Keystone Point-of-Service

Keystone 15S

Keystone HEALTH PLAN EAST
POINT-OF-SERVICE

Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

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.
- **Preauthorization** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. For in-network (referred) services, your participating provider will contact IBC for authorization. For out-of-network (self-referred) services, you are responsible for obtaining approval for certain services. For more information on the services requiring precertification, please refer to the Keystone Health Plan East benefits that require preauthorization flyer included in the enrollment kit.
- **Designated site** - Most 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 benefits 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	Referred	Self-Referred*
Benefit Period	Calendar Year[5]	Calendar Year[5]
Deductible		
Individual	None	$1,000
Family	None	$3,000
Coinsurance	None	50%
Out-of-Pocket Maximum[6]		
Individual	$1,500	$10,000[7]
Family	$3,000	$30,000[7]
Lifetime Maximum	Unlimited	Unlimited
Primary Care Physician		
Office Hours	$15 Copayment	50% after deductible
After Hours/Home Visits	$25 Copayment	50% after deductible
Pediatric Immunizations	100% (office visit copayment does not apply)	50% (no deductible)

* Out-of-network providers may bill you for any difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

5 A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount starts at $0 at the beginning of each calendar year on January 1.

6 In-network out-of-pocket maximum includes copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

7 Coinsurance and deductible applied to self-referred participating providers will accumulate toward the referred/in-network out-of-pocket maximum.

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

To receive maximum benefits, services must be provided or referred by your Keystone Primary Care Physician. This is a highlight of benefits available. The benefits and exclusions for Referred Care and Self-Referred Care are not the same. All benefits are provided in accordance with the HMO group contract and self-referred benefit booklet/certificate.

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Independence

Referred benefits are underwritten or administered by Keystone Health Plan East;
Self-Referred benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

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Benefit	Referred	Self-Referred*
Preventive Care for Adults and Children	Covered 100%	50% (no deductible)
Specialty Care		
Office Visits	$25 Copayment	50% after deductible
Routine Gyn/Pap (no referral required)	Covered 100%	50% (no deductible)
Allergy Injections (Office visit copayment waived if no office visit is charged)	Covered 100%**	50% after deductible
Hearing Screening	Covered 100%	50% after deductible
Respiratory Therapy	Covered 100%	50% after deductible
Chemotherapy	Covered 100%	50% after deductible
Radiation Therapy	Covered 100%	50% after deductible
Dialysis	Covered 100%	50% after deductible
Routine Eye Exam	$25 Copayment (once every two years)	Not Covered
Nutrition Counseling for Weight Management 6 visits per year	Covered 100%	50% after deductible
Laboratory Services	Covered 100%	50% after deductible
X-Ray Services (MRI/MRA, CT/CTA Scan, PET Scan and Nuclear Cardiac Studies require pre-authorization)	Covered 100%	50% after deductible
Routine Mammography (no referral required)	Covered 100%	50% (no deductible)
Maternity		
First OB Visit	$25 Copayment	50% after deductible
Hospital[3]	$250 Copayment per admission	50% after deductible[4]
Inpatient Hospitalization Services[3]		
Room and Board (Semiprivate)	$250 Copayment per admission***	50% after deductible***[4]
Surgery and Anesthesia	Covered 100%	50% after deductible***[4]
Medical and Surgical Specialist Care	Covered 100%	50% after deductible***[4]
Diagnostic Testing	Covered 100%	50% after deductible***[4]
Inpatient Hospital Days	Unlimited	120[4]
Emergency Room	$35 Copayment (which is waived if you are admitted to the hospital)	$35 Copayment (which is waived if you are admitted to the hospital)
Urgent Care Center	$24 Copayment	50% after deductible
Ambulance		
Emergency	Covered 100%	Covered 100%
Non-Emergency***	Covered 100%	50% after deductible
Outpatient Surgery		
Facility	$100 Copayment (facility)***	50% after deductible
Physician/Surgeon	Covered 100%	50% after deductible
Outpatient Therapy Services (including Speech*** Physical and Occupational Therapy)	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	50% after deductible

3 Copayment waived if readmitted within 10 days of discharge for any condition.

4 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

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** Office visit subject to copayment

*** 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.

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

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Benefit	Referred	Self-Referred*
Spinal Manipulation	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	50% after deductible
Orthoptic/Pleoptic 8 sessions per lifetime maximum	Covered 100%	50% after deductible
Skilled Nursing Facility	Covered 100% (up to 180 days)***[2]	50% after deductible(up to 240 days)***
Hospice	Covered 100%***	50% after deductible***
Home Health Care	Covered 100%***	50% after deductible***
Durable Medical Equipment	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by Primary Care Physician[1]	All purchases and rentals (including repairs and replacements) are covered 50% after deductible[1]
Prosthetics	All purchases (including repairs and replacements) are covered 100% when authorized by Primary Care Physician[1]	All purchases (including repairs and replacements) are covered 50% after deductible[1]
Mental Health		
Inpatient[3]	$250 Copayment per admission***	50% after deductible***[4]
Outpatient	$25 Copayment	50% after deductible
Serious Mental Illness (SMI)		
Inpatient[3]	$250 Copayment per admission***	50% after deductible***[4]
Outpatient	$25 Copayment	50% after deductible
Substance Abuse		
Inpatient Detoxification[3]	$250 Copayment per admission***	50% after deductible***[4]
Outpatient Detoxification	$25 Copayment	50% after deductible
Inpatient Rehabilitation[3]	$250 Copayment per admission***	50% after deductible***[4]
Outpatient Rehabilitation	$25 Copayment	50% after deductible

1 Purchases over $500 and all rentals require preauthorization.

2 Inpatient hospital copay applies if admitted without prior hospital stay.

3 Copayment waived if readmitted within 10 days of discharge for any condition.

4 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

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Services and Benefits Not Covered

As with all health insurance plans, Keystone Point of Service coverage excludes certain services. Those not covered include, but are not limited to, the following:

- Services not medically necessary
- 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
- Service 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
- Hearing Aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Radial keratotomy
- Custodial or domiciliary care
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephones, or similar items
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Transsexual surgery
- Cosmetic services/supplies
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or by additional rider
- Treatment for temporomandibular joint syndrome (TMJ)
- Care of the feet, unless medically necessary
- Dental care, including dental implants
- Long-term rehabilitative therapy, e.g., maintenance of chronic conditions (Referred Care)
- Alternative Therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Point of Service 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 HMO group contract/member handbook and self-referred group health benefits booklet/certificate 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).