

# Keystone Direct POS

## DPOS 2.1 Summary of Benefits



Keystone Direct POS lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. Under this plan, you must select a Primary Care Physician, but can access most care in-network or out-of-network without a referral. Referrals are required for routine radiology/diagnostic, podiatry, spinal manipulation and physical/occupational therapy. You maximize your benefits when you access care from a Keystone participating provider. If you access care from a provider who does not participate in our network higher out-of-pocket costs apply.

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** - Most PCPs are required to choose one radiology, physical therapy, occupational therapy, laboratory, and podiatry provider where they will send all their Keystone members. You can view the sites selected by your PCP at [www.ibx.com](http://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   | In-Network                  | Out-of-Network <sup>1</sup> |
|---|-----------------------------|-----------------------------|
| <b>BENEFIT PERIOD</b>   | Calendar Year <sup>4</sup>  | Calendar Year <sup>4</sup>  |
| <b>DEDUCTIBLE</b>   |                             |                             |
| Individual  | \$0                         | \$500                       |
| Family  | \$0                         | \$1,500                     |
| <b>AFTER DEDUCTIBLE, PLAN PAYS</b>                            | 100%                        | 70%                         |
| <b>COINSURANCE LIMIT</b><br>(includes coinsurance only)       |                             |                             |
| Individual  | None                        | \$3,000                     |
| Family  | None                        | \$9,000                     |
| <b>LIFETIME MAXIMUM</b>                                       | Unlimited                   | Unlimited                   |
| <b>ANNUAL COPAYMENT MAXIMUM</b><br>(includes copayments only) |                             |                             |
| Individual  | Not Applicable              | Not Applicable              |
| Family  | Not Applicable              | Not Applicable              |
| <b>DOCTOR'S OFFICE VISITS</b>                                 |                             |                             |
| Primary Care Services   | \$15 Copayment <sup>1</sup> | 70%, after deductible       |
| Specialist Services   | \$30 Copayment              | 70%, after deductible       |

\* 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.

1 Must go to the Primary Care Physician chosen by the member.

4 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.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

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



In-network benefits are underwritten or administered by Keystone Health Plan East;

Out-of-network benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

[www.ibx.com](http://www.ibx.com)

| Benefit | In-Network | Out-of-Network <sup>1</sup> |
|---------|------------|-----------------------------|
|---------|------------|-----------------------------|

To receive the highest level of benefits, you must receive the following services from your Primary Care Physician's designated sites. You can view your Primary Care Physician's designated sites at [www.ibx.com](http://www.ibx.com).

|   |                             |                       |
|---|-----------------------------|-----------------------|
| <b>OUTPATIENT X-RAY/RADIOLOGY***</b>  |                             |                       |
| Routine Radiology/Diagnostic  | \$30 Copayment <sup>2</sup> | 70%, after deductible |
| MRI/MRA, CT/CTA Scan, PET Scan  | \$60 Copayment              | 70%, after deductible |
| <b>OUTPATIENT LABORATORY/PATHOLOGY</b>  | 100%                        | 70%, after deductible |
| <b>PHYSICAL AND OCCUPATIONAL THERAPIES</b><br>30 total visits per year for PT/OT combined | \$30 Copayment <sup>2</sup> | 70%, after deductible |
| <b>PODIATRY</b>   | \$30 Copayment <sup>2</sup> | 70%, after deductible |

To receive the highest level of benefits, you can see any Keystone Health Plan East participating provider for the following services.

|  |   |   |
|--|---|---|
| <b>SPINAL MANIPULATIONS</b><br>20 visits per year  | \$30 Copayment <sup>2</sup>                                 | 70%, after deductible                                   |
| <b>THERAPY SERVICES</b>  |   |   |
| Cardiac Rehabilitation<br>36 visits per year   | \$30 Copayment  | 70%, after deductible                                   |
| Pulmonary Rehabilitation<br>36 visits per year   | \$30 Copayment  | 70%, after deductible                                   |
| Speech<br>20 visits per year   | \$30 Copayment  | 70%, after deductible                                   |
| Orthoptic/Pleoptic<br>8 session lifetime maximum   | \$30 Copayment  | 70%, after deductible                                   |
| <b>INPATIENT HOSPITAL SERVICES<sup>3</sup></b>   | \$100/day; maximum of 5 Copayments/ admission               | 70%, after deductible                                   |
| <b>INPATIENT HOSPITAL DAYS</b>   | Unlimited   | 70  |
| <b>OUTPATIENT SURGERY</b>  | \$100 Copayment   | 70%, after deductible                                   |
| <b>EMERGENCY ROOM</b>  | \$100 Copayment (not waived if admitted)                    | \$100 Copayment, No deductible (not waived if admitted) |
| <b>AMBULANCE</b>   |   |   |
| Emergency  | 100%  | 100%, No deductible                                     |
| Non-Emergency  | 100%  | 70%, after deductible                                   |
| <b>MATERNITY</b>   |   |   |
| First OB Visit   | \$15 Copayment  | 70%, after deductible                                   |
| Hospital <sup>3</sup>  | \$100/day; maximum of 5 Copayments/ admission               | 70%, after deductible                                   |
| <b>ROUTINE GYNECOLOGICAL EXAM/PAP</b><br>1 per year for women of any age                   | 100%, No deductible   | 70%, No deductible                                      |
| <b>MAMMOGRAM</b>   | 100%, No deductible   | 70%, No deductible                                      |
| <b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b><br>6 visits per year                     | 100%, No deductible   | 70%, after deductible                                   |
| <b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>   | 100%, No deductible   | 70%, No deductible                                      |
| <b>PEDIATRIC IMMUNIZATIONS</b>   | 100%, No deductible (office visit copayment does not apply) | 70%, No deductible                                      |
| <b>ROUTINE EYE EXAM</b>  | 100% (once every two years)                                 | Not Covered   |
| <b>ALLERGY INJECTIONS</b><br>(Office visit copayment waived if no office visit is charged) | 100%  | 70%, after deductible                                   |
| <b>INJECTABLE MEDICATIONS</b>  |   |   |
| Standard Injectables   | 100% <sup>**</sup>  | 70%, after deductible                                   |
| Biotech/Specialty Injectables  | \$75 Copayment  | 70%, after deductible                                   |

\* 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.

\*\* Office visits subject to copayment.

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

2 Referral required from Primary Care Physician.

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

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

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

| Benefit  | In-Network  | Out-of-Network <sup>*</sup>                    |
|--|---|--|
| <b>CHEMO/RADIATION/DIALYSIS</b>                                  | 100%  | 70%, after deductible                          |
| <b>OUTPATIENT PRIVATE DUTY NURSING</b><br>360 hours per year     | 90%   | 70%, after deductible                          |
| <b>SKILLED NURSING FACILITY</b>                                  | \$50/day; maximum of 5 Copayments/ admission<br>120 days per year     | 70%, after deductible;<br>60 days per year     |
| <b>HOSPICE AND HOME HEALTH CARE</b>                              | 100%  | 70%, after deductible                          |
| <b>DURABLE MEDICAL EQUIPMENT</b>                                 | 50%   | 50%, after deductible                          |
| <b>PROSTHETICS</b>   | 50%   | 50%, after deductible                          |
| <b>MENTAL HEALTH CARE</b>  |   |  |
| Outpatient   | \$30 Copayment per visit;<br>20 visits per year                       | 50%, after deductible;<br>20 visits per year   |
| Inpatient <sup>3</sup>   | \$100/day; maximum of 5 Copayments/ admission<br>30 days per year     | 70%, after deductible;<br>20 days per year     |
| <b>SERIOUS MENTAL ILLNESS CARE</b>                               |   |  |
| Outpatient   | \$30 Copayment per visit;<br>60 visits per year                       | 50%, after deductible;<br>60 visits per year   |
| Inpatient <sup>3</sup>   | \$100/day; maximum of 5 Copayments/ admission<br>30 days per year     | 70%, after deductible;<br>30 days per year     |
| <b>SUBSTANCE ABUSE TREATMENT</b>                                 |   |  |
| Outpatient/Partial Facility Visits<br>120 visit lifetime maximum | \$30 Copayment per visit;<br>60 visits per year                       | 70%, after deductible;<br>60 visits per year   |
| Inpatient Rehabilitation <sup>3</sup><br>90 day lifetime maximum | \$100/day; maximum of 5 Copayments/ admission<br>30 days per year     | 70%, after deductible;<br>30 visits per year   |
| Detoxification <sup>3</sup><br>4 admissions per lifetime         | \$100/day; maximum of 5 Copayments/ admission<br>7 days per admission | 70%, after deductible;<br>7 days per admission |

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<sup>3</sup> Copayment waived if readmitted within 10 days of discharge of any condition

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

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## What Is Not Covered?

- Services not medically necessary
- Services 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
- Contraceptives, except by additional rider
- 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 Direct POS 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 Out-of-Network 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).

## Services that require precertification

### INPATIENT SERVICES

Surgical and nonsurgical inpatient admissions  
 Acute Rehabilitation  
 Skilled Nursing Facility  
 Inpatient Hospice

### OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

MRI/MRA  
 CT/CTA scan  
 PET scan  
 Nuclear cardiac studies  
 Hyperbaric Oxygen  
 Hysterectomy  
 Cataract surgery  
 Cochlear implant surgery  
 Nasal surgery for submucous resection and septoplasty  
 Transplants (except cornea)  
 Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)  
 Obesity surgery  
 Day rehabilitation programs  
 Dental services as a result of accidental injury  
 Uvulopalatopharyngoplasty  
 (including laser-assisted)

### ALL HOME CARE SERVICES (including infusion therapy in the home)

### INFUSION THERAPY DRUGS

Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)

### MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

### ELECTIVE (non-emergency) AMBULANCE TRANSPORT

### OUTPATIENT PRIVATE DUTY NURSING

### PROSTHETICS AND ORTHOTICS

Purchase items over \$500, including repairs and replacements (except ostomy supplies)

### DURABLE MEDICAL EQUIPMENT

Purchase items over \$500, including repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

### RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES

Blepharoplasty/ptosis repair  
 Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants  
 Canthopexy/canthoplasty  
 Cervicoplasty  
 Chemical peels  
 Dermabrasion  
 Excision of excessive skin and/or subcutaneous tissue  
 Genetically and bio-engineered skin substitutes for wound care  
 Hair transplant  
 Injectable dermal fillers  
 Keloid removal  
 Labiaplasty  
 Lipectomy, liposuction, or any other excess fat removal procedure  
 Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies  
 Otoplasty  
 Rhinoplasty  
 Rhytidectomy  
 Scar revision  
 Skin closures, including skin grafts, skin flaps, tissue grafts  
 Sex reassignment surgery  
 Surgical treatment of gynecomastia  
 Surgery for varicose veins, including perforators and sclerotherapy

### MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

Mental health and serious mental illness treatment  
 (Inpatient/partial hospitalization programs/intensive outpatient programs)  
 Substance abuse treatment  
 (Inpatient/Outpatient/Partial Hospitalization)

### BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS (see list included in your open enrollment packet)

### SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES (IN-NETWORK CARE)

Preapproval/precertification 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 preapproval/precertification 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. Preapproval/precertification list subject to change annually.

In addition to the preapproval/precertification requirements listed above, you should contact KHPE and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by out-of-network providers (for members using Out-of-Network care). The categories of treatment (in any setting) include

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents 'new or emerging technology;' and
- Services that might be considered experimental/investigative.

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

### PENALTIES:

POS In-Network Care: It is the network provider's responsibility to obtain preapproval for services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.

POS Out-of-Network Care: It is the member's responsibility to initiate precertification for the services listed. The member will be subject to a 20% reduction in benefits if precertification is not obtained for the inpatient/outpatient treatment services listed above.