Independence

Medical Benefit Highlights

Keystone Direct POS C1-F1-01 Upper Merion SD

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$0/$0	$500/$1,500
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$1,000/$2,000	$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	$10	30% after deductible
Specialist Office Visit	$20	30% after deductible
Retail Health Clinic Visit	$10	30% after deductible
Telemedicine	No charge	Not covered
Urgent Care Visit	$52	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	$20	30% after deductible
Hospital Based	$20	30% after deductible
Occupational Therapy (In-Network: 30 visits/year; Out-of-Network: 30 visits/year)[3]		
Freestanding	$20	30% after deductible
Hospital Based	$20	30% after deductible
Speech Therapy (In-Network: 20 visits/ year; Out-of-Network: 20 visits/year)	$20	30% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$75	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

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Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[4]	No charge	30% after deductible
Observation Services	No charge	30% after deductible
Maternity Hospital Services[4]	No charge	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Outpatient Professional Services	No charge	30% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	$20	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	$20	30% after deductible
Hospital Based	$20	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$40	30% after deductible
Hospital Based	$40	30% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (In-Network: 20 visits/year; Out-of-Network: 20 visits/year)	$20	30% after deductible
Acupuncture	Not covered	Not covered
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables		
Home/Office	$50	30% after deductible
Outpatient	$50	30% after deductible
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (In-Network: 120 days/year; Out-of-Network: 60 days/year)	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Durable Medical Equipment (DME)	No charge	50% after deductible

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Mental Health – Outpatient (includes serious mental illness and substance abuse)	$20	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[4]	No charge	30% after deductible
Routine Eye Care	$20	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**

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Vision Benefit Highlights

$100 Eyewear Benefit

Covered Services	Your Costs (You pay)	
Benefits	**In-Network[1]**	**Out-of-Network**
Annual Plan Maximum	Unlimited	Unlimited
Deductible (Individual/Family)	$0/$0	$0/$0
Out-of-Pocket Maximum (Individual/Family)	$0/$0	$0/$0
Exam	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	Not covered	Not covered
Routine Eye Exam at Davis Participating Providers	Not covered	Not covered
Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Single Vision Lenses	No charge	$100 Reimbursement[3]
Bifocal Lenses	No charge	$100 Reimbursement[3]
Trifocal Lenses	No charge	$100 Reimbursement[3]
Lenticular Lenses	No charge	$100 Reimbursement[3]
Lens Options[4]		
Standard Progressive Lenses	$50	$100 Reimbursement[3]
Premium Progressive Lenses	$90	$100 Reimbursement[3]
Ultra Progressive Lenses	$140	$100 Reimbursement[3]
Ultimate Progressive Lenses	$175	$100 Reimbursement[3]
Polycarbonate Lenses - Single Vision[5]	$30	Not applicable
Polycarbonate Lenses - Multifocal Vision[5]	$30	Not applicable
Photosensitive Lenses – Single Vision	$60	Not applicable
Photosensitive Lenses – Multifocal Vision	$70	Not applicable
High-Index Lenses	$55	Not applicable
High-Index 1.74 Lenses	$120	Not applicable
Blue Light Lenses	$15	Not applicable
Polarized Lenses	$60	Not applicable
Lens Coatings		
Tinted Plastic Lenses	No charge	Not applicable
UV-Coated Lenses	$12	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	$15	Not applicable
Scratch-Resistant Coating Multifocal Lenses	$25	Not applicable
Scratch-Protection Plan Single Vision Lenses	Not covered	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	Not covered	Not applicable
Anti-Reflective Standard Lenses	$33	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable

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Anti-Reflective Ultimate Lenses	$85	Not applicable

Frames	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Davis Collection Fashion Frames	No charge	Not applicable
Davis Collection Designer Frames	No charge	Not applicable
Davis Collection Premier Frames	No charge	Not applicable
Non-Davis Collection Frames	Up to $65 Allowance (plus a 20% discount on overage)[6]	$100 Reimbursement[3]
Visionworks Frames Option	Up to $65 Allowance (plus a 20% discount on overage)[6]	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Every 24 Months	1 / Every 24 Months
Davis Collection Standard Daily Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	Not covered	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $100 Allowance; Evaluation: Not covered	$100 Reimbursement
Medically-Necessary Contact Lenses[7]	No charge	$225 Reimbursement

1 Participating Davis provider benefit.

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

3 Combined cost share.

4 Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

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

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

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.

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Dental Benefit Highlights

Pediatric Dental Program

Routine Covered Services

Keystone Health Plan East's Dental Program stresses prevention of dental disorders by encouraging you to have regular checkups. After a $0 copayment per visit, Keystone Health Plan East's Pediatric Dental Program provides 100% coverage for:

- Cleanings
- Oral Examinations
- Fluoride Treatments

Included as part of your Keystone Health Plan East Benefit package is a preventative Dental Program for children under the age of 12.

With Keystone Health Plan East's Dental Program, there are no deductibles and no annual maximums.

Discounts Available for other Dental Care

Additional dental care is offered at discounted amounts when visiting a participating provider, such as:

How the Program Works

- You must select a participating primary dental office for you and your family from the Primary Dental Office Network listed in the Dental Directory. All family members must receive treatment from the same primary dental office. Once coverage is effective, you may call the primary dental office you have selected for an appointment.
- Additional specialty services may be offered at a discount when visiting a participating provider.

How to Receive Your Dental Benefits

Be sure to indicate the name and number of the primary dental office you have selected from the network in section three of the Keystone Health Plan East Enrollment Form. Return the completed Keystone Health Plan East Enrollment Form to your benefits office.

This summary represents only a partial listing of benefits of the Pediatric Dental Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the dental policy. As a result, this dental plan may not cover all of your dental or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms limitations of the program. If you need more information, please call **1-800-ASK-BLUE** (TTY: 711).

This is intended only to be a summary to the services provided under the Pediatric Dental Program. For a complete listing of benefits refer to the Group Master Contract provided to your employer. As with Keystone Health Plan East's Medical Certificate of Coverage, there are specific exclusions and limitations under this Dental Program, including but not limited to: Services of dentists who are neither participating general dentists nor participating specialists; Services obtained from a specialist without written authorization from a participating primary dentist; Dental services or supplies that are cosmetic in nature, including personalized or specialized techniques; Dental services performed or initiated prior to the effective date of coverage or completed after the termination date of coverage; Dental services or supplies which are unnecessary or experimental according to accepted standards of dental practice; Surgical implants; Periodontal splinting; Services related to the treatment of temporomandibular joint dysfunction; General anesthesia; Any dental service for which the member is eligible under worker's compensation, under federal, state or local government programs, or dental services for which, in the absence of any health services or insurance program, no charge would be made to the individual; Services, the costs of which has been or is later recovered in any action at law or in compromise or settlement of any claim; Dental services performed in a hospital; Charges for broken appointments; Charges for additional treatment necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan; Treatment required as a result of an accidental injury, except for emergency treatment to relieve pain, and Services other than those specifically listed on the schedule.

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 નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ 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 Hilf griege 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'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: 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 នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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: civilrightscoordinator@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*.