Keystone Health Plan East

C1-F1

Independence

USW 286

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact IBC for authorization. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefit limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Coverage
Benefit Period	Calendar year*
Doctor's Office Visits	
Primary Care Services	$10 Copayment
Specialist Services	$20 Copayment
Telemedicine	100%
Preventive Care for Adults and Children	100%
Pediatric Immunizations	100% (office visit copayment does not apply)
Routine Eye Exam	$20 Copayment (once every two calendar years)
Routine Gynecological Exam/PAP *1 per calendar year for women of any age (No referral required)*	100%
Mammogram *(No referral required)*	100%
Nutrition Counseling for Weight Management *6 visits per calendar year*	100%
Outpatient Laboratory/Pathology	100%

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount resets to $0 at the start of the calendar year on January 1.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefits are administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross-
independent licensees of the Blue Cross and Blue Shield Association.
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Benefit	Coverage
Maternity	
First OB Visit	$10 Copayment
Hospital	100%
Inpatient Hospital Services	
Facility	100%
Physician/Surgeon	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	
Facility	100%
Physician/Surgeon	100%
Emergency Room	$100 Copayment (not waived if admitted)
Urgent Care Center	$70 Copayment
Ambulance	
Emergency	100%
Non-Emergency	100%
Outpatient X-Ray/Radiology+	
Routine Radiology/Diagnostic	$20 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	$40 Copayment
Therapy Services	
Physical and Occupational 30 total visits combined per calendar year	$20 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$20 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$20 Copayment
Speech 20 visits per calendar year	$20 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	$20 Copayment
Spinal Manipulations *20 visits per calendar year*	$20 Copayment
Allergy Injections *(Copayment waived if no office visit is charged)*	100%
Injectable Medications	
Standard Injectables	100%**
Biotech/Specialty Injectables	$50 Copayment
Chemo/Radiation/Dialysis	100%
Outpatient Private Duty Nursing *360 hours per calendar year*	90%
Skilled Nursing Facility *120 days per calendar year*	100%
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	70%

** Office visits subject to copayment.

+ Copayment not applicable when service is performed in Emergency Room or office setting.

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Benefit	Coverage
Mental Health Care	
Outpatient	$20 Copayment
Inpatient	100%
Serious Mental Illness Care	
Outpatient	$20 Copayment
Inpatient	100%
Substance Abuse Treatment	
Outpatient/Partial Facility Visits	$20 Copayment
Rehabilitation	100%
Detoxification	100%
Out-of-Pocket Maximum[1]	
Individual	$7,150
Family	$14,300

1 The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

What Is Not Covered?

- Services not medically necessary
- Services or supplies that are experimental or investigative except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Acupuncture
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Alternative therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (TTY: 711).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Standard Prescription Drug Program

$10/$20

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The Standard Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. Generic drugs are just as effective as brand drugs. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing *(Participating Pharmacy)*	
Generic	$10 Copayment
Brand	$20 Copayment
Mail Order Pharmacy - Member Cost Sharing *(Participating Pharmacy) Available for maintenance drugs*	
Generic	$5 Copayment (1-30 days supply); $5 Copayment (31-90 days supply)
Brand	$10 Copayment (1-30 days supply); $10Copayment (31-90 days supply)
Total Out-of-Pocket Maximum	Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan
Specialty Pharmacy Program *Mandatory for Self-Administered Specialty Drugs*	All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply. If your doctor wants you to start the drug immediately, an initial 30-day supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through the Specialty Pharmacy Program.
Preferred Generic	When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level. If you choose to purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.
Out-of-Network Reimbursement	50% of drugs retail cost for the total amount dispensed. Member must submit for reimbursement.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

Benefit	Coverage
Network	FutureScripts network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 30 days supply
Mail order for maintenance drugs	Up to 90 days supply
Covered Prescription Drugs[1]	Compound medications of which at least one ingredient is a prescription drug Self-injectable drugs Contraceptives Prescribed Smoking Cessation Drugs Retin-A through age 35 Insulin Insulin needles and syringes Lancets (no copayment required at participating pharmacies) Glucometers (no copayment required at participating pharmacies) Diabetic supplies (i.e., test strips)

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Devices or supplies except those specifically listed under covered drugs
- Nicotine gum or patches for smoking cessation
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Experimental drugs
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctors prescription)