Keystone Health Plan East

Summary of Benefits

Temple University

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 (e.g., 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	$10 copayment
	Home visits by your Primary Care Physician	$15 copayment
	Non-routine after hours visits to your Primary Care Physician	$15 copayment
	Office visits to referred specialists	$15 copayment
	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)
	Immunizations (except for travel or employment)	Covered 100%
	Routine gynecological care (no referral required)	Covered 100%

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

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
Preventive Health Services (Continued)	Mammography (no referral required)	Covered 100%
	Nutrition Counseling For Weight Management 6 visits per calendar year	Covered 100%
	Well-baby/well-child care	Covered 100%
Maternity	Obstetrical care (including pre- and postnatal care)	Covered with a $15 copayment for first visit. Subsequent visits to your OB/GYN covered 100%.
	Newborn care (both doctor and hospital)	Covered 100%
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 $35 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

* 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.

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

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Benefit	Benefits and Services	Coverage
Specialized Services (Continued)	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	$15 copayment (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]
	Prosthetics*	All purchases (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 Care	Inpatient Covered 100% Outpatient $15 Copayment
	Serious Mental Illness (SMI)	Inpatient Covered 100% Outpatient $15 Copayment
	Substance Abuse	Inpatient Covered 100% Outpatient $15 Copayment
	Detoxification	Inpatient Covered 100% Outpatient $15 Copayment
	Annual Copayment Maximum (includes copayments only)****	$1,000 per person or $2,000 per family annually

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** Office visit subject to copayment.

1 Purchases over $500 and all rentals require preauthorization.

**** 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.

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What is 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
- Services 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)
- Hearing Aids, hearing examinations/tests for the prescription/fitting of hearing aids and cochlear electromagnetic hearing devices
- Radial keratotomy
- Custodial or domiciliary care
- Assisted fertilization techniques such as in-vitro fertiliation, GIFT, and ZIFT
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones, or similar items
- Contraceptives, except by additional rider
- Reversal of voluntary sterilization
- Transsexual surgery
- Cosmetic services/supplies
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or 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 (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 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 (275-2583).