or third trimester, they may continue to see that provider through the pregnancy and postpartum period.

Benefit limits: Delivery at a facility outside the service area will only be covered in the case of an emergency.

Medical foods

Medical foods such as specially formulated enteral feedings and supplements are covered only for the medically necessary therapeutic treatment of certain genetic disorders. This benefit isn't intended to be normal food products used in the dietary

management of rare genetic metabolic disorders. Medical foods require prior authorization and must be prescribed by a physician or nurse practitioner. Special kinds of infant formulas are not medical foods and are not covered.

Benefit limits: None

Newborn coverage of infants born to CHIP members

This benefit pertains to newborn children of CHIP members who are covered from the time of birth for the first 31 days of life. You can access these services using the member's CHIP identification card. To assure no lapse in access to health care for the newborn after the first 31 days, the member must contact Member Services at **1-800-822-2447 (TTY: 711)** immediately after child is born to begin the process of getting the newborn his or her own health care coverage.

Benefit limits: This service ends after the CHIP member's baby turns 31 days of age. Members with newborns should follow the guidelines set forth in this handbook to access their benefits. If you have questions about newborn care benefits or how to access them, or need help applying for coverage for your newborn, call Member Services.

Oral surgery services

Oral surgery services may be performed in either an inpatient or outpatient setting depending on the nature of the procedure and require prior authorization. Examples of covered services include:

- Extraction of partially or totally bony impacted third molars (wisdom teeth)
- Baby bottle syndrome (early childhood dental caries)
- Surgery to correct dislocation or complete degeneration of the temporomandibular joint
- Non-dental treatments of the mouth relating to medical conditions such as:
  - Congenital defects
  - Birth abnormalities
  - Surgical removal of tumors

Benefit limits: None

We reserve the right to determine, based on medical necessity, what facility setting is most appropriate for the oral surgery services being provided. Anesthesia coverage varies based on the procedure and the type of facility where the service is provided. All services related to oral surgery require prior authorization.

Orthotic devices

Orthotic devices are rigid appliances or apparatuses used to support, align or correct bone and muscle injuries or deformities. This benefit covers the purchase, fitting and necessary adjustments of covered orthotic devices. It also covers the required repair because of normal wear and tear on the device.

Replacement of an orthotic device is only covered when it is deemed medically necessary.

Benefit Limit: None

Ostomy supplies

Ostomy supplies are medical supplies necessary for the care and drainage of a stoma.

Benefit Limit: None

Outpatient medical therapy services

This benefit provides members with an unlimited number of medically necessary outpatient visits for the following services:

- Dialysis treatments
- Cancer chemotherapy and hormone treatments
- Respiratory therapy
- Radiation therapy

Benefit limits: May require prior authorization. Member must have a documented diagnosis that indicates that the prescribed therapy is a medical necessity.

Outpatient rehabilitative therapy services

This benefit provides members with the following medically necessary rehabilitative services:

- Physical therapy
- Occupational therapy
- Speech therapy

Benefit limits: Coverage is limited to 30 days each of Physical, Occupational, and Speech therapy, for a combined total limit of 90 days outpatient therapy.

Aetna Better Health 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 American Cancer Society and the Health Resources and Services Administration (HRSA), the U.S. Preventive Services Task Force (USPSTF), (all items or services with a rate of A or B in the current recommendations). 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, breast feeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, The Preventive Services are provided at no cost to the Member.

Primary care physician office services

Preventive and well-child services play a very important part in keeping your child healthy. Regular preventive and well-child visits can prevent your child from getting ill in the future. They will also help your child's PCP find health conditions and/ or developmental delays, which may benefit from early treatment. It's important to schedule and keep appointments for preventive and well-child services based on the schedule recommended by your child's PCP.

Remember that you may contact your child's PCP 24 hours a day, 7 days a week if your child becomes ill and you need a doctor's advice. Your child's PCP can provide many of the health care services your child needs including:

- Preventive and well-child visits and services include the following, with no cost-sharing or copays:

Coverage will be provided for pediatric immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control,

U.S. Department of Health and Human Services. Pediatric Immunization ACIP schedules may be found by accessing the following link: **www.cdc.gov/vaccines/schedules/index.html**

- Influenza vaccines can be administered by a participating pharmacy for members starting at the age of five years old, with parental consent, per 2024 Act 77, COVID Vaccines.
- Sick and urgent care office visits including those that occur after normal office hours when medically necessary. These visits include well baby care, which generally includes a medical history, height and weight measurement, physical examination, routine diagnostic tests and counseling
- Blood Lead Screening and Lead Testing. This blood test detects elevated lead levels in the blood.
- Oral Health Risk Assessment, Fluoride Varnish for children ages 5 months-5 years old (US Preventative Task Force Recommendation).
  - Follow up care after emergency services
- Women's health services and family planning services (see benefit description for details)
  - Genetic counseling and testing

Benefit limits: None

Other Preventive Services

Benefits are covered for:

- All items and services recommended by the United States Preventive Services Task Force with a rating of A or B in the current recommendations, including:
  - Dental cavities prevention for preschool children
  - Healthy diet counseling
  - Oral fluoride supplementation
  - BRCA risk assessment and genetic counseling and testing
  - Prescribed Vitamin D
  - Prescribed iron supplementation
  - Chlamydial infection screening of pregnant women
  - Chlamydial infection screening for non-pregnant women
  - Sexually transmitted infections counseling
  - Folic acid supplementation
  - Tobacco use counseling and interventions
- Benefits as recommended by the Advisory Committee Immunization Practices (ACIP) of the Center for Disease Control and Prevention
- Benefits as recommended by the Health Resources and Services Administration (HRSA), including:
  - All Food and Drug Administration approved contraceptive methods
  - Sterilization procedures
  - Breast feeding equipment
  - Patient education and counseling for all women with reproductive capacity

Prosthetic devices

Prosthetic devices replace all or part of a missing body part and are medically necessary. They're also used to help a non-functioning organ to work again. This benefit covers the purchase, fitting and necessary adjustments of covered prosthetic devices. It also covers required repair that resulted from normal wear and tear on the device. Replacement of a prosthetic device is only covered when deemed medically necessary and appropriate due to the normal growth of the child.

Benefit limit: None.

Restorative or reconstructive surgery services (other than mastectomy-related services)
Covered services for medically necessary restorative and reconstructive surgery include services relating to:

- Surgery to correct a deformity resulting from:
  - Disease
  - Trauma
- Congenital or developmental anomalies (birth defects) through age 18
- Infection
- Surgery to correct a bodily functional defect resulting from:
  - Accidental injury
  - Incidental to surgery
- Surgery in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment, in order to achieve reasonable physical or bodily function

Benefit limits: None.

Skilled nursing inpatient facility services
Skilled nursing services are available if deemed medically necessary to children requiring around-the-clock skilled nursing services but not needing to be in a hospital.

Benefit limits: None

Specialist physician services
Office visits, diagnostic testing and treatment by specialists are covered when provided by a network provider

Benefit limits: None

Telehealth services
As an Aetna Better Health Kids member telehealth visits are covered. Your child may have the option to have a telehealth visit with their provider. Check with your child's provider to see if telehealth is an option they offer.

Benefit limits: None

Transplant services
Transplant services that are medically necessary and not considered experimental or investigative by Aetna Better Health Kids are covered for your child. Prior authorization is required.

Benefit limits: Covered services for patient selection criteria (testing required by the transplant facility to make sure your child is eligible for a transplant) are covered at only one designated transplant facility except when the services are rendered as part of a second opinion that has been prior authorized by Aetna Better Health Kids. This benefit does not provide coverage for services related to the donation of organs to non-members.
In order to provide your child with the best care possible, if your child is in need of an organ transplant, you should contact Member Services at **1-800-822-2447 (TTY: 711)** and request a consultation with a care manager.

Urgent care services
Always contact your PCP for questions, even after hours. You also have the option to use Urgent Care for immediate care for minor conditions. Urgent care centers are open days, evenings and weekends. You don't need an appointment. Coverage is described in the urgent care section of this handbook (see section 6).

Benefit limits: None.

Urological supplies
Urological supplies required for medically necessary urinary catheterization are covered only if your child has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected for your child within three months.

Benefit limits: None. Any DME request over $500 may require review by our Medical Director.

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

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.

Your child's PCP or a participating OB-GYN provider can provide gynecological and women's health services. Your child doesn't need a referral or prior authorization to receive an annual gynecological examination, family planning services or maternity services from an OB-GYN. Hospital and physician care services relating to antepartum, intrapartum, and postpartum care, including complications resulting from the member's pregnancy or delivery, are covered.

Covered Services and Supplies include, but are not limited to, the following:

- Pelvic exam, clinical breast exam and routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.
- Family Planning Services (refer to benefit described previously for further details and limitations)
- Maternity Services (refer to benefit described previously for further details and limitations)
- Treatment of gynecological illness, including injury or complications that result from an elective abortion

Benefit limits: The annual gynecological examination and associated services are limited to one per benefit year. Except in cases of an emergency, abortion services require prior authorization.

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

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.

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

Breastfeeding
Comprehensive support and counseling from trained Providers; access to breastfeeding supplies, coverage for an electric breast pump; 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. Coverage for rental of a hospital grade breast pump requires prior authorization.

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

Approved clinical trials
Appendix I on Page 61 lists more information on coverage for clinical trials or a generic drug is not available.

14. Expanded Services

Expanded Services are available only to our Aetna Better Health Kids members. More information on these exclusive benefits can be found on our website here:
AetnaBetterHealth.com/Pennsylvania/Whats-covered

Benefits include:

- Over the Counter Benefit – Each Aetna Better Health Kids member gets a $25 OTC credit each month. Members can purchase items such as:
  - Pain Relievers and First Aid
  - Oral and Dental Care
  - Cold, Cough and Allergy Remedies
  - Anti-Fungals
  - Ear and Eye Care
  - Vitamins and Minerals
  - Feminine hygiene products and tampons

  - Diapers
  - Miscellaneous products
- Transportation Benefit for Medical Appointments - Modivcare can help provide our members non-emergent medical transportation to and from appointments.
- Medically Tailored Meals, delivered by MANNA - MANNA will provide a series of meals that are designed for children who can benefit from a medically tailored diet based on certain diagnoses like diabetes, hypertension, and obesity.
- Keeping Kids Safe (Medication Lockbox) - Locking up medications benefits everyone's health, safety and well-being.
- Kids Sports Physicals – No cost sports physical exams for our members
- Enhanced Dental Benefits – Crowns for baby teeth that look like real teeth
- Enhanced Vision Benefits – $180 off fashion frames
- Pyx Behavioral Health & App – Connects kids to tools and activities that can support their behavioral health
- Go Get Active: $100 Debit Card – Members are given $100 on a debit card to use toward healthy activities or programs offered in your community.
- Maven: 24-hour pregnancy and postpartum support

Visit our website at **AetnaBetterHealth.com/Pennsylvania/Whats-covered** for more information on your expanded service benefits. You can also call Member Services at **1-800-822-2447 (TTY: 711)** if you have questions or would like to better understand how to use your expanded service benefits.

15. Pharmacy Benefits

We provide coverage for a broad range of prescription drugs. Our formulary explains which medications are covered. Typically, we won't pay for drugs not included in the formulary. Some important information to know about your pharmacy benefit includes:

- Some medications in the formulary may require prior authorization
- Some medications may only be covered if a member has met certain criteria.
- Examples include having the member or his or her health care provider submit documentation that the member has:
  - Certain medical conditions or diagnoses that indicate the medication is medically necessary
  - Drug allergies that limit the use of other medications a member might be treated with
  - Unsuccessful treatment of a condition or illness with a different medication

The member must present their ID card at the time of service in order to access their pharmacy benefits.

Visit our website at **AetnaBetterHealth.com/Pennsylvania/pharmacy-prescription-drug-benefits** to learn more about your pharmacy benefits. You can find easy steps to locate a pharmacy near you. The site also has a list of medicines we cover and any rules about using them. We explain how we manage prescriptions, including limits on some medicines, what doctors need to do if you need an exception, and how we handle generic drugs and step therapy. You can also call Member Services at **1-800-822-2447 (TTY: 711)** if you have questions about your pharmacy benefits, need help finding a participating pharmacy, including specialty network pharmacies for specialty medications and mail

order pharmacies.

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, HIV Pre- exposure prophylaxis (PrEP) medications, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to you when filled at a participating pharmacy with a valid prescription. If you have questions about whether a preventive medication is covered, call Member Services at **1-800-822-2447 (TTY: 711)**.

Are brand-name medications covered?
A generic drug will be substituted for a brand-name drug whenever a generic is available. The exception to this rule is when the physician indicates that the brand-name version of the drug is medically necessary, or the drug is available in a generic. If the physician believes the brand-name version of the drug is medically necessary, he or she must submit a special request to Aetna Better Health Kids, which we will review. This request must be approved before we cover the brand-name version of the medication.

Are over-the-counter medications covered?
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 and is recommended by the United States Preventative Task Force A & B, the medication may be covered. If you have questions about whether an over-the-counter medication is covered, call Member Services at **1-800-822-2447 (TTY: 711).**

If you believe you have a need for a drug that is not listed as covered by the health plan, you may call Member Services at the telephone number on the back of your ID card to get information on the process required to receive coverage of those drugs.

16. Mental Health Benefits

Some members diagnosed with severe mental health disorders or conditions that significantly impact a child's behavioral health (i.e., schizophrenia, autism, etc.) may be eligible for a broader range of services or different benefit limitations. Contact the Enhanced Member Services Unit at **1-855-346-9828** if you have questions regarding your child's eligibility for certain mental health services.

Who can my child receive mental health services from?
Except in the case of an emergency, mental health services must be provided by participating providers and facilities. The exception to this is if you get prior authorization for using a non-participating provider or facility.

Does my child need a referral to visit a mental health specialist?
Your child doesn't need a referral to see a participating mental health provider. A member (14 years of age or older) or a parent or guardian may self-refer.

Call Member Services at **1-800-822-2447 (TTY:711)** if you:

- Need self-referral help
- Require help finding a participating provider in your area
- Have trouble getting an appointment scheduled with a participating provider

- Have questions about behavioral health benefits

What if my child has a mental health emergency?
A mental health emergency is the sudden onset of a potentially life-threatening condition where you believe that your child is at risk of injury to himself/ herself or others if immediate medical attention is not given. If you think your child has a mental health emergency, go to the nearest emergency room.

If you think your child is in a mental health situation that needs urgent help, call Member Services at **1-800-822-2447 (TTY: 711).** You'll be connected with an internal clinician or care manager who will help assess the seriousness of the situation. If it's an emergency, the mental health professional will assist you in getting the treatment your child needs as quickly as possible.

If the condition is not life-threatening or one that requires immediate inpatient admission, we'll schedule your child for an urgent care appointment.

If your situation occurs after normal business hours or you think that your situation is a serious emergency, or life-threatening, call **911** or **988**.

The initial treatment for a mental health emergency is covered even when provided by non-participating mental health providers or rendered at a non-participating facility if the symptoms are severe enough to need immediate attention.

Inpatient mental health services can only be provided by participating providers at participating facilities unless the admission occurred as a result of a psychiatric emergency. If your child is admitted to a non-participating facility, you must contact Aetna Better Health Kids within 24 hours to notify them of the admission. Once your child's condition is determined to be non-emergent, your child may be transferred to a participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the non-participating facility may not be covered.

Inpatient benefits for medical and behavioral health hospitalizations, medically related inpatient rehabilitation and skilled nursing services are not limited.

Do outpatient mental health services need to be prior authorized?
Some mental health services may require prior authorization. Your child's mental health provider is responsible for getting necessary authorizations by calling Member Services at **1-800-822-2447 (TTY: 711)**.

What outpatient mental health benefits are covered?
There are no limits for mental health outpatient visits per benefit year. Covered services include:

- Psychological testing
- Visits with mental health providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication management

17. Substance Use Disorder Benefits

CHIP covers inpatient detoxification, non-hospital residential treatment and outpatient treatment relating to drug and alcohol abuse for your child.

If you think your child has a drug or alcohol problem, don't delay getting them the help they need. The sooner a child begins treatment with a professional provider, the more likely they are to have a successful recovery.

Substance use disorder benefits do not cover tobacco abuse related services. However, Aetna Better Health Kids provides nicotine replacement therapy and smoking cessation assistance to help your child stop using tobacco/vaping related products. Call Member Services at **1-800-822-2447 (TTY: 711)** to obtain smoking cessation assistance for your child.

Who can my child receive substance use disorder services from?
Substance use disorder services must be provided by participating providers and facilities, unless we prior authorize the use of a non-participating provider or facility.

Does my child need a referral to visit a substance use disorder specialist?
Your child doesn't need a referral from a PCP to see a participating substance use disorder provider. A member (14 years of age or older) or a parent or guardian may self-refer.

Call us at **1-800-822-2447 (TTY: 711)** if you:

- Need self-referral assistance
- Require help finding a participating provider in your area
- Have trouble getting an appointment scheduled with a participating provider
- Have questions about substance abuse benefits

For your convenience, you can find the Member Services number on your child's Aetna Better Health Kids ID card.

What if my child has a substance abuse emergency or crisis?
A substance use emergency is where your child is considered in imminent, potentially life-threatening physical danger with a need for immediate detoxification for drug withdrawal. Please go to the nearest emergency room.

What do I need to know about inpatient detoxification?
Detoxification is the process by which a drug- or alcohol-intoxicated or dependent member is assisted through the period of time needed to eliminate the presence of the intoxicating substance(s) or the dependency factor(s), while keeping the physiological or psychological risk to the member at a minimum. Inpatient detoxification is used when a member's withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with medical monitoring by medical and nursing professionals.

Inpatient detoxification services may only be provided by participating providers at participating facilities unless the admission occurred as a result of an emergency. If your child is admitted to a non-participating facility, you must contact Member Services at **1-800-822-2447 (TTY: 711)** within 24 hours to notify them of the admission. Once your child's condition is determined to be non-emergent, your child may be transferred to participating facility. If you refuse to transfer your child to a participating facility after the psychiatric emergency has ended, the services your child receives at the non-participating facility may not be covered.

What do I need to know about non-hospital residential treatment?
Non-hospital residential treatment refers to services administered at facilities where the member lives while participating in a comprehensive chemical dependency treatment program in a therapeutic environment that has met the minimum standards established by

the Pennsylvania Department of Health. Members who don't require medical monitoring for withdrawal may receive detoxification related services at these facilities as well.

Admission to a non-hospital residential treatment facility for drug and alcohol rehabilitation treatment is never considered emergency treatment.

Non-hospital residential treatment services may only be rendered by participating providers at participating facilities unless Member Services at **1-800-822-2447 (TTY: 711)** preauthorizes the use of a non-participating provider or facility before your child is admitted and begins receiving services. Non-hospital residential substance use services your child receives at a non-participating facility will not be covered by your child's insurance.

What outpatient substance use disorder benefits are covered?

Covered services include:

- Psychological and laboratory testing
- Visits with substance use disorder rehabilitation providers
- Partial hospitalization
- Intensive outpatient therapy
- Medication assistance therapy (MAT)

18. Dental Benefits

Help your child by encouraging them to practice good oral hygiene daily and taking them to see the dentist for regularly scheduled checkups. Together we strive to make sure your child has access to high-quality dental services that cultivate a lifelong healthy smile.

Aetna Better Health Kids covers many dental services to help our members prevent dental disease, promote oral health, restore oral structures to health and function, and treat emergency dental conditions. There are no copayments for covered dental services, and no referrals are needed from your PCP to make an appointment, receiving dental care that couldn't be easier.

Who can my child see for dental care?

You can make an appointment with any participating SKYGEN dentist. You can find a list of SKYGEN providers at **https://aetnapamwp.sciondental.com/MWP/Landing**, by clicking: **FIND A DENTIST** or by calling SKYGEN's Member Services at **1-800-508-2072** (**TTY 711)**.

If you need help finding a dental provider or getting an appointment, call SKYGEN's Member Services at **1-800-508-2072 (TTY 711)** and someone will help you.

How much does dental care cost?

Except in the case of an emergency, dental care should be provided by a dentist who is a participating SKYGEN provider. Covered dental benefits provided by a participating provider and approved by SKYGEN will have no out-of-pocket cost.

Services by nonparticipating out-of-network providers are not covered unless there are special circumstances.

What dental services are covered by CHIP?

Your child is eligible to have routine preventive exams and cleaning once per six months, with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy, completely free of cost when provided by a participating dentist. Certain services require prior authorization and may only be available if they

are determined to be medically necessary and age-appropriate care or may have frequency limits.

For any questions about dental benefits please contact SKYGEN's Member Services at **1-800-508-2086 (TTY 711)**.

Some dental benefits are restricted to certain age groups or have other clinical limitations. Certain services require prior authorization and may only be available if they are determined to be medically necessary and appropriate for your child. Below are some of the covered services provided:

Diagnostic and Preventive Services

- Routine exams (every 6 months)
- Cleanings (twice a year)
- Routine X-rays
- Topical Fluoride Application (By your dentist or PCP)
- Sealants
- Space Maintainers

Restorative Services

- Tooth colored fillings (composite)
- Silver fillings (amalgam)
- Crowns
- Occlusal Guards

Endodontic Services

- Pulpotomies (primary teeth)
- Root Canals (permanent teeth)
- Apicoectomy

Periodontal Services

- Full Mouth Debridement
- Scaling and Root Planing
- Periodontal Maintenance
- Soft Tissue Grafts

Oral Surgery

- Anesthesia
- Simple Extractions
- Surgical Extractions

Wisdom Teeth Removal

- Frenectomy

Prosthodontic Services

- Crowns
- Dentures
- Occlusal Guards

Orthodontics

Braces are covered only when they are medically necessary, not for cosmetic purposes. Medical necessity is determined only after your child is evaluated by an Orthodontist and they have submitted prior authorization to SKYGEN for clinical review. If medically necessary, services can include:

- Evaluation For Braces
- Placement of Braces, Adjustments, and Removal
- Retainer Placement
- Retainer Replacement (one time)

Emergency Dental Services

- Emergency Exam
- Dental X-rays
- Temporary Fillings
- Temporary Crowns
- Pulpal Treatment
- Palliative Treatment of Dental Pain

What dental services are not covered?

ABH Kids doesn't cover dental services performed for cosmetic purposes. ABH Kids also does not cover additional treatment due to noncompliance with prescribed dental care. If you have questions about your benefits, call SKYGEN's Member Services at **1-800-508-2072 (TTY 711)**. They have detailed information about specific benefit limitations that may apply to non-routine services. You can also visit their website at **https://aetnapamwp.sciondental.com/MWP/Landing** or by clicking: **SKYGEN's Member Web Portal**.

19. Vision / Eye Care Benefits

Untreated eye problems can result in learning and behavioral problems that negatively affect a child's life. With proper attention to eye care, including regular check-ups, you can avoid many problems.

Who can my child see for vision care?

You can make an appointment with any participating Superior Vision optician, optometrist or an Aetna Better Health Kids network ophthalmologist. You can find a list of vision providers on our website at **AetnaBetterHealth.com/Pennsylvania.** You can also call Superior Vision Member Services at **1-800-428-8789**.

You don't need to get a referral from your child's PCP in order to make an eye appointment. Call Superior Vision Member Services at **1-800-428-8789** if you're having trouble finding a participating vision provider or getting an appointment.

Can my child receive services from a non-participating vision provider?

Yes, but the non-participating provider may not consider the allowed amount for covered services as payment in full for the services rendered, or the equipment provided to your child. You'll have to pay the difference between the non-participating provider's charge and the allowance for covered services or equipment.

How much does vision care cost?

Aetna Better Health Kids participating providers will accept the allowance as payment in full for covered services. The participating provider will handle all of the paperwork for your child and payment will be made directly to them. When you use a participating provider, you won't have any out-of-pocket costs or be responsible for any portion of the bill. If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus, or aphakia, a copayment may apply.

Some non-participating vision providers will expect payment for the services rendered in full at the time of the visit. In this case, it'll be your responsibility to pay the bill. All you have to do is submit the bill to Aetna Better Health Kids and request reimbursement. We'll send you a check for the allowed amount of the covered services your child received. This check may be less than the amount you paid the non-participating provider.

In a case involving a covered service in which the vision provider, the member, or the member's parent selects a more expensive course of treatment or equipment than is usually provided, payment under this benefit will be based on the charge allowance for the lesser procedure or equipment. In this case, the vision provider may choose to balance bill you for the difference between the charge of the actual service rendered or equipment provided, and the amount received from Aetna Better Health Kids.

What vision benefits are covered?

Aetna Better Health Kids covers emergency, preventive and routine vision care.

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

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

- **Coverage of glass or plastic lenses** including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items.
- **Note: Polycarbonate lenses** are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.
- **Eye examination and refractive services** - Includes up to one routine eye examination and refractive test per benefit year, unless a second eye examination and refractive test is medically necessary. This includes dilation if professionally indicated. No Cost to member in network. Out- of-network - no coverage.
- **Lenses**: In Network - One pair covered in full every calendar year. Out-of-Network - no coverage.
- **Frames**: In Network - No cost to member. Expenses in excess of $130 allowance* payable by member. Additionally, a 20% discount applies to any amount over $130. Out-of-Network - no coverage.
- **Contact Lenses**: One prescription every year - in lieu of eyeglasses, or when medically necessary for vision correction.
  - Expenses in excess of a $130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $130.
    Note: In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).
- **Frequency of lens and frame replacement:** One pair of eyeglasses every 12 months, when medically necessary for vision correction. One replacement of medically necessary broken, lost or scratched corrective lenses, frames and contact lenses (one original and one replacement, not to exceed two per benefit year).

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

*Please see Section 13 for additional vision benefits under Enhanced Benefits

- **Low Vision:** 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.

What vision benefits are not covered?

- Refractive surgery

20. CHIP Exclusions

CHIP doesn't cover all services, supplies or charges. Unless listed specifically in the summary of CHIP benefits or identified as an enhanced Aetna Better Health Kids benefit in this handbook, no benefits will be provided for the following services, supplies and charges, including, but not limited to:

- Alternative medicine: Including, but not limited to: acupuncture, acupressure, aromatherapy, aversion therapy, Ayurvedic medicine, bioenergetic therapy, carbon dioxide therapy, confrontation therapy, crystal healing therapy, cult deprogramming, dolphin therapy, electric aversion therapy for alcoholism, equestrian therapy, guided imagery, herbal medicine, homeopathy, narcotherapy, naturotherapy, orthomolecular therapy, primal therapy, relaxation therapy, transcendental meditation, and yoga.
- Assisted fertilization
- Behavioral health services for the following reasons:
  - Any service related to disorders not defined as treatable mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Services not expected to result in demonstrable improvement in the member's condition and/ or level of functions, and chronic maintenance therapy, except in the case of serious mental illness/ disorders
  - Inpatient or outpatient treatments related to mental retardation
  - Methadone maintenance for the treatment of chemical dependency
  - Comfort & convenience items
- Corrective appliances: Primarily intended for athletic purposes or those related to a sports medicine treatment plan
- Cosmetic surgery or other procedures: Cosmetic surgery or other procedures to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except for surgery or services which are required by law or as specified in the covered benefits section above
- Court ordered: Court ordered services when not medically necessary for the member's medical or behavioral health condition as determined by the member's physician
- Custodial care
- Dental specific exclusions:
  - Bridges unless required as a result of an accident or an injury
  - Claims involving covered services in which the dentist and the member select a more expensive course of treatment than is usually provided by the dental profession and consistent with sound professional standards of dental practice for the dental condition concerned
  - Dentures and other prosthodontics, unless medically necessary as a result of surgery for trauma or a disease process that renders the dental condition untreatable by a less intensive restorative procedure

– Duplicate and temporary devices, appliances and services
– Gold foil restorations and restorations or prosthodontics using high noble or noble metals unless the use of such materials is determined to be medically necessary
– Labial veneers
– Laminates done for cosmetic purposes
– Local anesthesia when billed for separately by a dentist
– Oral surgery that is covered under the medical portion of the benefits
– Plaque control programs, oral hygiene education and dietary instruction
– Retainer replacement
– Drugs:
    - Drug efficacy study implementation (DESI) drugs
    - Experimental drugs
    - Weight loss drugs
    - Infertility agents
    - Drugs used for cosmetic purposes
    - Drugs labeled for investigational use
    - Drugs used for hair growth
    - Impotency drugs
– Durable medical equipment: Medical equipment/supplies that are:
    - Of an expendable nature
    - Dressings unless the level of care requires skilled nursing care in the home
    - Primarily used for non-medical purposes, e.g., air conditioners, humidifiers, or electric air cleaners
    - Basic comfort or convenience items or items primarily for the convenience of a person caring for a member
– Examinations: Physical examination or evaluation or any mental health or chemical dependency evaluation given primarily at the request of, for the protection or convenience of, or to meet a requirement of a third party, including, but not limited to, attorneys, employers, insurers, schools, camps, and driver's license bureaus
– Forms: Charges for completion of any specialized report, form, insurance form or copying of medical records
– No coverage is provided for dietary services, homemaker services, maintenance therapy, custodial care and food or home-delivered meals.
– Immunizations and drugs: Immunizations and drugs used for prevention of disease when required solely for employment or traveling outside of the United States
– Long-term care
– Medically unnecessary services or supplies
– Mental retardation: Services for treatment of mental retardation except as otherwise provided herein
– Military service: Care for military service-related disabilities and conditions for which the member is legally entitled to receive services under other coverage
– Motor vehicle accident/Workers' compensation:
    - The cost of hospital, medical or other health services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used - including such benefits mandated by law) of any automobile insurance policy unless otherwise prohibited by applicable law. Service for which coverage is required by federal, state, or local law to be purchased or provided through other arrangements, including, but not limited to, coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.
– Non-covered services:

- Any service, supply, or treatment not specifically listed as a covered benefit, service, supply, or treatment under CHIP unless it is a basic health service. Any covered services related to or necessitated by an excluded item or non-covered service unless such services are considered basic health services.
- Charges for co-payments, which are the member's responsibility
- Charges for telephone conversations or failure to keep a scheduled appointment

– Services or supplies which are not provided or arranged by a CHIP participating provider and authorized for payment in accordance with CHIP medical management policies and procedures
  - Services provided by a non-licensed provider or provider not recognized by CHIP
  - Services incurred after the date of termination of the member's coverage except as required by CHIP
  - Services provided before the member's effective date of coverage
  - Services rendered by a provider who is a member of the member's immediate family or household
  - Services for which the member would have no legal obligation to pay
  - Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program
  - Services related to purposes of obtaining or maintaining a license, employment, insurance, or for purposes related to judicial or administrative proceedings such as adjudication of marital, child support, or custody cases
  - Services requiring a prior authorization by CHIP for which the member or the treating provider did not obtain prior authorization
  - Services that are submitted by two different professional providers who provided the same services on the same date for the same member
  - Services which are primarily educational in nature, vocational rehabilitation, and recreational and educational therapy, except as required by law and when determined to be medically necessary
– Treatment of sexual dysfunction not directly related to organic disease or injury
– Non-medical items
– Nutritional supplements:
  - Any formula, when used for the convenience of the member or the member's household
  - Blenderized food, baby food, thickeners or regular shelf food when used with an enteral system
  - Milk or soy-based infant formula with intact proteins
  - Normal food products used in dietary management of rare hereditary genetic metabolic disorders
  - Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
  - Oral semi-synthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates
  - Regular food products or shelf products including oral nutritional supplements that are available over-the-counter
  - Food supplements, lactose-free foods, vitamins and/or minerals used to replace intolerable foods or certain infant formulas to supplement a deficient diet or to provide alternative nutrition
  - Vitamins and/or minerals taken orally unless covered by the pharmacy benefit
  - Enteral products and related supplies that are administered orally
– Oral surgery: Services relating to the treatment of temporomandibular joint syndrome or temporomandibular joint disorders, with the exception of surgery for temporomandibular joint disease as noted in the covered benefits section

- Routine foot care: Routine foot care (such as nail trimming) is not covered. Other foot-related services, such as treatment of ingrown nails and services for the treatment of diabetes or medically necessary due to severe peripheral vascular disease are covered.
- Pregnancy termination services: Except those provided for under the Commonwealth of Pennsylvania laws.
- Public facility/government: Care for conditions that federal, state or local law requires to be treated in a public facility, or services furnished by any level of government, unless coverage is legally required
- Rehabilitative therapy for psychoneurotic or personality disorders
- Reversal of voluntary sterilization procedures
- Services provided without the required prior authorization
- Surrogate motherhood: All services and supplies associated with surrogate motherhood, including, but not limited to, all services and supplies relating to the conception and prenatal through postnatal care of a member acting as a surrogate mother
- Transplants/organ donation
- Experimental or investigative transplants
- Services required by a member related to organ donation when the member serves as the organ donor unless the recipient is covered by CHIP
- Services required by a donor when benefits are available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits not available from another source, and provided to the donor, will be charged against the member's coverage.
- No payment will be made for human organs that are sold rather than donated
- Vision specific exclusions:
    - Coverage for medical or surgical treatment, drugs or medications, non-prescription lenses, examinations, training procedures, or materials not listed as a CHIP benefit
    - Procedures that are special or unusual, such as, but not limited to: orthoptics, vision training, subnormal vision aids, and tonography
    - Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, except at intervals specified in the CHIP Summary of Benefits
    - Services or materials provided by federal, state, or local government or workers' compensation
    - Surgery to correct myopia, hyperopia, astigmatism and radial keratotomy
- Weight reduction: Bariatric surgery, anti-obesity medication, including, but not limited to, appetite suppressants and lipase inhibitors

21. Care Management

Some members have special health care needs and medical conditions. Aetna Better Health Kids Care Management includes nurses and social workers who work with many health care providers, agencies and organizations to get the services and the care that you need.

Our Care Management team can help you learn more about your condition. They can help you and your provider make a care plan that is right for you. They can also connect you to support services for tobacco cessation and weight management issues related to obesity.

ABH Kids has a Maternity Matters program where our care managers can support members with education and resources throughout pregnancy and after pregnancy.

We want to help! Call Member Services and ask to speak to someone on our Care Management team.

Your membership in the Care Management program is voluntary. You can opt in or opt out at any time. Just call us at **1-800-822-2447 (TTY: 711)**.

22. Disease Management

Disease management programs provide specific information to members with certain health conditions. They provide specialized support and education to members diagnosed with certain conditions that require specific self-care efforts. Disease management helps improve a member's quality of life by preventing or minimizing the effects of a disease or condition. It also helps to reduce health care costs. Disease management programs are at no cost to CHIP members who are eligible. You can opt in or opt out of any of our Disease Management programs at any time.

What disease management programs are available?
CHIP members are eligible to participate in any of the following disease management programs:

a. Asthma
b. Diabetes
c. Hypertension
d. Obesity

Call Member Services at **1-800-822-2447 (TTY: 711)** to find out more about the disease management programs available to your child. We can help you and your child learn to manage these chronic conditions and lead a healthier life. You can learn about these programs in your member handbook and online at **AetnaBetterHealth.com/Pennsylvania.**

How can I enroll my child in a disease management program?
As a member you are eligible to participate. If you are diagnosed with any of these chronic conditions, we may call or text you to enroll your child in a disease management program. Your child's PCP can also request to enroll your child in one of Aetna Better Health Kids' disease management programs.

If your child isn't currently enrolled in a program and you think that he or she would benefit from disease management services, call Member Services at **1-800-822-2447 (TTY: 711)**.

Your membership in any Disease Management Program is voluntary. If at any time you wish to stop participating in the program, just call us at **1-800-822-2447 (TTY: 711**).

If you do not want to participate.

You have the right to make decisions about your health care. If we contact you to join one of our programs, you may refuse. If you are already in one of our programs, you may choose to stop at any time by contact us at **1-800-822-2447 (TTY: 711**). You will continue to get all covered benefits if you do not want to participate in our programs.

23. Utilization Management

Medical benefits	Authorization required
Autism spectrum disorder related services	May require authorization
Radiology (CT, PET scans)	May require authorization
Durable medical equipment	May require authorization
Emergency services	No
Ambulance transportation	Yes
Family planning services – OB/GYN	No
Outpatient rehabilitation services	Yes
Pharmacy and specialty drugs	Yes
Cochlear implants	Yes
Home health services	Yes
Surgery	Yes
Impatient hospital and skilled nursing facility stays	Yes
Maternity care services	May require authorization
Medical foods	Yes
Oral surgery	Yes

Utilization management is a process that we use to manage the use of medical services. This process allows us to ensure that your child receives necessary, appropriate and high-quality care in a cost-effective manner. Some benefit services require prior authorization to ensure that medically necessary services are being rendered.

You can get more information about the utilization process by calling us at **1-800-822-2447 (TTY: 711).** You can also call us to discuss the decision and see the criteria used to make that decision. Aetna Better Health Kids bases its utilization management decisions on the appropriateness of care and services and existence of coverage.

We don't reward practitioners or other individuals for issuing denials of coverage. We also don't offer financial incentives to people who make utilization or care decisions that could result in underutilization.

Also, we don't use incentives to encourage barriers to care and service. Aetna Better Health Kids prohibits from making decisions regarding hiring, promoting or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

As policies are revised and as changes occur, we will notify you via mailings, newsletters, etc.; or you can stay up to date by visiting our website at **AetnaBetterHealth.com/Pennsylvania** for more information on policies and procedures.

24. Evaluation of New Treatments and Technology

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

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

We're committed to evaluating all new treatments and technologies that are requested by your child's doctor for your child's care. Our medical directors consider new medical and scientific information as well as any applicable government requirements when reviewing these requests. Both you and your child's doctor will be notified of Aetna Better Health Kids' decision.

25. Quality Improvement Program

We have a program in place to monitor and improve the care your child receives as a CHIP member. This includes care your child receives from participating providers as well as services and other programs made available to you and your child.

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

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

a. Credentialing and re-credentialing of doctors and other providers
b. Preventive health care and opportunities to improve member wellness
c. Access to and satisfaction with care
d. Utilization management

If you want more information about the Aetna Better Health Kids quality improvement program, you can call Member Services at **1-800-822-2447 (TTY: 711).** We can send you a description of the program and an update on how we're doing in meeting any established goals.

You may also visit **www.chipcoverspakids.com** to view CHIP annual performance reports.

26. Privacy and Confidentiality

You'll get a copy of the Aetna Better Health Kids Privacy Notice in your welcome packet. The notice is also posted on the Aetna Better Health Kids website. It tells you how we may use your information for health plan activities. It also explains how you can look at your records, get a copy of them or change them. Your health information will be kept private and confidential. It will be given out only if the law allows or if you tell us to give it out.

27. Fraud and Abuse

We have a hotline number that may be used to report a medical provider, facility or business for suspected fraud or abuse. The hotline number is **1-800-333-0119**. Some common examples of fraud and abuse are:

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

28. Complaints and Grievances

Your comments are important to us. We continually work to improve the quality of the care and service that your child receives. If at any point you're not satisfied with responses from Aetna Better Health Kids or the services that your child received, you may ask to file a complaint or grievance. Your child's CHIP coverage will not be canceled because you filed a complaint or grievance.

The complaint process has two levels of internal review and the opportunity to appeal the decision to state agencies through an external review process. The grievance process has one level of internal review and the opportunity to appeal the decision to state agencies through an external review process. There is also an "expedited" or faster grievance review for situations where a decision needs to be made quickly due to your child's medical condition.

At any time during the complaint or grievance process, you have the right to choose someone to help you by acting on your behalf. This person is called your "member representative." If you want to appoint someone to be your member representative, you must notify us in writing. You'll be sent a form to complete and return to us so that we can formalize your request. You can request that someone stop being your member representative or change your member representative in a complaint or grievance at any time, by notifying Aetna Better Health Kids in writing.

If your problem relates to a grievance, your child's health care provider can, with your written consent, file the grievance for you. At any time during the complaint or grievance process, you have a right to request an Aetna Better Health Kids employee be appointed to help you, or your member representative, in preparing the complaint or grievance. This will not cost you anything. The employee that will be appointed will not have been involved in any decisions, which are the subject of your complaint or grievance, and they will be committed to act fairly on your behalf.

When you file your complaint or grievance, you have the right to send Aetna Better Health Kids any written comments, records, documents, or other information you have regarding your complaint or grievance. Aetna Better Health Kids is committed to fully and fairly consider any

material they receive from you.

If, at any time during the complaint or grievance process, you believe that Aetna Better Health Kids has misclassified a complaint or grievance, you may contact the Pennsylvania Department of Health for their opinion as to whether your issue is a complaint or grievance. Aetna Better Health Kids will follow their decision and use whichever process the Department of Health indicates is most appropriate.

If, at any time, you feel that Aetna Better Health Kids is using administrative requirements, time frames, or other tactics to directly or indirectly discourage you or your member representative from using the complaint or grievance process, you may contact the Pennsylvania Department of Health to investigate your concerns. The investigation of such allegations will not delay the processing of your complaint or grievance.

The contact information for these departments is as follows:
Bureau of Managed Care Pennsylvania
Department of Health/Health & Welfare Building,
Room 912
625 Forster Street
Harrisburg, PA 17120
Telephone Number: **717-787-5193** or **1-888-466-2787**
AT&T Relay Service: **1-800-654-5984**
(TT) Fax Number: **717-705-0947**

You can contact Member Services at the following toll-free telephone number for more information regarding the filing and status of a complaint or grievance: **1-800-822-2447 (TTY: 711)**.

Call **1-800-822-2447(TTY: 711)** if you're hearing impaired and are calling from a TTY phone.

What is a complaint?
A complaint is when you're unhappy with the care or services provided to your child by a participating provider, benefit issues including exclusions, limitations, and non-covered benefits, or the operations and management policies of Aetna Better Health Kids. A complaint does not include decisions based on medical necessity or the appropriateness of a health care service for your child. Member Services can help you decide if your problem is a complaint or a grievance if you're unsure.

What do I need to know about filing a first level complaint?
You or your member representative can file a first level complaint by calling Member Services at **1-800-822-2447 (TTY: 711**) if you're hearing impaired and are calling from a TTY phone, by submitting a fax to 1-860-754-1757, or by sending a letter to:

Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

You or your member representative must file your complaint within 60 calendar days of the event or from the date of your receipt of notice of Aetna Better Health Kids' decision. Aetna Better Health Kids will provide written notice to you or your member representative confirming the receipt of your complaint.

A first level complaint initial review committee will review and investigate your complaint. No one who was involved in making the decision related to the issue will be involved.

- You and your member representative are entitled to access all information relating to the matter being complained of.
- You and your member representative have a right to provide written data or other material in support of your complaint.
- Aetna Better Health Kids will complete its review and investigation of the complaint and will arrive at its decision within 30 days of receipt of the complaint.
- Aetna Better Health Kids will notify you or your member representative in writing of the initial review committee's decision within 30 calendar days from the date Aetna Better Health Kids (CHIP) received your complaint. The letter will include what decision was made and why, and how to request a second level review if you're dissatisfied with the decision rendered.

What do I need to know about filing a second level complaint?

To file a second level complaint, your complaint must have gone through the first level complaint process first.

You or your member representative can file a second level complaint by calling Member Services at **1-800-822-2447** or by submitting a fax to 1-860-754-1757. Call **1-800-822-2447 (TTY: 711**), if you're hearing impaired, and are calling from a TTY phone. You can also send a letter to:

Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

You or your member representative must file your second level complaint within 45 days from the date of your receipt of notice of the Aetna Better Health Kids' first level complaint decision.

You and your member representative have the right to appear before the second level review committee. The date and time of the review will be provided to you and your representative in writing at least 15 days in advance of the scheduled date. Efforts will be made to be reasonably flexible in terms of time and travel distance in order to allow you to attend. If you cannot attend in person, you have the right to request that you be allowed to participate by conference call. Aetna Better Health Kids will complete the second level review and arrive at a decision within 45 calendar days of their receipt of the request for a second level review.

- Aetna Better Health Kids will notify you, or your member representative, of the decision of the second level review committee in writing within 45 from the date Aetna Better Health Kids (CHIP) received your complaint. The letter will tell you what decision was made and why, and how to file an appeal with the Department of Health or the Insurance Department if you're dissatisfied with the decision rendered.

What do I need to know about filing a complaint with the Department of Health?

To file a complaint with the Department of Health, your complaint must have gone through both the Aetna Better Health Kids first and second level complaint processes first.

You or your representative can file a complaint by sending a letter to one of the addresses below. If you wish, you can request to file the complaint in an alternative format. Staff will be made available to transcribe an oral complaint.

Bureau of Managed Care Pennsylvania Department of Health & Welfare
Building, Room 912
625 Forster Street
Harrisburg, PA 17120
Telephone Number: **717-787-5193** or **1-888-466-2787**
AT&T Relay Service: **1-800-654-5984**
(TT) Fax Number: **717-705-0947**

Your complaint must include the following information:

- Your name, address, and telephone number
- Aetna Better Health Kids' name and your child's name and member ID number
- A brief description of the issue
- A copy of the second level decision letter

What is a grievance?

A grievance is different from a complaint. A grievance is filed when you disagree with a decision that concerns the medical necessity and appropriateness of a health care service.

You, your member representative, or a health care provider involved in your child's care can file the grievance.

Grievances are always reviewed by a licensed physician or licensed psychologist that practices in the same or a similar specialty as the area of medicine that your grievance pertains to. What do I need to know about filing a first level grievance? You, or your member representative, must file your grievance within 60 calendar days from the date of your receipt of notice of the Aetna Better Health Kids' decision.

You, or your member representative, may provide additional information for review and consideration relating to your case. You can file a first level grievance by sending a letter to:

Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

A grievance should be filed in written form unless you're unable to do so because of a disability or language barrier. If this is the case, you can request that a staff member record your verbal grievance by calling Member Services at **1-800-822-2447 (TTY: 711)** or by submitting a fax to 1-860-754-1757. You, your member representative, or your child's health care provider must file your grievance within 60 calendar days of the date of your receipt of notice of the Aetna Better Health Kids' decision.

Aetna Better Health Kids will provide written notice to you, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider, confirming the receipt of your grievance.

A first level grievance review committee will review and investigate your grievance. No one who was involved in making the decision related to the issue will be involved.

You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), and your child's health care provider, if they were involved with filing the grievance, are entitled to access all information relating to the matter being grieved.

You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), and your child's health care provider have a right to

provide written data or other material in support of your grievance.

Aetna Better Health Kids will complete its review and investigation of the grievance and will arrive at its decision within 30 calendar days of receipt of the grievance.

Aetna Better Health Kids will notify you, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider in writing of the decision of the review committee within 30 calendar days from the date Aetna Better Health Kids received the grievance. The letter will include what decision was made and why, and how to request an external review if you're dissatisfied with the decision rendered.

What do I need to know about filing an external grievance with the Department of Health?

To file a request for an external grievance, your grievance must have gone through the Aetna Better Health Kids grievance processes first. You can file an external grievance by sending a letter to:
Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

A request for an external grievance should be filed in written form unless you're unable to do so because of a disability or language barrier.

If this is the case, you can request that a staff member record your verbal request for an external grievance to be filed by calling Member Services at **1-800-822-2447 (TTY: 711)** Your request for an external grievance must include the following information:

- Your name, address, and telephone number.
- Aetna Better Health Kids' name and your child's name and member ID number.
- A brief description of the issue being grieved.
- A copy of the grievance letter.

You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider must file your external grievance within 15 calendar days from the date of your receipt of notice of the Aetna Better Health Kids' grievance decision.

Within 5 business days of receiving your request for an external grievance review, Aetna Better Health Kids will notify the Department of Health of your request for an external grievance and request that a Certified Utilization Review Entity (CRE) be assigned to conduct a review.

Within 2 business days of receiving a request for an external grievance review, the Department of Health will assign a CRE to review your grievance. You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider will be notified of the CRE that has been assigned to review your grievance.

You have the right to request information about your assigned CRE's accreditation from the Department of Health. If the Department of Health fails to select a CRE within 2 business days of receipt of a request for an external grievance review, Aetna Better Health Kids may designate a CRE to conduct the review from a list of CREs already approved by the Department of Health.

You have 7 days from the date on the notice of the assignment of the CRE to object either orally or in writing to the Department of Health about the CRE assigned if you feel there is a conflict of interest between the CRE and Aetna Better Health Kids. A conflict of interest exists if the CRE has or is entering into a contract with Aetna Better Health Kids.

Within 15 days of receipt of the request for an external grievance review, Aetna Better Health Kids shall forward the grievance file and all material considered as part of the first two reviews. Within this same 15-day period, you, your member representative, or your child's health care provider will be provided with the list of documents being forwarded to the CRE for external grievance review.

You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider will have 20 days from receipt of notice that the request for an external review was officially filed, may supply additional information to the CRE for consideration in the external review. You, your member representative, or your child's health care provider will have to also provide copies of this same information to Aetna Better Health Kids at this time.

The assigned CRE will review and issue a written decision to you, your member representative, or your child's health care provider within 60 days of the filing of the request for an external grievance review. If the CRE initially assigned was objected to, the 60 days will begin from when the reviewing CRE body was agreed upon. The letter will include what decision was made and why, and inform you that you, your member representative, or your child's health care provider have 60 days from the receipt of the decision to appeal to a court of competent jurisdiction if you are dissatisfied with the decision rendered.

What is an expedited grievance review?
An expedited review is a procedure that is available to you if your child's life, health, or ability to regain maximum function, would be placed in jeopardy by any delay that might be caused by following the normal review process.

What do I need to know about requesting an internal expedited grievance review?
A request for an internal expedited grievance review can be filed by calling Member Services at **1-800-822-2447 (TTY: 711)** or by submitting a fax to 1-860-754-1757. You can also file a request for an internal expedited grievance review by sending a letter to:

Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

In order to obtain an internal expedited grievance review, you will need to provide Aetna Better Health Kids with a certification, in writing, from your child's physician that your child's life, health, or ability to regain maximum function would be placed in jeopardy by any delay that might be caused by following the normal review process. The certification needs to include the clinical reasoning and facts to support the physician's opinion. The certification can be mailed to:

Aetna Better Health Kids (CHIP)
ATTN: Complaints and Grievances Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

You, your member representative, and your child's health care provider, have the right to appear before the internal expedited grievance review committee.

Aetna Better Health Kids will attempt to provide the physician's or psychologist's reports relating to your grievance prior to the hearing if possible. If they cannot, the reports will be read into the record at the hearing, and you will be provided with a copy of them at that time.

The hearing will take place within 48 hours of their receipt of the request for an internal expedited grievance review accompanied by a physician's certification. Efforts will be made to be reasonably flexible in terms of time and travel distance in order to facilitate your attendance. If you cannot attend in person, Aetna Better Health Kids will hold the hearing telephonically and ensure that all information presented at the hearing is read into the record.

Aetna Better Health Kids will complete the internal expedited grievance review and arrive at a decision within 48 hours of their receipt of the request for an internal expedited grievance review accompanied by a physician's certification. If Aetna Better Health Kids decides that expedited consideration with the initial request is not warranted, we will make a reasonable effort to give you prompt oral notice that the grievance is to be decided within the standard time frame – and will not be expedited. We will also send a written notice within two business days of the decision to deny the expedited review.

Aetna Better Health Kids will notify you, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider of the decision of the internal expedited grievance review committee. The notification will include what decision was made and why, and the procedure for obtaining an external expedited grievance review if you are dissatisfied with the decision rendered.

What do I need to know about requesting an external expedited grievance review?
You, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider will have 2 business days from the receipt of the internal expedited grievance review decision to contact Aetna Better Health Kids to request an external expedited grievance review.

Within 24 hours of the receipt of your request for an external expedited grievance review, Aetna Better Health Kids will submit a request for an external expedited grievance review to the Department of Health.

The Department of Health will assign a CRE within 1 business day of receiving the request for the external expedited grievance review. Aetna Better Health Kids will transfer a copy of the case file to the assigned CRE on the next business day.

The CRE will have 2 business days to issue a decision to you, your member representative (with proof of your written authorization for the representative to be involved and/or act on your behalf), or your child's health care provider. The notification will include what decision was made and why, and inform you that you, your member representative, or your child's health care provider have 60 days from the receipt of the decision to appeal to a court of competent jurisdiction if you are dissatisfied with the decision rendered.

29. Helpful Definitions

"Administrative denial" means an adverse benefit determination of prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy. The term does not include an adverse benefit determination subject to an external review.

"Affiliate" means any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization ("Person"), controlling, controlled by or under common control with the MCO or its parent(s), whether such control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of the MCO or its parent(s), directors, or subsidiaries of the MCO or parent(s) are Affiliates. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust.

"Amended Claim" means a Provider request to adjust the payment of a previously adjudicated claim. A Provider appeal is not an amended claim.

"Appeal" means to file a Complaint, Grievance, or request an external review.

"Applicant" means a child who has filed an application or who has an application filed on the child's behalf.

"Authorization" means approval for a service.

"Benefit year" is the specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Aetna Better Health Kids. A charge is considered incurred on the date the service or supply was provided to the member. Benefit limits may be calculated based on either a benefit year or a policy year, that is, the one-year period that begins with your child's enrollment in CHIP.

"Benefits" are services, procedures, and medications Aetna Better Health Kids will cover.

"Calendar year" means a one-year period that begins on January 1 and ends on December 31.

"Care management" means one-on-one help made available by Aetna Better Health Kids to provide education and coordination of benefits tailored to your child's individual needs.

"Case Management Services" means services that assist individuals with chronic and complex conditions in gaining access to necessary medical, behavioral health, educational and other services.

"Certified Registered Nurse Practitioner" means an individual licensed under the laws of the Commonwealth within the scope of Chapter 7 of Professions & Occupations, 63 P.S. §§218.1218.3.

"Child" means an individual under nineteen (19) years of age.

"Claim Reference Number" means a unique identifier assigned to a Provider of a medical service or product by CHIP.

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

"Copayment" means a fixed amount paid by a member to a Provider for a covered health care service. The amount can vary by the type of covered health care service.

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

"Cost Sharing" means the premium contributions and copayments a member's household is responsible to pay.

"County Assistance Office (CAO)" means the county offices of the Department that administer all benefit programs, including CHIP, on the county level. Department staff in these offices perform necessary functions such as determining and maintaining member eligibility.

"Coverage Area" means the geographic area the MCO is contracted to provide health care services to members.

"Covered Service" means a service or supply specified in this handbook for which benefits will be provided.

"Cultural Competency" means the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

"Custodial care" means services to assist an individual in the activities of daily living such as walking, bathing, dressing, and feeding. It typically involves personal care that does not require the continuing attention of skilled, trained medical personnel.

"Demographics" means social statistics about applicants, members and adults that includes race, date of birth, household income, ethnicity, gender, county of residence, marital status, and occupation.

"Discrimination" means discouraging enrollment or treating members differently based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability, except where medically indicated.

"Disease Management" means an integrated treatment approach that:

- Includes the collaboration and coordination of patient care delivery systems.
- Focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and
- Includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

"Disenrollment" means to stop your membership in Aetna Better Health Kids CHIP.

"Drug formulary" means a listing of preferred prescription drugs and supplies covered by Aetna Better Health Kids. The Aetna Better Health Kids drug formulary is available upon request.

"Effective date" means the date a member's coverage begins as shown on the records of Aetna Better Health Kids.

"Electronic Client Information System (eCIS)" means the Department's database of Medical Assistance (MA) recipients and CHIP members. The data base contains demographic and eligibility information for all MA recipients and CHIP Members.

"Eligibility Review" means review of an eligibility decision that resulted in denied or terminated coverage, changes to the budget category, or for failure to make a timely determination of eligibility.

"Eligible Child" means a child who has been determined as meeting all the eligibility requirements for CHIP.

"Emergency Services" means covered inpatient and outpatient services that are furnished by a Provider qualified to provide the services and are needed to evaluate or stabilize an Emergency Medical Condition.

"Enhanced Member Services Unit" means a special dedicated unit within the MCO's organizational structure established to deal with issues related to members with special needs.

"Enrollment Period" means the twelve (12) consecutive calendar months an eligible child receives services.

"External Grievance" means a review conducted by PID that occurs after the exhaustion of the MCO internal or Grievance process.

"External Quality Review" means a requirement under Section 42 CFR §457.1250 for independent, external review body to perform an annual review of the quality of services furnished by MCOs, including the evaluation of quality outcomes, timeliness and access to services.

"Free CHIP" means medical coverage provided to an eligible child whose household income is less than or equal to 208% of the FPL.

"Fraud" means dishonest, i.e., knowingly or intentionally false, misleading, or incomplete, statement or act.

"Full-Cost CHIP" means medical coverage provided to an eligible child whose household income is greater than 314% of the FPL. A member or adult is responsible for the full cost of the premium.

"Government Liaison" means the Department's primary point of contact within the MCO. This individual acts as the day-to-day manager of agreement and operational issues and works within the MCO and with the Department to facilitate compliance, solve problems, and implement corrective action.

"Habilitation Services" means health care services that help a member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a member 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 Members with disabilities in a variety of outpatient settings.

"Health Care Services" means any covered treatment, admission, procedure, medical supplies and equipment or other services prescribed or otherwise provided or proposed to be provided by a Provider to a member for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease under the terms of the CHIP State Plan, agreement, and CHIP Procedures Handbook.

"Home Infusion Therapy" The administration of parenteral, enteral, and intravenous solutions, which are provided in the home setting.

"Hospitalization" means care in a hospital that requires admission as an inpatient at a licensed hospital.

"In-Plan Services" means services which are the payment responsibility of the MCO under

CHIP.

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

"Limitations" means the maximum frequency, age restrictions or monetary caps associated with a covered service.

"Low-Cost CHIP" means medical coverage provided to an eligible child whose household income is greater than 208% and less than or equal to 314% of the FPL, and for which the responsible adult must pay a cost sharing premium established by the Department.

"Master Client Index (MCI)" means applicant identifier that is assigned across multiple Commonwealth systems.

"Medical Assistance" means the Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §§1396 et seq., and regulations promulgated thereunder, and 62 P.S. §§441.1 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq.

"Medical Necessity" means a service or benefit is Medically Necessary if it is compensable under the CHIP Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or improve the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

"Member" is a child who meets eligibility requirements for CHIP and is enrolled in Aetna Better Health Kids.

"Member Services Unit (MSU)" means a unit within the Office of CHIP that provides technical guidance and operational support for the maintenance of member records. Provide customer support via incoming and outgoing calls.

"Newborn" means an infant from birth to one (1) month of age.

"Non-Participating Provider" is a provider of covered services who has not entered into a contractual agreement with Aetna Better Health Kids. Except in the case of an emergency, prior authorization from Aetna Better Health Kids may be required before a member receives covered services from a non-participating provider regardless of the type of service rendered.

"Outpatient Drug" means a brand name drug, a generic drug, or an OTC drug which:

- Is approved by the Federal Food and Drug Administration.
- May be dispensed only upon prescription in CHIP.
- Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
- Is dispensed or administered in an outpatient setting. The term includes biological products and insulin.

"Out-of-Area Covered Services" means medical services provided to a member under one or more of the following circumstances:

• An Emergency Medical Condition occurs while outside the MCO coverage area.
• The health of a member would be endangered if a member returned to the MCO coverage area for needed services.
• The Provider is located outside a member's MCO coverage area but regularly provides medical services to members at the request of the MCO; or
• The medical services needed are not available in the MCO's coverage area. "Out-of-Pocket Expenses" means premiums and point-of-service co-payments paid by the household to MCOs or Providers on behalf of the member in a Low or Full-Cost category of CHIP for CHIP covered benefits and services only.

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

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

"Participating Provider" means a provider of covered services who has entered into a contractual agreement with Aetna Better Health Kids in order to provide care or supplies to members.

"PCP" means Primary Care Physician.

"Plan" means Aetna Better Health Kids.

"Post-stabilization Services" means covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition, or under the circumstances described in the agreement, as amended and in this Handbook, to improve or resolve a member's condition.

"Postpartum" means the 12-month period that begins at the end of pregnancy.

"Pre-Existing Condition" means a condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or has been received prior to the effective date of coverage.

"Preferred Drug List" means a list of Department-approved outpatient drugs designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the MCO's members by the MCO's Pharmacy and Therapeutics Committee.

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

"Prior Authorization" means the process by which services are approved by Aetna Better Health Kids prior to the member receiving a covered service or treatment by certain specialists or non-participating providers.

If prior authorization is required, typically, except in the case of a medical or dental emergency,

claims for these services will not be paid for unless the prior authorization is obtained before the date of service.

"PROMISe™ ID" means a 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

"Provider" is a medical professional such as a doctor, nurse, counselor, or physical therapist.

"Provider Directory" is a list of providers who participate with Aetna Better Health Kids to help take care of members' health care needs.

"Provider Dispute" means a written communication to the MCO, made by a Provider, expressing dissatisfaction with the MCO decision that directly impacts a Provider. This does not include decisions concerning Medical Necessity.

"Provider Reimbursement and Operations Management Information System Electronic (PROMISe™)" means the Department's current MMIS claims processing and management system that supports CHIP, FFS and MA Managed Care delivery programs.

"Quality Management" means an ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

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

"Routine Care" means care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings, and physical exams.

"Referral" means a special form of prior authorization used to allow the member to seek services from a specialist. Aetna Better Health Kids does not require referrals to see any specialists who participate in the network. We encourage you to always coordinate care with your PCP.

"Respite care" means palliative care given in a setting outside the member's home in order to provide a brief interval of relief for the member's primary care giver, which is usually a family member.

"Secretary" means Secretary of the Pennsylvania Department of Human Services.

"Self-referred services" means services not provided by a member's PCP, but that do not require prior authorization or a referral in order to receive them.

"Service area" means the geographic region that a member must live in.

"Skilled Nursing Services" means services provided by licensed nurses.

"Specialist" means a doctor or other health care provider that has specific, detailed training in a specialized medical field.

"Start Date" means the first date on which the MCO is operationally responsible and financially liable for the provision of Medically Necessary services to members.

"Step Therapy" means a type of prior authorization requirement, sometimes referred to as a fail-first requirement, intended as a cost savings that begins drug therapy with the most cost-effective drug therapy, and progresses to other costlier therapies determined to be

Medically Necessary.

"Substance Use Disorder" means any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency as evidenced by physical tolerance or withdrawal.

"Sustained Improvement" means improvement in performance documented through continued measurement of quality indicators after the performance project, study, or quality initiative is complete.

"Surgery" means the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, and other procedures.

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

"Termination" means discontinuance of CHIP enrollment for a member who had been previously enrolled and has ended the relationship with an approved MCO for one of the reasons enumerated in this handbook.

"Treatment" means the care a member receives from providers.

"Urgent Medical Condition" – An illness, injury or severe condition which under reasonable standards of medical practice should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or an emergency medical condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.

"Utilization Review Criteria" - Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of Medically Necessary including, but not limited to, level of care, place of service, scope of service, and duration of service.

Appendix I

Clinical Trials Citation

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

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health (NIH)
    2. The Centers for Disease Control and Prevention (CDC)
    3. The Agency for Health care Research and Quality (AHRQ)
    4. The Centers for Medicare and Medicaid Services (CMS)
    5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
    6. Any of the following, if the Conditions for Departments are met:
        a. The Department of Veterans Affairs (VA)
        b. The Department of Defense (DOD)
        c. The Department of Energy (DOE), if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

In the absence of meeting the criteria listed above, the clinical trial must be approved by the HMO/PPO as a 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, Aetna Better Health must be notified in advance of the Member’s participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional Provider and conducted in a Participating Facility Provider facility. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider facility, then Aetna Better Health 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 Aetna Better Health.

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

Nondiscrimination Notice

Aetna Better Health® Kids complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex gender, gender identity or expression or sexual orientation. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, sex gender, gender identity or expression or sexual orientation, health status or need for health care services.

Aetna Better Health Kids:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna Better Health Kids has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex gender, gender identity or expression, or sexual orientation, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
PO Box 818001
Cleveland, OH 44181-8001
Telephone: **1-888-234-7358 (TTY 711)**
Email:
MedicaidCRCoordinator@aetna.com

The Bureau of Equal Opportunity, Room 223
Health and Welfare Building
PO Box 2675
Harrisburg, PA 17105-2675
Phone: **717-787-1127 (TTY/PA Relay: 711)**
Fax: **717-772-4366**
Email: **RA-PWBEOAO@PA.gov**

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

This notice is available at the Aetna Better Health Kids website:
AetnaBetterHealth.com/Pennsylvania

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Aetna Better Health® Kids