

# Keystone Point-of-Service

## Keystone 5A Summary of Benefits



Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

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.
- **Preauthorization** - 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 Keystone Health Plan East benefits that require preauthorization flyer included in the enrollment kit.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, laboratory, and podiatry provider where they will send all their Keystone members. You can view the sites selected by your PCP at [www.ibx.com](http://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	Referred	Self-Referred
<b>Deductible</b>		
Individual	None	\$100
Family	None	\$300
<b>Coinsurance</b>	None	80%
<b>Coinsurance Limit</b>		
Individual	Not Applicable	\$500
Family	Not Applicable	\$1,500
<b>Lifetime Maximum</b>	Unlimited	\$1 Million
<b>Annual Copayment Maximum</b>		
Member	\$650	Not Applicable
<b>Primary Care Physician</b>		
Office Hours	\$5 Copayment	80% after deductible
After Hours/Home Visits	\$10 Copayment	80% after deductible
Pediatric Immunizations	100%**	80% (no deductible)

\* Out-of-network providers may bill you for any 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 visit subject to copayment

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.



Referred benefits are underwritten or administered by Keystone Health Plan East;  
Self-Referred 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](http://www.ibx.com)

Benefit	Referred	Self-Referred
<b>Specialty Care</b>		
Office Visits	\$5 Copayment	80% after deductible
Routine Gyn/Pap (no referral required)	\$5 Copayment	80% after deductible
Allergy Testing and Treatment	Covered 100%**	80% after deductible
Hearing Screening	Covered 100%**	80% after deductible
Respiratory Therapy	Covered 100%***	80% after deductible
Chemotherapy	Covered 100%***	80% after deductible
Radiation Therapy	Covered 100%***	80% after deductible
Dialysis	Covered 100%	80% after deductible
Routine Eye Exam	\$5 Copayment (once every two calendar years)	80% after deductible
<b>Nutrition Counseling for Weight Management</b> 6 visits per calendar year	Covered 100%	80% after deductible
<b>Laboratory Services</b>	Covered 100%	80% after deductible
<b>X-Ray Services</b> (MRI/MRA, CT/CTA Scan, PET Scan and Nuclear Cardiac Studies require pre-authorization)	Covered 100%	80% after deductible
Routine Mammography (no referral required)	Covered 100%	80% (no deductible)
<b>Maternity</b>		
First OB Visit	\$5 Copayment	80% after deductible
Hospital	Covered 100%	80% after deductible <sup>2</sup>
<b>Inpatient Hospitalization Services</b>	Covered 100%***	80% after deductible*** <sup>2</sup>
Room and Board (Semiprivate)		
Surgery and Anesthesia		
Medical and Surgical Specialist Care		
Diagnostic Testing		
<b>Inpatient Hospital Days</b>	Unlimited	120 <sup>2</sup>
<b>Emergency Room</b>	\$35 Copayment (which is waived if you are admitted to the hospital)	\$35 Copayment (which is waived if you are admitted to the hospital)
<b>Ambulance</b>		
Emergency	Covered 100%	80% after deductible
Non-Emergency	Covered 100%	80% after deductible
<b>Outpatient Surgery</b>	Covered 100%***	80% after deductible
<b>Outpatient Therapy Services (including Speech** Physical and Occupational Therapy)</b>	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	80% after deductible (\$5,000 aggregate maximum per benefit period)

\* Out-of-network providers may bill you for any 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 visit subject to copayment

\*\*\* 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 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

Benefit	Referred	Self-Referred
<b>Spinal Manipulation</b>	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	80% after deductible (\$1,000 per benefit maximum)
<b>Orthoptic/Pleoptic</b> 8 sessions per lifetime maximum	Covered 100%	80% after deductible
<b>Skilled Nursing Facility</b>	Covered 100%*** (up to 180 days)	80% after deductible*** (up to 240 days)
<b>Hospice</b>	Covered 100%***	80% after deductible***
<b>Home Health Care</b>	Covered 100%***	80% after deductible***
<b>Durable Medical Equipment</b>	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by Primary Care Physician <sup>1</sup>	All purchases and rentals (including repairs and replacements) are covered 80% after deductible <sup>1</sup>
<b>Prosthetics</b>	All purchases (including repairs and replacements) are covered 100% when authorized by Primary Care Physician <sup>1</sup>	All purchases (including repairs and replacements) are covered 80% after deductible <sup>1</sup>
<b>Mental Health</b>		
Inpatient	Covered 100%***	80% after deductible*** <sup>2</sup>
Outpatient	\$5 Copayment	80% after deductible
<b>Serious Mental Illness (SMI)</b>		
Inpatient	Covered 100%***	80% after deductible*** <sup>2</sup>
Outpatient	\$5 Copayment	80% after deductible
<b>Substance Abuse</b>		
Inpatient Detoxification	Covered 100%***	80% after deductible*** <sup>2</sup>
Outpatient Detoxification	\$5 Copayment	80% after deductible
Inpatient Rehabilitation	Covered 100%***	80% after deductible*** <sup>2</sup>
Outpatient Rehabilitation	\$5 Copayment	80% after deductible

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

\*\*\* 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.

1 Purchases over \$500 and all rentals require preauthorization.

2 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

## Services and Benefits Not Covered

As with all health insurance plans, Keystone Point of Service coverage excludes certain services. Those not covered include, but are not limited to, the following:

- Services not medically necessary
- 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
- Service 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
- 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
- Contraceptives, except by additional rider
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- 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
- Dental care, including dental implants
- Long-term rehabilitative therapy, e.g., maintenance of chronic conditions (Referred Care)
- Alternative Therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Point of Service 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 HMO group contract/member handbook and self-referred group health benefits booklet/certificate 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).

# \$100 Eyewear Benefit

## Biennial Benefit



The Keystone Health Plan East \$100 HMO/POS Vision Rider program, administered by Davis Vision, offers members corrective eyewear, including eyeglasses or contact lenses. The vision rider program is easy to use. Benefits are maximized by using Davis Vision providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from a select grouping known as the Davis Collection of Frames.

Benefit	Coverage
<p><b>Eyeglasses, including spectacle lenses and frames, at participating providers</b></p> <p>Spectacle lenses</p> <p>Additional lens options</p> <p>Frames Two options are available for selecting frames:</p>	<p>Spectacle lenses covered at no extra cost include: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal or lenticular lenses</p> <p>Additional spectacle lens options covered at no cost include: glass grey #3 prescription sunglass lenses, tinting, polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters</p> <p>Choose from participating provider's own frame collection and member receives allowance of \$65<sup>1</sup></p> <p>OR</p> <p>Choose from the Davis Collection of Frames that is available at most participating providers and frames are covered in full.</p>
<p><b>Eyeglasses including spectacle lenses and frames at non-participating providers</b></p>	<p>Eyeglasses (spectacle lenses and frames) are available up to a \$100 reimbursement to member<sup>2</sup></p>
<p><b>Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses and evaluation and fitting</b></p> <p>Participating providers</p> <p>Non-participating providers</p>	<p>Member receives allowance up to \$100<sup>1</sup></p> <p>Up to \$100 reimbursement to member<sup>2</sup></p>
<p><b>Benefit frequency</b></p>	<p>Once every two calendar years</p>
<p><b>Network</b></p>	<p>Davis Vision Network To locate a participating provider, go to <a href="http://www.ibx.com">www.ibx.com</a> and click on the 'Find a Doctor' feature.</p>

1 Member is responsible for balance

2 In lieu of participating provider benefit, member is responsible for balance

This summary is intended to highlight the benefits available to you. For a complete description, including benefits and exclusions, refer to your benefit booklet.

Administered by:



SEE LIFE

Benefits are underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

[www.ibx.com](http://www.ibx.com)

## Value-added Services\*

Spectacle lens options available at most participating providers, MEMBER PAYS fixed discounted prices:

Spectacle Lens Option	Fixed Discounted Price
Blended invisible bifocals	\$10
Ultraviolet (UV) coating	\$12
Scratch-resistant coating - single vision	\$15
Scratch-resistant coating - multifocal	\$25
Intermediate vision lenses	\$30
Anti-reflective coating - standard	\$33
Anti-reflective coating - premium	\$48
Anti-reflective coating - ultra	\$60
Progressive additional multifocal lenses - standard	\$50
Progressive additional multifocal lenses - premium	\$90
Polarized lenses	\$60
Polycarbonate <sup>3</sup>	\$30
High index	\$55
Photochromic glass - single vision	\$15
Photochromic glass - multifocal	\$25
Photochromic plastic - single vision	\$60
Photochromic plastic - multifocal	\$70

**Warranty** - Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

**Replacement Contact Lenses** - Through Lens 123, a free mail order program, member may receive replacement contact lenses offered at guaranteed, discounted prices.

**Laser Vision Correction Services** - Discount on Laser Vision Correction Services at Davis Vision Participating Laser Vision Correction Providers: Up to 25% off the participating provider's usual and customary fees or 5% off any participating provider's advertised specials, whichever is less.

**Additional Eyewear Discount** - Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

\* Not available at non-participating providers

<sup>3</sup> Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters are covered at no cost.

## Frequently Asked Questions

Below find answers to some frequently asked questions about how your IBC Vision benefit program works.

### Who are the participating providers in the IBC Vision network?

Our administrator, Davis Vision, contracts with a national network of providers including ophthalmologists, optometrists and opticians. They are primarily licensed providers in private practice and in some retail locations, such as Wal-Mart Vision Center and For Eyes. Please go to [www.ibx.com](http://www.ibx.com) to locate a participating 'Vision Provider' through the 'Find a Doctor' feature, or once enrolled, call the number on your Identification card.

### If a retail location such as Wal-Mart Vision Center is in the network, does that mean the doctor located in that store is in the network?

No. When going to a retail location such as Wal-Mart Vision Center for eyewear purchases, you should always confirm the participation status of the on-site doctor who provides the eye exam, since each provider contracts separately with Davis Vision. Please Note: Coverage for routine eye exam, if available, would be included under your medical benefit.

### What are the advantages of using a participating provider?

- Quality service standards: all participating providers have been extensively reviewed and credentialed to NCQA standards to ensure that stringent standards for quality service are maintained.
- Paid-in-full benefit available: in addition to their own selection of frames, most participating providers have available the Davis Collection of Frames. This allows you to utilize the paid-in-full benefit available through your IBC Vision Program when frames are selected from the Collection with standard lenses - single, bifocal, trifocal or lenticular.
- Spectacle lens options discount: additional services such as anti-reflective coating and Transitions® lenses (photochromic) are available at a discounted price.
- Eyewear quality and value: most eyewear (lenses, coatings, and frames) is fabricated on site at one of Davis Vision's Regional Fabrication Centers. This allows Davis to monitor quality assurance and costs associated with the fabrication process, thereby creating the most value for you, our member.
- Warranty: Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

### Will I need a claim form to receive services from a participating provider?

No, you will not need a claim form for in-network services. The process is simple. Here's what to do:

- Call the participating provider of your choice and schedule an appointment.
- Identify yourself as a member of IBC Vision, administered by Davis Vision.
- Provide the office with your ID number located on your Identification card and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and no claim forms are required!

### Will I be able to choose any frame available at a participating provider?

Yes, you may apply the amount of your frame benefit toward any available frame that you choose. You can maximize your benefit by selecting frames from the Davis Collection of Frames, which offers you the ability to have a paid in full pair of frames. The Collection is available at most participating providers. The 'Find a Doctor' feature on [www.ibx.com](http://www.ibx.com) also indicates the participating doctors that have the Davis Collection of Frames available.

### What types of frames are included in the Davis Collection of Frames?

The Davis Collection includes frames for men and women, adults and children. The collection includes many notable designer name frames that have passed rigorous inspections, such as Perry Ellis, Steve Madden, Alfred Sung, Converse, Bongo, Club Med, Catherine Deneuve, Scooby-Doo!, Garfield and Harley-Davidson. This frame collection is typically updated twice a year.

### How soon will I receive my glasses after they are ordered?

Your provider will advise you when to return to his/her office to pick up your new prescription eyeglasses. Delivery of your new eyeglasses to your participating provider from the fabrication center is generally within two to five business days of the doctor's submission of your order. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coatings), specialized prescriptions or a participating provider's frame is selected.

### What if my vision care provider does not participate in the network?

You may receive covered services from a non-participating provider, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose a non-participating provider, you pay the provider directly for all charges and then submit a Direct Reimbursement Claim Form. Covered services will be paid directly to you based on your out-of-network benefits. You are responsible for any balances.

[Where do I send the Direct Reimbursement Claim Form?](#)

Mail your completed Direct Reimbursement Claim Form with receipts attached to:

Vision Care Processing Unit

P. O. Box 1525

Latham, NY 12110

To obtain a claim form, please visit [www.ibx.com](http://www.ibx.com) and click on 'Forms'. The IBC Vision Direct Reimbursement Claim Form is located on this Forms page under the Claims section.

[How do I purchase replacement contact lenses through the Lens 123 Program?](#)

Enrolled members who have utilized their covered benefit may call 1-800-LENS 123 (1-800-536-7123) to register and set up your Lens 123 account. The Customer Service Representative will explain to you how to order replacement contact lenses and receive them in the mail. Lens 123 is an easy and convenient way to order replacement contact lenses. For additional information, go to [www.lens123.com](http://www.lens123.com).



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[www.ibx.com](http://www.ibx.com)

# Standard Prescription Drug Program

\$5/\$5



The Standard Drug Program is a comprehensive benefit that provides coverage for prescription drugs<sup>1</sup> 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
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<b>Retail Pharmacy - Member Cost Sharing (Participating Pharmacy)</b>	
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Generic	\$5 Copayment
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Brand	\$5 Copayment
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<b>Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy)</b> Available for maintenance drugs	
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Generic	\$5 Copayment (1-90 days supply)
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Brand	\$5 Copayment (1-90 days supply)
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<b>Out-of-Network Reimbursement</b>	
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Not covered unless due to an emergency. For emergency claims, you will be responsible for the copayment indicated above. Member must submit for reimbursement.
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<b>Network</b>	
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FutureScripts® network <sup>1</sup> includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on <a href="http://www.ibx.com">www.ibx.com</a> by selecting the <i>Find a Participating Pharmacy</i> feature.
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\* FutureScripts is an independent company providing pharmacy benefit management services.



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[www.ibx.com](http://www.ibx.com)

## 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<sup>1</sup>

Compound medications of which at least one ingredient is a prescription drug  
 Oral contraceptives  
 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)

<sup>1</sup> 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

# Keystone Health Plan East Point-of-Service Program



## Benefits that require preauthorization

### Referred care

Your primary care physician or provider contacts the Care Management and Coordination (CMC) team and provides information to support the request for services. The CMC team, made up of physicians and nurses, evaluates the proposed plan of care. The CMC team notifies the physician/provider whether services are approved for coverage. If the CMC team does not have sufficient information or the information evaluated does not support coverage, the physician/provider and participant are notified in writing of the decision. Participants and providers acting on behalf of a participant may appeal the decision. At any time during the evaluation process or the appeal, the provider or participant may provide additional information to support the request.

Services that require preauthorization include but are not limited to:

- all nonemergency hospital admissions (excluding maternity);
- all same-day surgery/short-procedure unit admissions;
- outpatient therapies: speech, cardiac, pulmonary, infusion, and lymphedema;
- PET scans, MRI, MRA, CT/CTA scans, and nuclear cardiology;
- other facility services: skilled nursing, home health, and hospice;
- prosthetics and orthotics: purchase items (including repairs and replacements) more than \$500 (except ostomy supplies);
- durable medical equipment: purchase items (including repairs and replacements) more than \$500, and all rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer);
- nonemergency ambulance services;
- inpatient psychiatric care;\*
- inpatient alcohol and substance abuse treatment;\*
- obesity surgery;
- day rehabilitation programs;
- dental services as a result of accidental injury;
- orthognathic surgery;
- infusion therapy for the drugs listed when administered in an outpatient facility or in a professional provider's office. Drugs included are: Aldurazyme®, Aredia®, Avastin® (except for certain ophthalmological conditions), Boniva®, Ceredase®, Cerezyme®, Elaprase®, Eloxatin®, Erbitux®, Fabrazyme®, Herceptin®, MG, Myozyme®, Orenicia®, Remicade®, rituximab, and Tysabri®. List subject to change;
- infusion therapy provided in a home setting or outpatient facility;
- medical injectables drugs listed when administered in an outpatient facility or in a professional provider's office. Drugs included are: Botox®; Synagis®; and hyaluronan agents: Euflexxa™, Hyalgan®, Orthovisc®, Supartz®, and Synvisc®/Synvisc-One™. List subject to change;
- services that are potentially cosmetic, experimental, or investigative.

Participants are not responsible for payment of services if the provider does not obtain pre-authorization of services.

\*Mental health and substance abuse benefits may not be included in the Point-of-Service program.

## Self-referred care

When a Keystone Point-of-Service participant seeks self-referred benefits the participant is required to preauthorize the following:

- all nonemergency hospital admissions;
- private-duty nursing;
- PET scans, MRI, MRA, CT/CTA scans, and nuclear cardiology;
- obesity surgery;
- prosthetics and orthotics: purchase items (including repairs and replacements) more than \$500 (except ostomy supplies);
- durable medical equipment: purchase items (including repairs and replacements) more than \$500, and all rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer);
- nonemergency ambulance services;
- day rehabilitation programs;
- dental services as a result of accidental injury;
- orthognathic surgery;
- infusion therapy for the drugs listed when administered in an outpatient facility or in a professional provider's office. Drugs included are: Aldurazyme, Aredia, Avastin (except for certain ophthalmological conditions), Boniva, Ceredase, Cerezyme, Elaprase, Eloxatin, Erbitux, Fabrazyme, Herceptin, IVIG, Myozyme, Orenicia, Remicade, rituximab, and Tysabri. List subject to change;
- medical injectables drugs listed when administered in an outpatient facility or in a professional provider's office. Drugs included are: Botox; Synagis; and hyaluronan agents: Euflexxa, Hyalgan, Orthovisc, Supartz, and Synvisc/Synvisc-One. List subject to change.

To maximize your benefits, you must remember to preauthorize these services. If you do not preauthorize these services, you will be responsible for higher out-of-pocket costs. You may obtain preauthorization for self-referred services by calling 1-800-ASK BLUE (1-800-275-2583). You will be asked to provide the patient's name, identification number, physician's name, facility name, address, telephone number, diagnosis, and procedure or indication for services. If you are seeing an out-of-network OB/GYN for maternity care, please contact the CMC team to notify it of your upcoming admission.

## Inpatient hospital stays

During and after an approved hospital stay, the CMC team is monitoring your stay to review whether you receive medically appropriate care and to see that a plan for your discharge is in place and to coordinate services that may be needed following discharge.

## Utilization review

To assist Keystone Health Plan East ("Keystone") in making coverage determinations regarding the medical necessity and appropriateness of requested services, Keystone uses medical guidelines based on clinically credible evidence. This is called utilization review. Utilization review can be done before a service is performed (precertification/preservice), during a hospital stay (concurrent review), or after services have been performed (retrospective/post service review). Keystone follows applicable state/federal standards pertaining to how and when these reviews are performed.

## Continuity of care

### Terminated providers

Keystone offers participants continuation of an ongoing course of treatment with a terminated provider (for reasons other than cause) for up to 90 days from the date that Keystone notified the participant of the

provider termination. Keystone will cover such continuing treatment under the same terms and conditions as if the treatment was being received from participating providers.

If a participant is in her second or third trimester of pregnancy at the time of the termination, the transitional period of authorization shall extend through post-partum care related to the delivery.

All authorized health care services provided during this transitional period shall be covered by Keystone under the same terms and conditions applicable for participating health care providers.

### **New Keystone Point-of-Service participants**

New Keystone Point-of-Service participants may continue an ongoing course of treatment with a nonparticipating health care provider for a transitional period of up to 90 days from the effective date of enrollment into the plan, subject to the requirements set forth herein and in the applicable plan materials.

If the new participant is in her second or third trimester of pregnancy at the time of the effective date of enrollment, the transitional period of authorization shall extend through post-partum care related to the delivery.

The nonparticipating provider must agree that all authorized health care services provided during this transitional period shall be covered by Keystone under the same terms and conditions applicable for participating health care providers.

In order to initiate continuity of care, participants must complete a *Continuity of Care* form and submit it to the CMC department. The form will be in the enrollment materials and available through Customer Service.

Nonparticipating health care providers (whose services are covered during the transitional period) must agree to be bound by the same terms and conditions as participating providers. The plan is *not* required to provide health care services that are not covered benefits.

### **Emergency care**

Emergency care: any health care services provided to a participant after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the participant or with respect to a pregnant participant, the health of the pregnant participant or her unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

In the event of an emergency, the participant should go to the nearest appropriate medical facility. The primary care physician should be contacted as soon as reasonably possible in the event of any emergency occurring either within or outside Keystone's service area.

### **Complaints and grievances**

You have a right to appeal any adverse decision through the complaint and grievance process. Instructions for the appeal will be described in the denial notifications and in the plan materials.

## Privacy policy

At Independence Blue Cross, protecting your privacy is very important to us. That is why we have taken numerous steps to see that your protected health information (PHI) is kept confidential. Protected health information is individually identifiable health information about you. This information may be in oral, written, or electronic form. Independence Blue Cross may obtain or create your PHI while conducting our business of providing you with health care benefits.

Independence Blue Cross has implemented extensive policies and procedures regarding the collection, use, and release or disclosure of PHI by and within our organization. We continually review our policies and monitor our business processes to make sure that your information is protected, while assuring that the information is available as needed for the provision of health care services. For example, our procedures include steps to assist us in verifying the identity of someone calling to request PHI, procedures to limit who on our staff has access to your PHI, and to share only the minimum amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks or by using encryption technology if the information is sent by email.

We do not use or share your PHI without your permission unless the law allows us to do so. Before using or disclosing your PHI for other purposes, we'll obtain your written permission, also called an authorization. You may also direct us to share your PHI with someone you chose by giving us your written authorization. However, this authorization must include certain specific information in order to be valid. You may print a copy of our *Authorization to Release Information* form from our website **www.ibx.com** or request a copy by calling our Privacy Office at 215-241-4735.

We are permitted to use or disclose your PHI for our payment and health care operations. Examples of these activities include paying claims for services you've received, coordinating the delivery of health care services, and monitoring the performance of our network providers to improve health care outcomes. We may also share your PHI in certain other circumstances, such as disclosures to health care oversight agencies for legally authorized health oversight activities like audits and investigations, or when we are required to do so by law. We may also share certain information with the sponsor of your group health plan so that they may perform their plan administration functions.

The laws that protect your privacy also give you certain rights related to your PHI. For example, you may request a copy of your PHI that we have in our "Designated Record Set." Please remember that IBC does not typically have copies of your medical records. Your health care provider should be contacted for copies of your medical records.

Please review our *Notice of Privacy Practices* for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy of our notice from our website **www.ibx.com** by clicking on *Privacy Policies*, or you may call our Privacy Office at 215-241-4735 to request that a copy of the notice be mailed to you.



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Referred benefits are administered by Keystone Health Plan East; self-referred benefits administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

KPOS - Self Insured  
KPOS - Pre-Authorization  
07480

# Procedures That Support Safe Prescribing



Independence Blue Cross utilizes an independent pharmacy benefits management (PBM) company, FutureScripts®, to manage the administration of its commercial prescription drug programs. As our PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our participants and providers.

## PRIOR AUTHORIZATION

Prior authorization is a requirement that your physician obtain approval from your health plan for coverage of, or payment for, your medication. Independence Blue Cross requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the participant's prescribing physician, and the participant's available prescription drug therapy history. Their review includes a determination that there are no drug interactions or contraindications, that dosing and length of therapy are appropriate, and that other drug therapies, if necessary, were utilized.

*Without prior authorization, the participant's prescription will not be covered at the retail or mail order pharmacy (see 96-Hour Temporary Supply Program on following page).* The prior authorization process may take up to two working days once complete information from the prescribing physician has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a participant to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Currently, the drugs listed below are a part of the prior authorization program. Prior authorization applies to all formulations of these specific drugs, including, but not limited to, tablet, capsule, and oral suspension. AcipHex®, Actiq®, Adcirca™, Afinitor®, Alodox™, Altanax™, Alvesco®, Ambien CR®, Amevive™, Ampyra™, AMRIX®, Apidra®, Apidra® SoloSTAR®, Aplenzin™, Atacand®/Atacand HCT®, Avapro®/Avalide®, Avidoxy™DK, AZOR®, Banzel™, Benicar®/Benicar HCT®, Bepreve™, BiDil®, Botox®, Byetta®, Caduet®, Caverject®, Cayston™, Celebrex®, Cesamet®, Cialis®, Cimzia®, Colcryst™, Cozaar®/Hyzaar®, Crestor®, Cymbalta®, Daytrana™, Diabetic Test Strips (except Autodisc®, Breeze® 2, Contour®, FreeStyle Lite® and Precision Xtra®), Diovan®/Diovan HCT®, Edex®, Edluar™, Effient™, Enbrel®, Exalgo™, Exforge®, EXFORGE HCT®, Exjade®, Fanapt™, Fentora®, Flector® Patch, Forteo™, Genotropin®, Gleevec®, Glumetza™, Humalog®, Humatrope®, Humira®, Humulin®, HYCAMTIN® Capsules, Intuniv™, Invega™, Iressa®, Janumet™, Januvia™, Kapidex™, Keppra XR™, Kineret®, Levitra®, Lipitor®, Lunesta®, Lyrica®, Magnacet™, Micardis®/Micardis HCT®, Mirapex ER®, Mobic®, MUSE®, Myobloc®, Nexavar®, Nexium®, Norditropin®, Noxafil®, Nucynta™, NutriDox™, Nutropin®, Nutropin AQ®, Nuvigil®, Oforta™, Omnitrope®, Onglyza™, Onsolis™, Opana®/Opana®ER, Oracea®, Pataday™, Pennsaid®, PrandiMet™, Prevacid®, Prevacid/NapraPAC®, Prilosec® Suspension, Pristiq™, Protonix®, Provigil®, Pylera™, Quaaliquin®, Ranexa®, ReliOn®/Novalin®, Renvela®, Requip® XL™, Revatio™, Revlimid®, Rozerem™, Ryzolt™, Sabril®, Saizen®, Samsca™, Saphris®, Savella™, Seroquel XR®, Serostim®, Silenor®, Simcor®, Simponi™, Singulair®, Sprycel®, Suboxone®, Subutex®, Sumavel™, Sutent®, Symlin®, Taclonex®, Taclonex Scalp® Suspension, Tarceva®, Tasigna®, Tekturna®/Tekturna HCT®, Temodar® Oral, Teveten®/Teveten HCT®, Tev-Tropin®, Thalomid®, Toviaz™, Treximet™, Trilipix™, Twynsta®, Tykerb®, Uloric®, Ultram® ER, Valturna®, Vectical™, Veramyst™, Viagra®, Victoza®, Vimpat™, Voltaren® Gel, Votrient™, Vytorin®, Vyvanse™, Xenazine™, Xyzal®, Zelapar®, Zipsor™, Zmax™, Zolanza®, Zorbitive and Zyvox®. This list is subject to change.

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## AGE AND GENDER LIMITS

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and to ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals 14 and older, such as ciprofloxacin, or prescribed only for females, such as prenatal vitamins. The pharmacist's computer provides up-to-date information about FDA rules. If the participant's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request preapproval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee which is an established group of medical directors and practicing area physicians and pharmacists. The participant should contact the prescribing physician to request that he or she initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age or gender limit, call FutureScripts at 1-888-678-7012.

## QUANTITY LEVEL LIMITS

Quantity level limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. We have several different types of quantity level limits that are explained in detail below.

## ROLLING 30-DAY PERIOD

This quantity limit is based on dosing guidelines over a rolling 30-day period. Examples of quantity level limits per rolling 30-day period are Emend® (four 125mg capsules + eight 80mg capsules or four trifold packs [one 125mg capsule + two 80mg capsules]); Boniva® (two 150mg tablets); Avonex® (one kit, four injections); Betaseron® (15 vials); Copaxone® (32 vials); Fosamax Plus D™ (five tablets); and Rebif® (12 injections); migraine drugs such as: Amerge® (nine 2.5mg tablets), Imitrex® (36 50mg tablets), Maxalt® (12 10mg tablets), Migranal® (eight 4mg nasal spray units), Stadol NS® (four 10mg units), and Zomig® (nine 5mg tablets); sedative hypnotic drugs, such as Sonata® (14 capsules) and Ambien® (14 tablets); and oral narcotic drugs such as OxyContin® (90 units), Percocet® (180 units), and Percodan® (180 units). For example, if a participant went to the pharmacy on October 1, 2009, for one of these medications, the computer system would have looked back 30 days to September 1, 2009, to see how much medication was dispensed. The purpose of these limits is to make certain that these drugs are being used appropriately and to guard against overuse or stockpiling.

- **Refill too soon.** With this quantity level limit, if a participant used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.
- **Therapeutic drug class.** This quantity level limit applies to some classes of drugs, such as narcotics (i.e. short and long acting). If a participant uses more than one drug within the same class, he or she may be unsafely duplicating medications and would be affected by the total quantity limits for a therapeutic drug class. Participants will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

If a physician requires that a participant needs a medication therapy that exceeds any of the quantity level limits described above, the physician must request a quantity limit override. The participant is required to contact the prescribing physician to initiate a preapproval request for an override.

Some drugs may have a time period for quantity limit exceptions of 6 to 12 months. If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a participant to continue the drug therapy that exceeds a quantity limit after the expiration date, a new request for a quantity limit exception will need to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity level limit, call FutureScripts® at 1-888-678-7012.

## 96-HOUR TEMPORARY SUPPLY PROGRAM

The 96-hour Temporary Supply Program applies to the following covered medications:

- Most medications that require prior authorization
- Medications that are subject to age limits (preapproval required for ages outside of recommended ranges)
- Migraine medications with quantity level limits such as Amerge®, Imitrex®, Maxalt®, Migranal®, Stadol NS® and Zomig® (preapproval of quantity override required for amounts over the quantity level limits)

Under the 96-hour Temporary Supply Program, if a participant's doctor writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity level limit for a medication, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the participant with no out-of-pocket cost sharing<sup>1</sup> at that time.
2. By the next business day, our PBM will contact the participant's doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by our PBM, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled and the appropriate prescription drug out-of-pocket cost sharing will be applied<sup>1</sup>.
5. If denied, notification will be sent to the doctor and the participant.

<sup>1</sup> Participants with an integrated drug benefit (e.g. CMM and Major Medical) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved) at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures.

*Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved.* Some medications are not eligible for the 96-hour temporary supply program due to packaging or other limitations such as Retin-A® (tube), Enbrel® (2-week injection kit), medroxyprogesterone acetate (monthly injectable) and erectile dysfunction drugs. Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually purchased at the pharmacy and must be special-ordered; therefore, they are not eligible for the 96-hour temporary supply.

### THE PROCESS FOR REQUESTING A PRIOR AUTHORIZATION/PREAPPROVAL OR OVERRIDE IS AS FOLLOWS:

- The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and submits it to our PBM by fax at 215-241-3073 or 1-888-671-5285. A participant's physician can request the form by calling 1-888-678-7012. Participants can request the form through Customer Service on behalf of their physician, but it must be completed and submitted by the doctor.
- The PBM will review the prior authorization request or letter of medical necessity. If a clinical pharmacist can not approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.

- *If approved*, the prescribing physician will be notified of approval via fax or telephone and the claims system will be coded with the approval.
- The participant can call the Customer Service phone number on his or her identification card to determine if the prescription is approved.
- *If denied*, the prescribing physician will be notified via letter, fax or telephone.
- The participant is also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to the participant's and physicians.

### **COVERAGE FOR MEDICATIONS NOT ON THE FORMULARY (SPECIFIC TO SELECT DRUG PROGRAM® PARTICIPANTS ONLY).**

Providers may request formulary coverage of a covered non-formulary medication when all formulary alternatives have been exhausted or there are contraindications to using the formulary alternatives. The provider should complete the covered non-formulary appeal form providing detail to support use of the covered non-formulary medication and fax the request to 215-241-3073 or 1-888-671-5285. If the non-formulary request is approved, the drug will be paid at the appropriate formulary benefit level. If the request is denied, the participant and provider will receive a denial letter with the appropriate appeals language. Whether or not an appeal is filed, the participant may always obtain benefits for the covered non-formulary drug at the appropriate non-formulary benefit level. Out-of-pocket expenses for non-formulary drugs are higher than for formulary drugs.

### **APPEALING A DECISION**

If a request for prior authorization/preapproval or override results in a denial, the participant or physician, on the participant's behalf, may file an appeal. Both the participant and his or her provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. In all cases, the physician needs to be involved in the appeal process to provide the required medical information for the basis of the appeal.

### **PRESCRIPTION DRUG PROGRAM PROVIDER PAYMENT INFORMATION**

A pharmacy benefits management company (PBM), administers our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence Blue Cross anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a participant copayment.

# Get the most from your benefits with [ibxpress.com](http://ibxpress.com)

With work, family, and friends, you don't always have the time or the resources to focus on your health. Our new and improved member website, [ibxpress.com](http://ibxpress.com), has all your benefits and claims information in one convenient location. By using the personalized tools, you can manage your health quickly and easily so that you get the most from your benefits.

## Get reliable health information

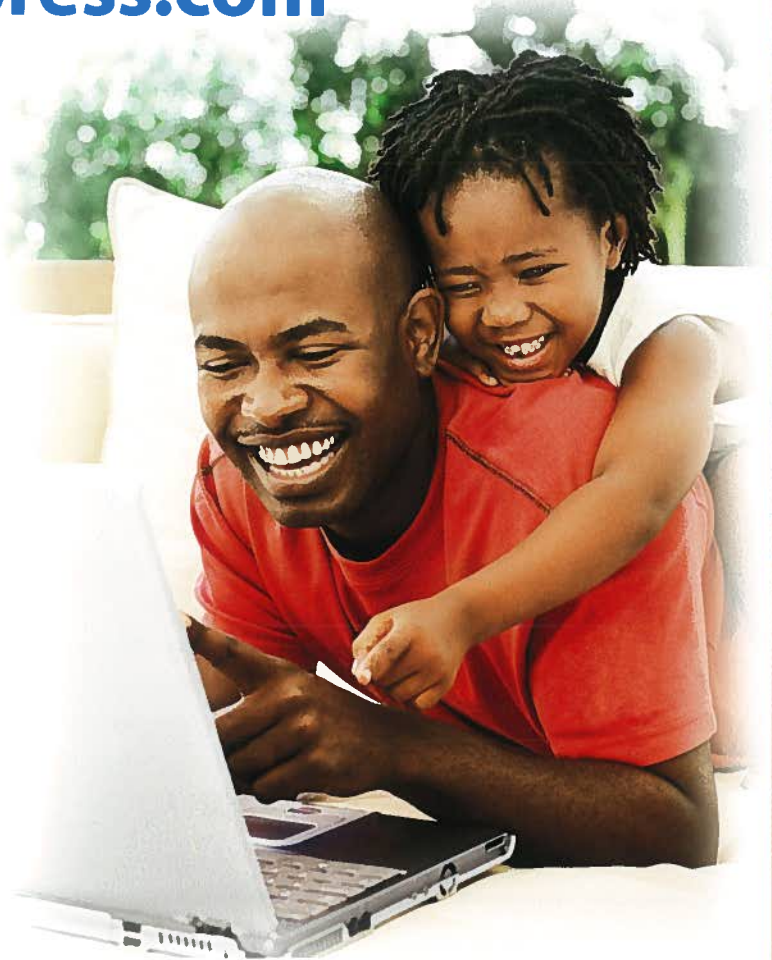
Searching for health information online can be frustrating and scary. There's so much available, how do you know what's really accurate? We've partnered with WebMD®, one of the most widely-recognized names in health information, to provide you with reliable, up-to-date information to make the decisions that are right for you.

**Provider Finder** and **Hospital Finder** help you find the participating doctors and hospitals that are best equipped to handle your needs. You can learn where your doctor went to medical school, his or her board certification, languages spoken, and more. You can compare hospitals based on experience, cost, patient satisfaction, and other factors important to you.

**Symptom Checker** provides a comprehensive tool to help you understand your symptoms – and what to do about them.

**Health Encyclopedia** provides information on more than 160 health topics and the latest news on common conditions.

**Treatment Cost Estimator** helps you estimate your costs for hundreds of common conditions – including tests, procedures, and health care visits, so you can plan and budget for your expenses.



## Get help getting healthy

Making a lifestyle change like losing weight or quitting smoking may seem overwhelming and costly, but [ibxpress.com](http://ibxpress.com) provides the tools you need to get started, set reachable goals, and track your progress – all for free.

**Personal Health Profile** – This powerful health assessment tool will give you a clear picture of what you are doing right and suggest ways to stay healthy. Just answer a few questions, and you'll receive an accurate, confidential, and personalized action plan.



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**Lifestyle Improvement Programs** – These personalized, self-paced, step-by-step programs will help you improve your health. You'll find several different programs, such as exercise, weight management, nutrition, and smoking cessation, designed to inspire and support your positive health changes. These online programs combine proven tactics with the ultimate in privacy, security, and convenience.

**Health Trackers** – Chart your progress over time to help you stay motivated. Track blood pressure, cholesterol, body fat, and other health factors. Or customize the tool by adding a new Health Tracker for additional data you want to track – like test results, number of push-ups, etc.

## Get more from your doctor's visit

You only have a few minutes with your doctor, and you want to make the most of it. Use **ibxpress.com** to help prepare for your doctor's visit so you can feel confident that you'll get the information you need to effectively manage your health.

- Learn the questions to ask, such as medication interactions and options to treat your condition.
- Organize your health information with the Personal Health Record so you can provide your doctor with your complete health history.

- Find tips on what to do if you have a limited amount of time with your doctor.
- Understand what questions your doctor may ask you about your symptoms.

## Our enhanced ibxpress.com still offers all the great tools you've come to know:

- Review claims and get a tax-year report.
- View the Member Payment Responsibility report, which shows how much Independence Blue Cross paid for your claims and any amounts you may owe.
- Request and print a temporary ID card.
- View and print referrals, if needed, for your health plan.

## Log on or register today!

For more information, call **215-567-4002** or **1-800-626-6076**.

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WebMD is an independent company offering online health information and wellness education to Independence Blue Cross members.

# How can a Personal Health Record help me?

**It's an organized, online, and secure way of storing important medical information — all for free on [ibxpress.com](http://ibxpress.com).**

Do you remember the last time you had a physical or what your cholesterol levels are? Do you draw a blank when your doctor asks if your medication is 10 mg or 20 mg? With the private, secure, online Personal Health Record on [ibxpress.com](http://ibxpress.com), you won't have to remember anymore. The Personal Health Record will keep track of your health information for you. It will be automatically updated each time your provider submits a claim for things like office visits, surgeries, tests, immunizations, and certain lab results, like those cholesterol levels you have a hard time remembering. You can personally update your Personal Health Record with additional information such as over-the-counter medications you take so you have a complete picture of your health.

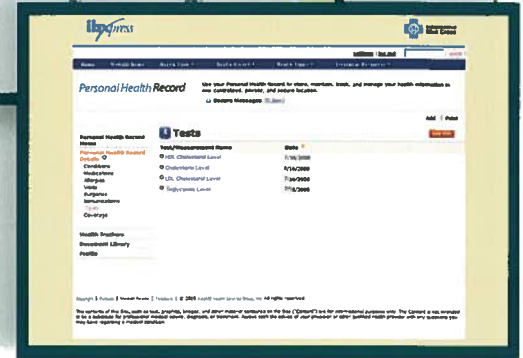
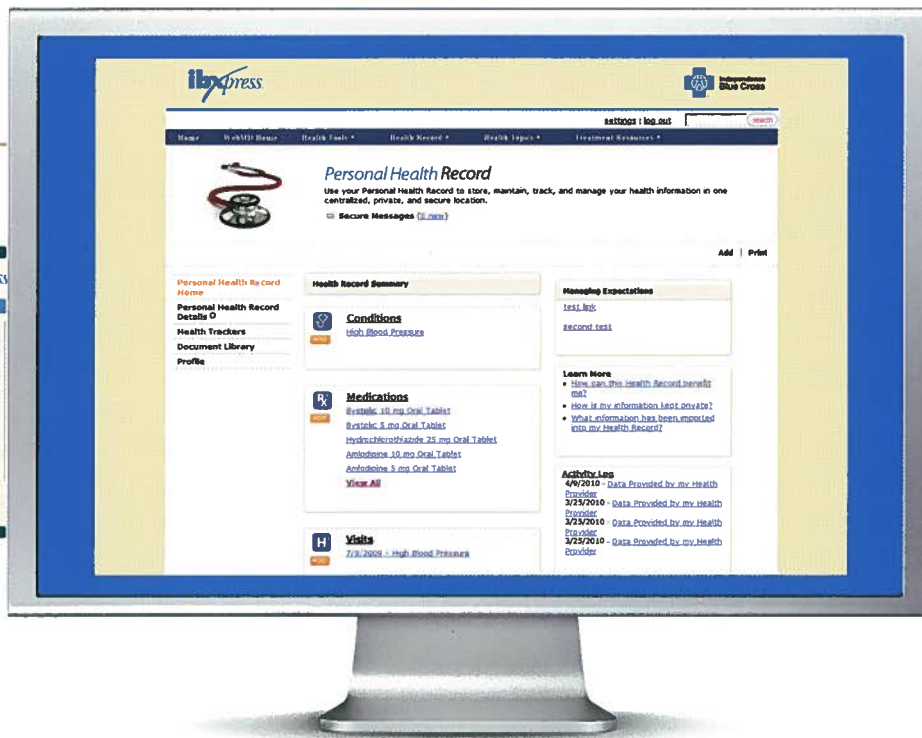
## Let us do the work for you!

Log on to [ibxpress.com](http://ibxpress.com) today and let us do the work for you. When a provider submits a claim your health information will be automatically populated in your Personal Health Record.

- **Have meaningful conversations with your doctor.** Your doctor may not have all of your health information handy, especially if you are going to a new doctor or see several doctors. Print a copy of your Personal Health Record and bring it to your next doctor's appointment. You will be prepared for any questions the doctor has about your health history and will be able to have an in-depth discussion about your health.
- **Know when it's time to put your health in check.** With all of your health information stored in one convenient location, you won't have to remember the details, and you won't have to keep track of when you need routine and preventive care. You'll get reminders to set up annual doctor's appointments and tests like routine GYN exams, immunizations, and physicals.



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- **Reach your future health goals.** After your Personal Health Record is populated, it will feed other **ibxpress.com** applications, like Health Trackers and your Personal Health Profile. When all applications work together, you'll get online notices about your health goals, like losing weight or quitting smoking, and even be able to chart your progress all online.
- **Share with a caregiver.** If you have an elderly parent, the Personal Health Record can also be a valuable resource for a caregiver. In an emergency, a detailed record of medical conditions and medications can save valuable time.

## Feel confident that your information is secure

Only you have access to your Personal Health Record, and only you decide what you want to record. Your doctor sees personal health information only when you print it and share it. The same goes for a loved one or anyone who helps with your care. Independence Blue Cross complies with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and other legal requirements to keep your Personal Health Record confidential and secure.

## Get started today

To start, log on to **ibxpress.com**. After your initial visit to the site, you'll begin to see medical and pharmacy claims data and certain lab results automatically populated in your Personal Health Record. You can find your Personal Health Record through the WebMD tab.

## Log on to **ibxpress.com** and get started today.



Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association. WebMD is an independent company offering online health information and wellness education to Independence Blue Cross members.

The Personal Health Record should not be viewed as the single source for your medical history. The information included in the Personal Health Record is believed to be accurate at the time it is posted but is subject to change.

# Pennsylvania Mandate

## Autism spectrum disorders coverage

Autism is a complex developmental disability that typically appears during the first three years of life and affects a person's ability to communicate and interact with others. Autism is defined by a certain set of behaviors and is a 'spectrum disorder', meaning it affects individuals differently and to varying degrees. Depending on the service that is being requested, members, or a doctor on their behalf, may be requested to submit a treatment plan to Independence Blue Cross for review and approval prior to receiving treatment. This plan may need to be reviewed and approved by Independence Blue Cross every six months.

Benefit	Autism spectrum disorders coverage
Benefit limit	\$36,000 per benefit period <sup>1</sup>
Benefit period	Members should refer to their medical benefits plan to determine if their benefit period is based on a contract year or calendar year.
Eligibility	Eligible individuals must have a primary diagnosis of Autism and be under 21. Coverage is provided only under policies issued or renewed in Pennsylvania, on or after July 1, 2009, to groups with 51 or more employees.
Covered services (services must be medically necessary and coverage is subject to the copayment, deductible, and coinsurance provisions of your medical benefit plan, as well as any applicable referral or prescription requirements)	evaluations and tests needed to diagnose an autism disorder rehabilitative Care, including applied behavioral analysis blood Level tests psychiatric and psychological services speech/language therapy occupational therapy physical therapy prescription drugs
Visit limits	Visit limits do not apply to the treatment of autism spectrum disorders.
Treatment plan review	Depending on the service that is being requested, members, or a health care provider on their behalf, may be required to submit a treatment plan to Independence Blue Cross prior to receiving treatment. This plan will need to be reviewed and approved by Independence Blue Cross every six months.
Precertification requirements	All standard precertification requirements and penalties under the member's medical benefits plan apply.

<sup>1</sup> Once a member reaches the benefit period maximum for approved services that have a primary diagnosis of autism, additional services may be eligible for coverage through a similar government agency. Expenses not eligible under this plan may also be eligible for coverage through a government agency. Pennsylvania residents should contact the Pennsylvania Department of Public Welfare. Members that reside outside of Pennsylvania should contact government agencies in their area. Beginning January 1, 2013, the benefit maximum for autism spectrum disorders coverage will be adjusted annually for inflation.

### What is Not Covered?

- Benefits that are normally excluded from coverage under the member's medical plan
- Services provided by an individualized education program and delivered in a school
- Services in excess of the \$36,000 benefit period maximum
- Services that are not medically necessary



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