Keystone Health Plan East

Keystone Select IV

USW Local 286 H & W Fund

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	$20 copayment
	Home visits by your Primary Care Physician	$40 copayment
	Non-routine after hours visits to your Primary Care Physician	$40 copayment
	Office visits to referred specialists	$40 copayment
	Preventive Care for Adults and Children	Covered 100%
	Telemedicine	Covered 100%
Preventive Health Services	Pediatric Immunizations (except for travel or employment)	Covered 100% (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 6 visits per calendar year	Covered 100%

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

Benefit	Benefits and Services	Coverage
Maternity	Obstetrical care (including pre- and postnatal care)	Covered with a $40 copayment for first visit. Subsequent visits to your OB/GYN covered 100%. Inpatient admission covered with a $240 copayment per admission[3] (waived if readmitted within 10 days of discharge for same diagnosis)
	Newborn care (both doctor and hospital)	Covered 100%
Hospital Services*	Unlimited inpatient stay	$240 copayment per admission[3] (waived if readmitted within 10 days of discharge for same diagnosis)
	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 $50 copayment (which is waived if you are admitted to the hospital)
Urgent Care Center	Treatment received in urgent care facility	Covered with a $35 copayment
Ambulance	Emergency	Covered 100% when medically necessary
	Non-Emergency*	Covered 100% when medically necessary
Specialized Services	Allergy testing and treatment	Covered 100%**
	Laboratory services	Covered 100%
	Diagnostic and X-Ray services	$40 copayment
	Short-term Rehabilitation Therapy (including Speech ,Occupational, and Physical Therapy)	$40 copayment. Up to 60 consecutive days per condition covered, subject to significant improvement
	Spinal Manipulation Services	$40 copayment. 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	$40 copayment (once every two calendar years)

* Pre-authorization required. Pre-authorization 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 pre-authorization 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.

3 Copayment waived if readmitted within 10 days of discharge for any condition.

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

Benefit	Benefits and Services	Coverage
Specialized Services (Continued)	Hearing Screening	Covered 100%**
	Skilled nursing facility services, as specified*[1]	Covered 100% up to 180 days per calendar year
	Outpatient Surgery*	Covered with a $240 copayment per admission (facility); $40 copayment per occurrence (physician)
	Durable Medical Equipment*	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by your primary care physician[2]
	Prosthetics*	All purchases (including repairs and replacements) are covered 100% when authorized by your primary care physician[2]
	Home Health Care*	Covered 100%
	Dialysis	Covered 100%
Mental Health	Inpatient*	$240 copayment per admission[3]
	Outpatient	$40 copayment
Serious Mental Illness (SMI)	Inpatient*	$240 copayment per admission[3]
	Outpatient	$40 copayment
Substance Abuse	Inpatient*	$240 copayment per admission[3]
	Outpatient	$40 copayment
Detoxification	Inpatient*	$240 copayment per admission[3]
	Outpatient	$40 copayment
Out-Of-Pocket Maximum *(includes copayments and coinsurance)*	Individual	$6,600
	Family	$13,200

* Pre-authorization required. Pre-authorization 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 pre-authorization 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.

1 Inpatient Hospital copay applies if admitted without prior hospital stay.

2 Purchases over $500 and all rentals require preauthorization.

3 Copayment waived if readmitted within 10 days of discharge for any condition.

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

Benefits and Services 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
- Service 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)
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute-care hospital
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Radial keratotomy
- Custodial or domiciliary care
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones, or similar items
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Transsexual surgery
- Cosmetic services/supplies
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or by 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. Refer to your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 215-241-2240 (if calling within Philadelphia) or 1-800-227-3115 (outside Philadelphia).

Select Drug Program

$10/$20/$35

Independence

USW Local 286

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing *(Participating Pharmacy)*	
Generic Formulary	$10 Copayment
Brand Formulary	$20 Copayment
Non-Formulary Brand	$35 Copayment
Mail Order Pharmacy - Member Cost Sharing *(Participating Pharmacy) Mandatory for maintenance drugs*	
Generic Formulary	$10 Copayment (1-30 days supply); $20 Copayment (31-90 days supply)
Brand Formulary	$20 Copayment (1-30 days supply); $40 Copayment (31-90 days supply)
Non-Formulary Brand	$35 Copayment (1-30 days supply); $70 Copayment (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	30% of drugs retail cost for the total amount dispensed. For an emergency, you will only be responsible for the applicable copayments listed above. Member must submit for reimbursement.

01/16 - PA - 51+ HMO-POS Select RX Rider $10/$20/$35 w Orals
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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
Formulary	IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**.
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
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- 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
- Experimental drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctors prescription)