

# Keystone Point-of-Service

## C3-F4-02 Summary of Benefits



## Temple University Students

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, 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	Referred	Self-Referred <sup>1</sup>
<b>BENEFIT PERIOD</b>	Calendar Year <sup>2</sup>	Calendar Year <sup>2</sup>
<b>DEDUCTIBLE</b>		
Individual	\$0	\$1,500
Family	\$0	\$4,500
<b>COINSURANCE LIMIT</b> (includes coinsurance only)		
Individual	None	\$10,000
Family	None	\$30,000
<b>LIFETIME MAXIMUM</b>	Unlimited	\$500,000

\* 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 amount starts at \$0 at the beginning of each calendar year on January 1.

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.

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

Benefit	Referred	Self-Referral*
<b>ANNUAL COPAYMENT MAXIMUM</b> (includes copayments only)		
Individual	\$3,000	Not Applicable
Family	\$6,000	Not Applicable
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	\$20 Copayment	50%, after deductible
Specialist Services	\$40 Copayment	50%, after deductible
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	\$20 Copayment	50%, NO deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100%**	50%, NO deductible
<b>ROUTINE EYE EXAM</b>	\$40 Copayment (once every two years)	Not Covered
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> 1 per year for women of any age (no referral required)	\$20 Copayment	50%, NO deductible
<b>MAMMOGRAM (no referral required)</b>	100%	50%, NO deductible
<b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b> 6 visits per year	100%	50%, after deductible
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%	50%, after deductible
<b>MATERNITY</b>		
First OB visit	\$20 Copayment	50%, after deductible
Hospital	\$250/day; maximum of 5 Copayments/ admission***	50%, after deductible <sup>1</sup>
<b>INPATIENT HOSPITAL SERVICES</b>	\$250/day; maximum of 5 Copayments/ admission***	50%, after deductible <sup>1</sup>
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70 <sup>1</sup>
<b>OUTPATIENT SURGERY</b>	\$125 Copayment	50%, 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%	50%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY****</b>		
Routine Radiology/Diagnostic	\$40 Copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	\$80 Copayment	50%, after deductible
<b>THERAPY SERVICES</b>		
Physical and Occupational 30 total visits per year for PT/OT combined	\$40 Copayment	50%, after deductible
Cardiac Rehabilitation 36 visits per year	\$40 Copayment	50%, after deductible
Pulmonary Rehabilitation 36 visits per year	\$40 Copayment	50%, after deductible
Speech 20 visits per year	\$40 Copayment	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	\$40 Copayment	50%, after deductible
<b>SPINAL MANIPULATIONS</b> 20 visits per year	\$40 Copayment	50%, after deductible
<b>ALLERGY INJECTIONS/TESTING</b> (Office visit copayment waived if no office visit is charged)	100%, NO deductible	50%, after deductible
<b>INJECTABLE MEDICATIONS</b>		
Standard Injectables**	100%	50%, after deductible
Biotech/Specialty Injectables	\$100 Copayment	50%, after deductible
<b>CHEMO/RADIATION/DIALYSIS</b>	100%	50%, after deductible
<b>OUTPATIENT PRIVATE DUTY NURSING</b> 360 hours per year	85%	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.

\*\* Office visits subject to copayment.

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

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

<sup>1</sup> 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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Benefit	Referred	Self-Referred <sup>1</sup>
<b>SKILLED NURSING FACILITY</b>	\$125/day; maximum of 5 Copayments/ admission <sup>***</sup> 120 days per year	50%, after deductible; 60 days per year
<b>HOSPICE AND HOME HEALTH CARE</b>	100%	50%, after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	50%	50%, after deductible \$2500 benefit maximum per calendar year
<b>PROSTHETICS</b>	50%	50%, after deductible
<b>MENTAL HEALTH CARE</b>		
Outpatient	\$40 Copayment	50%, after deductible
Inpatient	\$250/day; maximum of 5 Copayments/ admission <sup>***</sup> calendyear	50%, after deductible <sup>1</sup>
<b>SERIOUS MENTAL ILLNESS CARE</b>		
Outpatient	\$40 Copayment	50%, after deductible
Inpatient	\$250/day; maximum of 5 Copayments/ admission <sup>***</sup>	50%, after deductible <sup>1</sup>
<b>SUBSTANCE ABUSE TREATMENT</b>		
Outpatient/Partial Facility Visits	\$40 Copayment	50%, after deductible
Inpatient Rehabilitation	\$250/day; maximum of 5 Copayments/ admission <sup>***</sup>	50%, after deductible <sup>1</sup>
Detoxification	\$250/day; maximum of 5 Copayments/ admission <sup>***</sup>	50%, after deductible <sup>1</sup>

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

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

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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## 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 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 (275-2583).

## Services That Require Preapproval/Precertification

### INPATIENT SERVICES

Surgical and nonsurgical inpatient admissions  
Acute Rehabilitation  
Skilled Nursing Facility  
Inpatient Hospice  
Maternity Admission (for notification only)

### OUTPATIENT FACILITY/OFFICE SERVICES

(other than inpatient)

MRI/MRA  
CT/CTA Scan  
PET Scan  
Nuclear Cardiac Studies  
Hysterectomy  
Cataract Surgery  
Nasal Surgery for Submucous Resection and Septoplasty  
Transplants (except cornea)  
Comprehensive Outpatient Pain Management Programs (including epidural injections)  
Obesity Surgery  
Sleep Studies  
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)

### BIRTHING CENTER (for notification 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

Abdominoplasty  
Augmentation Mammoplasty  
Blepharoplasty  
Chemical Peels  
Dermabrasion  
Excision of Redundant Skin  
Keloid Removal  
Lipectomy/Liposuction  
Orthognathic Surgery Procedures  
Mastopexy  
Otoplasty  
Panniculectomy  
Reduction Mammoplasty  
Removal or Reinsertion of Breast Implants  
Rhinoplasty  
Varicose vein procedures  
Scar Revision  
Subcutaneous Mastectomy for Gynecomastia

### 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 (REFERRED 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 self-referred 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 Referred 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 Self-Referred 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.