

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



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# Keystone Point-of-Service

## C1-F1-01 Summary of Benefits



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. Of course, with Keystone Point-of-Service, you have the freedom to self-refer your care 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. 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	Referred	Self-Referred*
<b>DEDUCTIBLE</b>		
Individual	\$0	\$500
Family	\$0	\$1,500
<b>COINSURANCE LIMIT</b>		
Individual	None	\$3,000
Family	None	\$9,000
<b>LIFETIME MAXIMUM</b>		
	Unlimited	\$1 Million
<b>ANNUAL COPAYMENT MAXIMUM</b>		
Individual	\$1,000	Not Applicable
Family	\$2,000	Not Applicable
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	\$10 Copayment	70%, after deductible
Specialist Services	\$20 Copayment	70%, after deductible
<b>PEDIATRIC IMMUNIZATIONS</b>		
	100%**	70%, NO deductible
<b>ROUTINE EYE EXAM</b>		
	\$20 Copayment (once every two years)	Not Covered
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> 1 per calendar year for women of any age (no referral required)		
	\$10 Copayment	70%, NO deductible
<b>MAMMOGRAM (no referral required)</b>		
	100%	70%, 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.

\*\* Office visits subject to copayment.

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.



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-Referred*
<b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b> 6 visits per calendar year	100%	70%, after deductible
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%	70%, after deductible
<b>MATERNITY</b>		
First OB visit	\$10 Copayment	70%, after deductible
Hospital	100%	70%, after deductible
<b>INPATIENT HOSPITAL SERVICES</b>	100%	70%, after deductible
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70
<b>OUTPATIENT SURGERY</b>	100%	70%, after deductible
<b>EMERGENCY ROOM</b>	\$100 Copayment (not waived if admitted)	\$100 Copayment (not waived if admitted)
<b>AMBULANCE</b>	100%	70%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY***</b>		
Routine Radiology/Diagnostic	\$20 Copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	\$40 Copayment	70%, after deductible
<b>THERAPY SERVICES</b>		
Physical and Occupational 30 visits per calendar year	\$20 Copayment	70%, after deductible
Cardiac Rehabilitation 36 visits per calendar year	\$20 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per calendar year	\$20 Copayment	70%, after deductible
Speech 20 visits per calendar year	\$20 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	\$20 Copayment	70%, after deductible
<b>SPINAL MANIPULATIONS</b> 20 visits per calendar year	\$20 Copayment	70%, after deductible
<b>INJECTABLE MEDICATIONS</b>		
Standard Injectables	100%	70%, after deductible
Biotech/Specialty Injectables	\$50 Copayment	70%, after deductible
<b>CHEMO/RADIATION/DIALYSIS</b>	100%	70%, after deductible
<b>OUTPATIENT PRIVATE DUTY NURSING</b> 360 hours per calendar year	90%	70%, after deductible
<b>SKILLED NURSING FACILITY</b>	100% 120 days per calendar year	70%, after deductible; 60 days per calendar year
<b>HOSPICE AND HOME HEALTH CARE</b>	100%	70%, after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	70%	50%, after deductible \$2,500 benefit maximum per calendar year
<b>PROSTHETICS</b>	70%	50%, after deductible
<b>MENTAL HEALTH CARE</b>		
Outpatient	\$20 Copayment per visit; 20 visits per calendar year	50%, after deductible; 20 visits per calendar year
Inpatient	100%; 30 days per calendar year	70%, after deductible; 20 days per calendar year

\* 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 performed in Emergency Room or office setting.

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.

Benefit	Referred	Self-Referred*
<b>SERIOUS MENTAL ILLNESS CARE</b>		
Outpatient	\$20 Copayment per visit; 60 visits per calendar year	50%, after deductible; 60 visits per calendar year
Inpatient	100%; 30 days per calendar year	70%, after deductible; 30 days per calendar year
<b>SUBSTANCE ABUSE TREATMENT</b>		
Outpatient/Partial Facility Visits 120 visit lifetime maximum	\$20 Copayment per visit; 60 visits per calendar year	70%, after deductible; 60 visits per calendar year
Inpatient Rehabilitation 90 day lifetime maximum	100%; 30 days per calendar year	70%, after deductible; 30 visits per calendar year
Detoxification 4 admissions per lifetime	100%; 7 days per admission	70%, after deductible; 7 days per admission

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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.

## What Is Not Covered?

- Services not medically necessary
- Service 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 (effective 1/1/2010)
- 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 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  
 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 (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 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.