Keystone Point-of-Service

C2-F2-02 Summary of Benefits

Temple University Students

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, 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	Referred	Self-Referred*
BENEFIT PERIOD	Calendar Year[2]	Calendar Year[2]
DEDUCTIBLE		
Individual	$0	$1,500
Family	$0	$4,500
COINSURANCE LIMIT (includes coinsurance only)		
Individual	None	$10,000
Family	None	$30,000
LIFETIME MAXIMUM	Unlimited	$500,000

* 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.

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.
www.ibx.com

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Benefit	Referred	Self-Referred*
ANNUAL COPAYMENT MAXIMUM (includes copayments only)		
Individual	$1,500	Not Applicable
Family	$3,000	Not Applicable
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 Copayment	50%, after deductible
Specialist Services	$30 Copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	$15 Copayment	50%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%**	50%, NO deductible
ROUTINE EYE EXAM	$30 Copayment (once every two years)	Not Covered
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age (no referral required)	$15 Copayment	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	$15 Copayment	50%, after deductible
Hospital	$100/day; maximum of 5 Copayments/ admission***	50%, after deductible[1]
INPATIENT HOSPITAL SERVICES	$100/day; maximum of 5 Copayments/ admission***	50%, after deductible[1]
INPATIENT HOSPITAL DAYS	Unlimited	70[1]
OUTPATIENT SURGERY	$50 Copayment	50%, after deductible
EMERGENCY ROOM	$100 Copayment (not waived if admitted)	$100 Copayment, NO deductible (not waived if admitted)
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY**		
Routine Radiology/Diagnostic	$30 Copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$60 Copayment	50%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 total visits per year for PT/OT combined	$30 Copayment	50%, after deductible
Cardiac Rehabilitation 36 visits per year	$30 Copayment	50%, after deductible
Pulmonary Rehabilitation 36 visits per year	$30 Copayment	50%, after deductible
Speech 20 visits per year	$30 Copayment	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$30 Copayment	50%, after deductible
SPINAL MANIPULATIONS 20 visits per year	$30 Copayment	50%, after deductible
ALLERGY INJECTIONS/TESTING (Office visit copayment waived if no office visit is charged)	100%, NO deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables**	100%	50%, after deductible
Biotech/Specialty Injectables	$75 Copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per year	90%	50%, after deductible

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** Office visit subject to copayment.

*** 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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Benefit	Referred	Self-Referred[*]
SKILLED NURSING FACILITY	$50/day; maximum of 5 Copayments/ admission[***] 120 days per year	50%, after deductible 60 days per year
HOSPICE AND HOME HEALTH CARE	100%	50%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible $2,500 benefit maximum per calendar year
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$30 Copayment	50%, after deductible
Inpatient	$100/day; maximum of 5 Copayments/ admission[***]	50%, after deductible[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 Copayment per visit	50%, after deductible
Inpatient	$100/day; maximum of 5 Copayments/ admission[***]	50%, after deductible[1]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$30 Copayment per visit	50%, after deductible
Inpatient Rehabilitation	$100/day; maximum of 5 Copayments/ admission[***]	50%, after deductible[1]
Detoxification	$100/day; maximum of 5 Copayments/ admission[***]	50%, after deductible[1]

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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
- 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-ASK BLUE (215-275-2583)

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
- Dental 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 THEARAPY 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, inluding repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES & 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 (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 the 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.