# Keystone Health Plan East

Keystone 10

## *USW 286-B*

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 | Benefits and Services | Coverage |
|---|---|---|
| **Doctor Visits** | Office visits to your Primary Care Physician | $10 copayment |
| | Home visits by your Primary Care Physician | $15 copayment |
| | Non-routine after hours visits to your Primary Care Physician | $15 copayment |
| | Office visits to referred specialists | $15 copayment |
| | Preventive Care for Adults and Children | Covered 100% |
| | Telemedicine | Covered 100% |
| **Preventive Health Services** | Pediatric Immunizations (except for travel or employment) | Covered 100%<br>(office visit copayment does not apply) |
| | Routine gynecological care (no referral required) | Covered 100% |
| | Mammography (no referral required) | Covered 100% |
| | Nutrition Counseling For Weight Management<br>6 visits per calendar year | Covered 100% |
| **Maternity** | Obstetrical care (including pre- and postnatal care) | Covered with a $15 copayment for first visit. Subsequent visits to your OB/GYN covered 100%. |
| | Newborn care (both doctor and hospital) | Covered 100% |

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



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| Benefit | Benefits and Services | Coverage |
|---|---|---|
| **Hospital Services*** | Unlimited inpatient stay | Covered 100% |
| | Surgery | Covered 100% |
| | Anesthesia | Covered 100% |
| | Drugs and medication | Covered 100% |
| | Inpatient doctor care | Covered 100% |
| | General nursing care | Covered 100% |
| | Administration of blood | Covered 100% |
| | Organ transplantation, non-experimental | Covered 100% |
| **Emergency Care** | Treatment in hospital emergency room | Covered with a $35 copayment (which is waived if you are admitted to the hospital) |
| **Urgent Care Center** | Treatment received in urgent care facility | $24 Copayment |
| **Ambulance** | Emergency | Covered 100% when medically necessary |
| | Non-Emergency* | Covered 100% when medically necessary |
| **Specialized Services** | Allergy testing and treatment | Covered 100%** |
| | Diagnostic, Laboratory, and X-ray services*** | Covered 100% |
| | Short-term Rehabilitation Therapy* (including Speech ,Occupational, and Physical Therapy) | Covered 100%. Up to 60 consecutive days per condition covered, subject to significant improvement |
| | Spinal Manipulation Services | Covered 100%. Up to 60 consecutive days per condition covered, subject to significant improvement |
| | Orthoptic/Pleoptic | Covered 100%. 8 sessions maximum per lifetime |
| | Respiratory Therapy | Covered 100% |
| | Chemotherapy | Covered 100% |
| | Radiation Therapy | Covered 100% |
| | Vision Care, including screening, eye exams, and refractions | $15 copayment (once every two calendar years) |
| | Hearing Screening | Covered 100%** |
| | Skilled nursing facility services, as specified* | Covered 100% up to 180 days per calendar year |
| | Outpatient Surgery* | Covered 100% |
| | Durable Medical Equipment* | All purchases and rentals (including repairs and replacements) are covered 100% when authorized by your Primary Care Physician[1] |
| | Prosthetics* | All purchases (including repairs and replacements) are covered 100% when authorized by your Primary Care Physician[1] |
| | Home Health Care* | Covered 100% |
| | Dialysis | Covered 100% |

* Preauthorization required. Preauthorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preauthorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

** Office visit subject to copayment.

*** MRI/MRA, CT/CTA scan, PET scan and Nuclear Cardiac Studies require preauthorization.

1 Purchases and all rentals require preauthorization.

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

| Benefit | Benefits and Services | Coverage |
|---|---|---|
| **Mental Health** | Inpatient* | Covered 100% |
| | Outpatient | $15 copayment |
| **Serious Mental Illness (SMI)** | Inpatient* | Covered 100% |
| | Outpatient | $15 copayment |
| **Substance Abuse** | Inpatient* | Covered 100% |
| | Outpatient | $15 copayment |
| **Detoxification** | Inpatient* | Covered 100% |
| | Outpatient | $15 copayment |
| **Out-Of-Pocket Maximum**[2] | Individual | $6,600 |
| | Family | $13,200 |

* Preauthorization required. Preauthorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preauthorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

2 Out-of-pocket maximum includes copayments and coinsurance.

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

## What is Not Covered?

As with all health insurance plans, KHPE's coverage excludes certain services. Those not covered by KHPE include, but are not limited to, the following:

- Services not medically necessary
- Services not provided or referred by your Primary Care Physician, except in emergencies
- Services or supplies that are experimental or investigative except, when approved by Keystone Health Plan East, Routine Costs associated with Qualifying Clinical Trials
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- The cost of services for which another party has primary responsibility
- Long-term rehabilitative therapy (e.g. maintenance of chronic conditions)
- Hearing Aids, hearing examinations/tests for the prescription/fitting of hearing aids and cochlear electromagnetic hearing devices
- Radial keratotomy
- Custodial or domiciliary care
- Assisted fertilization techniques such as in-vitro fertiliation, GIFT, and ZIFT
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones, or similar items
- Reversal of voluntary sterilization
- Transsexual surgery
- Cosmetic services/supplies
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or additional rider
- Treatment for temporomandibular joint syndrome (TMJ)
- Care of the feet, unless medically necessary
- Services required by a member who is an organ donor
- Dental care, including dental implants
- 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 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).

# Standard Prescription Drug Program
$8/$14

Independence

## *USW 286-B Welfare Fund*

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 | $8 Copayment 34 days or 120 units,whichever is less supply |
| Brand | $14 Copayment 34 days or 120 units, whichever is less supply |
| Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy)<br>*Mandatory for maintenance drugs* | |
| Generic | $8 Copayment (1-90 days supply) |
| Brand | $14 Copayment (1-90 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<br>*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 | Not covered unless due to an emergency. For emergency claims, you will be responsible for the copayment indicated above. Member must submit for reimbursement. |

| 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 34 days or 120 units, whichever is less 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 |
| | Contraceptives |
| | Prescribed Smoking Cessation Drugs |
| | Self-injectable 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
- 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)