Keystone 65

A Blue Cross Medicare Advantage HMO Plan from Keystone Health Plan East

Keystone 65 Direct Rider

An Addendum to Your Evidence of Coverage

Effective January 1, 2008
through December 31, 2008

1-800-645-3965
TTY/TDD: 1-888-857-4816
Seven days a week
8 a.m. — 8 p.m.

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If you are a member of Keystone 65 Direct, you are in an Open Access Point-of-Service (POS) plan. As a member of Keystone 65 Direct, you have the freedom to obtain most covered services in or out of the network without a referral. You will need to choose a primary care physician (PCP), and that PCP will coordinate all of your routine care. There are certain services where you will need to obtain a referral in order to receive the highest level of benefit. Those services include diagnostic X-ray, PT/OT, podiatry, spinal manipulations (chiropractic), and mental health services (Magellan). Other than these services, you have the freedom to see any specialist in or out of network without a referral. If you choose to obtain services from a non-plan (out-of-network) provider, you will be responsible for deductibles and coinsurance.

SECTION 1

IMPORTANT DEFINITIONS

For the purpose of understanding benefits for non-plan (out-of-network) covered services, the terms below have the following meaning:

ALLOWED AMOUNT — The eligible dollar amount of self-referred covered services. The allowed amount will be determined based on:

A. When care is provided, not when payment is made; and

B. Whether the provider is a plan (in-network) professional provider, plan (in-network) facility provider, a non-plan (out-of-network) professional provider, or a non-plan (out-of-network) facility provider.

(i) The allowed amount for covered services provided by a plan facility provider is the billed charge for that covered service reduced by the plan-wide discount in effect for the time period in which the covered services are provided.

(ii) The allowed amount for covered services provided by a plan professional provider is the amount determined by the Keystone 65 Direct fee schedule.

(iii) The allowed amount for covered services provided by a non-plan facility provider or a non-plan professional provider that participates with Medicare is the amount determined by the Medicare fee schedule.

(iv) The allowed amount for covered services provided by a non-plan facility provider or a non-plan professional provider that does not participate with Medicare is the lesser of the actual charge or up to 115% of the Medicare-allowed amount. In some states, the member may be responsible for amounts in excess of the Medicare-allowed amount. Some states do not allow balance billing.

ANNUAL COINSURANCE MAXIMUM — The maximum amount of coinsurance that a member will pay for self-referred covered services in each calendar year, as shown in the Schedule of Copayments and Limitations. The annual coinsurance maximum does not include the deductible amount, any amounts above the allowed amount, or the amount for any non-covered service.

COINSURANCE — A type of cost-share for which the member assumes a percentage of the allowed amount for covered services (such as 20%).

DEDUCTIBLE — A specified amount of self-referred covered services paid by a member before benefits are provided for any remaining self-referred covered services.

LIFETIME BENEFIT MAXIMUM — The maximum amount of benefits available under this program for self-referred covered services as shown in Section 4.

SELF-REFERRED COVERED SERVICE (self-referred) — All covered services listed in Section 4 that the member receives from a plan (in-network) provider or a non-plan (out-of-network) provider without obtaining a referral from the primary care physician. Prior authorization (approval in advance) is required for some self-referred covered services.

PRIOR AUTHORIZATION (approval in advance) — The process whereby all self-referred, non-emergency inpatient and outpatient admissions (surgical, medical, and psychiatric), skilled nursing facility services, rehabilitation therapy services, home health care services, and durable medical equipment are reviewed and approved by Keystone 65 prior to being provided. The purpose of this review is to determine medical necessity and, for admissions, the appropriate length of stay. The member is required to notify Keystone of any self-referred admission at least five (5) working days prior to the scheduled admission. When covered services are required immediately, due to the severity of the member's medical condition, an expedited process is available. Upon notification, Keystone 65 will issue to the member an authorization form and an authorization number prior to the admission. The member must call the prior authorization (approval in advance) telephone number shown on the back of the member ID card in order to comply with this notification requirement and to obtain the required authorization form and authorization number. Services that require prior authorization (approval in advance) and that have not been prior authorized (approval in advance) will not be covered.

SECTION 2

SUMMARY OF BENEFITS

Benefits are provided under this program for medically necessary self-referred covered services as listed in the Schedule of Copayments and Limitations included in this summary. If the member self-refers to any provider other than for emergency services, urgently needed services, renal dialysis (while temporarily out of the area but within the United States), and post-stabilization care, the member may be responsible for payments in excess of the allowed amount in addition to the deductible and coinsurance shown in the Schedule of Copayments and Limitations. Some states do not permit providers to bill in excess of the Medicare-allowed charge.

Benefits for self-referred covered services incurred by a member in a calendar year will be paid at 100% of the allowed amount after the member has paid the annual coinsurance maximum for that calendar year. See the Schedule of Copayments and Limitations for the annual coinsurance maximum amount.

Prior authorization (approval in advance) is required for all non-emergency, self-referred inpatient and outpatient admissions, skilled nursing facility services, rehabilitation therapy services, home health care services, and durable medical equipment, and is the responsibility of the member.

IMPORTANT NOTE

If you have coverage through your former employer, Health and Welfare Fund or Association Group, your policy and procedures may differ. In some cases, benefits may vary. Consult your Schedule of Copayments and Limitations or Member Services for additional information.

APPLICATION OF COINSURANCE

Example 1: The member self-refers to a facility provider who is a plan (in-network) provider.

Charges, discount, allowance, deductible, coinsurance and covered benefit amount:

Provider charge	$30,000
Less Keystone 65 plan-wide discount*	-$24,000
Allowance eligible for deductible/coinsurance	$6,000
Less 20% coinsurance paid by member	-$1,150
Covered benefit amount	**$4,850**

*The plan reserves the right to change or adjust the Keystone 65 plan-wide discount.

Example 2: The member self-refers to a non-facility provider who is a plan (in-network) provider.

Charges, allowance, deductible, coinsurance and covered benefit amount:

Provider charge (allowance)	$600
Allowance eligible for deductible/coinsurance	$600
Less 20% coinsurance paid by member	-$70
Covered benefit amount	**$530**

Example 3: The member self-refers to a specialist who is a non-plan (out-of-network) provider.

Charges, allowance, deductible, coinsurance and covered benefit amount:

Provider charge (allowance)	$450
Allowance eligible for deductible/coinsurance	$450
Less 20% coinsurance paid by member	-$40
Covered benefit amount	**$410**

SECTION 3

EXCLUSIONS

In addition to the exclusions listed in the Evidence of Coverage, the following are also excluded from coverage or reimbursement as benefits for self-referred covered services:

- All preventive care, including routine physicals, and routine gynecological exams and associated screenings, hearing evaluations, and routine eye examinations and refractions.
- Any inpatient or outpatient admission, skilled nursing facility service, rehabilitation therapy service, home health care service, or durable medical equipment that is not prior authorized (approved in advance).
- All services provided under the dental and prescription drug benefits.
- All self-referred services that exceed the allowed amount, the lifetime benefit maximum, or the annual benefit maximum (see the Schedule of Copayments and Limitations).

SECTION 4

HOW TO RECEIVE REIMBURSEMENT FOR SELF-REFERRED COVERED SERVICES

Self-referred out-of-network services only. In-network self-referrals are covered at in-network benefit level.

Claims Procedure — The following information applies to self-referred covered services:

- The member will be required to file a claim in order to receive payment for all self-referred covered services.
- In order to receive a claim form, the member may call the Member Services department at the telephone number shown on the back of the member ID card.
- The member must follow the claim form instructions, including the submission of itemized bills and all required information. The claim form must be signed by the member in order for payment to be issued for self-referred covered services.
- A completed claim form may be submitted after incurred expenses for self-referred covered services that exceed the deductible for each calendar year.
- Submitted claim forms must be received no later than twelve (12) months after the end of the year in which self-referred covered services are received.
- All claim forms with required information should be sent to the address shown on the claim form.

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