Independence

Medical Benefit Highlights

Keystone HMO Villanova University

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**Referred**	**Out-of-Network**
Deductible		
Individual/Family	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1]		
Individual/Family	$1,500/$3,000	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$20	Not covered
Telemedicine Visit	$20	Not covered
Specialist		
Office Visit	$40	Not covered
Telemedicine Visit	$40	Not covered
Retail Health Clinic Visit	$20	Not covered
Urgent Care Visit	$50	Not covered
Virtual Care[2]	**Referred**	**Out-of-Network**
Telemedicine	$10	Not covered
Teledermatology	$10	Not covered
Telebehavioral Health	$10	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[3]		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered
Occupational Therapy (30 visits/year)[3]		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered
Speech Therapy (20 visits/year)	$40	Not covered
Emergency Services	**Referred**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$100	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	Not covered
Hospital Services	**Referred**	**Out-of-Network**
Inpatient Hospital Services	$250/Admission	Not covered
Observation Services	$100	Not covered
Maternity Hospital Services	$250/Admission	Not covered

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Inpatient Professional Services (includes Maternity)	No charge	Not covered

Outpatient Surgery	Referred	Out-of-Network
Freestanding	$100	Not covered
Hospital Based	$100	Not covered
Outpatient Professional Services	No charge	Not covered

Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	$20	Not covered
Routine Radiology (X-Ray)		
Freestanding	$20	Not covered
Hospital Based	$20	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$40	Not covered
Hospital Based	$40	Not covered

Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered

Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (20 visits/year)	$40	Not covered
Acupuncture (18 visits/year)	$40	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables		
Home/Office	No charge	Not covered
Outpatient	No charge	Not covered
Chemotherapy	No charge	Not covered
Dialysis	No charge	Not covered
Skilled Nursing Facility (120 days/year)	$250/Admission	Not covered
Home Health	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment (DME)	30%	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$20	Not covered
All Other Services	$20	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$250/Admission	Not covered
Routine Eye Care	$40	Not covered

1 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.

2 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.

3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at **www.ibx.com**.

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.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Vision Benefit Highlights

Vision Care 150: 12/12/12-Voluntary

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	1 / Contract Year	1 / Contract Year
Routine Eye Exam at Davis Participating Providers	No charge	Not covered
Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 / Contract Year	1 / Contract Year
Single Vision Lenses	$20	$40 Reimbursement
Bifocal Lenses	$20	$60 Reimbursement
Trifocal Lenses	$20	$80 Reimbursement
Lenticular Lenses	$20	$100 Reimbursement
Lens Options[3]		
Standard Progressive Lenses	No charge	$60 Reimbursement
Premium Progressive Lenses	$40	$60 Reimbursement
Ultra Progressive Lenses	$90	$60 Reimbursement
Ultimate Progressive Lenses	$175	$60 Reimbursement
Polycarbonate Lenses - Single Vision[4]	No charge	Not applicable
Polycarbonate Lenses - Multifocal Vision	No charge	Not applicable
Photosensitive Lenses - Single Vision	$65	Not applicable
Photosensitive Lenses - Multifocal Vision	$65	Not applicable
High-Index Lenses	$55	Not applicable
High-Index 1.74 Lenses	$120	Not applicable
Blue Light Lenses	$15	Not applicable
Polarized Lenses	$75	Not applicable
Lens Coatings		
Tinted Plastic Lenses	No charge	Not applicable
UV-Coated Lenses	No charge	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	No charge	Not applicable
Scratch-Resistant Coating Multifocal Lenses	No charge	Not applicable
Scratch-Protection Plan Single Vision Lenses	$20	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	$40	Not applicable
Anti-Reflective Standard Lenses	$35	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable
Anti-Reflective Ultimate Lenses	$85	Not applicable
Frames	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	1 / Contract Year	1 / Contract Year
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 $270 Allowance (plus a 20% discount on overage)[5]	$100 Reimbursement

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Visionworks Frames Option	No charge	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Contract Year	1 / Contract Year
Davis Collection Standard Daily Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	No charge	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $250 Allowance; Evaluation: Up to $60 Allowance; (plus a 15% discount on overage)[5]	$105 Reimbursement
Medically-Necessary Contact Lenses[6]	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 Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

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 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**