

Keystone Health Plan East

Keystone 105 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 benefits contract
- Not medically necessary
- Limited by a benefits maximum (i.e. visit limit)

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

Benefit	Benefits and Services	Coverage
Doctor Visits	Office visits to your Primary Care Physician	\$5 copayment
	Home visits by your Primary Care Physician	\$10 copayment
	Non-routine after hours visits to your Primary Care Physician	\$10 copayment
	Office visits to referred specialists	\$25 copayment
Preventive Health Services	Periodic health assessment	\$5 copayment
	Immunizations (except for travel or employment)	Covered 100%**
	Routine gynecological care (no referral required)	\$25 copayment
	Mammography (no referral required)	Covered 100%
	Well-baby/Well-child care	\$5 copayment
Maternity	Obstetrical care (including pre- and postnatal care)	Covered with a \$25 copayment for first visit. Subsequent visits to your OB/GYN covered 100%. Inpatient admission covered with a \$100 copayment per admission
	Newborn care (both doctor and hospital)	Covered 100%

** Office visits subject to copayment.

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 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	\$100 copayment per admission (waived if readmitted within 90 days of discharge for same diagnosis)
	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 \$50 copayment (which is waived if you are admitted to the hospital)
	Ambulance service	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	\$25 copayment (once every two calendar years)
	Hearing Screening	Covered 100%**
Skilled nursing facility services, as specified* ¹	Covered 100% up to 180 days per calendar year	

* 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 visits subject to copayment.

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

¹ Inpatient Hospital copay applies if admitted without prior hospital stay.

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Benefit	Benefits and Services	Coverage
Specialized Services (Continued)	Outpatient Surgery*	Covered 100%
	Durable Medical Equipment*	Rental or purchase including repairs and replacements covered 100% when authorized by Primary Care Physician and preapproved by KHPE
	Prosthetics*	Purchase covered 100% when authorized by Primary Care Physician and preapproved by KHPE, including repairs and replacements
	Home Health Care*	Covered 100%
	Dialysis	Covered 100%
	Mental Health Care, as specified	20 outpatient visits per calendar year covered with a \$25 copayment per visit. 35 inpatient days per calendar year with a \$100 copayment per admission.*
	Serious Mental Illness	60 outpatient days/visits per calendar year covered with a \$25 copayment per visit. 30 inpatient days per calendar year covered with a \$100 copayment per admission.*
	Treatment for Substance Abuse	60 outpatient visits per calendar year covered with a \$25 copayment per visit. 30 inpatient days per calendar year covered with a \$100 copayment per admission.* (lifetime limits of 120 outpatient visits and 90 inpatient days)
	Detoxification	7 outpatient visits/sessions per episode covered with a \$25 copayment. 7 inpatient days per admission covered with a \$100 copayment per admission.* (lifetime limits of 4 outpatient episodes and 4 inpatient admissions)
	Annual Copayment Maximum	\$1,000 per person or \$2,000 per family annually

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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
- Contraceptive devices and birth control pills, except by additional benefits rider
- 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

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).