

Please be aware, benefit explanations are updated each year and when the carrier issues a policy change in writing.



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Keystone Direct POS

C4-F5-02 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.

This program may not cover all your health care services. Services may not be covered because they are:

- Not covered under your benefit contract
- Not medically necessary
- Limited by a benefit maximum (i.e. visit limit)

Your Member Handbook identifies details about your benefit program. It also includes information about exclusions and benefit limitations. After reviewing this information, please contact our Member Service department if you have additional questions.

| Benefit | In-Network | Out-of-Network* |
|---------------------------------|-----------------------------|-----------------------|
| DEDUCTIBLE | | |
| Individual | \$0 | \$1,500 |
| Family | \$0 | \$4,500 |
| COINSURANCE LIMIT | | |
| Individual | None | \$10,000 |
| Family | None | \$30,000 |
| LIFETIME MAXIMUM | | |
| | Unlimited | \$500,000 |
| ANNUAL COPAYMENT MAXIMUM | | |
| Individual | \$3,000 | Not Applicable |
| Family | \$6,000 | Not Applicable |
| DOCTOR'S OFFICE VISITS | | |
| Primary Care Services | \$30 Copayment ¹ | 50%, after deductible |
| Specialist Services | \$50 Copayment | 50%, after deductible |

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 | \$50 Copayment ² | 50%, after deductible |
| MRI/MRA, CT/CTA Scan, PET Scan | \$100 Copayment | 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.

2 Referral required from Primary Care Physician.

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

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.



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

| Benefit | In-Network | Out-of-Network* |
|---|--|---|
| OUTPATIENT LABORATORY/PATHOLOGY | 100% | 50%, after deductible |
| PHYSICAL AND OCCUPATIONAL THERAPIES 30 visits per calendar year | \$50 Copayment ² | 50%, after deductible |
| PODIATRY | \$50 Copayment 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 calendar year | \$50 Copayment ² | 50%, after deductible |
| THERAPY SERVICES | | |
| Cardiac Rehabilitation 36 visits per calendar year | \$50 Copayment | 50%, after deductible |
| Pulmonary Rehabilitation 36 visits per calendar year | \$50 Copayment | 50%, after deductible |
| Speech 20 visits per calendar year | \$50 Copayment | 50%, after deductible |
| Orthoptic/Pleoptic 8 session lifetime maximum | \$50 Copayment | 50%, after deductible |
| INPATIENT HOSPITAL SERVICES³ | \$400/day; maximum of 5 Copayments/ admission ^{***} | 50%, after deductible |
| INPATIENT HOSPITAL DAYS | Unlimited | 70 |
| OUTPATIENT SURGERY | \$200 Copayment | 50%, after deductible |
| EMERGENCY ROOM | \$125 Copayment (not waived if admitted) | \$125 Copayment (not waived if admitted) |
| AMBULANCE | 100% | 50%, after deductible |
| MATERNITY | | |
| First OB Visit | \$30 Copayment | 50%, after deductible |
| Hospital ³ | \$400/day; maximum of 5 Copayments/ admission ^{***} | 50%, after deductible |
| ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age | \$30 Copayment | 50%, NO deductible |
| MAMMOGRAM | 100% | 50%, NO deductible |
| NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year | 100% | 50%, after deductible |
| PEDIATRIC IMMUNIZATIONS | 100%** | 50%, NO deductible |
| ROUTINE EYE EXAM | \$50 Copayment (once every two calendar years) | Not Covered |
| INJECTABLE MEDICATIONS | | |
| Standard Injectables | 100%** | 50%, after deductible |
| Biotech/Specialty Injectables | \$125 Copayment | 50%, after deductible |
| CHEMO/RADIATION/DIALYSIS | 100% | 50%, after deductible |
| OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year | 80% | 50%, after deductible |
| SKILLED NURSING FACILITY | \$200/day; maximum of 5 Copayments/ admission ^{***} 120 days per calendar year | 50%, after deductible; 60 days per calendar year |
| HOSPICE AND HOME HEALTH CARE | 100% | 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 90 days of discharge.

² Referral required from Primary Care Physician.

³ Copayment waived if readmitted within 90 days of discharge for 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.

| Benefit | In-Network | Out-of-Network* |
|--|---|--|
| DURABLE MEDICAL EQUIPMENT | 50% | 50%, after deductible \$2,500 benefit maximum per calendar year |
| PROSTHETICS | 50% | 50%, after deductible |
| MENTAL HEALTH CARE | | |
| Outpatient | \$50 Copayment per visit; 20 visits per calendar year | 50%, after deductible; 20 visits per calendar year |
| Inpatient ³ | \$400/day; maximum of 5 Copayments/ admission*** 30 days per calendar year | 50%, after deductible; 20 days per calendar year |
| SERIOUS MENTAL ILLNESS CARE | | |
| Outpatient | \$50 Copayment per visit; 60 visits per calendar year | 50%, after deductible; 60 visits per calendar year |
| Inpatient ³ | \$400/day; maximum of 5 Copayments/ admission*** 30 days per calendar year | 50%, after deductible; 30 days per calendar year |
| SUBSTANCE ABUSE TREATMENT | | |
| Outpatient/Partial Facility Visits 120 visit lifetime maximum | \$50 Copayment per visit; 60 visits per calendar year | 50%, after deductible; 60 visits per calendar year |
| Inpatient Rehabilitation ³ 90 day lifetime maximum | \$400/day; maximum of 5 Copayments/ admission***; 30 days per calendar year | 50%, after deductible; 30 visits per calendar year |
| Detoxification ³ 4 admissions per lifetime | \$400/day; maximum of 5 Copayments/ admission*** 7 days per admission | 50%, after deductible; 7 days per admission |

* 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.

*** Copayment waived if readmitted within 90 days of discharge.

3 Copayment waived if readmitted within 90 days of discharge for 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.

What Is Not Covered?

- Services not medically necessary
- Services or supplies which 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-injectible drugs (effective 1/1/2010)
- 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 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
 Surgery for Varicose Veins
 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 (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.