Keystone Point-of-Service

PHO Summary of Benefits

Keystone HEALTH PLAN EAST POINT-OF-SERVICE

Drexel University College of Medicine/Dragon Benefit Plan

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 specialist or to specialists 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.

BENEFITS	REFERRED CARE Tenet Preferred Care	All Other Referred Care	OUT OF NETWORK Self-Referred Care**
DEDUCTIBLE			
Individual	$0	$0	$300
Family	$0	$0	$900
COINSURANCE	$0	$0	80%
OUT-OF-POCKET MAXIMUM			
Individual	$1,500	$1,500	Not applicable
Family	$3,000	$3,000	Not applicable
LIFETIME MAXIMUM	Unlimited	Unlimited	$1,000,000
DOCTOR'S OFFICE VISITS			
Primary Care Services	$5 Copayment	$15 Copayment	80%, after deductible
Specialist Visit	$10 Copayment	$25 Copayment	80%, after deductible
PEDIATRIC IMMUNIZATIONS	$5 Copayment	$15 Copayment	80%, NO deductible
ROUTINE GYN/PAP (No referral required)	$10 Copayment	$25 Copayment	80%, NO deductible
NUTRITIONL COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year	Covered 100%	Covered 100%	80%, after deductible
MAMMOGRAPHY (No referral required)	Covered 100%	Covered 100%	80%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	Covered 100%	Covered 100%	80%, after deductible

**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.

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.

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BENEFITS	REFERRED CARE Tenet Preferred Care	All Other Referred Care	OUT OF NETWORK Self-Referred Care**
MATERNITY			
First OB visit	$10 Copayment (1st Visit)	$25 Copayment (1st Visit)	80%, after deductible
Hospital	$240 Copayment per admission	$240 Copayment per admission	80%, after deductible
INPATIENT HOSPITAL SERVICES*	$240 Copayment per admission	$240 Copayment per admission	80%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited	120
OUTPATIENT SURGERY*	Covered 100%	Covered 100%	80%, after deductible
EMERGENCY ROOM	$50 Copayment (waived if admitted)	$50 Copayment (waived if admitted)	$50 Copayment (waived if admitted)
OUTPATIENT X-RAY/RADIOLOGY			
Routine Radiology/Diagnostic	Covered 100%	Covered 100%	80%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan*	Covered 100%	Covered 100%	80%, after deductible
THERAPY SERVICES			
Physical, Speech* and Occupational Up to 60 consecutive days per condition, subject to significant improvement	Covered 100%	Covered 100%	80%, after deductible ($5,000 benefit period maximum)
Cardiac Rehabilitation	Covered 100%	Covered 100%	80%, after deductible
Pulmonary Rehabilitation	Covered 100%	Covered 100%	80%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum	Covered 100%	Covered 100%	80%, after deductible
SPINAL MANIPULATIONS Up to 60 consecutive days per condition, subject to significant improvement	Covered 100%	Covered 100%	80%, after deductible ($1,000 benefit period maximum)
CHEMO/RADIATION/DIALYSIS*	Covered 100%	Covered 100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING*	Covered 100%	Covered 100%	80%, after deductible
SKILLED NURSING FACILITY*	Covered 100%*** (up to 180 days)	Covered 100%*** (up to 180 days)	80%, after deductible (up to 240 days)
HOSPICE AND HOME HEALTH CARE*[1]	Covered 100%	Covered 100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT*[1]	Covered 100%	Covered 100%	80%, after deductible
PROSTHETICS*[1]	Covered 100%	Covered 100%	80%, after deductible
MENTAL HEALTH CARE			
Outpatient 20 visits per calendar year	$35 Copayment	$35 Copayment	50%, after deductible
Inpatient* 35 days per calendar year	$240 Copayment per admission	$240 Copayment per admission	80%, after deductible

* 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.

**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.

BENEFITS	REFERRED CARE Tenet Preferred Care	All Other Referred Care	OUT OF NETWORK Self-Referred Care**
SERIOUS MENTAL ILLNESS CARE			
Outpatient 60 visits per calendar year	$35 Copayment	$35 Copayment	50%, after deductible
Inpatient* 30 days per calendar year	$240 Copayment per admission	$240 Copayment per admission	80%, after deductible
SUBSTANCE ABUSE TREATMENT			
Outpatient/Partial Facility Visits 60 visits per calendar year, 120 visits lifetime maximum	$10 Copayment	$10 Copayment	80%, after deductible
Inpatient* 30 days per calendar year, 90 day lifetime maximum	$240 Copayment per admission	$240 Copayment per admission	80%, after deductible
Detoxification* 7 days per admission, 4 admissions lifetime maximum	$240 Copay per admission	$240 Copay per admission	80%, after deductible

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What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- 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 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 benefit rider
- Immunizations for travel or employment
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care

This summary represents only a partial listing of the 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 POS 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 1-800-227-3115 (outside Philadelphia) or 215-241-2240 (if calling within the Philadelphia area).

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