Keystone 65

A Blue Cross Medicare Advantage HMO Plan from Keystone Health Plan East

Keystone 65 Prescription Drug Benefits Rider

An Addendum to Your Evidence of Coverage

Effective January 1, 2008
through December 31, 2008

1-800-645-3965
TTY/TDD: 1-888-857-4816
Seven days a week
8 a.m. to 8 p.m.

INTRODUCTION TO THE PLAN OUTPATIENT PRESCRIPTION DRUG BENEFIT

The purpose of this section is to give the details about the Keystone 65 outpatient prescription drug benefit. This benefit covers certain drugs that require a prescription and that have been approved by the Food and Drug Administration (the FDA) for the intended purpose. The Keystone 65 prescription drug benefit is above and beyond the basic Original Medicare benefit. Original Medicare covers a limited number of prescription drugs, usually those that must be administered by a health professional. See Section 3 of your Evidence of Coverage book for more information on Original Medicare-covered drugs. Original Medicare-covered prescriptions do not apply toward any applicable annual prescription benefit maximum (discussed below). If you have outpatient prescription drug coverage, please refer to your appropriate Schedule of Copayments and Prescription Drug Limitations for your specific maximum coverage amounts.

Prescription drug benefits will be available for covered drugs or supplies dispensed by a prescription order for use when you are not an inpatient. When you are in an inpatient setting, e.g., hospital or skilled nursing facility, prescription medications are covered according to Medicare guidelines.

Prescription Drug benefits are subject to Copayments & Limitations as shown on the Schedule of Copayments & Prescription Drug Limitations.

HOW DOES THE PRESCRIPTION BENEFIT WORK?

Benefits will be provided for covered prescription drugs and medicines prescribed by a physician and dispensed by a licensed pharmacy up to the benefit period maximums shown on the Schedule of Copayments and Prescription Drug Limitations. Benefits for prescription drugs are available for up to a 30-day supply when dispensed from a retail pharmacy.

Charges for immunosuppressive drugs incurred within 44 months of the patient's discharge from an inpatient admission for covered transplant services will not accrue to any benefit period prescription drug maximum amount, nor will charges incurred for Medicare approved self-administered drugs and biologicals accrue to that benefit period maximum amount. Immunosuppressive drugs are covered according to Medicare guidelines.

Benefits are also available for diabetic supplies such as blood testing strips, insulin syringes and lancets, up to a 90-100 day supply per prescription or refill dispensed by a pharmacy.

IMPORTANT NOTE

If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.

Prior authorization (approval in advance)

In certain cases, Keystone 65 may determine that the use of certain covered prescription drugs for a member's medical condition requires your primary care physician or plan specialist to obtain prior authorization (approval in advance) from Keystone 65 to determine medical necessity. Keystone 65 reserves the right to apply eligible dispensing limits for certain covered prescription drugs. These limits result from age, gender or quantity limits as conveyed by the Food and Drug Administration (FDA) or the Plan's Pharmacy and Therapeutics Committee.

The following prescription drugs require prior authorization (approval in advance):

- Viagra®
- MUSE®
- Caverject®
- Edex®
- Celebrex®
- Enbrel®
- Provigil®
- Mobic®
- Prevacid®
- AcipHex®
- Levitra®
- Humira®
- Kineret®
- Thalomid®

This list is subject to change.

Requesting prior authorization (approval in advance)

1. The prescribing physician completes a prior authorization (approval in advance) form available from Keystone 65 by calling **1-800-227-3116** outside Philadelphia, or writing a letter describing the medical necessity and submits it to Keystone 65's pharmacy services department. This can be done by fax at **1-215-241-3073** or **1-888-671-5285**. You can obtain the form by calling Member Services, but it must be completed and submitted by your physician.
2. The plan's pharmacy department will review the prior authorization (approval in advance) form or letter of medical necessity. If the pharmacist cannot approve the request based on established review criteria, a medical director will review the document.
3. A decision is made regarding the request.
4. If approved, the prescribing physician will be notified of the approval via fax, and the system will be coded with the approval. You can call Member Services to find out if your request was approved.
5. If denied, the prescribing physician will be notified by fax and letter, and you will be notified by letter.
6. The appeals process will be described on the denial letter should you choose to appeal the decision.

HOW DO YOU FILL YOUR PRESCRIPTION?

Drugs from a plan pharmacy:

When you show your ID card, you can obtain covered drugs or supplies furnished by a plan pharmacy for the applicable drug cost share for each prescription order or refill. The quantity of a prescription drug dispensed per drug copay from a pharmacy pursuant to a prescription order or refill is limited to thirty (30) consecutive days.

Through a plan pharmacy:

- A 1-30 day supply of a prescription drug may be obtained for one (1) times the drug copay.
- A 31-60 day supply of a maintenance prescription drug may be obtained for two (2) times the drug copay.
- A 61-90 day supply of a maintenance prescription drug may be obtained for three (3) times the drug copay.

Drugs from a non-plan pharmacy:

You will be reimbursed for covered drugs or supplies furnished by a non-plan pharmacy when you submit acceptable proof of payment with a direct reimbursement form. Reimbursement for covered drugs or supplies will not exceed thirty percent (30%) of the usual and customary charge. You will be entitled to reimbursement only if your purchase is related to covered services for emergency care or urgent care within the United States. All claims for payment must be received within ninety (90) days of the date of proof of purchase. Direct reimbursement forms may be obtained by contacting the Member Services department at the telephone number on your ID card.

Through a mail-service pharmacy:

Benefits shall also be provided for covered prescription drugs ordered by mail if a covered person or prescribing physician submits to a plan mail-order pharmacy a written prescription drug order specifying the amount of the covered prescription drug to be supplied. Benefits shall be available for up to a 90-day supply of a covered prescription drug, subject to the amount specified in the prescription drug order and applicable law.

- A 1-30 day supply of a prescription drug may be obtained for one (1) times the drug copay.
- A 31-90 day supply of a maintenance prescription drug may be obtained for two (2) times the drug copay.

IMPORTANT NOTE

If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.

DRUG FORMULARY—DEFINITION AND OTHER INFORMATION

A formulary is a comprehensive list of U.S. Food and Drug Administration (FDA) approved prescription medications selected by our Pharmacy and Therapeutics Committee. We have established this independent committee of physicians and pharmacists to help ensure that our formularies are medically sound and support members' health. Each medication is selected based on safety and efficacy to help ensure clinical integrity in all therapeutic categories.

If you need a covered medicine that is not on the formulary (ie: non-formulary), your health care provider has the right to request an exception for continued use of a drug scheduled to be removed from the formulary. This process includes obtaining additional information from your provider. Your provider will need to complete the **Exception Request Form** that was included in the provider mailing and at **www.site65.com**. Once received, the request will be reviewed for a possible formulary copay exception, and if approved you will be eligible to obtain the drug at the formulary copayment level. If it is not approved, you will receive a denial notice but can still obtain the medication at the nonformulary copay.

A Pharmacy and Therapeutics Committee reviews and updates the Keystone 65 formulary list regularly throughout the year. This means that drugs can be added to the formulary list at any time (without notice). Drugs are deleted twice a year, in January and July. Changes in the formulary list can affect which drugs are covered for you and the amount of your copayment when you fill a prescription. For example, if a non-formulary drug you are using is added to the formulary list, your copayment would be lower. If a formulary drug you are using is dropped from the formulary list, your copayment would increase. You can call the Member Services department at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** to find out if your drug is on the formulary list or to get a copy of the formulary list.

During the year, we use mailings to tell providers and plan members about changes in the formulary list. If a change in the formulary list affects one of your prescriptions, we will let you know in writing.

From time to time, Keystone 65 may make decisions that affect your prescription drug coverage, such as whether a particular drug is covered, or the amount of payment for a prescription, You have the right to make an appeal (an appeal asks us to reconsider and change our decision about coverage or payment). If you want to make any other types of complaints related to your prescription drug benefit, you would file a "grievance." Section 7 of the Evidence of Coverage booklet discusses grievances and appeals. You can also call Member Services to get additional information or help with a grievance or appeal. If you would like to make a complaint or file a grievance, follow the complaint and grievance process listed in Section 7 of the Evidence of Coverage booklet.

Should you have any questions or concerns about your drug therapy, please discuss this with your doctor or pharmacist. If you have any questions about your prescription drug program, or need a new Select Drug Program® formulary guide, please call our Member Services department at **1-800-645-3965 (TTY/TDD: 1-888-857-4816)** seven days a week from 8 a.m. to 8 p.m.

PRESCRIPTION DRUG LIMITATIONS

1. A pharmacy need not dispense a prescription order which, in the pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.

2. Prescription refills will not be provided beyond six (6) months from the most recent dispensing date.

3. Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed. Example: If you have a prescription filled on January 1 for a quantity of 30 pills, which is a 30-day supply, you can refill on January 23, leaving you a seven-day supply. If you go for another 30-day supply, you will now have a 37-day supply. You can refill after 75% of your 37-day supply is used.

4. You must present your identification card, and the existence of prescription drug coverage must be indicated on the card.

5. You will pay to a plan pharmacy:

   a. One hundred percent (100%) of the cost for a prescription drug dispensed when you fail to show your identification card. A claim for reimbursement for covered drugs or supplies may be submitted to Keystone 65; or

   b. One hundred percent (100%) of a non-covered drug or supply; or

   c. The prescription drug cost-share as specified in the Schedule of Copayments and Limitations applicable to your current coverage.

6. In certain cases, Keystone 65 may determine that the use of certain covered prescription drugs for a member's medical condition requires your primary care physician or plan specialist to obtain prior authorization (approval in advance) from Keystone 65 to determine medical necessity.

Keystone 65 reserves the right to apply eligible dispensing limits for certain covered prescription drugs. These limits result from age, gender, or quantity limits as conveyed by the FDA or the plan's Pharmacy and Therapeutics Committee.

PRESCRIPTION DRUG EXCLUSIONS

The following are excluded from your prescription drug benefits:

1. Drugs used for experimental or investigative purposes.

2. Drugs used for cosmetic purposes, such as wrinkle removal or hair growth.

3. Health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.

4. Vitamins, unless they require a prescription and are medically appropriate/medically necessary for the treatment of a specific illness, as determined by the plan.

5. Drugs available over-the-counter, even if prescribed by the physician.

6. Drugs which have no currently accepted medical use for treatment in the United States.

7. Drugs dispensed to a member while a patient in a hospital, nursing home or other institution (inpatient medications are covered according to Medicare guidelines).

8. Smoking deterrent agents.

9. Administration or injection of drugs.

10. Prescription drugs not approved by the plan, or prescribed drug amounts exceeding the eligible dosage limits established by the plan.

11. Prescription drugs that are subject to prior authorization (approval in advance) for medical necessity and are dispensed without pre-approval by the plan.

12. Devices of any type, even though such devices may require a prescription order. This includes, but is not limited to, contraceptive devices, therapeutic devices or appliances, hypodermic needles, syringes or similar devices. This exclusion does not apply to devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin.

13. Prescription drugs obtained through mail-order prescription drug services of a non-plan mail-order pharmacy.

14. Drugs prescribed and administered in the physician's office; (except as covered by Original Medicare).

15. Contraceptive drug.

16. Replacement of lost, stolen, returned, or damaged prescriptions are not covered.

17. Drugs purchased outside of the United States.

All other terms and conditions set forth in your Evidence of Coverage remain in effect.

IMPORTANT DEFINITIONS

For the purpose of understanding your prescription drug benefits, the terms below have the following meaning:

APPEAL—Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by the Medicare Advantage Organization, an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the board, and judicial review.

BRAND-NAME DRUG—A single-source, FDA-approved drug manufactured by one company for which there is no FDA-approved generic available. Examples include, but are not limited to, Lipitor®, Premarin®, and Insulin.

CALENDAR YEAR—A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later, on December 31.

CONTRACEPTIVE DRUGS—FDA-approved drugs requiring a prescription order to be dispensed for the use of contraception. These include oral contraceptives (birth control pills), IUDs (intrauterine devices), diaphragms, and topical patches.

CONTROLLED SUBSTANCE—Any medicinal substance as defined by the Drug Enforcement Administration which requires a Prescription Order in accordance with the Controlled Substance Act-Public Law 91-513.

COVERED DRUGS OR SUPPLIES—Drugs or supplies approved under federal law by the Food and Drug Administration for general use and limited to the following:

A. Prescription drugs prescribed by a primary care physician or plan specialist and, when required, pre-approval by Keystone 65 subject to the prescription drug exclusions, limitations and other exclusions listed in your Evidence of Coverage.

B. Compounded prescription drugs containing at least one legend drug or controlled substance in an amount requiring a prescription order.

EFFECTIVE DATE OF COVERAGE—The date coverage begins for a member under this contract. All coverage begins at 12:01 a.m. on the date reflected on the records of Keystone Health Plan East. The member will receive written notification of the effective date from Keystone 65 upon Keystone 65's receipt of confirmation of eligibility from CMS.

ERECTILE DYSFUNCTION DRUGS—FDA-approved drugs requiring prescription order to be dispensed for erectile dysfunction. These include, but are not limited to, Viagra® (sildefanil), Caverject® (alprostadil), MUSE®, Levitra®, and related drugs. These drugs require prior authorization by Keystone 65.

EXCLUSION—A service or supply specified in the prescription drug exclusion section of this contract for which no benefits will be provided under the terms of this contract.

EXPERIMENTAL OR INVESTIGATIVE PROCEDURES OR ITEMS—Drugs, devices, medical treatments, items or procedures that have not been approved by the FDA (Food and Drug Administration).

GENERIC DRUG—The equivalent version of a brand-name drug produced when the patent on the brand-name drug has expired. Generic drugs have the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. The generic drug may cost at least 20% less than the brand version in order to be assessed the generic cost-share at the pharmacy.

GRIEVANCE—Any complaint or dispute other than one involving an organization determination.

INCURRED—A charge shall be considered incurred on the date the member receives the service or supply for which the charge is made.

LEGEND DRUG—Any medicinal substance which is required by the Federal Food, Drug, and Cosmetic Act to be labeled as follows: "Caution: federal law prohibits dispensing without a prescription."

LIMITATIONS—The maximum number of covered services, measured in number of dollars, visits or days, that are eligible for coverage. Limitations may vary depending on the type of program and covered services provided. Limitations, if any, are identified in the Schedule of Copayments and Limitations applicable to your current coverage.

MAIL-ORDER PHARMACY—The plan pharmacy contracted by Keystone 65 or an agent of Keystone 65 to provide prescription drugs through the mail.

MAINTENANCE PRESCRIPTION DRUG—A prescription drug, as determined by Keystone 65, used for the ongoing treatment of chronic or long-term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

NON-PLAN PHARMACY—A pharmacy which has not entered into a written agreement with an agent of Keystone 65 to render covered services to members.

NON-PLAN MAIL-ORDER PHARMACY—A mail-order pharmacy same as above.

OPTIONAL SUPPLEMENTAL BENEFITS—Additional non-Medicare covered benefits beyond the benefits included in basic benefits, which may be elected at a member's option. There is an additional plan premium associated with optional supplemental benefits. Members of Keystone 65 must voluntarily elect optional supplemental benefits in order to receive them.

PLAN MAIL-ORDER PHARMACY—A pharmacy that is a member of the Keystone 65 network and has agreed to a rate of reimbursement determined by contract to provide members with mail-order prescription drug services.

PHARMACIST—An individual, duly licensed as a pharmacist by the State Board of Pharmacy or other governing body having jurisdiction, who is employed by or associated with a pharmacy and has the authority to dispense prescription drugs.

PLAN PHARMACY—A pharmacy that has an agreement with Keystone 65 to provide the member with medication(s) prescribed by the member's contracting medical provider in accordance with Keystone 65.

PRIOR AUTHORIZATION (approval in advance)—The prior authorization (approval in advance) which the primary care physician or specialist must obtain from Keystone 65 to confirm coverage for certain covered prescription drugs for a member's medical condition to determine medical necessity. Such prior authorization must be obtained by the primary care physician or specialist prior to providing the prescription drug. Keystone 65 also reserves the right to apply eligible dispensing limits for certain covered prescription drugs. These limits result from age, gender or quantity limits as conveyed by the FDA or Keystone 65's Pharmacy and Therapeutics Committee.

PRESCRIBE OR PRESCRIBED—To write or give a prescription order.

PRESCRIPTION DRUG—Prescription drugs shall mean drugs or medications:

1. which by law require a prescription order to dispense;
2. which are approved by the plan and approved for distribution by the federal government;
3. for which medical appropriateness/medical necessity exists; and
4. which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

PRESCRIPTION DRUG COST-SHARE (Drug Copay)—The amount as shown in the Schedule of Copayments charged to the member by the plan pharmacy or the mail-service pharmacy for the dispensing or refilling of any prescription order. The member is responsible at the time of service for payment of the drug copay directly to the plan, pharmacy, or mail-service pharmacy.

PRESCRIPTION ORDER OR REFILL—The authorization for a prescription drug issued by a primary care physician or specialist who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

PRESCRIPTION UNIT—The maximum amount (quantity) of medication that may be dispensed per prescription for a single cost-share. For most oral medications, the prescription unit represents up to a thirty (30)-day supply of medication. The prescription unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the prescription unit is set at a smaller quantity for your protection and safety.

STATE RESTRICTED DRUG—Any non-federal legend drug which, according to state law, may not be dispensed without a prescription order.

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