Keystone Health Plan East

HMO 7.1 Summary of Benefits

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact IBC for authorization. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - Most 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.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefit limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Coverage
BENEFIT PERIOD	Calendar Year*
DEDUCTIBLE	
Individual	$3,000
Family	$9,000
AFTER DEDUCTIBLE, PLAN PAYS	70%
COINSURANCE LIMIT (includes coinsurance only)	
Individual	$5,000
Family	$15,000
LIFETIME MAXIMUM	Unlimited
DOCTOR'S OFFICE VISITS	
Primary Care Services	$20 Copayment, No deductible
Specialist Services	$40 Copayment, No deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, No deductible
PEDIATRIC IMMUNIZATIONS	100%, No deductible**

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount resets to $0 at the start of the calendar year on January 1.

** Office visit subject to copayment

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

Benefits are 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

Benefit	Coverage
ROUTINE EYE CARE	100%, No deductible (once every two calendar years)
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	100%, No deductible
MAMMOGRAM (no referral required)	100%, No deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year	100%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, No deductible
MATERNITY	
First OB Visit	$20 Copayment, No deductible
Hospital	70%, after deductible
INPATIENT HOSPITAL SERVICES	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited
OUTPATIENT SURGERY	70%, after deductible
EMERGENCY ROOM	70%, after deductible (not waived if admitted)
AMBULANCE	
Emergency	70%, after deductible
Non-Emergency	70%, after deductible
OUTPATIENT X-RAY RADIOLOGY+	
Routine Radiology/Diagnostic	$40 Copayment, No deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment, No deductible
THERAPY SERVICES	
Physical and Occupational 30 total visits combined per calendar year	$40 Copayment, No deductible
Cardiac Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Pulmonary Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Speech 20 visits per calendar year	$40 Copayment, No deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	$40 Copayment, No deductible
SPINAL MANIPULATIONS 20 visits per calendar year	$40 Copayment, No deductible
ALLERGY INJECTIONS (Copayment waived if no office visit is charged)	100%, No deductible
INJECTABLE MEDICATIONS	
Standard Injectables	100%, No deductible**
Biotech/Specialty Injectables	$100 Copayment, No deductible
CHEMO/RADIATION/DIALYSIS	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year	70%, after deductible
SKILLED NURSING FACILITY 120 days per calendar year	70%, after deductible
HOSPICE AND HOME HEALTH CARE	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	50%, after deductible

** Office visit subject to copayment

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

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

Benefit	Coverage
MENTAL HEALTH CARE	
Outpatient 20 visits per calendar year	$40 Copayment, No deductible
Inpatient 30 days per calendar year	70%, after deductible
SERIOUS MENTAL ILLNESS	
Outpatient 60 visits per calendar year	$40 Copayment, No deductible
Inpatient 30 days per calendar year	70%, after deductible
SUBSTANCE ABUSE TREATMENT	
Outpatient/Partial Facility Visits 60 visits per calendar year; 120 visits per lifetime	$40 Copayment, No deductible
Rehabilitation 30 days per calendar year; 90 days lifetime maximum	70%, after deductible
Detoxification 7 days per admission; 4 admissions per lifetime	70%, after deductible

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

What Is Not Covered?

- Services not medically necessary
- Routine foot care, unless medically necessary or associated with the treatment of diabetes.
- Services or supplies that are experimental or investigative except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Foot orthotics, except for orthotics and podiatric apliances required for the prevention of complications associated with diabetes
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Cranial prostheses including wigs intended to replace hair
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Routine physical exams for non preventive purposes such as insurance or employment applications, colege or premarital examinations
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute care hospital
- Reversal of voluntary sterilization
- Contraceptives, except by additional rider
- Expenses related to organ donation for non member recipients
- Immunization for travel or employment
- Alternative therapies/complementary medicine
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance or other legislation of similar purpose
- Dental care including dental implants and nonsurgical treatment of tempomandibular joint syndrome (TMJ)
- Cosmetic services/supplies
- Music therapy, equestrian therapy and hippotherapy
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Cosmetic surgery except for those services which occurred while a member of KHPE and are performed to restore bodily function or correct deformity resulting from disease, recent trauma or previous therapeutic process
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Self-injectable drugs

This summary represents only a partial listing of the benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 215-241-2240 (if calling within the Philadelphia area) or 1-800-227-3115 (outside Philadelphia).

Services That Require Precertification

INPATIENT SERVICES

- Surgical and Nonsurgical Inpatient Admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- MRI/MRA
- CT/CTA Scan
- PET Scan
- Nuclear Cardiac Studies
- Hyperbaric Oxygen
- Hysterectomy
- Cataract Surgery
- Cochlear implant surgery
- Nasal Surgery for Submucous Resection and Septoplasty
- Transplants (except Cornea)
- Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
- Obesity Surgery
- Day Rehabilitation Programs
- Dental Services as a Result of Accidental Injury
- Uvulopalatopharyngoplasty (including laser-assisted)

ALL HOME CARE SERVICES (including infusion therapy in the home)

INFUSION THERAPY DRUGS in an OUTPATIENT FACILITY or in a PROFESSIONAL PROFESSIONAL PROVIDER'S OFFICE
(See list included in your Open Enrollment packet)

MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

ELECTIVE (NON-EMERGENCY) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS
Purchase items over $500, including repairs and replacements (except ostomy supplies)

DURABLE MEDICAL EQUIPMENT
Purchase items over $500 including, repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES

- Blepharoplasty/ptsosis repair
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical Peels
- Dermabrasion
- Excision of excessive skin and/or subcutaneous tissue
- Genetically and bio-engineered skin substitutes for wound care
- Hair transplant
- Injectable dermal fillers
- Keloid Removal
- Labiaplasty
- Lipectomy, Liposuction, or any other excess fat removal procedure
- Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar Revision
- Skin closures, including skin grafts, skin flaps, tissue grafts
- Sex reassignment surgery
- Surgical treatment of gynecomastia
- Surgery for varicose veins, including perforators and sclerotherapy

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

- Mental health and serious mental illness treatment
  (Inpatient/partial hospitalization programs/intensive outpatient programs)
- Substance Abuse Treatment
  (Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS
(see list included in your open enrollment packet)

SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES

Preapproval 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 benefit plan when the preapproval is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefit plan that apply to the coverage request. Preapproval list subject to change annually.

In addition to the preapproval requirements listed above, you should contact Independence Blue Cross and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. The categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents 'new or emerging technology;' and
- Services that might be considered experimental/investigative.

Your PCP or other network provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories and should generally provide this prenotification to you.

PENALTIES:

It is the network provider's responsibility to obtain preapproval for the services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.