



Medical Benefit Highlights

Keystone Health Plan East HMO \$15/\$30 AFSCME DC 47

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	Referred	Out-of-Network
Deductible		
Individual/Family	\$0/\$0	Not covered
Out-of-Pocket Maximum (Embedded) ¹		
Individual/Family	\$5,000/\$10,000	Not covered
Coinsurance	0%	Not covered
Preventive Services		
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Physician Services		
Primary Care Physician (PCP) Office Visit	\$15	Not covered
Specialist Office Visit	\$30	Not covered
Retail Health Clinic Visit	\$15	Not covered
Telemedicine	No charge	Not covered
Urgent Care Visit	\$40	Not covered
Therapy Services		
Physical Therapy (30 visits/year) ²		
Freestanding	\$20	Not covered
Hospital Based	\$20	Not covered
Occupational Therapy (30 visits/year) ²		
Freestanding	\$20	Not covered
Hospital Based	\$20	Not covered
Speech Therapy (20 visits/year)	\$20	Not covered
Emergency Services		
Emergency Room (copay not waived if admitted)	\$150	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	Not covered
Hospital Services		
Inpatient Hospital Services	\$100/Day; max of 5 copays per admission	Not covered
Observation Services	No charge	Not covered
Maternity Hospital Services	\$100/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	Not covered
Outpatient Surgery		
Freestanding	\$50	Not covered
Hospital Based	\$50	Not covered

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Outpatient Professional Services	No charge	Not covered
Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	\$30	Not covered
Routine Radiology (X-Ray)		
Freestanding	\$30	Not covered
Hospital Based	\$30	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$30	Not covered
Hospital Based	\$30	Not covered
Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (60 consecutive days/year)	No charge	Not covered
Acupuncture (18 visits/year)	\$30	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables		
Home/Office	No charge	Not covered
Outpatient	No charge	Not covered
Chemotherapy	No charge	Not covered
Dialysis	No charge	Not covered
Skilled Nursing Facility	\$100/Day; max of 5 copays per admission	Not covered
Home Health	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment (DME)	No charge	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$30	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	\$100/Day; max of 5 copays per admission	Not covered
Infertility Treatment – (covers artificial insemination and assisted reproductive technology; \$15,000 lifetime limit)	No charge	Not covered
Routine Eye Care	\$30	Not covered

¹ Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

² Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

Keystone 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.

This summary represents only a partial listing of benefits and exclusions of the Medical 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. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit

Reference ID: 1003683805012020

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www.ibx.com/LGBooklet or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

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.

Benefits underwritten or 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