

Medical Benefit Highlights

Keystone Direct POS C2-F2-01 Springfield Twp SD

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$500/\$1,500
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$1,500/\$3,000	\$3,000/\$9,000
Coinsurance	0%	30%
Preventive Services	In-Network	Out-of-Network
Preventive Care	No charge	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	\$25	30% after deductible
Specialist Office Visit	\$40	30% after deductible
Retail Health Clinic Visit	\$25	30% after deductible
Telemedicine	\$25	Not covered
Urgent Care Visit	\$70	30% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (In-Network: 30 visits/ year; Out-of-Network: 30 visits/year) ³		
Freestanding	\$30	30% after deductible
Hospital Based	\$30	30% after deductible
Occupational Therapy (In-Network: 30 visits/year; Out-of-Network: 30 visits/year) ³		
Freestanding	\$30	30% after deductible
Hospital Based	\$30	30% after deductible
Speech Therapy (In-Network: 20 visits/ year; Out-of-Network: 20 visits/year)	\$30	30% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room (copay not waived if admitted)	\$100	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

Hospital Services

Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)⁴

Observation Services

Maternity Hospital Services⁴

Inpatient Professional Services (includes Maternity)

Outpatient Surgery

Freestanding

Hospital Based

Outpatient Professional Services

Outpatient Diagnostics

Diagnostic Medical (EKG)

Routine Radiology (X-Ray)

Freestanding

Hospital Based

Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)

Freestanding

Hospital Based

Outpatient Lab and Pathology

Freestanding

Hospital Based

Other Medical Services

Spinal Manipulations (In-Network: 20 visits/year; Out-of-Network: 20 visits/year)

Acupuncture

Standard Injectables

Allergy Injections

Biotech/Specialty Injectables

Home/Office

Outpatient

Chemotherapy

Dialysis

Skilled Nursing Facility (In-Network: 120 days/year; Out-of-Network: 60 days/year)

Home Health

Hospice

In-Network

\$100/Day; max of 5 copays per admission

No charge

\$100/Day; max of 5 copays per admission

No charge

In-Network

\$75

\$75

No charge

In-Network

\$30

\$30

\$30

\$60

\$60

In-Network

No charge

No charge

In-Network

\$35

Not covered

No charge

No charge

\$75

\$75

No charge

No charge

\$50/Day; max of 5 copays per admission

No charge

No charge

Out-of-Network

30% after deductible

30% after deductible

30% after deductible

30% after deductible

Out-of-Network

30% after deductible

Not covered

30% after deductible

Out-of-Network

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Durable Medical Equipment (DME)	30%	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$40	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	\$100/Day; max of 5 copays per admission	30% after deductible
Routine Eye Care	\$40	Not covered

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.
- 4 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

Keystone Direct Point-of-Service 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, 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.

This summary represents only a partial listing of benefits and exclusions of the Medical 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. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

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.

In-network benefits are underwritten or administered by Keystone Health Plan East; Out-of-network benefits are underwritten by QCC Insurance company, subsidiaries of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Vision Benefit Highlights

\$125 Eyewear Benefit - Biennial - Self Funded

Covered Services (Calendar Year)		Your Costs (You pay)	
Exam		In-Network	Out-of-Network
Routine Eye Exam at Davis Participating Providers		Not covered	Not covered
Retinal Imaging		\$39	Not covered
Lenses (1 pair/Every 24 Months) ¹		In-Network	Out-of-Network ²
Single Vision Lenses		No charge	\$125 Reimbursement ³
Bifocal Lenses		No charge	\$125 Reimbursement ³
Trifocal Lenses		No charge	\$125 Reimbursement ³
Lenticular Lenses		No charge	\$125 Reimbursement ³
Lens Options		In-Network	Out-of-Network
Progressive Lenses - Standard/Premium/Ultra/Ultimate		No charge/\$40/\$90/\$125	\$125 Reimbursement ³
Polycarbonate Lenses - Single/Multifocal ⁴		\$30	Not covered
Digital/Intermediate Lenses		\$30	Not covered
Photochromic Lenses - Single/Multifocal		\$15/\$25	Not covered
Photosensitive Lenses - Single/Multifocal		\$60/\$70	Not covered
High-Index 1.67 / High-Index 1.74 Lenses		\$55/\$120	Not covered
Blue Light Lenses		\$15	Not covered
Polarized Lenses		\$60	Not covered
Lens Coatings			
Tinted Plastic Lenses		No charge	Not covered
UV-Coated Lenses		\$12	Not covered
Scratch-Resistant Coating - Single/Multifocal		\$15/\$25	Not covered
Scratch-Protection Plan - Single/Multifocal		Not covered	Not covered
Anti-Reflective Coating - Standard/Premium/Ultra/Ultimate		\$33/\$48/\$60/\$85	Not covered
Frames (1 pair/Every 24 Months) ¹		In-Network	Out-of-Network
Collection Fashion Frames		No charge	Not covered
Collection Designer Frames		No charge	Not covered
Collection Premier Frames		No charge	Not covered
Non-Collection Frames		Up to \$100 Allowance (plus a 20% discount on overage) ⁵	\$125 Reimbursement ³
Visionworks Frames Option		Up to \$100 Allowance (plus a 20% discount on overage) ⁵	Not covered

Contact Lenses (in lieu of glasses) (1 pair/ Every 24 Months) ¹	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Collection Contact Lenses	Not covered	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care ⁶	Up to \$125 Allowance	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care ⁶	Up to \$125 Allowance	Not covered
Non-Collection Contact Lenses	Up to \$125 Allowance (plus a 15% discount on overage) ⁵	Not covered
Medically-Necessary Contact Lenses ⁷	No charge	\$225 Reimbursement

¹ Combined in and out-of-network.

² Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

³ Combined reimbursement.

⁴ Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

⁵ Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

⁶ Only covered with purchase of Non-Collection Contact Lenses.

⁷ Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/LGBooklet or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Administered by Davis Vision.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilfgrieche in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.