Keystone Direct POS

C2-F2-01

Independence

DELCO TRUST

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, 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 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	In-Network	Out-of-Network*
BENEFIT PERIOD	Contract Year[5]	Contract Year[5]
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,500
OUT-OF-POCKET MAXIMUM[6]		
Individual	$1,500	$3,000
Family	$3,000	$9,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 Copayment[1]	70%, after deductible
Specialist Services	$30 Copayment	70%, 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 Members must select and use their Primary Care Physician for primary care services.

5 A contract year benefit period is a consecutive 12-month period that begins on your employer's effective date. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each contract year.

6 The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible. The out-of-network out-of-pocket maximum includes coinsurance only.

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.

The benefits may be changed by IBC to comply with the 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.

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Benefit	In-Network	Out-of-Network*
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	$30 Copayment[2]	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$60 Copayment	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY[4]	100%	70%, after deductible
PHYSICAL AND OCCUPATIONAL THERAPIES *30 total visits per year for PT/OT combined*	$30 Copayment[2]	70%, 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 year*	$30 Copayment[2]	70%, after deductible
THERAPY SERVICES		
Cardiac Rehabilitation 36 visits per year	$30 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per year	$30 Copayment	70%, after deductible
Speech 20 visits per year	$30 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$30 Copayment	70%, after deductible
INPATIENT HOSPITAL SERVICES		
Facility	$100/day; maximum of 5 Copayments/ admission[****]	70%, after deductible[3]
Physician/Surgeon	100%	70%, after deductible[3]
INPATIENT HOSPITAL DAYS	Unlimited	70[3]
OUTPATIENT SURGERY		
Facility	$50 Copayment	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$100 Copayment (not waived if admitted)	$100 Copayment, NO deductible (not waived if admitted)
URGENT CARE CENTER	$70 Copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	70%, after deductible
MATERNITY		
First OB Visit	$15 Copayment	70%, after deductible
Hospital	$100/day; maximum of 5 Copayments/ admission[****]	70%, after deductible[3]
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*	100%	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*	100%	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%[1]	70%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, NO deductible
ROUTINE EYE EXAM	$30 Copayment (once every two years)	Not Covered

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

1 Members must select and use their Primary Care Physician for primary care services.

2 Referral required from Primary Care Physician.

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

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

4 Lab requisition form required from an in-network provider.

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Benefit	In-Network	Out-of-Network*
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%**	70%, after deductible
Biotech/Specialty Injectables	$75 Copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*	90%	70%, after deductible
SKILLED NURSING FACILITY	$50/day maximum of 5 Copayments/ admission**** 120 days per year	70%, after deductible 60 days per year
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$30 Copayment	70%, after deductible
Inpatient	$100/day maximum of 5 Copayments/ admission****	70%, after deductible[3]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 Copayment	70%, after deductible
Inpatient	$100/day maximum of 5 Copayments/ admission****	70%, after deductible[3]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$30 Copayment	70%, after deductible
Inpatient Rehabilitation	$100/day maximum of 5 Copayments/ admission****	70%, after deductible[3]
Detoxification	$100/day maximum of 5 Copayments/ admission****	70%, after deductible[3]

* 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 10 days of discharge for any condition.

3 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

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.

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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
- 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-injectible drugs
- 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 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.