Please be aware, benefit explanations are updated each year and when the carrier issues a policy change in writing.

TheAdministratorsInc.com
BenefitHelp@TheAdministratorsInc.com
800-634-4428

Keystone Health Plan East

C3-F4 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 (e.g., 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	Coverage
Doctor's Office Visits	
Primary Care Services	$20 Copayment
Specialist Services	$40 Copayment
Pediatric Immunizations	100%*
Routine Eye Exam	$40 Copayment (once every two years)
Routine Gynecological Exam/PAP 1 per calendar year for women of any age (No referral required)	$20 Copayment
Mammogram (No referral required)	100%
Nutrition Counseling For Weight Management 6 visits per calendar year	100%
Outpatient Laboratory/Pathology	100%
Maternity	
First OB Visit	$20 Copayment
Hospital	$250/day; maximum of 5 Copayments/admission**
Inpatient Hospital Services	$250/day; maximum of 5 Copayments/admission**

* Office visit subject to copayment.

** Copayment waived if readmitted within 90 days of discharge for any condition.

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
Inpatient Hospital Days	Unlimited
Outpatient Surgery	$125 Copayment
Emergency Room	$100 Copayment (not waived if admitted)
Ambulance	100%
Outpatient X-Ray/Radiology+	
Routine Radiology/Diagnostic	$40 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment
Therapy Services	
Physical and Occupational 30 visits per calendar year	$40 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$40 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$40 Copayment
Speech 20 visits per calendar year	$40 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	$40 Copayment
Spinal Manipulations 20 visits per calendar year	$40 Copayment
Injectable Medications	
Standard Injectables	100%
Biotech/Specialty Injectables	$100 Copayment
Chemo/Radiation/Dialysis	100%
Outpatient Private Duty Nursing 360 hours per calendar year	85%
Skilled Nursing Facility 120 days per calendar year	$125/day; maximum of 5 Copayments/admission**
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%
Mental Health Care	
Outpatient 20 visits per calendar year	$40 Copayment**
Inpatient 30 days per calendar year	$250/day; maximum of 5 Copayments/admission**

** Copayment waived if readmitted within 90 days of discharge for any condition.

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

Benefit	Coverage
Serious Mental Illness Care	
Outpatient 60 visits per calendar year	$40 Copayment**
Inpatient 30 days per calendar year	$250/day; maximum of 5 Copayments/admission**
Substance Abuse Treatment	
Outpatient/Partial Facility Visits 60 visits per calendar year, 120 visits lifetime maximum	$40 Copayment
Rehabilitation 30 days per calendar year, 90 days lifetime maximum	$250/day; maximum of 5 Copayments/admission**
Detoxification 4 admissions per lifetime	$250/day; maximum of 5 Copayments/admission**
Annual Copayment Maximum	
Individual	$3,000
Family	$6,000

** Copayment waived if readmitted within 90 days of discharge for any condition.

What Is Not Covered?

- Services not medically necessary
- Services or supplies which 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
- 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
- Cranial prostheses including wigs intended to replace hair
- 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 (effective 1/1/2010)

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 Preapproval

INPATIENT SERVICES

- Surgical and Nonsurgical Inpatient Admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice
- Maternity Admission (for notification only)

OUTPATIENT FACILITY/OFFICE SERVICES
(other than inpatient)

- MRI/MRA
- CT/CTA Scan
- PET Scan
- Nuclear Cardiac Studies
- Hysterectomy
- Cataract Surgery
- Nasal Surgery for Submucous Resection and Septoplasty
- Transplants (except cornea)
- Comprehensive Outpatient Pain Management Programs (including epidural injections)
- Obesity Surgery
- Sleep Studies
- 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)

BIRTHING CENTER (for notification 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

- Abdominoplasty
- Augmentation Mammoplasty
- Blepharoplasty
- Chemical Peels
- Dermabrasion
- Excision of Redundant Skin
- Keloid Removal
- Lipectomy/Liposuction
- Orthognathic Surgery Procedures
- Mastopexy
- Otoplasty
- Panniculectomy
- Reduction Mammoplasty
- Removal or Reinsertion of Breast Implants
- Rhinoplasty
- Surgery for Varicose Veins
- Scar Revision
- Subcutaneous Mastectomy for Gynecomastia

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

- Mental Health & 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.