Keystone Point-of-Service

POS $15-$25/$250

Independence

Neshaminy

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.
- **Preapproval/Precertification** - 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 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 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[1]
BENEFIT PERIOD	Calendar Year[2]	Calendar Year[2]
DEDUCTIBLE		
Individual	$0	$1,000
Family	$0	$3,000
OUT-OF-POCKET MAXIMUM[3]		
Individual	$3,500	$10,000[4]
Family	$7,000	$30,000[4]
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 copayment	50%, after deductible
Specialist Services	$25 copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, no deductible

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

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

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

4 Copayments, coinsurance and deductible applied to self-referred participating providers will accumulate toward the referred/in-network out-of-pocket maximum.

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.

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

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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04/18 - PA - 100+ POS $15-$35/$150
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Benefit	Referred	Self-Referred[1]
PEDIATRIC IMMUNIZATIONS	100%	50%, no deductible
ROUTINE EYE EXAM *(once every two years)*	$25 copayment	not covered
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age (no referral required)*	100%	50%, no deductible
MAMMOGRAM (no referral required)	100%	50%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[9]	100%	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible
MATERNITY		
First OB visit	$25 copayment	50%, after deductible
Hospital	$250 copayment per admission[5]	50%, after deductible[6]
INPATIENT HOSPITAL SERVICES		
Facility	$250 copayment per admission[5]	50%, after deductible[6]
Physician/Surgeon	100%	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[6]
OUTPATIENT SURGERY		
Facility	$100 copayment	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	$100 copayment (copayment waived if admitted)	$100 copayment, no deductible (copayment waived if admitted)
URGENT CARE CENTER	$24 copayment	50%, after deductible
AMBULANCE		
Emergency	100%	100%, no deductible
Non-Emergency	100%	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY[7]		
Routine Radiology/Diagnostic	100%	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%	50%, after deductible
THERAPY SERVICES *60 consecutive days per condition covered, subject to significant improvement*		
Physical, Speech and Occupational	100%	50%, after deductible
Cardiac Rehabilitation	100%	50%, after deductible
Pulmonary Rehabilitation	100%	50%, after deductible
SPINAL MANIPULATIONS *100 visits per year*	100%	50%, after deductible
ORTHOPTIC/PLETOPTIC THERAPY *8 sessions per lifetime*	100%	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables[8]	100%	50%, after deductible
Biotech/Specialty Injectables	100%	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
SKILLED NURSING FACILITY	100% 180 days per year	50%, after deductible 240 days per year
HOSPICE	100%	50%, after deductible
HOME HEALTH CARE	100%	50%, after deductible
DURABLE MEDICAL EQUIPMENT	100%	50%, after deductible
PROSTHETICS	100%	50%, after deductible

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

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

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

8 Office visit subject to copayment.

9 Individuals diagnosed by a physician with Anorexia & Bulimia are eligible for 6 additional visits per year.

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Benefit	Referred	Self-Referred[1]
MENTAL HEALTH CARE		
Outpatient	$25 copayment	50%, after deductible
Inpatient	$250 copayment per admission[5]	50%, after deductible[6]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$25 copayment	50%, after deductible
Inpatient	$250 copayment per admission[5]	50%, after deductible[6]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$25 copayment	50%, after deductible
Inpatient Rehabilitation	$250 copayment per admission[5]	50%, after deductible[6]
Detoxification	$250 copayment per admission[5]	50%, after deductible[6]

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What Is Not Covered?

- Services not medically necessary
- Service or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses, including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Self-injectable drugs
- Alternative therapies/complementary medicine

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 of 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 1-800-ASK-BLUE (TTY: 711).

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.