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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefits and Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period</td>
<td>Contract Year&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Contract Year&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Deductible</td>
<td>Individual $250</td>
<td>Family $500</td>
</tr>
<tr>
<td>Doctor Visits</td>
<td>Office visits to your Primary Care Physician $20 copayment, no deductible</td>
<td></td>
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<tr>
<td></td>
<td>Home visits by your Primary Care Physician $25 copayment, no deductible</td>
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<tr>
<td></td>
<td>Non-routine after hours visits to your Primary Care Physician $25 copayment, no deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits to referred specialists $30 copayment, no deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care for adults and children Covered 100%, no deductible</td>
<td></td>
</tr>
</tbody>
</table>

2 A contract year benefit period begins on July 1 and ends June 30. The out of pocket maximum amount starts at $0 at the beginning of each contract year on July 1.

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

3 Copayment waived if readmitted within 10 days of discharge
<table>
<thead>
<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>Preventive Health Services</td>
<td>Pediatric Immunizations (except for travel or employment)</td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Immunizations (except for travel or employment)</td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Routine gynecological care (no referral required)</td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Mammography (no referral required)</td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Nutrition Counseling For Weight Management 6 visits per contract year</td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Well-baby/well-child care</td>
<td>Covered 100%, no deductible</td>
</tr>
</tbody>
</table>
| Maternity                       | Obstetrical care (including pre- and postnatal care)       | Covered with a $20 copayment, no deductible for first visit. Subsequent visits to your OB/GYN covered 100%.
|                                 | Newborn care (both doctor and hospital)                    | Doctor services covered 100%, no deductible. Hospital Services covered $100 copay per day, no deductible; maximum of 3 copayments per admission³ |
| Hospital Services³              | Unlimited inpatient stay                                  | $100 copay per day, no deductible; maximum of 3 copayments per admission³ |
|                                 | Surgery                                                   | Covered 100%, after deductible                    |
|                                 | Anesthesia                                                | Covered 100%, after deductible                    |
|                                 | Drugs and medication                                      | Covered 100%, after deductible                    |
|                                 | Inpatient doctor care                                      | Covered 100%, after deductible                    |
|                                 | General nursing care                                       | Covered 100%, after deductible                    |
|                                 | Administration of blood                                   | Covered 100%, after deductible                    |
|                                 | Organ transplantation, non-experimental                   | Covered 100%, after deductible                    |
| Emergency Care                  | Treatment in hospital emergency room                      | Covered with a $100 copayment, no deductible (which is waived if you are admitted to the hospital) |
| Urgent Care Center              | Treatment received in urgent care facility                | $50 Copayment, no deductible                      |
| Ambulance                       | Emergency                                                 | Covered 100%, no deductible, when medically necessary |
|                                 | Non-Emergency                                             | Covered 100%, no deductible, when medically necessary |
| Specialized Services            | Allergy testing and treatment                             | Covered 100%, no deductible                       |
|                                 | Diagnostic, Laboratory, and X-ray services³               | Covered 100%, no deductible                       |

* 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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³ Copayment waived if readmitted within 10 days of discharge
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<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialized Services (Continued)</strong></td>
<td><strong>Short-term Rehabilitation Therapy (including Speech, Occupational, and Physical Therapy)</strong></td>
<td>Covered 100%, no deductible. Up to 60 consecutive days per condition covered, subject to significant improvement</td>
</tr>
<tr>
<td></td>
<td><strong>Spinal Manipulation Services</strong></td>
<td>Covered 100%, no deductible. Up to 60 consecutive days per condition covered, subject to significant improvement</td>
</tr>
<tr>
<td></td>
<td><strong>Orthoptic/Pleoptic</strong></td>
<td>Covered 100%, no deductible. 8 sessions maximum per lifetime</td>
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<tr>
<td></td>
<td><strong>Respiratory Therapy</strong></td>
<td>Covered 100%, no deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Chemotherapy</strong></td>
<td>Covered 100%, after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Radiation Therapy</strong></td>
<td>Covered 100%, after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Vision Care, including screening, eye exams, and refractions</strong></td>
<td>$30 copayment, no deductible (once every two contract years)</td>
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<td></td>
<td><strong>Hearing Screening</strong></td>
<td>Covered 100%, no deductible**</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing facility services, as specified</strong></td>
<td>Covered 100%, after deductible up to 180 days per contract year</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient Surgery</strong></td>
<td>Covered 100%, after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Durable Medical Equipment</strong></td>
<td>All purchases and rentals (including repairs and replacements) are covered 100%, after deductible, when authorized by your Primary Care Physician</td>
</tr>
<tr>
<td></td>
<td><strong>Prosthetics</strong></td>
<td>All purchases (including repairs and replacements) are covered 100%, after deductible, when authorized by your Primary Care Physician</td>
</tr>
<tr>
<td></td>
<td><strong>Home Health Care</strong></td>
<td>Covered 100%, after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Dialysis</strong></td>
<td>Covered 100%, after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Care</strong></td>
<td>Inpatient covered $100 copay per day, no deductible; maximum of 3 copayments per admission*; Outpatient $30 Copayment, no deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Serious Mental Illness (SMI)</strong></td>
<td>Inpatient covered $100 copay per day, no deductible; maximum of 3 copayments per admission*; Outpatient $30 Copayment, no deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Substance Abuse</strong></td>
<td>Inpatient covered $100 copay per day, no deductible; maximum of 3 copayments per admission*; Outpatient $30 Copayment, no deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Detoxification</strong></td>
<td>Inpatient covered $100 copay per day, no deductible; maximum of 3 copayments per admission*; Outpatient $30 Copayment, no deductible</td>
</tr>
</tbody>
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** Office visit subject to copayment.

1 Precertification required on certain services.

3 Copayment waived if readmitted within 10 days of discharge.

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<tbody>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Individual</td>
<td>$4,400</td>
</tr>
<tr>
<td>(includes deductible, coinsurance</td>
<td>Family</td>
<td>$13,200</td>
</tr>
<tr>
<td>and copayments)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

3 Copayment waived if readmitted within 10 days of discharge
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 fertilization, GIFT, and ZIFT
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones, or similar items
- 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

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).