Keystone Health Plan East

HMO 1.1 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*
Doctor's Office Visits	
Primary Care Services	$10 Copayment
Specialist Services	$20 Copayment
Preventive Care for Adults and Children	100%
Pediatric Immunizations	100% (office visit copayment does not apply)
Routine Eye Exam	100%
Routine Gynecological Exam/PAP 1 per calendar year for women of any age (No referral required)	100%
Mammogram (No referral required)	100%
Nutrition Counseling for Weight Management 6 visits per calendar year	100%

* 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.

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

Independence Blue Cross

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

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Benefit	Coverage
Outpatient Laboratory/Pathology	100%
Maternity	
First OB Visit	$10 Copayment
Hospital	100%
Inpatient Hospital Services	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	100%
Emergency Room	$100 Copayment (not waived if admitted)
Ambulance	
Emergency	100%
Non-Emergency	100%
Outpatient X-Ray/Radiology+	
Routine Radiology/Diagnostic	$20 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	$40 Copayment
Therapy Services	
Physical and Occupational 30 total visits combined per calendar year	$20 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$20 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$20 Copayment
Speech 20 visits per calendar year	$20 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	$20 Copayment
Spinal Manipulations 20 visits per calendar year	$20 Copayment
Allergy Injections (Copayment waived if no office visit is charged)	100%
Injectable Medications	
Standard Injectables	100%**
Biotech/Specialty Injectables	$50 Copayment
Chemo/Radiation/Dialysis	100%
Outpatient Private Duty Nursing 360 hours per calendar year	90%
Skilled Nursing Facility 120 days per calendar year	100%
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%

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

** Office visits subject to copayment.

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Benefit	Coverage
Mental Health Care	
Outpatient 20 visits per calendar year	$20 Copayment
Inpatient 30 days per calendar year	100%
Serious Mental Illness Care	
Outpatient 60 visits per calendar year	$20 Copayment
Inpatient 30 days per calendar year	100%
Substance Abuse Treatment	
Outpatient/Partial Facility Visits 60 visits per calendar year, 120 visit lifetime maximum	$20 Copayment
Rehabilitation 30 days per calendar year, 90 day lifetime maximum	100%
Detoxification 7 days per admission, 4 admissions per lifetime	100%
Annual Copayment Maximum (includes copayments only)	
Individual	Not Applicable
Family	Not Applicable

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What Is Not Covered?

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

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 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 Philadelphia) 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 benefits 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 benefits 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 for 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.