Keystone Health Plan East

HMO C2-F2

Univ of Pennsylvania

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	Coverage
Benefit Period	Contract year*
Deductible	
Individual	$100
Family	$200
Coinsurance	90%, after deductible
Out-of-Pocket Maximum *(includes deductible, coinsurance, and copays)*	
Individual	$1,200
Family	$2,400
Doctor's Office Visits	
Primary Care Services	$25 Copayment, no deductible
Specialist Services	$45 Copayment, no deductible
Preventive Care For Adults and Children	100%, no deductible
Pediatric Immunizations	100%, no deductible (office visit copay does not apply)
Routine Eye Exam	$35 Copayment, no deductible (once every two years)

* Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period that begins on your employer's effective date which is July 1, 2017.

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	Coverage
Routine Gynecological Exam/PAP *1 per plan year for women of any age (No referral required)*	100%, no deductible
Mammogram *(No referral required)*	100%, no deductible
Nutrition Counseling For Weight Management *6 visits per plan year*	100%, no deductible
Outpatient Laboratory/Pathology	$25 copayment, no deductible
Assisted Reproductive Technologies (only at HUP) *Invitro Fertilization limited to 2 cycles per lifetime*	Covered at 90% after deductible, after initial office visit copayment
Maternity	
First OB Visit***	$35 Copayment, no deductible
Hospital	90%, after deductible
Inpatient Hospital Services	
Facility	90%, after deductible
Physician/Surgeon	90%, after deductible
Inpatient Hospital Days	Unlimited
Outpatient Surgery**	
Facility	90%, after deductible
Physician/Surgeon	90%, after deductible
Emergency Room	$150 Copayment (waived if admitted)
Urgent Care Facility	$50 Copayment
Retail Clinic	$25 Copayment
Ambulance	
Emergency	100%
Non-emergency	90%, after deductible
Outpatient X-Ray/Radiology+	
Routine Radiology/Diagnostic	$40 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	$100 Copayment
Therapy Services	
Physical and Occupational 60 total visits combined per plan year	$35 Copayment, no deductible
Cardiac Rehabilitation 36 visits per plan year	$35 Copayment, no deductible
Pulmonary Rehabilitation 36 visits per plan year	$35 Copayment, no deductible
Speech 60 visits per plan year	$35 Copayment, no deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	$35 Copayment, no deductible
Spinal Manipulations *60 visits per plan year*	$45 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	$50 Copayment, no deductible
Chemo/Radiation/Dialysis	90%, after deductible
Outpatient Private Duty Nursing	90%, after deductible

** Office visits subject to copayment

*** Tubal ligation is covered at 100%, no deductible under Keystone Network.

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

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Benefit	Coverage
Skilled Nursing Facility *180 days per plan year*	90%, after deductible
Hospice and Home Health Care	90%, after deductible
Durable Medical Equipment and Prosthetics *includes coverage for wigs*	90%, after deductible
Contraceptive Devices	100%, no deductible
Mental Health Care	
Outpatient	$25 Copayment, no deductible
Inpatient	90%, after deductible
Serious Mental Illness Care	
Outpatient	$25 Copayment, no deductible
Inpatient	90%, after deductible
Substance Abuse Treatment	
Outpatient/Partial Facility Visits	$25 Copayment, no deductible
Rehabilitation	90%, after deductible
Detoxification	90%, after deductible

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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
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- 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
- 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
- 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 1-800-ASK-BLUE (1-800-275-2583).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.