Keystone Health Plan East

Deductible Plan - D4 N2

DELCO TRUST

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	$1,000
Family	$3,000
AFTER DEDUCTIBLE, PLAN PAYS	80%
OUT-OF-POCKET MAXIMUM* **	
Individual	$4,200
Family	$12,600
LIFETIME MAXIMUM	Unlimited
DOCTOR'S OFFICE VISITS	
Primary Care Services	$20 Copayment, No deductible
Specialist Services	$40 Copayment, No deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, No deductible
PEDIATRIC IMMUNIZATIONS	100%, No deductible**
ROUTINE EYE CARE	$40 Copayment, No deductible (once every two calendar years)

* A contract year benefit period is a consecutive 12-month period that begins on your employer's effective date. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each contract year.

** Office visit subject to copayment

*** In-Network Out-of-Pocket Maximum includes copayments, coinsurance and deductible.

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.

www.ibx.com

Benefit	Coverage
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per calendar year for women of any age*	100%, No deductible
MAMMOGRAM (no referral required)	100%, No deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per calendar year*	100%, No deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, No deductible
MATERNITY	
First OB Visit	$20 Copayment, No deductible
Hospital	80%, after deductible
INPATIENT HOSPITAL SERVICES	
Facility	80%, after deductible
Physician/Surgeon	80%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited
OUTPATIENT SURGERY	
Facility	80%, after deductible
Physician/Surgeon	80%, after deductible
EMERGENCY ROOM	80%, after deductible (not waived if admitted)
URGENT CARE CENTER	80%, after deductible
AMBULANCE	
Emergency	80%, after deductible
Non-Emergency	80%, after deductible
OUTPATIENT X-RAY RADIOLOGY+	
Routine Radiology/Diagnostic	$40 Copayment, No deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment, No deductible
THERAPY SERVICES	
Physical and Occupational 30 total visits combined per calendar year	$40 Copayment, No deductible
Cardiac Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Pulmonary Rehabilitation 36 visits per calendar year	$40 Copayment, No deductible
Speech 20 visits per calendar year	$40 Copayment, No deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	$40 Copayment, No deductible
SPINAL MANIPULATIONS *20 visits per calendar year*	$40 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	$100 Copayment, No deductible
CHEMO/RADIATION/DIALYSIS	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per calendar year*	80%, after deductible
SKILLED NURSING FACILITY *120 days per calendar year*	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%, no deductible

** Office visit subject to copayment

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

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Benefit	Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	50%, after deductible
MENTAL HEALTH CARE	
Outpatient	$40 Copayment, No deductible
Inpatient	80%, after deductible
SERIOUS MENTAL ILLNESS	
Outpatient	$40 Copayment, No deductible
Inpatient	80%, after deductible
SUBSTANCE ABUSE TREATMENT	
Outpatient/Partial Facility Visits	$40 Copayment, No deductible
Rehabilitation	80%, after deductible
Detoxification	80%, after deductible

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What Is Not Covered?

- Services not medically necessary
- Routine foot care, unless medically necessary or associated with the treatment of diabetes.
- Services or supplies that are experimental or investigative except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Foot orthotics, except for orthotics and podiatric apliances required for the prevention of complications associated with diabetes
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Cranial prostheses including wigs intended to replace hair
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Routine physical exams for non preventive purposes such as insurance or employment applications, colege or premarital examinations
- Non-medical, rehabilitative services for the treatment of substance abuse in an acute care hospital
- Reversal of voluntary sterilization
- Expenses related to organ donation for non member recipients
- Immunization for travel or employment
- Alternative therapies/Complementary medicine
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance or other legislation of similar purpose
- Dental care including dental implants and nonsurgical treatment of tempomandibular joint syndrome (TMJ)
- Cosmetic services/supplies
- Music therapy, equestrian therapy, and hippotherapy
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Cosmetic surgery except for those services which occurred while a member of KHPE and are performed to restore bodily function or correct deformity resulting from disease, recent trauma or previous therapeutic process
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Self-injectable drugs

This summary represents only a partial listing of the 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 the Philadelphia area) or 1-800-227-3115 (outside Philadelphia).

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.