Keystone Point-of-Service

PHO

Independence

Drexel University

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.
- **Preauthorization** - 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 Keystone Health Plan East benefits that require preauthorization flyer included in the enrollment kit.
- **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.

BENEFITS	REFERRED CARE Tenet Preferred	Keystone Health Plan East Network - KHPE	OUT-OF-NETWORK Self-Referred Care **
DEDUCTIBLE			
Individual	Not Applicable	Not Applicable	$500
Family	Not Applicable	Not Applicable	$1,500
AFTER DEDUCTIBLE, PLAN PAYS	100% Unless otherwise noted for Tenet and KHPE	100% Unless otherwise noted for Tenet and KHPE	70%
OUT-OF-POCKET MAXIMUM (Deductibles, copayments, and coinsurance amounts apply to maximums)			
Individual	$1,500	$2,000	$3,000
Family	$3,000	$4,000	$9,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited

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

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

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BENEFITS	REFERRED CARE Tenet Preferred	Keystone Health Plan East Network - KHPE	OUT-OF-NETWORK Self-Referred Care**
DOCTOR'S OFFICE VISITS			
Primary Care Services	$0 copayment	$20 copayment	70%, after deductible
Specialist Services	$10 copayment	$40 copayment	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	Covered at 100%	Covered at 100%	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per calendar year for women of any age*	Covered 100%	Covered 100%	70%, no deductible
MAMMOGRAPHY *(No referral required)*	Covered 100%	Covered 100%	70%, no deductible
NUTRITIONAL COUNSELING FOR WEIGHT MANAGEMENT *6 visits per calendar year*	Covered 100%	Covered 100%	70%, no deductible
OUTPATIENT LABORATORY/PATHOLOGY[3]	Covered 100%	Covered 100%	70%, after deductible
MATERNITY			
First OB visit	$10 copayment	$20 copayment	70%, after deductible
Hospital	$240 copayment per admission[4]	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]
INPATIENT HOSPITAL SERVICES*			
Facility	$240 copayment per admission[4]	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]
Physician/Surgeon	Covered 100%	Covered 100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited	70[2]
OUTPATIENT SURGERY*			
Facility	Covered 100%	$50 copayment	70%, after deductible
Physician/Surgeon	Covered 100%	Covered 100%	70%, after deductible
EMERGENCY ROOM	$100 copayment (waived if admitted)	$100 copayment (waived if admitted)	$100 copayment, no deductible (waived if admitted)
URGENT CARE CENTER	Covered 100% at St. Chris Pediatric Urgent Care	$35 copayment	70%, after deductible
AMBULANCE			
Emergency	Covered 100%	Covered 100%	100%, no deductible
Non-emergency	Covered 100%	Covered 100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY[3]			
Routine Radiology/Diagnostic	Covered 100%	$20 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan*	Covered 100%	$80 copayment	70%, after deductible

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

3 At your Primary Care Physician designated site.

4 Inpatient hospital $240 copayment at Hahnemann and Saint Christopher hospitals are reimbursable. Submit your receipt to Drexel HR for reimbursement.

5 Copayment waived if readmitted within 10 days of discharge.

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THERAPY SERVICES			
Physical and Occupational[3]	Covered 100%	$20 copayment; 30 visits per calendar year	70%, after deductible; 30 visits per calendar year
Cardiac Rehabilitation	Covered 100%	$20 copayment; 36 visits per calendar year	70%, after deductible; 36 visits per calendar year
Pulmonary Rehabilitation	Covered 100%	$20 copayment; 36 visits per calendar year	70%, after deductible; 36 visits per calendar year
Speech	Covered 100% (up to 60 consecutive days per condition, subject to significant improvement)	$20 copayment; 20 visits per calendar year	70%, after deductible; 20 visits per calendar year
Orthoptic/Pleoptic	Covered 100% 8 sessions lifetime maximum	$20 copayment; 8 sessions lifetime maximum	70%, after deductible 8 sessions lifetime maximum
SPINAL MANIPULATIONS	Provider is only available in the KHPE network	$20 copayment; 20 visits per calendar year	70%, after deductible; 20 visits per calendar year
STANDARD INJECTABLES****	Covered 100%	Covered 100%	70%, after deductible
BIOTECH/SPECIALTY INJECTABLES*	$100 copayment	$100 copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS*	Covered 100%	Covered 100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING*	Provider is only available in the KHPE network	Covered 90%; 360 hours per calendar year	70%, after deductible; 360 hours per calendar year
SKILLED NURSING FACILITY*	Provider is only available in the KHPE network	$50/day; maximum of 5 copayments/admission 120 days per calendar year[5]	70%, after deductible; 60 days per calendar year
HOSPICE AND HOME HEALTH CARE*	Covered 100%	Covered 100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT*	Provider is only available in the KHPE network	Covered 70%	50%, after deductible
PROSTHETICS*	Provider is only available in the KHPE network	Covered 70%	50%, after deductible
MENTAL HEALTH CARE			
Outpatient	Provider is only available in the KHPE network	$40 copayment	70%, after deductible
Inpatient	Provider is only available in the KHPE network	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]
SERIOUS MENTAL ILLNESS CARE			
Outpatient	Provider is only available in the KHPE network	$40 copayment	70%, after deductible
Inpatient	Provider is only available in the KHPE network	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]

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**** Subject to office visit copayment.

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SUBSTANCE ABUSE TREATMENT			
Outpatient/Partial Facility Visits	Provider is only available in the KHPE network	$40 copayment	70%, after deductible
Detoxification	Provider is only available in the KHPE network	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]
Inpatient	Provider is only available in the KHPE network	$100/day; maximum of 5 copayments/admission[5]	70%, after deductible[2]

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What Is Not Covered?

- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- 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 non-surgical 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 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
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Self-injectable drugs

This summary represents only a partial listing of the 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 POS 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 1-800-227-3115 (outside Philadelphia) or 215-241-2240 (if calling within the Philadelphia area).

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