Keystone Direct POS

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USW Local 286 H & W Fund

Keystone Direct POS lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. Under this plan, you must select a Primary Care Physician, but can access most care in-network or out-of-network without a referral. Referrals are required for routine radiology/diagnostic, podiatry, spinal manipulation and physical/occupational therapy. You maximize your benefits when you access care from a Keystone participating provider. If you access care from a provider who does not participate in our network higher out-of-pocket costs apply.

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. For in-network (referred) services, your participating provider will contact IBC for authorization. For out-of-network (self-referred) services, you are responsible for obtaining approval for certain services. 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 benefits 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	In-Network	Out-of-Network*
BENEFIT PERIOD	Calendar Year[5]	Calendar Year[5]
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,500
LIFETIME MAXIMUM	Unlimited	Unlimited
OUT-OF-POCKET MAXIMUM[6]		
Individual	$1,000	$3,000
Family	$2,000	$9,000
DOCTOR'S OFFICE VISITS		
Primary Care Services	$10 Copayment[1]	70%, after deductible
Specialist Services	$20 Copayment	70%, after deductible
Telemedicine	Covered 100%	Covered 100%

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

1 Members must select and use their Primary Care Physician for primary care services.

5 A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year on January 1.

6 In-network out-of-pocket maximum includes deductible, copays and coinsurance. Out-of-network out-of-pocket maximum includes coinsurance only.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

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

In-network benefits are underwritten or administered by Keystone Health Plan East;
Out-of-network benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-
independent licensees of the Blue Cross and Blue Shield Association.
www.ibx.com

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Benefit	In-Network	Out-of-Network*
To receive the highest level of benefits, you must receive the following services from your Primary Care Physician's designated sites. You can view your Primary Care Physician's designated sites at www.ibx.com.		
OUTPATIENT X-RAY/RADIOLOGY[***]		
Routine Radiology/Diagnostic	$20 Copayment[2]	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$40 Copayment	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY[4]	100%	70%, after deductible
PHYSICAL AND OCCUPATIONAL THERAPIES *30 total visits per year for PT/OT combined*	$20 Copayment[2]	70%, after deductible
To receive the highest level of benefits, you can see any Keystone Health Plan East participating provider for the following services.		
SPINAL MANIPULATIONS *20 visits per year*	$20 Copayment[2]	70%, after deductible
THERAPY SERVICES		
Cardiac Rehabilitation 36 visits per year	$20 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per year	$20 Copayment	70%, after deductible
Speech 20 visits per year	$20 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$20 Copayment	70%, after deductible
INPATIENT HOSPITAL SERVICES		
Facility	100%	70%, after deductible[3]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[3]
OUTPATIENT SURGERY		
Facility	100%	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$100 Copayment (not waived if admitted)	$100 Copayment, NO deductible (not waived if admitted)
URGENT CARE CENTER	$70 Copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	70%, after deductible
MATERNITY		
First OB Visit	$10 Copayment	70%, after deductible
Hospital	100%	70%, after deductible[3]
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*	100%	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*	100%	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%[1]	70%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, NO deductible
ROUTINE EYE EXAM	$20 Copayment (once every two years)	Not Covered

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

1 Members must select and use their Primary Care Physician for primary care services.

2 Referral required from Primary Care Physician.

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

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

4 Lab requisition form required from Primary Care Physician.

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

Benefit	In-Network	Out-of-Network*
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%**	70%, after deductible
Biotech/Specialty Injectables	$50 Copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*	90%	70%, after deductible
SKILLED NURSING FACILITY	100% 120 days per year	70%, after deductible 60 days per year
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$20 Copayment	70%, after deductible
Inpatient	100%	70%, after deductible[3]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$20 Copayment	70%, after deductible
Inpatient	100%	70%, after deductible[3]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$20 Copayment per visit	70%, after deductible
Inpatient Rehabilitation	100%	70%, after deductible
Detoxification	100%	70%, after deductible[3]

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

** Office visits subject to copayment.

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

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

What Is Not Covered?

- Services not medically necessary
- Service 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
- Acupuncture
- 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
- 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
- Self-injectible drugs
- Alternative therapies/complementary medicine

This summary represents only a partial listing of benefits and exclusions of the Keystone Direct POS 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 HMO group contract/member handbook and Out-of-Network group health benefits booklet/certificate 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

Independence

USW Local 286

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.

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)