

Keystone 15 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 by a Keystone Primary Care Physician. Your Keystone Primary Care Physician may also refer you to other Keystone providers for care, if needed.

This program may not cover all your health care services. Services may not be covered because they are:

- Not covered under your benefit contract
- Not medically necessary
- Limited by a benefit maximum (i.e. visit limit)

Your Member Handbook identifies details about your benefit program. It also includes information about exclusions and benefit limitations. After reviewing this information, please contact our Member Service department if you have additional questions.

Benefit	Benefits and Services	Coverage
Doctor Visits	Office visits to your primary care physician	\$15 Copayment
	Home visits by your primary care physician	\$25 Copayment
	Non-routine after hours visits to your primary care physician	\$25 Copayment
	Office visits to referred specialists	\$15 Copayment
Preventive Health Services	Periodic health assessment	\$15 Copayment
	Immunizations (except for travel or employment)	\$15 Copayment
	Routine gynecological care (no referral required)	\$15 Copayment
	Mammography (no referral required)	Covered 100%
	Well-baby/Well-child care	\$15 Copayment
Maternity	Obstetrical care (including pre- and postnatal care)	Covered with a \$15 copaym for the first visit. Subsequen visits to your OB/GYN cove 100%
	Newborn care (both doctor and hospital)	Covered 100%
Hospital Services*	Unlimited inpatient stay	Covered 100%
	Surgery	Covered 100%
	Anesthesia	Covered 100%

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	Drugs and medication	Covered 100%
	Inpatient doctor care	Covered 100%
	General nursing care	Covered 100%
	Administration of blood	Covered 100%
	Organ transplantation, non-experimental	Covered 100%
Emergency Care	Treatment in hospital emergency room	Covered with a \$35 copaym (which is waived if you are admitted to the hospital)
	Ambulance service	Covered 100% when medic necessary
Specialized Services	Allergy testing and treatment	Covered 100%**
	Diagnostic, Laboratory and X-ray services	Covered 100%
	Short-term Rehabilitation Therapy (including Speech*, Occupational and Physical Therapy)	Covered 100%. Up to 60 consecutive days per condit covered, subject to significa improvement
	Respiratory Therapy*	Covered 100%
	Chemotherapy*	Covered 100%
	Radiation Therapy*	Covered 100%
	Vision Care, including screening, eye exams and refractions	Covered 100% once every t calendar years**
	Hearing Screening	Covered 100%**
	Skilled nursing facility services, as specified*	Covered 100% up to 180 da per calendar year
	Outpatient Surgery*	Covered 100%
	Durable Medical Equipment*	Rental or purchase covered 100% when authorized by Primary Care Physician and pre-approved by KHPE
	Home Health Care*	Covered 100%
	Dialysis*	Covered 100%
	Mental Health Care, as specified	20 outpatient visits per cale year covered with a \$25 per copayment per visit. 35 inpa days per calendar year cove in full*

Serious Mental Illness	4 15	60 outpatient days/visits per calendar year covered with \$25 copayment per visit. 30 inpatient days per calendar year covered in full*
Treatment for Substance Abuse		60 outpatient visits per calendar year covered with a \$15 copayment per visit. 30 inpatient days per calendar year covered in full* (lifetime limits of 120 outpatient visits and 90 inpatient days)
Annual Copay Maximum		\$1,000 per person or \$2,000 family annually

*Pre-authorization required. Pre-authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of health benefits plan that apply to the coverage request.

**Office visits subject to copay

Independence Blue Cross and Keystone Health Plan East (KHPE) are independent licensees of the Blue Cross and Blue Shield Association. Benefits underwritten or administered by KHPE.

Benefits and Services Not Covered

As with all health insurance plans, KHPE's coverage excludes certain services. Those not covered by KHPE include, but are not limited to, the following:

- Services not medically necessary
- Services not provided or referred by your primary care physician, except in emergencies
- Experimental and investigational services or items
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premar examinations
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- The cost of services for which another party has primary responsibility
- Care for military service connected disabilities when appropriate government facilities are reasonably accessible
- Long-term rehabilitative therapy (e.g. maintenance of chronic conditions)
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute care hospital
- Hearing Aids
- Radial keratotomy
- Custodial or domiciliary care
- Weight loss programs except when provided through Healthy LifestylesSM1 programs
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones or similar items
- Normal deliveries outside the KHPE service area within 30 days of the estimated delivery date
- Contraceptive devices and birth control pills, except by additional benefit rider
- In-vitro fertilization, embryo transplant, and ovum retrieval
- Reversal of voluntary sterilization
- Transsexual surgery
- Cosmetic surgery except for those services which are performed to restore bodily function or correct deformity resulting from disease, recent trauma or previous therapeutic process
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or by additional rider

- Whole blood or blood plasma
- Treatment for temporomandibular joint syndrome (TMJ)
- Care of the feet, unless medically necessary
- Services required by a member who is an organ donor
- Dental care including, but not limited to, orthognathic surgery, unless as a result of an accident
- Treatment for injuries sustained while committing a felony

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all your health care expenses. 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 Philadelphia) or 1-800-227-3115 (outside Philadelphia).