Keystone Direct POS

DPOS 4.1 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.

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*
BENEFIT PERIOD	Calendar Year[3]	Calendar Year[3]
DEDUCTIBLE		
Individual	$1,000	$5,000
Family	$3,000	$15,000
AFTER DEDUCTIBLE, PLAN PAYS	80%	50%
COINSURANCE LIMIT (includes coinsurance only)		
Individual	$3,000	$15,000
Family	$9,000	$45,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$20 Copayment, No deductible[1]	50%, after deductible
Specialist Services	$40 Copayment, No deductible	50%, 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.

3 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 Care 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.

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Benefit	In-Network	Out-of-Network*
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.		
OUTPATIENT X-RAY / RADIOLOGY* **		
Routine Radiology/Diagnostic	$40 Copayment, No deductible[2]	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 Copayment, No deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, No deductible	50%, after deductible
PHYSICAL AND OCCUPATIONAL THERAPIES 30 total visits per year for PT/OT combined	$40 Copayment, No deductible[2]	50%, after deductible
PODIATRY	$40 Copayment, No deductible[2]	50%, after deductible
To receive the highest level of benefits, you can see any Keystone Health Plan East participating provider for the following services.		
SPINAL MANIPULATIONS 20 visits per year	$40 Copayment, No deductible[2]	50%, after deductible
THERAPY SERVICES		
Cardiac Rehabilitation 36 visits per year	$40 Copayment, No deductible	50%, after deductible
Pulmonary Rehabilitation 36 visits per year	$40 Copayment, No deductible	50%, after deductible
Speech 20 visits per year	$40 Copayment, No deductible	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$40 Copayment, No deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES	80%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY	80%, after deductible	50%, after deductible
EMERGENCY ROOM	80%, after deductible (not waived if admitted)	80%, after deductible (not waived if admitted)
AMBULANCE		
Emergency	80%, after deductible	80%, after deductible
Non-Emergency	80%, after deductible	50%, after deductible
MATERNITY		
First OB visit	$20 Copayment, No deductible	50%, after deductible
Hospital	80%, after deductible	50%, after deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age	100%, No deductible	50%, No deductible
MAMMOGRAM	100%, No deductible	50%, No deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per year	100%, No deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, No deductible	50%, No deductible
PEDIATRIC IMMUNIZATION	100%, No deductible (office visit copayment does not apply)	50%, No deductible
ROUTINE EYE EXAM	100%, No deductible (once every two years)	Not Covered
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%, No deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%, No deductible**	50%, after deductible
Biotech/Specialty Injectables	$100 Copayment, No deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	80%, after deductible	50%, after deductible

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** Office visits subject to copayment.

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

2 Referral required from Primary Care Physician.

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

Benefit	In-Network	Out-of-Network*
OUTPATIENT PRIVATE DUTY NURSING 360 hours per year	80%, after deductible	50%, after deductible
SKILLED NURSING FACILITY	80%, after deductible; 120 days per year	50%, after deductible; 60 days per year
HOSPICE AND HOME HEALTH CARE	80%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%, after deductible	50%, after deductible
PROSTHETICS	50%, after deductible	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$40 Copayment per visit, No deductible; 20 visits per year	50%, after deductible; 20 visits per year
Inpatient	80%, after deductible; 30 days per year	50%, after deductible; 20 days per year
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$40 Copayment per visit, No deductible; 60 visits per year	50%, after deductible; 60 visits per year
Inpatient	80%, after deductible; 30 days per year	50%, after deductible; 30 days per year
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits 120 visit lifetime maximum	$40 Copayment per visit, No deductible; 60 visits per year	50%, after deductible; 60 visits per year
Inpatient Rehabilitation 90 day lifetime maximum	80%, after deductible; 30 days per year	50%, after deductible; 30 days per year
Detoxification 4 admissions per lifetime	80%, after deductible; 7 days per admission	50%, after deductible; 7 days per admission

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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 Care 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.

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
- Alternative therapies/complementary medicine
- 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-injectible drugs

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
- Hysterectomy
- Hyperbaric Oxygen
- Cataract surgery
- Nasal surgery for submucous sesection and septoplasty
- Cochlear implant surgery
- Transplants (except cornea)
- Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
- 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 THEARAPY 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)

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

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS
Purchase items over $500, including repairs and replacements (except ostomy supplies)

DURABLE MEDICAL EQUIPMENT
Purchase items $500, inluding repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES

- Blepharoplasty/ptsosis 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 the 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.