CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

ELIGIBILITY AND BENEFITS HANDBOOK

Released April 5, 2017

Introduction

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, allowed for the creation of the Children's Health Insurance Program (CHIP). CHIP was established to provide health coverage to uninsured children that reside in households with income exceeding the current levels for Medical Assistance through the Department of Human Services.

The CHIP Eligibility Handbook serves to provide contractors with a comprehensive guide that will ensure proper implementation of statutory requirements, pursuant to Title XXI of the Social Security Act, the Children's Health Care Act, and the Patient Protection and Affordable Care Act (PPACA or more commonly referred to as ACA).

The Policy Manual is divided into 2 parts:

Part 1: describes the program policy. Each subsection states the requirement, how to verify the requirement (if needed), and whether there are special circumstances or exceptions related to the requirement.

Part 2: describes the current benefit package, co-payments and deductibles.

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GLOSSARY

For the purpose of this Eligibility Handbook, the following definitions shall apply:

Annual Tax Household Gross Income – Income used for determination of eligibility is defined for the purposes of this eligibility handbook tax household (see Modified Adjusted Gross Income).

Applicant – An applicant is defined as a child who wants his/her eligibility for CHIP determined. The adult (custodial parent or legal guardian) with whom the child lives will be the applicant on the behalf of the child.

Central Eligibility Unit (CEU) – The name of the unit within CHIP that verifies citizenship and identity, reviews data exchanges and finalizes CHIP eligibility.

Child – A person under nineteen (19) years of age.

Children's Health Insurance Program (CHIP) – The name of the program that provides Free- and Low-Cost or Full-Cost health care services in accordance with Act 2006-136.

CHIP Application Processing System – The various software applications that manage CHIP applications and renewals for the Commonwealth of Pennsylvania.

Citizen – An applicant or enrollee whose United States citizenship has been verified.

Commonwealth Of Pennsylvania Application for Social Services (COMPASS) – Pennsylvania's online portal for applying for and renewing health and human services benefits.

Contractor – An insurer awarded a contract to provide health care services.

Cost Sharing – The premium contributions and copayments that the applicant's household is responsible to pay as their share of health insurance coverage.

County Assistance Office (CAO) – The Pennsylvania Department of Human Service's offices located in each county where Medicaid eligibility is determined.

County of PCP – County where the enrollee's Primary Care Provider is located.

County of Residence – County of the enrollee's principle residence.

County of Service – County where the CHIP-eligible service was provided.

Creditable Health Insurance – Health insurance coverage that meets a minimum set of qualifications established by ACA. (See section 5.2).

Department – Refers to the Department of Human Services and specifically to the CHIP Office.

Eligible Child – A child who has been determined as meeting all of the eligibility requirements for CHIP.

Enrollee – A child who has been determined to be eligible for CHIP and is enrolled with an insurance contractor.

Enrollment Period – A period of eligibility for CHIP which consists of 12 consecutive calendar months beginning with the first month that an eligible child is enrolled.

Federal Poverty Level (FPL) - The Federal Poverty Level is a scale to judge whether or not a family's income meets the financial needs for the basic necessities of life. New guidelines are issued every year in late January or early February to account for fiscal changes such as higher utility costs, inflation, and minimum wage levels.

Free CHIP - Medical coverage provided to an eligible child whose family income is less than or equal to 208% of the FPL.

Full-Cost CHIP – Allows families with income greater than 314% of the FPL to purchase CHIP insurance by paying the full premium.

Health Management System (HMS) – the Company that maintains a national insurance enrollment database. The Department contracts with HMS to match eligible individuals to verify if an applicant has other health insurance.

Health Insurance Portability and Accountability Act (HIPAA) – For purposes of this handbook, HIPAA means the federal standards for privacy and security of individual identifiable health information in Title II of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §1320d et seq.) and it regulations (45 C.F.R. Parts 160 and 164 Subparts A and E).

Insurer – A health insurance entity licensed in this commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under Act 2006-136 or any of the following:

- The Act of December 29, 1972 (P.L. 1701, No. 364), known as the “Health Maintenance Organization Act.”
- The Act of May 18, 1976 (P.L. 123, No. 54), known as the “Individual Accident and Sickness Insurance Minimum Standards Act.”
- 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
- Article XXIV of the Insurance Company Law of 1921.

Lawfully Present – As defined in Chapter 3, Appendix 3-E.

Lawfully Residing – A child that is legally present in the United States and is living in the state with the intent to reside in the state, including those without a fixed address or a child who has entered the state with a job commitment or seeking employment (whether or not that individual is currently employed).

Legal Guardian – A person who has the legal authority (and the corresponding duty) to assume care, control of, and financial responsibility for another person.

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

Medicaid – Federal medical assistance program established under Title XIX of the Social Security Act.

Medical Assistance (MA) - The state program established under the act of June 13, 1967, known as the "Human Services Code".

Minimum Essential Coverage (MEC) – Coverage required to meet the individual responsibility requirement under the Affordable Care Act.

Modified Adjusted Gross Income (MAGI) – Calculated as total adjusted gross income plus tax-exempt interest income, foreign earned income excluded from taxes, and tax- exempt social security benefits. Determined as point-in-time, projected for twelve months, including predictable increases or decreases in household income.

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

Out-of-Pocket Cost Sharing – Includes premiums and point-of-service co-payments paid by families to contractors or providers on behalf of children enrolled in a Low- or Full-Cost category of CHIP for CHIP covered benefits and services only.

Parent – A natural parent, stepparent, adoptive parent, legal guardian, or legal custodian of a child, unless otherwise noted in policy.

Personal Property – A privately owned possession which is not real property, such as cash on hand, motor vehicles, and life insurance.

Pre-existing Condition – 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.

Premium Lock-out Period – A period up to 90 days in which a family has to pay overdue premiums to have the child reinstated back to the termination date without having to reapply

for coverage.

Primary Care Provider (PCP) – A health care provider, who within the scope of the provider's practice supervises, coordinates, prescribes, or otherwise provides or proposes to provide health care services to a member; initiates member referral for specialist care; and maintains continuity of member care.

Qualified Alien – An applicant that meets the definition of Qualified Alien as defined by Section 431 of the Personal Responsibility and Work Reconciliation Act of 1996, P.L. 104-193 (PRWORA).

Real Property – Real property includes any land and related outbuildings needed to operate the home.

Reinstatement – The act of restoring a child's CHIP benefit without a lapse in coverage pending payment of any past due premiums, if applicable.

Renewal – The outcome of a review of eligibility that results in an eligible child receiving another 12-month enrollment period of CHIP coverage.

Renewal Due Date (RDD) – Date renewal of coverage must be completed to remain enrolled in CHIP.

Residency – A resident of Pennsylvania is someone who is living and intends to reside in Pennsylvania, with or without a fixed or permanent address.

Resource – Real or personal property.

Supplemental Security Income (SSI) – Monthly cash payments made to the aged, blind, or disabled under the authority of Title XVI of the Social Security Act, as amended, Section 1616 (A) of the Social Security Act, or Section 212 (A) of Pub. L. 93-66. (The SSI income is not included in an eligibility determination).

Systematic Alien Verification for Entitlements (SAVE) – The program maintained by the United States Citizenship and Immigration Services that verifies immigration status for non U.S. citizens.

Tax household – The group of persons and their income used to determine a child's CHIP eligibility based upon the rules further defined in Chapter 7.

Termination – Discontinuance of CHIP coverage for a child who had been previously enrolled and has severed his/her relationship with an approved CHIP contractor for one of the reasons enumerated in the CHIP Eligibility Handbook.

United States Citizenship and Immigration Services (USCIS) – The governmental agency that oversees lawful immigration into the United States.

ACRONYMS

ACR – Awaiting Contractor Response (premium payment).

CAO – County Assistance Office.

CEU – Central Eligibility Unit.

CHAMPUS/TRICARE – Civilian Health and Medical Program of the Uniformed Services/TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide**.**

CHAMPVA – The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries.

CHIP – Children's Health Insurance Program.

CMS – Centers for Medicare and Medicaid Service.

COMPASS – Commonwealth of Pennsylvania Application for Social Services.

DHS – The Pennsylvania Department of Human Services.

FPL – Federal Poverty Level.

HIPAA – Health Insurance Portability and Accountability Act.

HMS – Health Management System.

INA – Immigration and Nationality Act.

MA – Medical Assistance or Medicaid.

MAGI – Modified Adjusted Gross Income.

MEC – Minimum Essential Coverage.

PCP – Primary Care Provider.

RDD – Renewal Due Date.

SAVE – Systematic Alien Verification for Entitlements.

SNAP – Supplemental Nutrition Assistance Program.
SSI – Supplemental Security Income.

TANF – Temporary Assistance for Needy Families.

USCIS – United States Citizenship and Immigration Services.

PART 1 – POLICY

CHAPTER 1: AGE OF ELIGIBLE CHILD

1.1 GENERAL REQUIREMENTS

A child under 19 years of age is eligible. The age of a child does not need to be verified, unless questionable. Verification may be requested if discrepancies are discovered during the application or renewal process. Verification should be provided during the match through the SSA composite. However, if there are inconsistencies during the match, paper verifications may be requested.

1.2 SPECIAL CIRCUMSTANCES

CHIP coverage is provided for 12 consecutive months from the date of enrollment/renewal. Coverage is terminated on the last day of the calendar month in which the child turns 19.

EXAMPLE 1:
Johnny was born on December 10. He is 18 years old and applies for CHIP in January. He meets all of the eligibility requirements and he is enrolled in CHIP in February. His eligibility period runs from February 1 through December 31.

EXAMPLE 2:
Jimmy is 18 years old, tax household income is greater than 314% of the FPL, and applies for CHIP in January. He had health insurance that ended in December. Jimmy turns 19 years old in February. His application should be forwarded to the FFM for processing.

1.3 AGING OUT OF CHIP

When CHIP coverage is terminated due to a child turning 19 years old, the child will be screened for MA eligibility. Under no circumstances will a child remain enrolled in CHIP beyond the last day of the month in which the child turns 19.

EXAMPLE 3:
Joey is turning 19 on April 15. In the beginning of March, CHIP Application Processing Systems will conduct a sweep to identify all children that are turning 19 the next month. CHIP Application Process Systems will create a new Tax Household and follow MAGI methodology. If income is under the MA limits for this individual's household, the individual will be referred to the CAO for an eligibility determination. Joey will be terminated due to aging out effective May 1. If the income exceeds the DHS limit, the child will be referred to the FFM by the CAO.

CHAPTER 2: RESIDENCY

2.1 GENERAL REQUIREMENTS

A child must be considered a resident of Pennsylvania on the day eligibility is determined.

2.2 Residency Defined (42 CFR 435.403(h))

The state where the individual resides, including without a fixed address; or

The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.

2.3 VERIFICATION REQUIREMENTS

The Pennsylvania residency status of a child need not be verified. However, verification may be requested on a case-by-case basis if there is reason to question information provided on the application or renewal forms.

Examples of verification for residence:

- Pay statements showing employee/applicant's address.
- Rent receipts.
- Mortgage receipts.
- Utility payments (gas, electric, water, cable, but not cellular/mobile/pager).
- Property deed.
- Voter registration.
- Driver's license or permit.
- Tax return.

CHAPTER 3: IDENTITY/CITIZENSHIP

3.1 GENERAL REQUIREMENTS

A child must be a citizen of the United States (U.S.), a U.S. national, or lawfully residing as determined by the United States Citizenship and Immigration Service (USCIS). Refer to Appendix 3-E for categories of lawfully residing entities.

3.2 VERIFICATION REQUIREMENTS

The verification of citizenship requirement includes verifying the identity of the applicant child claiming to be a U.S. citizen or lawfully residing. Citizenship and identity must only be verified once. Refer to Appendix 3-C for list of acceptable documents for identity and citizenship verification.

Note: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) modified the Deficit Reduction Act of 2005 (DRA) Medicaid citizenship documentation requirements and extended those requirements to CHIP for new applicants with an application date of January 1, 2010 or later, or those with a break in coverage. The citizenship and identity verification requirement does not apply to renewals or to children enrolled in CHIP as of December 31, 2009. These children are considered to have been "grandfathered" into the program, unless there is a break in coverage (see Section 3.6).

3.3 ELECTRONIC VERIFICATION

CHIPRA permits the verification of citizenship and identity for new applicants to be completed electronically through a data match with the Social Security Administration (SSA).

3.4 SSA DATA MATCH

An electronic match with the SSA will take place to match the child's name, date of birth, gender, and Social Security Number (SSN) in the CHIP Application Processing System to the SSA database. If there is a match, citizenship and identity will be considered verified.

Key factors used by SSA to confirm citizenship and identity are:

- Spelling of the first name.
- Spelling of the last name.
- Middle initial.
- Date of birth.
- Social Security Number (SSN).
- Gender.

Accurate data entry is vital. All information contained in CHIP application processing system **must match exactly** what SSA has on file to confirm citizenship and identity.

If SSA confirms citizenship and identity for a CHIP child, no further action is required. The citizenship and identity will be electronically updated in CHIP's application processing system.

If SSA cannot confirm citizenship and identity, additional verification methods will be performed by the Central Eligibility Unit (CEU) to confirm citizenship and identity.

See Section 3.5 this Chapter – Citizenship and Identity Cannot be Confirmed by SSA.

Note: If at any time a contractor needs copies of documents the CAO used to confirm citizenship and identity (i.e. audit), the contractor must contact the CAO to request

copies of documents.

3.5 CITIZENSHIP AND IDENTITY CANNOT BE CONFIRMED BY SSA

A child's enrollment will not be denied or delayed due to unverified citizenship and identity. Contractors are not to delay processing of applications to request citizenship or identity documentation.

3.5.1 CONDITIONAL ENROLLMENT

If citizenship and identity **cannot** be confirmed electronically by SSA, the child will be conditionally enrolled in CHIP for 90 days pending verification of citizenship and identity.

During that time, the family will be required to provide citizenship and identity documentation for the child if electronic verification cannot be completed.

A child will only be given one 90-day period of conditional eligibility. If another application is submitted, the application will be considered incomplete and ultimately denied if the contractor is unable to obtain citizenship and identity verification.

3.6 BREAK IN COVERAGE

A break in coverage is considered a period of 90 days or less, after which the family takes all necessary steps to maintain coverage prior to the elapse of the 90th day. If the family completes the necessary steps prior to the 90th day, the child is not considered to be dis-enrolled from the program. For eligibility purposes the child will be considered as a continuation of their current coverage with no break in eligibility.

Based on a continuation of coverage, a grandfathered child is not required to establish citizenship and identity and the family is not required to have a go bare period of 3 months for non-payment of premium. For example, if the family completes their renewal within 90 days after their prior Renewal Due Date, they are considered continuously enrolled as a renewal rather than a new applicant.

If the family is late in making the required premium payment, the child will be terminated for failure to pay premiums. However, if the overdue premium payments are paid within 90 days of the termination date, the child's grandfathered status is reinstated. However, if the child is terminated for failure to pay premiums, but the overdue premiums are not paid within 90 days of the termination, the child is not eligible for a continuation of coverage and will lose their grandfathered status for citizenship and identity verification. They must provide the required documentation prior to being re-enrolled.

Examples:

1. A child is enrolled in CHIP with a renewal due date (RDD) of April 30. The child is terminated from CHIP May 1 because the family did not complete the renewal process. On May 15, the family completes the renewal process. The child is eligible for CHIP and is enrolled with an effective date of May 1, based on the continuation of coverage. Therefore, there is no break in coverage. The child's grandfathered status for citizenship and identity verification is retained.

2. A child is enrolled in CHIP with a renewal due date (RDD) of April 30. The child is terminated from CHIP May 1 because the family did not complete the renewal process. On August 15, the family completes the renewal process. The child is eligible for CHIP and is enrolled with an effective date of September 1. There is a break in coverage because the renewal was not completed within the 90 days. Therefore, the child loses the grandfathered status for citizenship and identity verification and must provide the required documentation.

3. A child has been enrolled continuously in Low-Cost CHIP since prior to January 1, 2010. At the end of February 2016, the child is terminated because the family did not make February's premium payment. His family paid for February and March on March 5, 2016. The child is reinstated in CHIP and retains his grandfathered status.

4. The child has been enrolled continuously in Low-Cost CHIP since prior to January 1, 2010. At the end of January 2016, the child is terminated because the family did not make January's premium payment. On April 15, the family paid the premiums for January, February, March and April. The child may be reinstated in CHIP only upon verification of citizenship and identity. The contractor must request adequate documentation as required in Section 3.7 below.

   NOTE: If the child is terminated due to nonpayment of the premium, the child is required to serve a 90 day premium lock-out period before enrollment can begin unless the parent agrees to pay all unpaid premium payments; however, the child still must verify citizenship and identity.

3.6.1 BREAK IN CHIP COVERAGE DUE TO MA ENROLLMENT

If the break in coverage was because the child was enrolled in MA, grandfathered status is lost; however, establishment of citizenship and identity should not be required. Citizenship and identity should have been verified prior to enrollment in MA.

If for some reason the child's citizenship and identity have not been verified by DHS, then the child will lose "grandfathered" status. Citizenship and identity must be verified.

3.7 NON U.S. CITIZENS

All non-citizens must meet the definition of "lawfully residing" and provide proof of their

legal status by presenting documentation from the United States Citizenship and Immigration Services. Refer to Appendix 3-D for list of qualified aliens and acceptable documentation.

3.8 SPECIAL CIRCUMSTANCES

Proof of Citizenship: A child that is income eligible for Medicaid, but is denied or terminated from Medicaid for failure to provide proof of U.S. citizenship is not eligible for CHIP.

Newborn Consideration: Children who are born to CHIP eligible individuals under the approved state plan are considered by Pennsylvania as targeted low-income children on the date of the child's birth. These children are considered to have applied and been determined otherwise eligible for Medicaid or CHIP, as appropriate, on the date of birth. These children remain eligible for Medicaid or CHIP until attaining the age of 1 year when a redetermination of eligibility is completed.

The newborn meets the U.S. citizenship and identity requirements based upon the contractor's record of claim payment to the hospital located in the U.S. where the child was born. Additional citizenship and identity verification for the newborn is not required.

Appendix 3-A: CITIZENSHIP AND IDENTITY DOCUMENTATION

Note: The Child Citizenship Act which became effective on February 27, 2001, amended the Immigration and Nationality Act to provide U.S. citizenship to certain foreign born children – including adopted children – of U.S. citizens. In general, children who are less than 18 years of age and have at least one parent who is a U.S. citizen, whether by birth or naturalization, will benefit from this law. Under the law, qualifying children who permanently reside in the U.S. with a U.S. citizen parent automatically acquire U.S. citizenship. This does not alleviate the need to verify the citizenship; however, depending upon the type of adoption, different documents may be required to verify eligibility for benefits (Hague, Orphan, or immediate relative process).

The following are accepted as *Primary Level* Documentation of citizenship and identity. All of these documents contain a photograph of the individual named in the document. See Appendix 3-B for Citizenship and Identity Desk Guide.

- U.S. passport.
- A Certificate of Naturalization (Department of Homeland Security (DHS) Forms N-550 or N-570).
- A Certificate of United States Citizenship (DHS Forms N-560 or N-561).
- Documents issued by a federally recognized Indian tribe.

If an individual does not have any of the above documentation, the individual must provide a document as proof of citizenship or Nationality and a document as proof of identity.

The following are accepted as *Secondary Level* Documentation of Citizenship (but not Identity):

- A U.S. Birth Certificate from one of the 50 states or the District of Columbia.
- A certification of birth. This card is issued by the Department of Homeland Security (DHS) (Form DC-1350).
- A report of birth abroad of a Citizen of the U.S. (Form FS-240).
- A certification of birth abroad (Form FS-545).

  Note: A Certification of Birth (Form FS-545 or DS-1350) or replacement of a Consular Report of Birth (Form FS-240) may be obtained by writing to:

  Department of State
  Vital Records Section Passport Services
  1111 19th Street, NW, Suite 510
  Washington, DC 20522-1705

  A written request must be notarized and include a copy of valid photo identification of the requestor. The written request must include:

  - Full name of child at birth (plus any adoptive names).
  - Date and place of birth.
  - Names of parents.
  - Serial number, if known, of the FS-240 (on those issued after November 1, 1990).
  - Any available passport information.
  - Signature of requester.
  - Notarized affidavit for a replacement FS-240 (if applicable).

- A U.S. Citizen Identification Card (DHS Form I-197 or I-179). Neither card is currently issued, but either card that was previously issued is still valid.
- An American Indian Card (I-872) issued by the DHS with the classification code "KIC". This card is issued by the DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
- A Northern Mariana Identification Card (I-873). This card was issued by the DHS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. This card is no longer issued, but those previously issued are still valid.
- A final adoption decree. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to the final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
- Evidence of Civil Service employment by the U.S. government before June 1976.
- An official military record of service showing a U.S. place of birth. (A DD-214 or similar official document showing U.S. place of birth).

- Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000 for a biological or adopted child born outside of the United States.

The following are accepted as *Third Level* Documentation of Citizenship (but not Identity):

- Extraction of a hospital record of birth on hospital letterhead established at the time of the individual's birth, indicating a U.S. place of birth and created at least five years before the CHIP application date.

  NOTE: For children under 16, the document must have been created near the time of birth or five years before the date of application. Do not accept souvenir birth certificates issued by the hospital.

- Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. Examples of such records include baptismal certificates.

  Caution: In questionable cases (for example, where the child's religious record was recorded near an International border and the child may have been born outside the U.S.), the state must verify the religious record documents that the mother was in the U.S. at the time of birth.

  NOTE: Entries in the family Bible are not considered religious records.

- Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the child's parents.

- A life or health or other insurance record showing a U.S. place of birth and created at least five years before the application (or near time of birth for children under age 16).

The following are accepted as *Fourth Level* Documentation of Citizenship (but not Identity):

  NOTE: Fourth level evidence of citizenship is documentation evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstance (when no other higher tier documents are available).

- A federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900-1950).

- A U.S. State Vital Statistics official notification of birth registration that was created at least five years before the application date, (or near the time of birth for children under age 16).

- A delayed (amended) U.S. public birth record that was recorded more than five years after the individual's date of birth and was created at least five years before the application date (or near the time of birth for children under age 16).

- A statement signed by the physician or midwife who was in attendance at the time of birth that was created at least five years before the application date (or near the time of birth for children under age 16).

- Institutional admission papers from a nursing home, skilled nursing facility, or other institution indicating a U.S. place of birth that was created at least five years before the application date.

- Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least five years before the application date (or near the time of birth for children under age five).

  NOTE: An immunization record is not considered a medical record for the purpose of establishing Citizenship.

- Written affidavits may be used only when the state is unable to secure evidence of citizenship from another listing.

If the documentation of citizenship requirement needs to be met through affidavits, the following rules apply:

- There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's claim of citizenship (the two affidavits could be combined in a joint affidavit).

- At least one of the individuals making the affidavit cannot be related to the individual for whom citizenship is being verified and cannot be the applicant.

- In order for the affidavit to be acceptable, the individuals making them must be able to provide proof of their own citizenship and identity.

- If an individual making the affidavit has information explaining why documentary evidence establishing the individual's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

- A separate affidavit must be obtained from the individual or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.

- The affidavit must be signed under penalty of perjury.

NOTE: Naturalized citizens are permitted to utilize the affidavit process.

NOTE: An individual may not use affidavits as documentation of BOTH citizenship and identity. The individual must choose one or the other.

The following documents are accepted as *Primary Level* Documentation of Nationality (but not Identity):

- Puerto Rico: Evidence of birth in Puerto Rico on or after April 11, 1899 and the individual's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or evidence that the individual was a Puerto Rican citizen and the individual's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

- U.S. Virgin Islands: Evidence of birth in the U.S. Virgin Islands, and the individual's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or the individual's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or evidence of birth in the U.S. Virgin Islands and the individual's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

- Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI): Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a Territory or possession on November 3, 1986 (NMI local time) and the individual's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975 and the individual's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or evidence of continuous domicile in the NMI since before January 1, 1974 and the individual's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time).

- Guam: Evidence of birth in Guam on or after April 10, 1899.

- Swain's Island and American Samoa: Evidence of birth in Swain's Island and American Samoa. Persons born in American Samoa and Swain's Island are generally U.S. non-citizen nationals.

The following are documents that are acceptable as *Secondary Level* Documentation of identity.

NOTE: These documents cannot be used as proof of citizenship or nationality.

NOTE: States may accept identity documents that have recently expired as long as there is

no reason to believe that the document does not match the individual.

- A Pennsylvania or out-of-state driver's license bearing the individual's picture or containing other identifying information, such as name, age, sex, race, height, and weight, or eye color (does not need to be current).
  NOTE: Do not accept a Canadian driver's license.

- A Pennsylvania or out-of-state identity card issued to a non-driver bearing the individual's picture or containing other identifying information, such as name, age, sex, race, height, weight, or eye color (does not need to be current).

  NOTE: Do not accept a voter's registration card.

- U.S. Military identification or draft record (active duty, dependent, retired, reserve, or National Guard).

- U.S. Coast Guard Merchant Mariner card.

- Identification card issued by the federal, state, or local government bearing the individual's picture or other identifying information such as name, age, sex, race, height, weight, or eye color.

- Military dependent's identification card.

- Three or more corroborating documents such as marriage licenses, divorce decrees, high school, and college diplomas from accredited institutions (including general education and high school equivalency diplomas), property deeds/titles and employer ID cards to verify the identity of an individual.

  NOTE: These documents can only be used as proof of identity if they have not been used to establish the individual's citizenship and the individual submitted secondary or third level citizenship documentation – not fourth level documentation.

  NOTE: A combination of three or more of these documents must corroborate and must not conflict. The documents must be originals or certified copies).

- For children under 16, a school record including a report card, child care or pre-kindergarten record. However, the record must be verified with the issuing entity.

- School identification card (primary education, secondary education, beyond high school, educational institution) bearing the individual's picture.

- Clinic, doctor or hospital record, for children under age 16.

- Properly executed Acknowledgement of Paternity Form (PA/CS 611).

NOTE: The contractor should try to obtain other forms of ID before resorting to the Acknowledgement of Paternity Form.

- Data matches with other agencies such as the Department of Health and the Department of Transportation (Penn Dot).
  NOTE: Social Security cards are NOT acceptable verification for proof of identity.

- An affidavit may be used as acceptable proof of identity only if the individual was unable to provide either one of the acceptable documents listed as primary or secondary level of documentation as proof of identity.

If the documentation requirement needs to be met through an affidavit, the following rules apply:

- Individuals with disabilities in residential care facilities may have their identity attested to by the facility director or administrator when the individual does not have or cannot get any document on the preceding lists. Again, the affidavit is signed under the penalty of perjury, but need not be notarized. The definition of disability will be determined by the facility itself.

- An affidavit of identity can be used for children under the age of 16.

  EXCEPTION: Identity affidavits may be used for children under age 18 in limited circumstances, when school ID cards and driver's licenses are not available to an individual before the age of 18.

- When an affidavit is used as proof of citizenship, another affidavit cannot be used as proof of identity.

- The affidavit must be signed under the penalty of perjury by a parent, guardian or caretaker relative.

  NOTE: The affidavit may be signed by a parent who is an illegal alien. The contractor should ask for proof of identity for the illegal parent, but if the parent cannot provide it, the affidavit is still to be accepted. The affidavit does not need to be notarized.

  NOTE: If the parent, guardian, or caretaker relative is unwilling or unable to sign the affidavit, a representative of the county may sign the affidavit when legal custody has been transferred to the Children and Youth Agency or when the child is court-ordered to placement through the Juvenile Probation Office.

Appendix 3-B: Citizenship and Identity Desk Guide

List A Provides Proof of Citizenship and Identity	
• U.S. Passport (current or expired) • Certificate of Naturalization (Department of Homeland Security (DHS) form N-550 or N-570 • A certification of United States Citizenship (DHS Forms N-560 or N-561) • Native American tribal document (must verify federally-recognized Indian Tribe which issued the document, identify the individual by name, and confirm the individual membership, enrollment in, or affiliation with that Tribe • SSA Clearance electronic verification code (V) in CIS	
List B - Provides Proof of Citizenship	**List C - Provides Proof of Identity**
• S. Birth Certificate • Certification of Birth (Form DS-1350) • Certification of Birth Abroad (Form FS-545) • Report of Birth Abroad of a U.S. Citizen (Form FS-240) • U.S. Citizen ID Card (Form I-197) • Resident Citizen ID Card (Form I-179) • Northern Mariana ID Card (Form I-873) • American Indian Card (Form I-872) with classification code "KIC" • Final adoption decree showing child's name and U.S. place of birth • Evidence of Civil Service employment by the U.S. government prior to June 1976 • Military records showing U.S. place of birth • Evidence of meeting criteria for U.S. Citizenship outlined in the Child Citizenship Act of 2000 • Hospital record of birth created at least 5 years before initial CHIP application date - NOTE: For children under 16, the document must have been created near the time of birth or five years before the application date • Life, health, or other insurance records showing a U.S. place of birth created at least five years before the CHIP application date • Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens. • Religious record recorded in the U.S. within three months of birth showing the birth a U.S. place of birth and either the date of the birth or the individual's age at the time the record was made (example – baptismal certificates). Must be an official record with the religious organization. Entries in the family Bible are not considered religious records.	• State-issued Driver's License bearing individual's picture and/or identifying information (name, age, sex, race, height, weight, eye color) • federal, state, or local government-issued Identity Card bearing individual's picture and/or identifying information (name, age, sex, race, height, weight, eye color) • School identification card bearing the individual's picture • U.S. military identification card, draft record, or discharge papers • U.S. Coast Guard Merchant Mariner card • Military dependent's identification card • Three or more corroborating documents, such as a marriage license, divorce decree, high school diploma, or employer ID card • Individuals with disabilities in residential care facilities may have their identity attested to by the facility director or administration by written affidavit, if no other proof of identity is available. • For Children under 16: o School records, such as report cards, child care or pre-kindergarten records; o Clinic, doctor, or hospital record; o If none of the above documents are available, an affidavit may be used. An affidavit may be used. An affidavit must be signed under penalty of perjury by a parent or guardian stating the date and place of birth of the child and cannot be used if an affidavit for citizenship was provided

• Early school record must include name of child, U.S. place of birth, date of birth, date of admission to school, parents names and places of birth • Federal or state census record showing U.S. citizenship or U.S. place of birth (generally for person born 1900-1950) • Institutional admission records from LTC or other institution that was created at least five years before the CHIP application date and indicates a U.S. place of birth • Medical records created at least five years before the CHIP application date and indicate a U.S. place of birth. **Note:** An immunization record is not considered a medical record for the purposes of establishing U.S. citizenship • One of the following documents that show a U.S. place of birth and was created at least five years before the application for Medicaid. (For children under 16 the document must have been created near the time of birth or five years before the date of application.) This document must be one of the following and show a U.S. place of birth: - (i) Seneca Indian tribal census. - (ii) Bureau of Indian Affairs tribal census records of the Navajo Indians. - (iii) U.S. State Vital Statistics official notification of birth registration. - (iv) A delayed U.S. public birth record that is recorded more than five years after the person's birth. - (v) Statement signed by the physician or midwife who was in attendance at the time of birth. - (vi) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs • Written affidavit made by two individuals who must prove their own citizenship and identity (Affidavits must be signed under penalty of perjury).	

Appendix 3-C: INA Codes and Annotations

Codes and annotations that may appear on the USCIS form I-94, I-688B, passport or I-766:

Asylee

- I-94 annotated with stamp showing grant of asylum under section 208 of the INA.
- I-688B annotated “274a.12(a)(5)”.
- I-766 annotated “A5”.
- Grant letter from the Asylum Office on USCIS.
- Order of an immigration judge granting asylum.

Refugee

- I-94 annotated with stamp showing admission under Sec 207 of the INA.
- I-688B annotated “274a.12(a)(3)”.
- I-766 annotated “A3”.

Alien Paroled into the U.S. for at least One Year

- I-94 with stamp showing admission for at least one year under Section 212(d) (5) on the INA.

Alien whose Departure or Removal was withheld

- I-688B annotated “274a.12(a)(10)”.
- I-766 annotated “A10”.
- Order from immigration judge showing deportation withheld under Sec. 243(h) of the INA or removal withheld under Sec. 241(b)(3) of the INA.

Alien Granted Conditional Entry

- I-94 with stamp showing admission under Sec. 203(a) (7) of the INA.
- I-688B annotated “274a.12 (1) (3)”.

Cuban/Haitian Entrant

- I-551 with code CU6, CU7 or CH6.
- Unexpired I-551 stamped in foreign passport or in INS Form I-94 with the code CU6 or CU7.
- I-94 with stamp showing parole as ‘Cuban/Haitian Entrant’ under Section 212(d) (5) of the INA.

Appendix 3-D: Qualified Non-Citizens

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c).

   8 U.S.C. 1641(b) – lawfully admitted for permanent residence, asylee, refugee, parolee, alien whose deportation is being withheld, Cuban/Haitian entrants.

   8 U.S.C. 1642(c) – battered aliens.

2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (8 U.S.C. 1101(a)(17)).

   8 U.S.C. 1101(a)(15) – "immigrant" means every alien except: ambassadors/immediate family/staff, has residence in foreign country and only temporarily visiting for business/recreation, in immediate/continuous transit to U.N.H.Q., alien crewmen, alien entitled to enter the U.S. under treaties of commerce/navigation, full-time foreign students who are only here for education and family, commuting students from Canada/Mexico ,a fiancé/fiancée of a U.S. citizen who seeks to enter the U.S. to become married within 90 days of admission, an alien who has worked for a company for at least a year and wishes to move into the U.S. to continue employment with same employer in an executive/special capacity (and family), an alien seeking full-time vocational study or other non-academic institution who is only here for education (and family),aliens of extraordinary talent/ability (and necessary company/family), temporary performers, aliens residing less than 15 months as a participant in a cultural exchange program, alien who has been a member of a religious denomination having a bona fide nonprofit organization w/in the U.S. for the 2 years preceding application for entry, aliens determined to be valuable for information of criminal activity/terrorism, victims of trafficking (and family),aliens helpful to the prosecution of criminal activity (and family), or an alien who is the beneficiary to a petition to accord status if the petition has been pending 3 or more years or has been approved and immigrant visa is unavailable.

3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

   8 U.S.C. 1182(d)(5) – case-by-case temporary parole for urgent humanitarian reasons.

4. A non-citizen who belongs to one of the following classes:

   a. Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively.

      8 U.S.C. 1160 – special agricultural workers
      8 U.S.C. 1255a – adjusted status of entrants prior to Jan. 1, 1982

   b. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and

individuals with pending applications for TPS who have been granted employment authorization.

c. Granted employment authorization under 8 CFR 274a.12(c).

   8 CFR 274a.12(c) – spouse/children of foreign govt. officials, spouse/children of alien employees of the Coordination Council for North American Affairs, nonimmigrant students, spouse/minor child of an exchange visitor, dependent of an alien classified as NATO-1 through NATO-7, an alien who has filed complete application for asylum/withholding of deportation, an alien who has filed an application for adjustment of status, an alien who has filed for suspension of deportation, temporarily paroled aliens, alien spouse of a long-term investor in the Commonwealth of Northern Mariana Islands, an alien granted deferred action, an alien who has filed an application for creation of record of permanent residence, a nonimmigrant visitor for business, an alien with final order of deportation who cannot be removed due to refusal to receive from home country, an alien applying for TPS, an alien who has filed a completed legalization application, a principal nonimmigrant witness, and immediate family members of trafficking victims.

d. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended.

   Pub. L. 101-649, Section 301 – Qualified immigrant who is spouse/unmarried child of a legalized alien.

e. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President.

f. Granted Deferred Action status.

g. Granted an administrative stay of removal under 8 CFR 241.

   8 CFR 241.6 - custom time limits/conditions by Commissioner/Director.

h. Beneficiary of approved visa petition who has a pending application for adjustment of status.

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture, who:

   a. Has been granted employment authorization.
   b. Is under the age of 14 and has had an application pending for at least 180 days.
   c. Has been granted withholding of removal under the Convention Against Torture.

d. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J).

   8 U.S.C. 1101(a)(27)(J) – immigrant present in the U.S. that has been declared dependent on a juvenile court in the U.S., or legally committed/under custody of an agency/department of the State, or individual/entity appointed by the State, and cannot be reunited with either parent due to abuse, neglect, or abandonment.

e. Is lawfully present in American Samoa under the immigration laws of American Samoa.

f. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

   22 U.S.C. 7105(b)(1)(C) – A person who has been subjected to sex trafficking or involuntary servitude and has not yet reached 18 years of age.

6. **Exception:** An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs one through nine of this definition.

Appendix 3-E: Non-citizen Documentation Desk Guide

Non-citizen Verification Documents	
Permanent Residence, Asylee, Refugee, Parolee, withheld deportation, Cuban/Haitian entrants	I-551, I-94
Battered Aliens	I-797
Ambassadors (and family)	A-2 Visa
Temporarily visiting for business	B-1 Visa
Immediate/continuous transit to U.N.H.Q.	G-2, G-3, or G-4 Visa
Alien Crewmen	I-68, I-94W
Alien entering U.S. under treaty of commerce	E-Visa
Full-time foreign students (and family)	F-Visa
Commuting students from Canada	I-185
Commuting students from Mexico	I-186
Fiancé(e) of U.S. citizen	K-Visa
Alien continuing employment with U.S. branch of current	L-1A Visa
Full-time vocational/non-academic student (and family)	M-Visa
Aliens with extraordinary talent/ability	O-1 Visa
Temporary performers	P-Visa
Aliens in cultural exchange program	Q-Visa
Alien member of religious denomination w/ nonprofit organization	R-1 Visa
Aliens valuable for information of criminal activity/trafficking	U-Visa
Alien beneficiary to petition to accord status	Approval notice from USCIS
Temporary parole for humanitarian reason	I-94
Temporary resident status for special agricultural worker	H-2A Visa
Temporary resident status due to adjust status of entrants prior to Jan 1, 1982	Approval notice from USCIS
Temporary Protected Status	I-94 and approval notice from USCIS
Granted employment authorization under 8 CFR 274a.12(c)	Approval notice from USCIS
Family Unity beneficiaries	I-817 and approval notice (I-797) from USCIS
Alien under Deferred Enforced Departure	Approval notice from USCIS

Alien granted Deferred Action status	Approval notice from USCIS
Alien granted an administrative stay of removal	I-688B or I-766 EAD
Beneficiary of approved visa petition	Approval notice from USCIS
Alien with pending application for asylum	I-589 and approval notice from USCIS
Alien granted withholding of removal under Convention Against Torture	I-589 and approval notice from USCIS
Child pending application for Special Immigrant Juvenile status	Approval notice from USCIS
Lawfully present in American Samoa	Approval notice from USCIS
Victim of severe trafficking of persons	T-Visa

CHAPTER 4: SOCIAL SECURITY NUMBERS

4.1 SOCIAL SECURITY NUMBERS

All applicants for CHIP are required to provide Social Security Numbers (SSN). Contractors are required to outreach to families to obtain the SSN if an SSN is not listed on the application form.

Families should be made aware that simplification efforts (electronic citizenship and identity verification and income verification) will not be effective without SSNs.

Without SSNs, the family will be required to provide additional paper verifications which could delay enrollment.

See Part 1, Policy, Chapter 3 – Citizenship/Alien, Section 3.3 – Electronic Verification.

- Contractors will attempt to contact family to obtain SSN for any applicant who is greater than 90 days of age.
- Application will be suspended in Application Entry and status will change to “Pending SSN Check”.
- A “Missing SSN” alert will be generated to the CEU.
- The CEU will have 2 working days to respond to the alert and attempt to provide the SSN.
- The CEU will either enter an SSN, mark that the SSN is still missing, or override the requirement and proceed through clearance allowing the contractor to proceed with normal processing.
- A child more than 90 days of age that is missing an SSN and does not have an SSN override will go incomplete and the appropriate notice will be generated upon completion of the application entry/eligibility processing.

CHAPTER 5: OTHER SOURCES OF HEALTH INSURANCE COVERAGE

5.1 GENERAL

A child is not eligible for CHIP if at the time of initial application or renewal he or she:

- Has other creditable health insurance coverage (see 5.2 of this Chapter).
- Is eligible for or is enrolled in MA.
- Is an inmate of a public institution or a patient in a public institution for mental diseases.
- Is covered by a self-insurance plan.
- Is covered by a self-funded plan.
- Has access to health care coverage by court order (this fact may not be known to the contractor).

- Is eligible for coverage through a state health benefit plan based on a parent, legal guardian, or legal custodian's employment with or retirement from a state/public agency.

Note: In Pennsylvania, a guardian or custodian must provide their employer with proof that they have legal custody or guardianship of a child before the child may be added to the employees' state health benefits plan.

If a contractor discovers a child has other health insurance, a complete eligibility determination must be performed. A notice listing all reasons resulting in ineligibility must be sent to the family.

5.2 CREDITABLE HEALTH INSURANCE COVERAGE

Creditable coverage is insurance coverage provided under any of the following:

- A group health plan.
- Group or individual health insurance coverage.
- Medicare.
- Medicaid (Medical Assistance or MA).
- CHAMPUS/TRICARE/CHAMPVA.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered to federal employees under Chapter 89 of Title 5, United States Code.
- A public health plan.
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Note: An individual who is enrolled in an MA program with a limited benefits package such as Family Planning, Mental Health, or Early Intervention programs is not considered to have creditable health insurance coverage through MA.

Note: HIPP (Health Insurance Premium Payment) Program is administered by DHS. It is a cost containment program in order to save taxpayers money by purchasing cost effective employment-related health insurance available to a Medical Assistance recipient. The termination of HIPP means the state has ceased paying the MA recipient's share of the employer-related coverage. It does not mean that the employer's health care coverage has been terminated. A DHS termination notice of HIPP is irrelevant. The child's application/renewal should be denied/terminated due to having private insurance, unless the applicant can show proof that the private insurance has ended.

5.2.1 STATE HEALTH BENEFITS FOR GOVERNMENT EMPLOYEES

A state health benefits plan is a plan organized by the state government for state employees and retirees or other public agency employees.
A large proportion of state/public agency employees/retirees are eligible for family health benefits coverage under a state health benefit plan for public employees.

Child of a parent or legal guardian or legal custodian who is employed by or retired from a state/public agency is ineligible for CHIP when the employee becomes eligible to receive family coverage through the state health benefit plan (even if the family declines to accept coverage).

See Appendix 5A for list of State/Public Agencies. See Section 5.2.2 below for verification requirements.

A child is considered eligible for health coverage under a state health plan if a state contributes more than a nominal contribution (i.e., $10 per month) to an employee's dependent health care coverage. This is typically the case for Pennsylvania state employees.

At application, a child who appears to be eligible for a state health benefits plan will be denied.

For children found to be enrolled or eligible for enrollment in a state health plan at renewal or through other means, CHIP coverage will be terminated at the end of the month that the CHIP contractor or the Department becomes aware of the wrongful enrollment.

A 30-day notice of termination is not required in this situation; however, a notice must be sent as soon as possible.

5.2.2 STATE HEALTH BENEFITS VERIFICATION

Every effort must be made to closely review all submitted income documentation and the CHIP application processing system income history to determine if a parent, legal guardian, or legal custodian is employed with or retired from a state/public agency. This includes reviewing the electronic information received via an e-Referral and COMPASS (i.e., the employer's name appears to be a state agency).

For employees, most paystubs will have "Commonwealth of Pennsylvania Employee Pay Statement" as a banner at the top. Form W2 will have "Commonwealth of PA, Exec. Off - Bur of Com Pay Op". For retirees, the Form 1099-R or pension notice will have "Commonwealth of Pennsylvania, State Employees' Retirement System".

On the paystub, there is a line item for "EE Pretx M/H Pct" which indicates the

employee is paying a percentage of the cost of the health plan. Confirmation of the parent being enrolled in the state health plan would appear under the Employer Paid Benefits section as “PR Blue Cross PPO” or as “PR Keystone Hlth Plan East HMO” (a SE region HMO provider) or “PR Blue Care HMO” (a NE region HMO provider). The HMO provider will vary depending on the region in which the employee works. If the parent, legal guardian, or legal custodian is paying the “EE Pretx M/H Pct”, it’s highly likely the children are eligible.

Should a parent, legal guardian, or legal custodian appear to be employed with or retired from a state/public agency and there is no indication of the parent, legal guardian, or legal custodian is paying for the state health benefit plan, the contractor will fax a copy of the paystub to DHS before taking any action. If received via e-Referral or COMPASS, the contractor should secure email the UFI and the employee’s name or email the employee’s name, address, SSN, and the names and SSNs of the children to the CHIP eligibility review officer.

CHIP will verify the employment status of the parent, legal guardian, or legal custodian, and availability of benefits. CHIP will enter comments and update the program integrity section in the CHIP application processing system and respond directly to the contractor.

NOTE: Upon receipt of the cancellation notice, the state/public agency employee must contact his/her HR Service Center at www.myworkplace.pa.gov or 1-866-377-2672 to enroll or change the child’s benefits.

NOTE: CHIPRA Section 311 classifies eligibility for or termination from CHIP or Medicaid as a “life changing event” and allows the child to be enrolled in the group health plan if requested within 60 days of the termination from CHIP.

5.3 VERIFICATION REQUIREMENTS

Contractors must match all applicants against their own data base to ensure applicants/enrollees do not currently have private insurance coverage.

The CHIP application processing system will match with the third party (HMS) contractor file on a nightly basis for all new applicants to ensure applicants/enrollees with income greater than 208% of the FPL do not currently have private insurance coverage.

CHIP application processing system will also match with DHS on a nightly basis for all new applicants to ensure applicants are not currently enrolled in MA. A monthly match is also conducted to identify CHIP enrollees who have become enrolled in MA. The CHIP application processing system will terminate CHIP coverage effective the first of the month following the month in which the dual coverage was identified.

APPENDIX 5-A: LIST OF STATE AGENCIES

This list contains a large sample of the Departments, Offices, Bureaus, and Commissions of state agencies. It is not inclusive of all public agencies covered by state health benefits plans within the Commonwealth of Pennsylvania (CoPA).

The Department, Office, Bureau, or Commission of:

- Administration
- Aging
- Agriculture
- Attorney General
- Auditor General
- Banking
- Capitol Police
- Civil Service Commission (SCSC)
- Crime and Delinquency
- Community and Economic Development (DCED)
- Conservation and Natural Resources (DCNR)
- Consumer Advocate
- Corrections (COR/SCI)
- Drug and Alcohol Programs (DDAP)
- Education (PDE)
- Environmental Protection (DEP)
- Fish and Boat Commission
- Game Commission
- Health (DOH)
- Historical and Museum Commission
- Human Services (DHS)
- Insurance (PID)
- Labor and Industry (L&I)
- Liquor Control Board (LCB)
- Liquor Control Enforcement (LCE)
- Medical Care Availability and Reduction Error Fund (Mcare)
- Military and Veterans Affairs (MV)
- Milk Marketing Board
- Probation and Parole
- Public Utility Commission (PUC)
- Revenue (DOR)
- Securities Commission State (DOS)
- State Police
- State Employees' Retirement System (SERS)
- State System of Higher Education (SSHE)
    - 14 state-owned universities of Bloomsburg, California, Cheyney, Clarion, East Stroudsburg, Edinboro, Indiana, Kutztown, Lock Haven, Mansfield, Millersville, Shippensburg, Slippery Rock, West Chester, and Pennsylvania State University
- Transportation (PennDOT)
- Turnpike Commission

CHAPTER 6: FACTORS THAT DO NOT AFFECT ELIGIBILITY

6.1 GENERAL REQUIREMENTS

The eligibility criteria that are considered when a determination of eligibility is completed are described throughout the Eligibility Handbook. There are no other criteria to consider when a child's eligibility is being determined.

6.2 FACTORS THAT ARE NOT CONSIDERED

6.2.1 PRE-EXISTING CONDITION

An applicant may not be excluded from enrollment based upon a pre-existing condition.

6.2.2 RESOURCES

Resources are not considered when determining eligibility for the program. Examples include but are not limited to:

- Bank accounts
- Resident or nonresident property
- Life insurance
- Vehicles
- Jewelry
- Non-recurring lottery winnings
- One-time payments (i.e. severance pay)

CHAPTER 7: TAX HOUSEHOLD

7.1 GENERAL REQUIREMENTS

When determining CHIP eligibility effective on and after January 1 2014 household composition must be established using MAGI based tax filer or non-filer rules.

7.2 MAGI TAX FILER HOUSEHOLD

The MAGI tax filer household composition includes: the tax dependent child, their claiming tax filer, tax filer's spouse if living with tax filer, tax dependent's spouse if living with tax filer, and tax filer's other dependents.

7.2.1 USE TAX FILER RULES FOR:

- Individuals who are expected to be tax filers and not claimed as a tax dependent

- Individuals who are expected to be claimed as a tax dependent

7.3 MAGI NON-TAX FILER HOUSEHOLD

MAGI non-tax filer household composition includes: the applicant child under age 19, their parents (biological, adoptive or step), their siblings under 19 (biological, adoptive or step), their spouse, if married, and their dependent children under 19 (biological, adoptive or step).

7.3.1 USE NON-FILER RULES FOR:

- Individuals not expected to file taxes that are not tax dependents
- Tax dependents that do not have an immediate relationship with the tax filer
- Children under the age of 19 living with both parents in the household and the parents are not expected to file taxes together
- Children under the age of 19 who are expected to be claimed as tax dependents by non-custodial parents

NOTE: Due to the recent allowance of same-sex marriages, contractors must ensure the eligibility determination includes the appropriate parents and their income.

EXAMPLE 1:
John Smith lives with his adopted son, Lucas Smith, and his partner Matthew Williams. Matthew has not adopted Lucas. Only John's income will count towards the eligibility determination.

EXAMPLE 2:
Jason Rodriguez lives with his spouse, Michael, and his biological son, Juan. ,

Child Claimed as a Tax Dependent (Tax filer rules)	Child Not claimed as a Tax Dependent (Non-filer Rules)
HH = Tax dependent + Their claiming Tax Filer + Tax Filer's spouse if living with Tax Filer + Tax dependent's spouse if living with Tax Filer + Tax Filer's other dependents **Exception to using Tax Filer Rules** If any of this is true: • Child is expected to be claimed by someone other than a spouse or a (biological, adopted, step) parent • Child (age <19) who lives with both parents, but both parents do not expect to file taxes jointly, and only one parent expects to claim child as his/her tax dependent • Child (age <19) who expects to be claimed as tax dependents to a non-custodial parent Then HH is determined by rule #2 (Non-Filer Rules)	HH = Child + IF living with the child • The child's [biological, adopted, step] parent(s) • The child's [biological, adopted, step] sibling(s) (age <19) • The child's spouse • The child's natural, adopted and step children under age 19

7.4 VERIFICATION REQUIREMENTS

The tax filing status of the household does not need to be verified. However, verification may be requested on a case-by-case basis if there is reason to question information provided or missing on the application or renewal forms.

EXAMPLE:
Mom applies for a child as a family size of two, but marks her marital status as “married”. This should cause the contractor to question the whereabouts of the spouse.

NOTE: Any application received without the tax-filing status for adult household members is considered incomplete, and must be requested. However, children on the application without a tax-filing status will default to “non-filing” and no verification is necessary.

7.5 SPECIAL CIRCUMSTANCES

7.5.1 PREGNANCY IN THE APPLICANT FAMILY

When an application is received, a determination of eligibility must be made for CHIP. A fetus is not counted in the family size for CHIP. However, MA does count the fetus in its determination of eligibility. The federal regulations require that a child be enrolled in the program for which the child is eligible. Therefore, a determination must be made to see if an applicant is eligible for MA, which is 215 percent of FPL for children under 1 and 208 percent of FPL for children ages 1 through 18. A module has been developed in the CHIP application processing system that determines the correct program in which to enroll the applicants when there is a pregnancy in the family.

EXAMPLE 1:
A family of four submits a renewal for CHIP and the children are enrolled – ACR (household income is $53,613) with an effective date of May 1. On April 23, the family reports that one of the children is pregnant. As is stated above, contractors are responsible for screening for MA eligibility. The fact that one of the children is pregnant would have no impact on the rest of the household unless the current head of household states that the newborn will become a tax dependent and mother of newborn is not required to file a tax return. If that is the case, when the child is born, the household size would increase to five and would be reassessed against 215 percent of FPL for the newborn, 157 percent for any child under age six and 133 percent for ages six to 18. The children would be enrolled in the proper program for their income and age group. If the head of household is not claiming the child as a dependent, upon birth, the child would be referred to DHS for an eligibility determination as a family of two.

EXAMPLE 2:

A family of four applies for CHIP and the children are in ACR status (household income is $51,316) with an effective date of May 1. On April 23, the family reports that one of the children is pregnant. As is stated above, contractors are responsible for screening for MA eligibility. In this case, the contractor would check to see if the pregnant child had income exceeding the limit for a two person household at 215% FPL. If not, the contractor would manage the pregnant child to a Terminated – CAO Referral status because the change is effective prior to the enrollment effective date. The child is not enrolled in CHIP and according to federal and state law must be enrolled in the program for which the child is eligible. The 12 months of continuous eligibility rule does not come into play because the enrollment period has not begun. The child should be found eligible for MA.

EXAMPLE 3:
A family of four applies for CHIP – mom, dad, Jane (3), and John (6). Mom indicates on the application that she is pregnant with twins. The household income is reported as $43,692. For a family size of four, the children would have been found eligible for Free CHIP; however, because mom is pregnant, the contractor must add the two fetuses to the family size for the MA screening creating a family size of six. Jane will be referred to the CAO for an MA eligibility determination. John will be enrolled in Free CHIP.

CHAPTER 8: CHIP INCOME GUIDELINES

8.1 GENERAL REQUIREMENTS

CHIP benefits are available to all children under the age of 19 who are not enrolled in or eligible for Medical Assistance, regardless of income, who meet all other eligibility requirements.

A child is eligible for Free CHIP if the annual tax household income is no greater than 208% FPL.

A child is eligible for Low-Cost CHIP (subsidized coverage groups on chart below) if the annual tax household income is no greater than 314% of the FPL.

A child is eligible for Full-Cost CHIP if the annual tax household income is greater than 314% of the FPL. Families may purchase the CHIP benefits package at 100% of the rate negotiated by the state.

APPENDIX 8-A: FEDERAL INCOME GUIDELINES FOR DETERMINING CHIP ELIGIBILITY FOR ALL CHILDREN

Appendix 8-A 2017 ***Federal Income Guidelines for Determining CHIP Eligibility for All Children***

Federal Poverty Limit for This Family Size	Your Family Size	Free Coverage For Ages 1 thru 5	Free Coverage For Ages 6 thru 18	Subsidized Coverage 1 For Ages 0 to 1	Subsidized Coverage 1 For Ages 1 thru 18	Subsidized Coverage 2 For Ages 0 thru 18	Subsidized Coverage 3 For Ages 0 thru 18	At Cost For Ages 0 thru 18
		Income Level	*Income Level*	*Income Level*	*Income Level*	*Income Level*	*Income Level*	*Income Level*
$12,060.00	1	$ 18,935 - $ 25,085	$ 16,040 - $ $25,085	$ $25,929 - $ $31,598	$ $25,085 - $ $31,598	$ $31,598 - $ $34,733	$ $34,733 - $ $37,869	$ $37,869 - No Limit
$16,240.00	2	$ 25,497 - $ 33,780	$ 21,600 - $ $33,780	$ $34,916 - $ $42,549	$ $33,780 - $ $42,549	$ $42,549 - $ $46,772	$ $46,772 - $ $50,994	$ $50,994 - No Limit
$20,420.00	3	$ 32,060 - $ 42,474	$ 27,159 - $ $42,474	$ $43,903 - $ $53,501	$ $42,474 - $ $53,501	$ $53,501 - $ $58,810	$ $58,810 - $ $64,119	$ $64,119 - No Limit
$24,600.00	4	$ 38,622 - $ 51,168	$ 32,718 - $ $51,168	$ $52,890 - $ $64,452	$ $51,168 - $ $64,452	$ $64,452 - $ $70,848	$ $70,848 - $ $77,244	$ $77,244 - No Limit
$28,780.00	5	$ 45,185 - $ 59,863	$ 38,278 - $ $59,863	$ $61,877 - $ $75,404	$ $59,863 - $ $75,404	$ $75,404 - $ $82,887	$ $82,887 - $ $90,370	$ $90,370 - No Limit
$32,960.00	6	$ 51,748 - $ 68,557	$ 43,837 - $ $68,557	$ $70,864 - $ $86,356	$ $68,557 - $ $86,356	$ $86,356 - $ $94,925	$ $94,925 - $ $103,495	$ $103,495 - No Limit
$37,140.00	7	$ 58,310 - $ 77,252	$ 49,397 - $ $77,252	$ $79,851 - $ $97,307	$ $77,252 - $ $97,307	$ $97,307 - $ $106,964	$ $106,964 - $ $116,620	$ $116,620 - No Limit
$41,320.00	8	$ 64,873 - $ 85,946	$ 54,956 - $ $85,946	$ $88,838 - $ $108,259	$ $85,946 - $ $108,259	$ $108,259 - $ $119,002	$ $119,002 - $ $129,745	$ $129,745 - No Limit
$45,500.00	9	$ 71,435 - $ 94,640	$ 60,515 - $ $94,640	$ $97,825 - $ $119,210	$ $94,640 - $ $119,210	$ $119,210 - $ $131,040	$ $131,040 - $ $142,870	$ $142,870 - No Limit
$49,680.00	10	$ 77,998 - $ 103,335	$ 66,075 - $ $103,335	$ $106,812 - $ $130,162	$ $103,335 - $ $130,162	$ $130,162 - $ $143,079	$ $143,079 - $ $155,996	$ $155,996 - No Limit
$53,860.00	11	$ 84,561 - $ 112,029	$ 71,634 - $ $112,029	$ $115,799 - $ $141,114	$ $112,029 - $ $141,114	$ $141,114 - $ $155,117	$ $155,117 - $ $169,121	$ $169,121 - No Limit
$58,040.00	12	$ 91,123 - $ 120,724	$ 77,194 - $ $120,724	$ $124,786 - $ $152,065	$ $120,724 - $ $152,065	$ $152,065 - $ $167,156	$ $167,156 - $ $182,246	$ $182,246 - No Limit
$62,220.00	13	$ 97,686 - $ 129,418	$ 82,753 - $ $129,418	$ $133,773 - $ $163,017	$ $129,418 - $ $163,017	$ $163,017 - $ $179,194	$ $179,194 - $ $195,371	$ $195,371 - No Limit
$66,400.00	14	$ 104,248 - $ 138,112	$ 88,312 - $ $138,112	$ $142,760 - $ $173,968	$ $138,112 - $ $173,968	$ $173,968 - $ $191,232	$ $191,232 - $ $208,496	$ $208,496 - No Limit
$70,580.00	15	$ 110,811 - $ 146,807	$ 93,872 - $ $146,807	$ $151,747 - $ $184,920	$ $146,807 - $ $184,920	$ $184,920 - $ $203,271	$ $203,271 - $ $221,622	$ $221,622 - No Limit
$74,760.00	16	$ 117,374 - $ 155,501	$ 99,431 - $ $155,501	$ $160,734 - $ $195,872	$ $155,501 - $ $195,872	$ $195,872 - $ $215,309	$ $215,309 - $ $234,747	$ $234,747 - No Limit
$78,940.00	17	$ 123,936 - $ 164,196	$ 104,991 - $ $164,196	$ $169,721 - $ $206,823	$ $164,196 - $ $206,823	$ $206,823 - $ $227,348	$ $227,348 - $ $247,872	$ $247,872 - No Limit
$83,120.00	18	$ 130,499 - $ 172,890	$ 110,550 - $ $172,890	$ $178,708 - $ $217,775	$ $172,890 - $ $217,775	$ $217,775 - $ $239,386	$ $239,386 - $ $260,997	$ $260,997 - No Limit
$87,300.00	19	$ 137,061 - $ 181,584	$ 116,109 - $ $181,584	$ $187,695 - $ $228,726	$ $181,584 - $ $228,726	$ $228,726 - $ $251,424	$ $251,424 - $ $274,122	$ $274,122 - No Limit
$91,480.00	20	$ 143,624 - $ 190,279	$ 121,669 - $ $190,279	$ $196,682 - $ $239,678	$ $190,279 - $ $239,678	$ $239,678 - $ $263,463	$ $263,463 - $ $287,248	$ $287,248 - No Limit
$4,180.00	+Person	$ $6,563 $ 8,695	$ 5,560 $ $8,695	$ $8,987 $ $10,952	$ $8,695 $ $10,952	$ $10,952 $ $12,039	$ $12,039 $ $13,126	$ $13,126
	% FPL	> 157% <= 208%	> 133% <= 208%	> 215% <= 262%	> 208% <= 262%	> 262% <= 288%	> 288% >= 314%	> 314%

Note 1: Income guidelines according to the January 31, 2017 Federal Register.

Note 2: The bottom income limit for CHIP forms the upper income limit for Medicaid. The Affordable Care Act permits an income disregard of 5% of the upper Medicaid limit for applicants with incomes near the limit. This provision could result in some CHIP applicants being referred to the Department of Human Service if the household income is near the upper Medicaid limit.

CHAPTER 9: ENROLLMENT GUIDELINES

9.1 GENERAL REQUIREMENTS

Once all eligibility requirements have been met and final eligibility is determined, CHIP coverage is normally provided for 12 consecutive months from the date of enrollment or renewal.

EXAMPLE:
Determination of Eligibility made April 10
Effective Date of Coverage: May 1
Period of Enrollment: May 1 - April 30

9.2 ENROLLMENT BEGIN DATES

The contractor shall use its best efforts to have the coverage become effective on the first day of the calendar month following the month in which a determination of eligibility is made.

In no case shall the effective date of coverage be delayed beyond the first day of the second calendar month following the month in which a determination of eligibility is made.

In the case where a child is Low-Cost or Full-Cost eligible, the child is placed in ACR status pending receipt of payment. The child is enrolled for the processing date for which money was received within 60 days from the determination of eligibility.

9.3 FACTORS THAT WOULD AFFECT THIS 12 MONTH ENROLLMENT PERIOD:

- A child becomes 19 years of age
- See Part 1, Policy - Age, Section 1.3 – Aging Out of CHIP
- A child is found to have other insurance, is eligible for or receiving MA, or is eligible for coverage through a state health benefit plan based on a parent, legal guardian, or legal custodian's employment/retirement with a state/ public agency
- A child moves out of the household
- A child moves out of state
- A child is deceased
- A voluntary termination of coverage is requested by the head of household
- Information was omitted or misinformation was provided at the time of the application or renewal that would have resulted in a different eligibility determination had the correct information been provided
- Citizenship and identity are not verified within the 90-day conditional eligibility period
- See Part 1, Policy – Chapter 3 - Citizenship/Aliens, Section 3.5.1 - Conditional Enrollment

- Failure to pay the required monthly premium payment for Low-Cost or Full-Cost CHIP
- See Part 1, Policy - Chapter 10 - Cost Sharing and Premium Co- Pays, Section 10.2
- A child is temporarily enrolled in CHIP awaiting an MA eligibility determination (newborns, children with special needs, others). See Sections 9.4 and 9.5 below

NOTE: Financial changes of the family during the enrollment period do not affect the 12-month period of enrollment.

9.4 PREGNANT ENROLLEES AND NEWBORN CHILDREN

CHIP contractors are required to identify children who may be potentially eligible for MA.

A child enrolled in CHIP who is identified during her 12-month term of eligibility as being pregnant will remain in CHIP for the duration of the 12-month term.

A child who is identified as being pregnant at the time of **renewal** will be subject to the usual screening and referral processes to determine eligibility for MA.

A child born to a CHIP enrollee is guaranteed one year of coverage through either MA or CHIP.

The newborn will be covered under the mother's CHIP insurance for the first 31 days from birth using the mother's identification number. A separate application or eligibility determination will not be required.

9.5 ADOPTIONS

CHIP contractors should treat adopted children the same as newborn children. If the applicant informs the CHIP contractor within 30 days of the formal adoption of the child, the date of adoption would be considered the same way as the date of birth for a newborn.

9.5.1 FOSTER CARE ADOPTIONS

In all cases where foster care leads to Adoption (including private adoption), regardless of any name or other change or the availability of federal /state adoption assistance, the contractor will do the following:

- Zero the SSN in all Foster Care closings that lead to adoption.
- Close the eligibility for the child's existing record in CHIP application processing system.
- Register a new application (including the child's new name (if changed) and Social Security Number (SSN). Use the original SSN if the child does not

have a new one.

- If an unduplicated screen is presented, select the "new recipient" option. If the system does not allow that option, the most likely cause is that zeroing out the SSN has not been completed.
- Call the CHIP application processing system helpdesk for instructions if unable to resolve the clearance issue, and have a new individual number assigned.
- When the child is authorized under the new case and has been assigned a new recipient number, a new insurance card should be issued by the contractor.

9.6 CHILDREN WITH SPECIAL NEEDS

MA provides extensive medical and mental health coverage for children with special needs that may not be available or may be limited through CHIP.

A child who has a documented illness or disability may be determined eligible for MA without counting parental income; only the income of the child is counted.

Contractors will identify a child who is potentially eligible for MA as a child with special needs by reviewing billing and claims management information. A child who is identified as a potential child with special needs is **not guaranteed 12 months of enrollment in CHIP** and may be terminated prior to the Renewal Due Date (RDD).

9.7 PCP SELECTION

Within ten calendar days of the eligibility determination date for CHIP, the contractor must provide the parent with the opportunity to select a primary care provider (PCP) for the child. If the parent makes no selection, the contractor will assign a PCP on the child's behalf. In making an assignment, the contractor will consider such things as the age of the child, any special health condition(s) (if known), travel time, and distance.

CHAPTER 10: COST SHARING AND PREMIUM CO-PAYS

10.1 GENERAL REQUIREMENTS

A family will be required to pay premium co-pays and cost-sharing if the tax household income exceeds 208% of the FPL. Co-pays and cost-sharing are based on a sliding scale according to income. As stated in the contract, the contractor has sole responsibility for collection of the premium payments. Contractors must notify each enrollee's parent or guardian of any change in the monthly payment amount at least thirty (30) days in advance of any change. This requirement is waived in cases where renewals are not received timely (by administrative renewal due date).

Co-payments are limited to physical health services and do not include routine preventative and diagnostic dental services or vision services. Co-payments will be

due at the point of service. See Appendix 10 - Co-Payments and Premiums Chart.

10.2 NON-PAYMENT OF PREMIUMS

Failure to pay required premium payments in accordance with applicable insurance laws will result in the termination of benefits.

If a child is terminated from CHIP because of non-payment of the required premium, the 90-day premium lock out period must be met if the family reapplies for benefits.

This applies only to those families with income above 208% of the FPL. (This policy prevents episodic coverage.)

10.2.1 GRACE PERIOD

A minimum 30-day grace period must be given if the family fails to pay the required premium payment by the due date.

The grace period will begin the first of the month immediately following the last month for which premium has been paid, even if the payment due date is before the first of the month of coverage.

A manual notice must be generated by the contractor within seven days of the start of the grace period to inform the family that the premium payment must be paid or coverage will be terminated effective the first day of the month in which the grace period began.

Example:
May's premium is received on time so CHIP coverage is paid for through the month of May.

May 15 is the cut-off date for receipt of June's premium payment; however, no payment is received.

Sometime between June 1 and June 7, the contractor will generate a manual notice to inform the enrollee that payment must be received prior to June 30 or coverage will be terminated effective June 1.

Enrollees who do not pay within the grace period will be retro-terminated to the beginning of the grace period (in this example, June 1).

10.3 REINSTATEMENT FOLLOWING TERMINATION FOR NON-PAYMENT OF PREMIUMS

If a child is terminated due to non-payment of premiums, the family may opt to have the child re-enrolled within 90 days. If the family waits longer than the 90 day period, they must complete a new application. This is known as the 90-day premium lock out period. In order to avoid incurring the 90-day lockout period, the family must reinstate the child by paying any unpaid premiums. Families cannot choose to skip any months of coverage, as enrollment is guaranteed in 12-month periods. All unpaid monthly premiums must be paid before the child can be reenrolled on a continuous basis (without the 90-day lockout period).

There is no limit to the number of reinstatements that may be granted as long as the family is willing to pay all unpaid monthly premiums.

If the family is unwilling to pay all unpaid premiums, then the 90-day premium lock out period will be imposed.

This policy does not apply to families that fail to make their initial premium payments.

EXAMPLE 1
A child is terminated March 1 for failure to pay premium. On May 1, the applicant requests to have the child reinstated. The applicant pays for March, April, and May, and the child is reinstated.

EXAMPLE 2
A child is terminated March 1 for failure to pay premium. On May 1, the applicant requests to have the child reinstated. The applicant wants the child to be reinstated May 1, but does not want to pay for March or April because there were no unpaid medical bills. The applicant will have to complete a new application and receive a start date of June 1 due to the 90-day premium lock out period.

10.4 MAXIMUM OUT-OF-POCKET COST SHARING

Out-of-pocket cost sharing is limited to five percent of a tax household's annual income.

Only rare circumstances of low-income families combined with very high utilization of non-preventive services by multiple CHIP enrolled family members would result in the family potentially exceeding the five percent of family income out-of-pocket limit. The MAGI eligibility calculation will calculate the cost sharing amount.

Contractors will:

- Use the cost-sharing limit annually and assist the state in reviewing and providing appropriate documentation in instances where the family indicates that they feel they have exceeded this amount
- Include cost-sharing limit on initial enrollment notice
- Provide instructions to the family regarding tracking cost sharing

- Provide instructions regarding what to do when the family's cost-sharing limit has been exceeded (send copies of the receipts to the state for calculation)
- Discontinue collection of any copays and send the family a new insurance card if the cost sharing limit has been reached and there are more than 90 days remaining prior to the RDD

Once the limit has been reached, a family can apply to the state for a rebate of any cost sharing already paid in excess of the limit. Upon verification that the family exceeded the five percent limit, the state will issue a letter to each child in the family to present to the provider that explains that cost sharing is exempt until the RDD (this specified date will be included in the letter to the household. The appropriate contractors will also receive the letter and will then know that the premiums will not be required from the enrollees until the next eligibility period begins.

10.5 SPECIAL CIRCUMSTANCES

There are no co-pays for well-baby/well-child services for children within the 208% - 314% FPL income guidelines.

Well-Baby/Well-Child Services include:

- All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis
- Routine physical examinations, as recommended and updated by American Academy of Pediatrics
- Laboratory tests associated with the well-baby and well-child routine physical examinations
- Immunizations and related office visits
- Routine preventive and diagnostic vision and dental services

American Indian and Alaska Native children are excluded from cost-sharing.

APPENDIX 10-A: PREMIUMS AND COPAYMENTS

Income Level	Premium	Co-payments
Less than or equal to 208%	None	None
Greater than 208% up to 262%	25% of the state negotiated rate per month, per child	$5 primary care physician visit (exclude well baby/well child visits) $10 specialist visit $25 emergency room visit (waived if admitted) $6 generic prescription $9 brand name prescription
Greater than 262% up to 288%	35% of the state negotiated rate per month, per child	$5 primary care physician visit (exclude well baby/well child visits) $10 specialist visit $25 emergency room visit (waived if admitted) $6 generic prescription $9 brand name prescription
Greater than 288% up to 314%	40% of the state negotiated rate per month, per child	$5 primary care physician visit (exclude well baby/well child visits) $10 specialist visit $25 emergency room visit (waived if admitted) $6 generic prescription $9 brand name prescription
Over 314%	100% of the state negotiated rate per month, per child	$15 primary care physician visit $25 specialist visit $50 emergency room visit (waived if admitted) $10 generic prescription $18 brand name prescription

PART 2: BENEFITS

CHAPTER 11: CHIP BENEFIT PACKAGE, CO-PAYMENTS, AND DEDUCTIBLES

11.1 GENERAL REQUIREMENTS

Contractors are required to provide all benefits described below. The Department reserves the right to change the benefit package as required by state or federal law and/or as the Department deems appropriate to meet the needs of the CHIP population. Implementation of such changes by the contractor will be on the date determined by the Department. If changes to the Benefit Package or eligibility criteria occur, the Department will conduct an actuarial analysis to determine if there is a need for a rate change based upon data provided by contractors.

Contractors may establish and maintain a referral process to effectively manage the care of its enrollees, but that process may not restrict access to medically necessary services. Enrollees are permitted to use providers of their choice to the extent that those providers are (except in emergencies) in the contractor’s provider network.

Providers are prohibited from charging any co-payments or requiring after-the-fact reimbursement for any in-plan service except as permitted by law and as outlined in this policy manual. A provider may bill the difference between the covered charges and the total cost of covered services where the family opts for a selection that exceeds the dollar limit or allowances established for a particular service, e.g., eyeglasses, durable medical equipment, and hearing aids.

11.2 BENEFIT PACKAGE

Section 2311 (j) (6) of the Act (40 P.S. §991.2301) requires that each contactor provide the following benefit package with the scope and duration determined by the Department:

- Preventive care/well-child visits.
- Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness or injury and other conditions provided on an ambulatory basis such as laboratory tests, x-rays, wound dressing, and casting to immobilize fractures.
- Injections and medications.
- Inpatient hospitalization.
- Outpatient hospital services.
- Emergency, accident, and emergency medical care.
- Emergency, preventive, and routine dental care.
- Emergency, preventive, and routine vision care.
- Emergency, preventive, and routine hearing care.
- Prescription drugs.

The Department has determined that this benefit package must include the following:

PRIMARY AND PREVENTIVE CARE SERVICES: This includes well-child care in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to: immunizations, health education (to include all types of tobacco use prevention and cessation), tuberculosis testing, and developmental screening in accordance with the routine schedule of well-child visits. Care must also include a comprehensive physical examination, including x-rays, if necessary, for any child exhibiting symptoms of possible child abuse. Allergy diagnosis and treatment is also covered. Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits and consults, and follow-up appointments or sick visits are covered.

The primary and preventive services are based on recommendations from organizations such as the American Academy of Pediatrics; the American College of Physici
ans; the U.S. Preventive Services Task Force (USPSTF), all items or services
with a rate of A or B in the current recommendations; the American Cancer Society; and the Health Resources and Services Administration (HRSA). Examples of covered "USPSTF A" recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, and tobacco use counseling and interventions. Examples of "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. Preventive services are provided at no cost to the member.

Pediatric Preventive care includes:

- A comprehensive health and developmental history, including health education, nutrition, tobacco use, and developmental assessment
- An unclothed physical exam
- Laboratory tests
- Vision testing
- Hearing testing
- Newborn hearing screens
- Tuberculosis testing
- Immunizations (see Immunizations below in benefits package)
- Dental screening (oral exam by PCP as part of comprehensive examination required before age three)

- Fluoride varnish as recommended by the USPSTF
- Blood lead levels screening of all children at ages one and two years and for all children ages three through six without a confirmed prior lead blood test consistent with current DOH and Pennsylvania MA program requirements
- Obesity prevention, including office visits to review results of the mandatory Growth Screening Assessment provided by the child's school
- All other medically necessary screening services

MEDICAL SERVICES:

Physician Office Services: Includes visits for the examination, diagnosis and treatment of an illness or injury at the member's PCP's office, during and after regular office hours, emergency visits, house-calls in the physician's service area, and telehealth services. Coverage includes medical care at a Retail Health Clinic staffed by a Certified Registered Nurse Practitioner (CRNP) supported by a local physician who is on-call during clinic hours or at an Urgent Care Center.

Specialist Physician Services: Includes medical care in any generally accepted medical specialty or subspecialty. Covers office visits, diagnostic testing, and treatment if medically necessary and the member has an illness or condition outside the scope of practice of the member's PCP. Services must be within the scope of practice of the specialist. PCP referral is not required to see a specialist. However, some services may require preauthorization.

Chiropractic Care: Includes manipulation of the spine or other body parts as treatment of diagnosed musculoskeletal conditions for which treatment is expected to restore a level of functioning due to this condition. Consultations and x-rays are included. Preauthorization may be required. Limit of 20 visits per year applies.

Dental Care (Emergency, Preventive, and Routine): Includes medically necessary diagnostic, restorative, endodontic, periodontic, prosthodontic, oral surgery, orthodontic, and adjunctive services as identified in the CHIP dental benefit package. Does not include cosmetic dental services. See Appendix 37-A

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

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

Diabetic Treatment, Equipment, and Supplies: Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices,

pharmacological agents for controlling blood sugar, orthotics, and outpatient self-management training and education, including information on proper diets (see Act 1998-98, as amended (40 P.S. §764e)).

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

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

Hearing care: Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary. Payment limited to one routine hearing examination and one audiometric examination per calendar year. Includes the cost of examinations and one hearing aid or device per ear every two calendar years.

Home Health Care: Covered for a child who is homebound. A child is considered homebound if her/his medical condition prevents them from leaving home with a great deal of effort. This includes medically necessary benefits such as nursing services; home health aide services; physical, speech and occupational therapies; medical and surgical supplies; oxygen and its administration; home medical equipment; and home infusion therapy, except for blood and blood products. Private duty nursing and custodial services are not covered. This benefit is offered with no copayments and no visit limitations.

Hospice Care: Covered services include palliative and supportive services provided through a hospice program by a participating hospice provider for a terminally ill child. Services require preauthorization and physician certification that the child has a terminal illness. Respite care is also included. A child receiving hospice care may still receive care for other illness or conditions. Hospice care benefits are provided until death or discharge from hospice.

Immunizations: Coverage will be provided for pediatric immunizations (except those required for employment of travel), including immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Pediatric and adult immunization schedules may be found by accessing the following

link: http://www.cdc.gov/vaccines/rec/schedules/default.htm.

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

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

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

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

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

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

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

Outpatient Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people

with disabilities in a variety of outpatient settings. Covered services are limited to 30 visits per calendar years for physical therapy, 30 visits per calendar year for occupational therapy, and 30 visits per calendar year for speech therapy, for a combined visit limit of 90 days per calendar year.

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

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

Outpatient Rehabilitative Therapy Services: Speech, occupational, and physical therapy to regain lost skills. Members must have a documented diagnosis that indicates the prescribed therapy is medically necessary. Limited to sixty visits per for each type of therapy per calendar year.

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

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

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

the member must contact their insurance Contractor before beginning the trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a participating professional provider, and conducted in a participating facility provider facility. If there is no comparable Qualifying Clinical Trial being performed by a participating professional provider, and in a participating facility provider facility, then the Contractor 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.

Qualifying Clinical Trials are phase I, II, III, or IV clinical trials conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:

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

- The study or investigation is conducted under an investigational new drug application reviewed by the Federal Drug Administration

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

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

Urgent Care Services: Covers care at walk-in medical facilities for conditions that do

not require emergency care but that need to be treated within 24 hours.

Vision Care: Includes the cost of exams, corrective lenses, frames, or contacts in lieu of glasses or when medically necessary. Limited to one exam every 12 months unless an additional exam is medically necessary. Includes dilation if professionally indicated. Covers one pair of prescription eyeglass lenses and one frame, unless a second frame is medically necessary, or contacts every calendar year. Eyeglass lenses may be plastic or glass, single vision, bifocal or trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, or polycarbonate prescription lenses with scratch resistant coating. There may be copayments for optional lens types and treatments.The replacement of lost, damaged, or stolen corrective lenses, frames, and medically necessary contacts will occur once per year (one original and one replacement). A referral from a PCP is not required to see a vision provider. There is no copayment for routine eye examinations, covered standard eyeglass lenses or contact lenses. If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus, or aphakia, a copayment may apply.

Coverage includes one comprehensive low vision evaluation every five (5) years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for item 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 preauthorization for these services.

MENTAL HEALTH SERVICES:

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

Inpatient Mental Health Services: Includes services furnished in a state-operated mental hospital, residential facility, or other 24-hour therapeutically structured services. Covers medical care including psychiatric visits and consultations, nursing care, group and individual counseling, and therapeutic services concurrent care and services normally provided relating to inpatient hospitalization. Members may self-refer. There are no day limits. No copays apply.

Outpatient Mental Health Services: Includes services furnished at a state-operated mental hospital and including community-based services. Includes partial hospitalization programs and intensive outpatient programs. Covered services include

psychological testing, visits with outpatient mental health providers, individual, group, and family counseling, therapeutic services, targeted mental health case management, and medication management. There are no limits for mental health outpatient visits per benefit year. No copays apply.

Inpatient Substance Use Disorder Services: Services provided in a hospital of an inpatient non-hospital facility that meets the requirements established by the Department of Health and is licensed as an alcohol/drug addiction treatment program. Covers detoxification stays, services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy and interventions, equipment use, medication management and services normally provided to inpatients. No day limits apply. Tobacco use cessation is not covered. No copays apply.

Outpatient Substance Use Disorder Services: Services provided in a facility licensed by the Department of Health as an alcohol/drug treatment program. Includes treatment in a partial hospitalization program and intensive outpatient therapy. Covers services of physicians, psychologist, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy, and medication management. Tobacco use cessation is not covered. There are no limits for substance use services visits per benefit year. No copays apply.

SURGICAL SERVICES:

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

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

Consultations for a second opinion consultations to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment. No referral is needed.

Mastectomy and Breast Reconstruction: Benefits are provided for a mastectomy performed on an inpatient or outpatient basis. Benefits include all stages of reconstruction on the breast on which the mastectomy has been performed, surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, mastopexy, and surgery on the other breast to produce a symmetrical appearance. Covers surgery for initial and

subsequent insertion or removal prosthetic devices to replace to removed breast or portions of the breast, and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

Oral surgery: Oral surgery may be performed at an inpatient or outpatient facility depending on the nature of the surgery and medical necessity. Examples of covered services include: removal of partially or fully impacted third molars (wisdom teeth), non-dental treatments of the mouth relating to medically diagnosed congenital defects, birth abnormalities, surgical removal of tumors, cysts and infections, surgical correction of dislocated or completely degenerated temporomandibular joints, and baby bottle syndrome.

Reconstructive Surgery: Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease or in relation to gender transition surgery deemed medically necessary in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.

WOMEN'S HEALTH SERVICES:

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

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

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

Breastfeeding: Comprehensive support and counseling from trained providers, access to breastfeeding supplies, including coverage for renting of hospital-grade breast pumps under DME and medical necessity review, and coverage for lactation support and counseling provided during postpartum hospitalization, mother's option visits, and

obstetrician or pediatrician visits for pregnant or nursing women with no cost sharing to the member.

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

Obstetrical Services: Includes prenatal, intrapartum and postpartum care, including care related to complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician or gynecologist, certified nurse-midwife, or a PCP. Services provided by a participating hospital or birthing center are covered.

Mothers and infants can remain in the hospital for 48 hours after a normal vaginal delivery or 96 hours after a Cesarean delivery. A shorter stay may be covered if the attending provider (physician, nurse mid-wife, or physician assistant), in consultation with the mother, discharges the mother and infant earlier.

Newborn Care: Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one (31) days following birth. Includes routine nursery care, prematurity services, preventive/well-child health care services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Maternity Home Health Care Visit: Enrollees are covered for at least one (1) maternity home health care visit provided at their home when the CHIP member is released prior to: (a) 48 hours of inpatient care following a normal vaginal delivery or 96 hours of inpatient care following a Cesarean delivery, or in the case of a newborn, in consultation with the mother of the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance, and training in breast feeding 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 visit. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits hollowing an inpatient stay for maternity services are not subject to copayments, deductibles, or coinsurance.

Family Planning Services: Includes, but is not limited to, birth control pills, injectable contraceptives, transdermals (patches), and insertions and implantation of contraceptive devices approved by the Federal Food and Drug Administration, voluntary sterilization, and counseling. Abortifacient drugs are not covered. There are no copays when

services are provided by a participating provider.

Abortions: Includes only abortions that satisfy the requirements of 18 PA.C.S. § 3204-3206 and 35 P.S. §§ 10101, 10103-10105. Covered abortions include those that meet the following criteria:

- A physician has certified that the abortion is necessary to save the life of the mother
- The abortion is performed to terminate a pregnancy resulting from an act of rape or incest reported within 72 hours from the date when the female first learned she was pregnant

Elective abortions are not covered. Services rendered to treat illness or injury resulting from an elective abortion are covered. The contractor and its subcontractors will respect the conscience rights of individual providers and provider organizations and comply with the Pennsylvania law prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization-related activities as outlined in 43 P.S. §955.2 and 18 Pa. C.S.A. §3213(d).

PHARMACY SERVICES:

Prescription Drugs: Includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, dispensed by order of a health care provider with applicable prescriptive authority. Contractors may use a closed or restrictive formulary provided it meets the minimum clinical needs of CHIP enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions. Generic drugs will be automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicates that the brand-name drug is medically necessary. Copays may apply.

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

Over-the-Counter Drugs: Covered when the drug is a part of the formulary, the member has a prescription for the drug, and a documented medical condition that indicates the drug is medically necessary. Copays may apply.

Preventive Medications: Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription. Members need to call their insurance provider regarding questions on coverage.

11.3 EMERGENCY ROOM SERVICES

The definition of emergency services is defined by the Department and found in Section 2102 of Act 1998-68 (40 P.S. §991.2102). Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prior authorization by the contractor.

11.4 CO-PAYMENTS AND DEDUCTIBLES

- No premiums or co-payments may be collected from enrollees in the free component.
- Low-Cost CHIP enrollees are responsible for co-payments, except for specific services described below, up to a cap of five percent of gross household income for all enrolled children in the household. Co-payments for Low-Cost enrollees are:

  - $5 Doctors Visits (see exceptions below)
  - $10 Specialists Visits
  - $25 Emergency Department Visit (waived if admitted)
  - $6 Generic Prescriptions
  - $9 Brand Name Prescriptions

  Exceptions: Per 42 CFR §457.520, contractors may not impose co-payments, coinsurance, deductibles, or similar fees on well-baby and well-child care services in either the managed care delivery setting or the fee-for-service delivery setting. Well-baby and well-child care services include:

  - All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis

  - Routine physical examinations as recommended and updated by the American Academy of Pediatrics, "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"

  - Laboratory tests associated with the well-baby and well-child routine physical examinations

  - Immunizations and related office visit as recommended and updated by the Advisory Committee on Immunization Practices

  - Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the American Academy of Pediatric Dentistry

- Full-Cost Health Care Insurance is provided to eligible children in accordance with the Act if private insurance is unaffordable or unavailable as defined by the (40 P.S. §991.2311(e.4). No state or federal dollars are provided for this coverage. Co-payments for full-cost enrollees are:

    - $15 Doctors Visits (see exceptions below)
    - $25 Specialists Visits
    - $50 Emergency Department Visit (waived if admitted)
    - $10 Generic Prescriptions
    - $18 Brand Name Prescriptions

    Exceptions: Per 42 CFR §457.520, contractors may not impose co-payments, coinsurance, deductibles, or similar fees on well-baby and well-child care services in either the managed care delivery setting or the fee-for-service delivery setting. Well-baby and well-child care services include:

    - All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis

    - Routine physical examinations as recommended and updated by the American Academy of Pediatrics, "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"

    - Laboratory tests associated with the well-baby and well-child routine physical examinations

    - Immunizations and related office visit as recommended and updated by the Advisory Committee on Immunization Practices

    - Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the American Academy of Pediatric Dentistry

CHIP DENTAL BENEFITS PLAN

GENERAL INFORMATION
All benefits are subject to the definitions, limitations, and exclusions given below and are payable only when the service is necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
The following is a list of services most commonly provided to covered individuals. It is not an all-inclusive list. Benefits for ADA codes not listed below will be provided, subject to exclusions and limitations shown in this plan.
Some services may be subject to dental review. The dentist should submit a pre-determination/pre-certification request prior to start of service.
There is no deductible if you use an in-network provider. There is no annual limit for dental services or medically necessary orthodontic dental services. There are no deductibles, copayments or coinsurance for PA CHIP covered dental benefits.
All exams, oral evaluations and treatments, such as fluorides and some images are combined under one limitation under the plan. Periodic oral exam (D0120) oral evaluations (D0145), and comprehensive oral exam (D0150, D0180) are combined and limited to one exam every 6 months from the date services were last rendered. There must be a 6 month separation between services, even if the separation of services enters a new benefit year.
All services requiring more than one visit are payable once all visits are completed.
All major prosthodontic services are combined under one replacement limitation under the plan. Benefits for prosthodontic services are combined and limited to one every 60 months. For example, if benefits for a partial denture are paid, this includes benefits to replace all missing teeth in the arch.
The periodicity scheduled used for the CHIP dental package is the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.

BASIC SERVICES		
Diagnostic Services		
Code	**Service**	**Limits**
D0120	Oral Evaluation	One every six months
D0140	Limited Evaluation – problem focused	As medically necessary w/review
D0145	Oral Evaluation	One oral evaluation for a patient under three years of age and counseling with primary caregiver every six months.
D0150	Oral Evaluation	One oral evaluation is eligible during a six-month period.
D0160	Oral Evaluation	One oral evaluation is eligible during a six-month period. Detailed and Extensive oral evaluations problem focused are only eligible by report when not related to non-covered medical, dental or adjunctive dental services including

		Temporomandibular Joint Dysfunction.
D0170	Re-evaluation	One re-evaluation is eligible during a 30-day period.
D0180	Comprehensive periodontal Evaluations	One every six months
D0210	Full Mouth Radiographic Series	One Full Mouth Radiographic Series (**D0210**) or Panoramic Radiograph (**D0330**) is eligible in a 60 month period
D0220	Periapical film (first)	One per visit, Ten in any 12-month period unless additional film is medically necessary
D0230	Periapical film (each additional film)	Ten in any 12-month period
D0240	Occlusal radiographic image	By report as medically necessary
D0270	Bitewing Radiographs – single image	One radiograph every 6 months
D0272	Bitewing radiographs – two images	One set every 6 months
D0274	Bitewing radiographs – four images	One set every 6 months
D0277	Vertical bitewings 7-8 images	One set every 6 months
D0290	Skull X-Ray	Once in a 12-month period
D0330	Panoramic Radiograph	One Full Mouth Radiographic Series (D0210) or Panoramic Radiograph (D0330) is eligible in a 60 month period.
D0340	Cephalometric radiographic image	By report demonstrating medical necessity
D0350	2D Oral Facial Photographic Images obtained intraorally or extraorally	limit removed
D0351	3D photographic image	By report demonstrating medical necessity
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image	Interpretation of diagnostic image and report only
D0415	Collection of microorganism for culture and sensitivity	As medically necessary as a program exception
D0422	Collect and prep genetic sample	One per lifetime
D0423	Genetic test -- specimen analysis	One per lifetime
D0460	Pulp vitality test	One per 30 day period
D0470	Diagnostic models	Substantiation of medical necessity
Services Not Covered		

D0320	TMJ Arthrogram	
D0321	Temporomandibular Joint films	
D0322	Tomographic survey	
D0360 **D0362** **D0363**	Cone Beam	
D0415	Collection of microorganism for culture and sensitivity	Program exception
D0416	Viral Culture	
D0417	Collection and preparation of saliva for laboratory diagnostic testing	
D0418	Analysis Of Saliva Sample – Chemical Or Biological Analysis Of Saliva Sample For Diagnostic Purposes	
D0421	Genetic Test For Susceptibility To Oral Diseases	
D0425	Caries Susceptibility Tests	
D0431	Adjunctive Pre-Diagnostic Test	
D0472 **D0473, D0474**	Accession Of Tissue	By report with substantiation of medical necessity. May be covered as a medical benefit
D0475	Decalcification Procedure	
D0476	Special stains for microorganisms	
D0477	Special stains, not for microorganisms	
D0478	Immunohistochemical Stains	
D0479	Tissue In-Situ Hybridization, Including Interpretation	
D0480	Accession Of Exfoliative Cytologic Smears	
D0481	Electron Microscopy – Diagnostic	
D0482 **D0483**	Immunofluorescence	
D0484	Consultation on slides prepared elsewhere	
D0485	Consultation including preparation of slides	
D0486	Laboratory Accession Of Transepithelial Cytologic Sample	
D0502	Oral Pathology Procedure	
D9950	Occlusion Analysis	
D0210, D0220, D0230, D0240, D0250, D0260,	Diagnostic Dental X-Rays Performed In Conjunction With Temporomandibular Joint	

D0270, D0272, D0273, D0274, D0277, D0290, D0330	Dysfunction Are Not Covered	
Preventive Services		
D1110, D1120	Routine cleaning	One every 6 months
D1206	Topical application of fluoride varnish	Two every 12 months
D1208	Topical application of fluoride (excluding prophylaxis)	Two every 12 months
D1351	Sealants	one sealant per tooth every 36 months
D1352	Preventive resin restorations on a moderate to high caries risk patient – permanent teeth	One-preventive resin per tooth every 36 months
D1353	Sealant repair – permanent tooth	One per tooth every 36 months
D1354	Interim caries medicament – permanent teeth	I per tooth every 36 months, molars/bicuspids, excluding wisdom teeth. Per arch two times per calendar year.
D1510, D1515, D1520, D1525	Space maintainers that replace prematurely lost teeth – fixed or removable space maintainers	Limited to children under age 19
D1550	Re-cementation or re-bond of space maintainers	Limited to children under age 19
D1555	Removal of fixed space maintainers	Only eligible for children under age 19
D9110	Palliative treatment of dental pain – minor procedure	By report. As medically necessary.
Services Not Covered		
D1310	Nutritional counseling	
D1320	Tobacco Counseling	
D1330	Oral Hygiene Instruction	
D5986	Fluoride Gel Carrier	
D5991	Topical Medicament Carrier	

INTERMEDIATE SERVICES		
Minor Restorative Services: Eligible amalgam and composite fillings are limited to once in a 24 month period.		
Code	**Service**	**Limits**
D2140	Amalgam, one surface- primary or permanent	

D2150	Amalgam – two surfaces, primary or permanent	
D2160	Amalgam – three surfaces, primary or permanent	
D2161	Amalgam – four surfaces, primary or permanent	
D2330	Resin-based composite – one surface, anterior	
D2331	Resin-based composite – two surfaces, anterior	
D2332	Resin-based composite – three surfaces, anterior	
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	
D2910	Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	
D2920	Re-cement or re-bond crown	
D2929	Prefabricated porcelain crown --primary	Under age 15 where no permanent successor exists
D2930	Prefabricated stainless steel crown – primary tooth	Under age 15 – limited to 1 per tooth every 60 months
D2931	Prefabricated stainless steel crown- permanent tooth	Under age 15 – limited to 1 per tooth every 60 months
D2940	Protective Restoration	
D2951	Pin retention	Per tooth – in addition to restoration
Endodontic Services		
D3220	Therapeutic pulpotomy (excluding final restoration)	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to one tooth per lifetime

D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	Incomplete endodontic treatment when you discontinue treatment. limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to one tooth per lifetime
Periodontal Services		
D4341	Periodontal scaling and root planning – four or more teeth per quadrant	limited to 1 per quadrant every 24 months
D4342	Periodontal scaling and planning – one to three teeth per quadrant	limited to 1 every 24 months
D7921	Collect – apply autologous product	limited to 1 in 36 months
Prosthodontic Services		
D5410, D5411	Adjust complete denture	Limit removed
D5421, D5422	Adjust partial denture	Limit removed
D5510	Repair broken complete denture base	Limit removed
D5520	Replace missing or broken teeth – complete denture (each tooth)	Limit removed
D5610	Repair resin denture base	Limit removed
D5620	Repair cast framework	Limit removed
D5630	Repair or replace broken clasp	Limit removed
D5640	Repair or replace broken tooth – per tooth	Limit removed
D5650	Add tooth to existing partial denture	Limit removed
D5660	Add clasp to existing partial denture	Limit removed
D5710, D5711	Rebase complete denture	limited to 1 in 36 month period 6 months after initial installation
D5720, D5721	Rebase partial denture	limited to 1 in 36 month period 6 months after initial installation
D5730, D5731	Reline complete denture	limited to 1 in 36 month period 6 months after initial installation
D5740, D5741	Reline partial denture	limited to 1 in 36 month period 6 months after initial installation
D5750, D5751	Reline complete denture (laboratory)	limited to 1 in 36 month period 6 months after initial installation
D5760, D5761	Reline partial denture (laboratory)	limited to 1 in 36 month period 6 months after initial installation
D5850, D5851	Tissue conditioning	Limit removed
D6930	Re-cement fixed partial dentures	None
D6980	Fixed partial denture repairs	By report

Oral Surgery		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Medical necessity
D7210	Removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Medical necessity
D7220	Removal of impacted tooth – soft tissue	Medical necessity
D7230, D7240, D7241	Removal of impacted tooth	Medical necessity
D7250	Removal of residual tooth roots (cutting procedure)	Medical necessity
D7251	Coronectomy – intentional partial tooth removal	Medical necessity
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	does not need to be a bundled service
D7280	Surgical access of an unerupted tooth	Medical necessity
D7310, D7311	Alveoloplasty in conjunction with extractions	One per tooth per lifetime
D7320, D7321	Alveoloplasty not in conjunction with extractions	One per tooth per lifetime
D7471	Removal of exostosis	Limited to once per lifetime
D7510	Incision and drainage of abscess – intraoral soft tissue	Does not need to be a bundled service
D7910	Suture of recent small wounds up to 5 cm	Medical necessity
D7953	Bone replacement graft for ridge preservation – per site	Medical necessity. May be covered as a medical benefit
D7971	Excision of pericoronal gingiva	Medical necessity
Services Not Covered		
D7292	Surgical replacement of screw retained plate	
D7293	Surgical replacement with surgical flap	
D7294	Surgical replacement without surgical flap	
D7880	TMJ appliance	
D7881	Occlusal orthotic device adjustment	
D7899	TMJ therapy	
D7951	Sinus augmentation – lateral	
D7952	Sinus augmentation of vertical	
D7997	Appliance removal	

D7998	Intraoral placement of a fixation device	

Major Services		
Restorative Services		
Note: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc. was not placed while covered by a CHIP plan, or paid by a CHIP plan, the frequency limitations may apply.) inlays, onlays, and crowns require preauthorization.		
Code	**Service**	**Limits**
D0160	Detailed and extensive oral evaluation – problem focused	By report
D2510, D2520, D2530	Inlay – metallic	an alternate benefit will be provided
D2542, D2543, D2544	Onlay – metallic	1 per tooth every 60 months
D2740	Crown – porcelain/ceramic substrate	limited to 1 per tooth every 60 months
D2750	Crown – porcelain fused to high noble metal	limited to 1 per tooth every 60 months
D2751	Crown- porcelain fused to predominantly base metal	limited to 1 per tooth every 60 months
D2752	Crown – porcelain fused to noble metal	limited to 1per tooth every 60 months
D2780	Crown ¾ cast high noble metal	limited to 1per tooth every 60 months
D2781	Crown -3/4 cast predominantly base metal	limited to 1per tooth every 60 months
D2783	Crown – ¾ porcelain/ceramic	limited to 1per tooth every 60 months
D2790	Crown – full cast high noble metal	limited to 1per tooth every 60 months
D2791	Crown – full cast predominantly base metal	limited to 1per tooth every 60 months
D2792	Crown – full cast noble metal	limited to 1per tooth every 60 months
D2794	Crown – titanium	limited to 1per tooth every 60 months
D2950	Core buildup, including any pins	limited to 1per tooth every 60 months
D2954	Prefabricated post and core, in addition to crown	Limited to once per tooth per lifetime
D2980	Crown repair	By report one per tooth per 12 month period
D2981	Inlay repair	
D2983	Veneer repair	By report

D2990	Resin infiltration/smooth surface	limited to 1 tooth every 36months
Endodontic Services		
D3310, D3320, D3330	endodontic therapy	Excluding final restoration
D3346, D3347, D3348	Retreatment of previous endodontic therapy	
D3351, D3352, D3353	Apexification/recalcification	
D3354	Pulpal regeneration	Does not include final restoration
D3410, D3421, D3425, D3426	Apicoectomy/periadicular surgery	
D3450	Root amputation – per root	
D3920	Hemisection (including any root removal) not including root canal therapy	
Periodontal Services		
D4210, D4211	Gingivectomy or gingivoplasty	Limited to 1 every 36 months Per quadrant
D4212	Gingivectomy or gingivoplasty	With restorative procedures, per tooth, limited to 1 every 36 months
D4240	Gingival flap procedure, 4 or more teeth	Limited to 1 every 36 months Per quadrant
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or bounded teeth spaces per quadrant	Limited to 1 every 36 months Per quadrant or site
D4249	Clinical crown lengthening - hard tissue	Per tooth per lifetime
D4260, D4261	Osseous surgery (including flap entry and closure	Limited to 1 every 36 months Per quadrant
D4263	Bone replacement graft – first site in quadrant	Limited to 1 every 36 months Per quadrant
D4270	Pedicle soft tissue graft procedure	Limited to 1 every 36 months per quadrant
D4273	Autogenous connective tissue graft procedures (including donor site surgery)	Limited to 1 every 36 months per quadrant
D4275	Non-autogenous connective tissue graft	Limited to 1 every 36 months per quadrant
D4277, D4278	Free soft tissue graft	
D4283	Subepithelial tissue graft/each additional contiguous tooth, implant, or edentulous tooth position in same graft site	

D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant, or edentulous tooth position in the same graft site	Limited to 1 every 36 months
D4355	Full mouth debridement	Limited to 1 per lifetime
Prosthodontic Services		
D5110, D5120	Complete denture	Limited to 1 every 60 months
D5130, D5140	Immediate denture	Limited to 1 every 60 months
D5211, D5212	Partial denture – resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5213, D5214	Partial denture –resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5221, D5222	Immediate partial denture - resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5223, D5224	Immediate partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	Limited to 1 every 60 months
Note: an implant is a covered procedure of the plan only if determined to be a dental necessity. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthesis phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.		
D6010	Endosteal implant	Limited to 1 every 60 months
D6012	Surgical placement of interim implant body	Limited to 1 every 60 months
D6040	Eposteal implant	Limited to 1 every 60 months
D6050	Transosteal implant including hardware	Limited to 1 every 60 months
D6055	Connecting bar – implant or abutment supported	Limited to 1 every 60 months
D6056	Prefabricated abutment	Limited to 1 every 60 months
D6057	Custom abutment	Limited to 1 every 60 months
D6058	Abutment supported porcelain ceramic crown	Limited to 1 every 60 months
D6059	Abutment supported porcelain fused to high noble metal	Limited to 1 every 60 months

D6060	Abutment supported porcelain fused to predominantly base metal crown	Limited to 1 every 60 months
D6061	Abutment supported porcelain fused to noble metal crown	Limited to 1 every 60 months
D6062	Abutment supported cast high noble metal crown	Limited to 1 every 60 months
D6063	Abutment supported cast predominantly base metal crown	Limited to 1 every 60 months
D6064	Abutment supported cast noble metal crown	Limited to 1 every 60 months
D6065	Implant supported porcelain/ceramic crown	Limited to 1 every 60 months
D6066	Implant supported porcelain fused to high metal crown	Limited to 1 every 60 months
D6067	Implant supported metal crown	Limited to 1 every 60 months
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	Limited to 1 every 60 months
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	Limited to 1 every 60 months
D6070	Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture	Limited to 1 every 60 months
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture	Limited to 1 every 60 months
D6072	Abutment supported retainer for cast high noble metal fixed partial denture	Limited to 1 every 60 months
D6073	Abutment supported retainer for cast noble metal fixed partial denture	Limited to 1 every 60 months
D6074	Abutment supported retainer for cast noble metal fixed partial denture	Limited to 1 every 60 months
D6075	Implant supported retainer for ceramic fixed partial denture	Limited to 1 every 60 months
D6076	Implant supported retainer for porcelain fused to high noble metal fixed partial denture	Limited to 1 every 60 months
D6077	Implant supported retainer for cast metal fixed partial denture	Limited to 1 every 60 months
D6080	Implant maintenance	Limited to 1 every 60 months
D6090	Repair implant prosthesis	Limited to 1 every 60 months
D6091	Replacement of semi-precision	Limited to 1 every 60 months

	or precision attachment	
D6095	Repair implant abutment	Limited to 1 every 60 months
D6100	Implant removal	Limited to 1 every 60 months
D6101	Debridement periimplant defect	Limited to 1 every 60 months Covered if implants are covered
D6102	Debridement and osseous peiimplant defect	Limited to 1 every 60 months Covered if implants are covered
D6103	Bone graft periimplant defect	Covered if implants are covered
D6104	Bone graft implant replacement	Covered if implants are covered
D6110, D6111	Implant/abutment supported removable denture for edentulous arch	Limited to 1 every 60 months
D6112, D6113	Implant/abutment supported removable partial denture for partially edentulous arch	Limited to 1 every 60 months
D6114, D6115	Implant/abutment supported fixed denture for edentulous arch	Limited to 1 every 60 months
D6116, D6117	Implant/abutment supported fixed denture for partially edentulous arch	Limited to 1 every 60 months
D6190	Implant index	Limited to 1 every 60 months
D6210	Pontic –cast high noble metal	Limited to 1 every 60 months
D6211	Pontic – cast predominantly base metal	Limited to 1 every 60 months
D6212	Pontic – cast noble metal	Limited to 1 every 60 months
D6214	Pontic – titanium	Limited to 1 every 60 months
D6240	Pontic – porcelain fused to high noble metal	Limited to 1 every 60 months
D6241	Pontic – porcelain fused to predominantly base metal	Limited to 1 every 60 months
D6242	Pontic – porcelain fused to noble metal	Limited to 1 every 60 months
D6245	Pontic – porcelain/ceramic	Limited to 1 every 60 months
D6519	Inlay/onlay – porcelain/ceramic	Limited to 1 every 60 months
D6520, D6530	Inlay – metallic	Limited to 1 every 60 months
D6543, D6544	Onlay – metallic	Limited to 1 every 60 months
D6545	Retainer – cast metal for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6549	Retainer –for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6740	Crown – porcelain/ceramic	Limited to 1 every 60 months
D6750	Crown – porcelain fused to high noble metal	Limited to 1 every 60 months
D6751	Crown – porcelain fused to	Limited to 1 every 60 months

	predominantly base metal	
D6752	Crown – porcelain fused to noble metal	Limited to 1 every 60 months
D6780	Crown – ¾ cast high noble metal	Limited to 1 every 60 months
D6781	Crown – ¾ cast predominantly base metal	Limited to 1 every 60 months
D6781	Crown – ¾ cast noble metal	Limited to 1 every 60 months
D6783	Crown – ¾ porcelain/ceramic	Limited to 1 every 60 months
D6790	Crown – full cast high noble metal	Limited to 1 every 60 months
D6791	Crown – full cast predominantly base metal	Limited to 1 every 60 months
D6792	Crown – full cast noble metal	Limited to 1 every 60 months
D9932, D9933	Cleaning and inspection of removable complete denture	Limited to 1 every 60 months
D9934, D9935	Cleaning and inspection of removable partial denture	Limited to 1 every 60 months
D9940	Occlusal guard, by report	I in 12 months for patients 13 and older
D9943	Occlusal guard	In every 24 months
Services Not Covered		
D0171	Reevaluation-post-operative office visit	
D2410, D2420, D2430	Gold foil	
D2799	Provisional crown	
D2955	Post removal	
D2975	Coping	
D3460	Endodontic implant	
D3470	Intentional reimplantation	
D3910	Surgical procedure for isolation of tooth	
D3950	Canal preparation	
D4230, D4231	Anatomical crown exposure	
D4320	Splinting intracoronal	
D4321	Splinting extracoronal	
D5810, D5811	Complete denture – interim	
D5820, D5821	Partial denture - interim	
D5862	Precision attachment	
D5867	Replacement precision attachment	
D5986	Fluoride gel carrier	
D6051	Interim abutment	
D6199	Unspecified implant procedure, by report	
D6253	Provisional pontic	

D6793	Provisional retainer crown	
D6920	Connector bar	
D6940	Stress breaker	
D6950	Precision attachment	
D9219	Evaluation for deep sedation or general anesthesia	
D9986	Missed appointment	
D9987	Cancelled appointment	

Orthodontia		
Prior authorization required for orthodontic services		
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
D8040	Limited orthodontic treatment of the adult dentition	
D8050	Interceptive orthodontic treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8090	Comprehensive orthodontic treatment of the adult dentition	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
Services Not Covered		
Repair of damaged orthodontic appliances		
Removable orthodontic retainer adjustment		
Replacement of lost or missing appliance		

Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

General Services		
Anesthesia		
D9230	Nitrous oxide	No age limit for CHIP enrollees
D9223	Deep sedation/general anesthesia	Each 15 minute increment
D9241	Intravenous moderate (conscious) sedation/analgesia	First 30 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia	Each 15 minute increment
D9248	Non-intravenous conscious sedation	
D9310	Consultation (diagnostic service provided by dentist or physician other than the practitioner providing treatment	
D9610	Therapeutic drug injection	By report
D9930	Treatment of complications (post-surgical) – unusual circumstances	By report
Services Not Covered		
D0310	Sialography	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia	
D9248	Non-intravenous conscious sedation	
D9410	House/extended care facility call	
D9420	Hospital call	
D9450	Case presentation	
D9630	other drugs and medicaments	
D9920	Behavior management	
D9941	Fabrication of athletic mouthguard	
D9950	Occlusion analysis – mounted case	
D9951, D9952	Occlusal adjustment	
D9970	Enamel microabrasion	
D9971	Odontoplasty 1-2 teeth	
D9972, D9973	External bleaching	

D9974	Internal bleaching	
D0472, D0473, D0474, D0480, D0502	Oral pathology lab	
The following services may be covered under medical benefits. Preauthorization required		
D5911, D5912	Facial moulage	
D5913	Nasal prosthesis	
D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5915	Ocular prosthesis	
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	
D5923	Ocular prosthesis (interim)	
D5924	Cranial prosthesis	
D5925	Facial augmentation implant	
D5926	Nasal prosthesis (replacement)	
D5927	Auricular prosthesis (replacement)	
D5928	Orbital prosthesis (replacement)	
D5929	Facial prosthesis (replacement)	
D5931, D5932, D5933	Obturator prosthesis	
D5934	Mandibular resection prosthesis w/guide flange	
D5935	Mandibular resection prosthesis w/o guide flange	
D5936	Obturator prosthesis (interim)	
D5937	Trismus appliance	
D5951	Feeding aid	
D5952, D5953	Speed aid prosthesis	
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis (definitive)	
D5958	Palatal lift prosthesis (interim)	
D5959	Palatal lift prosthesis (modification)	
D5960	Speech aid prosthesis (modification)	
D5982	Surgical stent	
D5983	Radiation carrier	
D5984	Radiation shield	
D5985	Radiation cone locator	
D5987	Commissure splint	
D5988	Surgical splint	
D5992	Adjust maxillofacial prosthetic appliance, by report	
D7285	Biopsy oral tissue (hard)	

D7286	Biopsy oral tissue (soft)	
D7295	Harvest bone for autogenous grafting procedure	
D7410, D7411	Surgical excision lesion (benign) soft tissue	
D7412	Surgical excision Complicated lesion (benign)	
D7413, D7414	Surgical excision Lesion (malignant) soft tissue	
D7415	Surgical excision Complicated lesion (malignant)	
D7440, D7441	Surgical excision Lesion (malignant) intra-osseous	
D7460, D7461	Surgical excision Removal of benign lesion (nonodontogenic)	
D7465	Destruction of lesion (by report)	
D7490	Radical resection of maxilla or mandible	
D7530	Removal of foreign body	
D7540	Removal of reaction producing foreign body	
D7550	Partial ostectomy	
D7560	Maxillary sinusotomy	
D7610	Upper open reduction	
D7620	Upper closed reduction	
D7630	Lower open reduction (simple)	
D7640	Lower closed reduction (simple)	
D7650	Open reduction (simple)	
D7660	Closed reduction (simple)	
D7670	Alveolus closed reduction (simple)	
D7671	Alveolus open reduction (simple)	
D7680	Facial bones (simple)	
D7710	Upper open reduction (compound)	
D7720	Upper closed reduction (compound)	
D7730	Lower open reduction (compound)	
D7740	Lower closed reduction (compound)	
D7750	Malar and/or zygomatic arch open reduction (compound)	
D7760	Malar and/or zygomatic arch closed reduction (compound)	
D7770	Alveolus open reduction (compound - stabilization of	

	teeth)	
D7771	Alveolus closed reduction (compound – stabilization of teeth)	
D7780	Facial bones (compound)	
D7810	TMJ open reduction	
D7820	TMJ closed reduction	
D7830	TMJ manipulation	
D7840	Condylectomy	
D7850	Surgical discectomy	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthroscopic lysis and lavage	
D7872	Arthroscopy with or without a biopsy	
D7873	Arthroscopy surgical adhesions	
D7874	Arthroscopy disc repositioning and stabilization	
D7875	Arthroscopy synovectomy	
D7876	Arthroscopy surgical discectomy	
D7877	Arthroscopy surgical debridement	
D7911, 7912	Complicated sutures	
D7920	Skin graft	
D7940	Osteoplasty for orthognatic deformities	
D7941	Osteotomy lower rami	
D7943	Osteotomy – lower rami with bone graft	
D7944	Osteotomy – segmented	
D7945	Osteotomy – body of mandible	
D7946	Lefort I upper total	
D7947	Lefort I upper segmented	
D7948	Lefort II or Lefort III without bone graft	
D7949	Lefort II or Lefort III with bone graft	
D7950	Bone graft – mandible or face	
D7955	Repair of maxillofacial soft or hard tissue	
D7980	Sialolithotomy	

D7981	Excision of a salivary gland	
D7982	sialodochoplasty	
D7983	Closure of a salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft	
D7996	Implant lower for augmentation purposes	
D9975	External bleaching per arch	

General Exclusions
Services and treatment not prescribed by or under the direct supervision of a dentist, except where a dental hygienist is permitted to practice without supervision by a dentist.
Services or treatment which are experimental or investigational
Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
Services and treatment received from a dental or medical department maintained by on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
Services and treatment performed prior to your effective date of coverage.
Services and treatment incurred after termination date of your coverage unless otherwise indicated.
Services and treatment which are not dentally necessary of which do not meet generally accepted standards of dental practice.
Services and treatment resulting from your failure to comply with professionally prescribed treatment.
Telephone consultations.
Any charge for failure to keep a scheduled appointment.
Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ).
Services or treatment provided as a result of intentionally self-inflicted injury or illness.
Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging is an illegal occupation, or participating in a riot, rebellion, or insurrection.
Office infection control charges.
Charges for copies of your records, charts, or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays.
State or territorial taxes on dental services performed.
Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.

Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
Those which are for specialized procedures and techniques.
Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
Duplicate, provisional and temporary devices, appliances, and services.
Plaque control programs, oral hygiene instruction, and dietary instructions.
Services to alter vertical dimensions and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration from misalignment of teeth.
Gold foil restorations.
Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
Treatment or services for injuries resulting from war or an act of war, whether declared or undeclared, for from police or military service for any country or organization.
Hospital costs or any additional fees that the dentist or hospital charges for treatment as the hospital (inpatient of outpatient).
Charges by the provider for completing dental forms.
Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
Cone beam imaging and cone beam MRI procedures.
Precision attachments, personalization, precious metal bases and other specialized techniques.
Repair of damaged orthodontic appliances.
Replacement of lost or missing appliances.
Fabrication of athletic mouthguard.
Internal and external bleaching.
Oral sedation.
Topical medicament center.
Bone grafts when done in connection with extractions, apicoectomies, or non-covered/non-eligible implants
When two or more services are submitted and the services are considered part of the same service to one another, the plan will pay the most comprehensive service (the service that includes the other non-benefitted service) as determined by the plan.
When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service) the plan will pay for the service that represents the final treatment
All out of network services covered are subject to the usual and customary maximum allowable fee charges as defined by the CHIP plan. The member is responsible for all remaining charges that exceed the allowable amount.

CHAPTER 12: Minimum Essential Coverage (MEC)

12.1 Under the Affordable Care Act, the federal government, state governments, insurers, employers, and individuals each are given roles in reforming and improving the availability, quality, and affordability of health insurance coverage in the United States. Starting January 1, 2014, the individual shared responsibility provision calls for each individual to have minimum essential health coverage (known as “minimum essential coverage” or MEC) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.

Many individuals in the United States have health coverage today that is already recognized as MEC and will not need to do anything more than continue the coverage that they have.

As a result of the Affordable Care Act, insurance coverage must now meet MEC guidelines. Free and Low Cost CHIP categories meet MEC guidelines because they are government-sponsored and funded.

CHAPTER 13: PATIENT-CENTERED MEDICAL HOMES

13.1 GENERAL REQUIREMENTS

The patient-centered medical home model of care is designed to improve quality and lower medical costs by providing patients with a comprehensive, coordinated approach to primary care. A medical home includes:

- A partnership between the family and the child's primary health care professional.
- Connections to support and services to meet the non-medical and medical needs of the child and their family.
- Respect for a family's cultural and medical and religious beliefs.
- After hours and weekend access to medical consultation.
- Primary health care professionals coordinating care with a team of other care providers.

Through this partnership, the primary health care professional can help the family/patient access and coordinate specialty care, educational services in and out of home care, family support, and other public and private community services that are important to the overall health of the child and family.