Keystone Health Plan East

Keystone 2

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** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory 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	Benefits and Services	Coverage
Doctor Visits	Office visits to your Primary Care Physician	$2 copayment
	Home visits by your Primary Care Physician	$5 copayment
	Non-routine after hours visits to your Primary Care Physician	$5 copayment
	Office visits to referred specialists	Covered 100%
	Preventive Care for Adults and Children	Covered 100%
Preventive Health Services	Pediatric Immunizations (except for travel or employment)	Covered 100% (office visit copayment does not apply)
	Routine gynecological care (no referral required)	Covered 100%
	Mammography (no referral required)	Covered 100%
	Nutrition Counseling for Weight Management 6 visits per calendar year	Covered 100%
Maternity	Obstetrical care (including pre- and postnatal care)	Covered 100%
	Newborn care (both doctor and hospital)	Covered 100%

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

Independence

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	Benefits and Services	Coverage
Hospital Services*	Unlimited inpatient stay	Covered 100%
	Surgery	Covered 100%
	Anesthesia	Covered 100%
	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 $15 copayment (which is waived if you are admitted to the hospital)
Urgent Care Center	Treatment received in urgent care facility	Covered with a $10 copayment
Ambulance	Emergency	Covered 100% when medically necessary
	Non-Emergency*	Covered 100% when medically 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 condition covered, subject to significant improvement
	Spinal Manipulation Services	Covered 100%. Up to 60 consecutive days per condition covered, subject to significant improvement
	Orthoptic/Pleoptic	Covered 100%. 8 sessions maximum per lifetime
	Respiratory Therapy	Covered 100%
	Chemotherapy	Covered 100%
	Radiation Therapy	Covered 100%
	Vision Care, including screening, eye exams, and refractions	Covered 100% (once every two calendar years)
	Hearing Screening	Covered 100%**
	Skilled nursing facility services, as specified*	Covered 100% up to 180 days per calendar year
	Outpatient Surgery*	Covered 100%
	Durable Medical Equipment*	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by your Primary Care Physician[1]

* 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

** Office visit subject to copayment.

*** MRI, MRA, CT/CTA scan, PET scan, and Nuclear Cardiac Studies require preauthorization.

1 Purchases over $500 and all rentals require preauthorization.

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Benefit	Benefits and Services	Coverage
Specialized Services (Continued)	Prosthetics*	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by your Primary Care Physician[1]
	Home Health Care*	Covered 100%
	Dialysis	Covered 100%
Mental Health	Inpatient*	Covered 100%
	Outpatient	Covered 100%
Serious Mental Illness (SMI)	Inpatient*	Covered 100%
	Outpatient	Covered 100%
Substance Abuse	Inpatient*	Covered 100%
	Outpatient	Covered 100%
Detoxification	Inpatient*	Covered 100%
	Outpatient	Covered 100%
Out-of-Pocket Maximum** (includes copayments only)	Individual	$500
	Family	$1500

* 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

**** Once the annual copayment maximum amount has been reached, please contact member services. You will be asked to supply copay receipts to demonstrate that the maximum has been met.

1 Purchases over $500 and all rentals require preauthorization.

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

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
- Service 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
- 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
- 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, 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
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- 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
- Services required by a member who is an organ donor
- Dental care, including dental implants
- 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 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).