Keystone Point-of-Service

POS Plus 4B

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 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.

Benefit	Referred	Self-Referred*
BENEFIT PERIOD	Calendar Year[2]	Calendar Year[2]
DEDUCTIBLE		
Individual	$0	$5,000
Family	$0	$15,000
OUT-OF-POCKET MAXIMUM[3]		
Individual	$7,150	$15,000[4]
Family	$14,300	$45,000[4]
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$40 Copayment	50%, after deductible
Specialist Services	$60 Copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, NO 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.

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.

3 In-network out-of-pocket maximum includes copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

4 Copayments, coinsurance and deductible applied to self-referred participating providers will accumulate toward the referred/in-network out-of-pocket maximum.

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.

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Benefit	Referred	Self-Referred*
PEDIATRIC IMMUNIZATIONS	100%	50%, NO deductible
ROUTINE EYE EXAM	$60 Copayment (once every two years)	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age (no referral required)*	100%	50%, NO deductible
MAMMOGRAM (no referral required)	100%	50%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*	100%	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible
MATERNITY		
First OB visit	$40 Copayment	50%, after deductible
Hospital	$500/day; maximum of 5 Copayments/ admission***	50%, after deductible[1]
INPATIENT HOSPITAL SERVICES		
Facility	$500/day; maximum of 5 Copayments/ admission***	50%, after deductible[1]
Physician/Surgeon	100%	50%, after deductible[1]
INPATIENT HOSPITAL DAYS	Unlimited	70[1]
OUTPATIENT SURGERY		
Facility	$500 Copayment	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	$200 Copayment (waived if admitted)	$200 Copayment, NO deductible (waived if admitted)
URGENT CARE CENTER	$140 Copayment	50%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY**		
Routine Radiology/Diagnostic	$60 Copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$200 Copayment	50%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 total visits per year for PT/OT combined	$60 Copayment	50%, after deductible
Cardiac Rehabilitation 36 visits per year	$60 Copayment	50%, after deductible
Pulmonary Rehabilitation 36 visits per year	$60 Copayment	50%, after deductible
Speech 20 visits per year	$60 Copayment	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$60 Copayment	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year*	$60 Copayment	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%	50%, after deductible
Biotech/Specialty Injectables	$100 Copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*	50%	50%, after deductible
SKILLED NURSING FACILITY	$250/day maximum of 5 Copayments/ admission*** 120 days per year	50%, after deductible 60 days per year
HOSPICE	100%	50%, after deductible

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

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

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

Benefit	Referred	Self-Referred*
HOME HEALTH CARE *60 visit maximum per 90 day period*	$60 Copayment	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$60 Copayment	50%, after deductible
Inpatient	$500/day maximum of 5 Copayments/ admission***	50%, after deductible[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$60 Copayment	50%, after deductible
Inpatient	$500/day maximum of 5 Copayments/ admission***	50%, after deductible[1]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$60 Copayment per visit	50%, after deductible
Inpatient Rehabilitation	$500/day maximum of 5 Copayments/ admission***	50%, after deductible[1]
Detoxification	$500/day maximum of 5 Copayments/ admission***	50%, after deductible[1]

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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
- 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 (TTY: 711).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.