

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

DPOS 7 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*
DEDUCTIBLE		
Individual	\$3,000	\$5,000
Family	\$9,000	\$15,000
AFTER DEDUCTIBLE, PLAN PAYS	70%	50%
COINSURANCE LIMIT		
Individual	\$5,000	\$15,000
Family	\$15,000	\$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.

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.

www.ibx.com

Benefit	In-Network	Out-of-Network
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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
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PHYSICAL AND OCCUPATIONAL THERAPIES

30 visits per calendar year

	\$40 Copayment, No deductible ²	50%, after deductible
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PODIATRY

	\$40 Copayment, No deductible ²	50%, after deductible
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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	\$40 Copayment, No deductible ²	50%, after deductible
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THERAPY SERVICES

Cardiac Rehabilitation 36 visits per calendar year	\$40 Copayment, No deductible	50%, after deductible
Pulmonary Rehabilitation 36 visits per calendar year	\$40 Copayment, No deductible	50%, after deductible
Speech 20 visits per calendar year	\$40 Copayment, No deductible	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	\$40 Copayment, No deductible	50%, after deductible

INPATIENT HOSPITAL SERVICES	70%, after deductible	50%, after deductible
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INPATIENT HOSPITAL DAYS	Unlimited	70
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OUTPATIENT SURGERY	70%, after deductible	50%, after deductible
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EMERGENCY ROOM	70%, after deductible (not waived if admitted)	70%, after deductible (not waived if admitted)
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AMBULANCE

Emergency	70%, after deductible	70%, after deductible
Non-Emergency	70%, after deductible	50%, after deductible

MATERNITY

First OB visit	\$20 Copayment, No deductible	50%, after deductible
Hospital	70%, after deductible	50%, after deductible

ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	100%, No deductible	50%, No deductible
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MAMMOGRAM	100%, No deductible	50%, No deductible
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NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year	100%, No deductible	50%, after deductible
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PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, No deductible	50%, No deductible
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PEDIATRIC IMMUNIZATION	100%, No deductible	50%, No deductible
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ROUTINE EYE EXAM	100%, No deductible (once every two calendar years)	Not Covered
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* 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 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*
INJECTABLE MEDICATIONS		
Standard Injectables	100%, No deductible**	50%, after deductible
Biotech/Specialty Injectables	\$100 Copayment, No deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS		
	70%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year		
SKILLED NURSING FACILITY	70%, after deductible; 120 days per calendar year	50%, after deductible; 60 days per calendar year
HOSPICE AND HOME HEALTH CARE	70%, 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 calendar year	50%, after deductible; 20 visits per calendar year
Inpatient	70%, after deductible; 30 days per calendar year	50%, after deductible; 20 days per calendar year
SERIOUS MENTAL ILLNESS CARE		
Outpatient	\$40 Copayment per visit, No deductible; 60 visits per calendar year	50%, after deductible; 60 visits per calendar year
Inpatient	70%, after deductible; 30 days per calendar year	50%, after deductible; 30 days per calendar year
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits 120 visit lifetime maximum	\$40 Copayment per visit, No deductible; 60 visits per calendar year	50%, after deductible; 60 visits per calendar year
Inpatient Rehabilitation 90 day lifetime maximum	70%, after deductible; 30 days per calendar year	50%, after deductible; 30 days per calendar year
Detoxification 4 admissions per lifetime	70%, after deductible; 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.

** Office visits subject to copayment.

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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
- 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-injectable 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 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 \$500, including repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND 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 (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.