

# Keystone Point-of-Service

## Keystone 10B Summary of Benefits



## PAISIG

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, 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](http://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*
<b>Deductible</b>		
Individual	None	\$200
Family	None	\$600
<b>Coinsurance</b>	None	80%
<b>Coinsurance Limit</b>		
Individual	Not Applicable	\$1,000
Family	Not Applicable	\$3,000
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Annual Copayment Maximum</b>		
Individual	\$1,000	Not Applicable
Family	\$2,000	Not Applicable

\* 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.

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-Referral
<b>Primary Care Physician</b>		
Office Hours	\$10 Copayment	80% after deductible
After Hours/Home Visits	\$15 Copayment	80% after deductible
Pediatric Immunizations	Covered 100%	80% (no deductible)
<b>Preventive Care for Adults and Children</b>	Covered 100%	80% (no deductible)
<b>Specialty Care</b>		
Office Visits	\$15 Copayment	80% after deductible
Routine Gyn/Pap (no referral required)	Covered 100%	80% (no deductible)
Allergy Testing and Treatment	Covered 100%**	80% after deductible
Hearing Screening	Covered 100%**	80% after deductible
Respiratory Therapy	Covered 100%***	80% after deductible
Chemotherapy	Covered 100%***	80% after deductible
Radiation Therapy	Covered 100%***	80% after deductible
Dialysis	Covered 100%	80% after deductible
Routine Eye Exam	\$15 Copayment (once every two calendar years)	Not Covered
<b>Nutrition Counseling for Weight Management</b> 6 visits per calendar year	Covered 100%	80% after deductible
<b>Laboratory Services</b>	Covered 100%	80% after deductible
<b>X-Ray Services</b> (MRI/MRA, CT/CTA Scan, PET Scan and Nuclear Cardiac Studies require pre-authorization)	Covered 100%	80% after deductible
Routine Mammography (no referral required)	Covered 100%	80% (no deductible)
<b>Maternity</b>		
First OB Visit	\$15 Copayment	80% after deductible
Hospital	\$100/day; maximum of 5 Copayments/admission <sup>3</sup>	80% after deductible <sup>4</sup>
<b>Inpatient Hospitalization Services</b>	\$100/day; maximum of 5 Copayments/admission <sup>*** 3</sup>	80% after deductible <sup>***4</sup>
Room and Board (Semiprivate)		
Surgery and Anesthesia		
Medical and Surgical Specialist Care		
Diagnostic Testing		
<b>Inpatient Hospital Days</b>	Unlimited	120 <sup>4</sup>

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\*\* Office visit subject to copayment

\*\*\* Preauthorization required. Preauthorization 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 preauthorization 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.

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

3 Inpatient copayment waived if readmitted within 10 days of discharge.

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-Referral 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-Referral <sup>†</sup>
<b>Emergency Room</b>	\$150 Copayment (which is waived if you are admitted to the hospital)	\$150 Copayment (which is waived if you are admitted to the hospital)
<b>Ambulance</b>		
Emergency	Covered 100%	100% no deductible
Non-Emergency <sup>***</sup>	Covered 100%	80% after deductible
<b>Outpatient Surgery</b>	\$50 Copayment (facility) <sup>***</sup>	80% after deductible
<b>Outpatient Therapy Services</b> (including Speech <sup>†††</sup> Physical and Occupational Therapy)	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	80% after deductible
<b>Spinal Manipulation</b>	Covered 100% (up to 60 consecutive days per condition covered, subject to significant improvement)	80% after deductible
<b>Orthoptic/Pleoptic</b> 8 sessions per lifetime maximum	Covered 100%	80% after deductible
<b>Skilled Nursing Facility</b>	Covered 100% <sup>***</sup> (up to 180 days)	80% after deductible <sup>***</sup> (up to 240 days)
<b>Home Health Care</b>	Covered 100% <sup>***</sup>	80% after deductible <sup>***</sup>
<b>Durable Medical Equipment</b>	All purchases and rentals (including repairs and replacements) are covered 100% when authorized by Primary Care Physician <sup>1</sup>	All purchases and rentals (including repairs and replacements) are covered 80% after deductible <sup>1</sup>
<b>Prosthetics</b>	All purchases (including repairs and replacements) are covered 100% when authorized by Primary Care Physician <sup>1</sup>	All purchases (including repairs and replacements) are covered 80% after deductible <sup>1</sup>
<b>Mental Health</b>		
Inpatient	\$100/day; maximum of 5 <sup>3</sup> Copayments/admission <sup>***</sup>	80% after deductible <sup>***4</sup>
Outpatient	\$15 Copayment	80% after deductible
<b>Serious Mental Illness (SMI)</b>		
Inpatient	\$100/day; maximum of 5 <sup>3</sup> Copayments/admission <sup>***</sup>	80% after deductible <sup>***4</sup>
Outpatient	\$15 Copayment	80% after deductible
<b>Substance Abuse</b>		
Detoxification	\$100/day; maximum of 5 <sup>3</sup> Copayments/admission <sup>***</sup>	80% after deductible <sup>***4</sup>
Outpatient Detoxification	\$15 Copayment	80% after deductible
Inpatient Rehabilitation	\$100/day; maximum of 5 <sup>3</sup> Copayments/admission <sup>***</sup>	80% after deductible <sup>***4</sup>
Outpatient Rehabilitation	\$15 Copayment	80% after deductible

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1 Purchases over \$500 and all rentals require preauthorization.

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## Services and Benefits Not Covered

As with all health insurance plans, Keystone Point of Service coverage excludes certain services. Those not covered include, but are not limited to, the following:

- Services not medically necessary
- Services or supplies that are experimental or investigative except, when approved by Keystone Health Plan East, Routine Costs associated with Qualifying Clinical Trials
- Routine physical exams for non-preventive purposes, such as insurance or employment applications, college, or premarital examinations
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- The cost of services for which another party has primary responsibility
- Hearing Aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Radial keratotomy
- Custodial or domiciliary care
- Personal or comfort items not medically necessary, such as air conditioners, humidifiers, telephone, or similar items
- Contraceptives, except by additional rider
- Assisted fertilization techniques, such as in-vitro fertilization, GIFT, and ZIFT
- Transsexual surgery
- Cosmetic services/supplies
- Immunization for travel or employment
- Prescription drugs and medications, except as required by law or by additional rider
- Treatment for temporomandibular joint syndrome (TMJ)
- Care of the feet, unless medically necessary
- Dental care, including dental implants
- Long-term rehabilitative therapy, e.g., maintenance of chronic conditions (Referred Care)
- Alternative Therapies/complementary medicine
- Self-injectable drugs

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 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).