Independence

Medical Benefit Highlights

Keystone HMO Villanova University

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**Referred**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual/Family	$250/$500	Not covered
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$3,300/$6,600	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$20 no deductible	Not covered
Telemedicine Visit	$20 no deductible	Not covered
Specialist		
Office Visit	$40 no deductible	Not covered
Telemedicine Visit	$40 no deductible	Not covered
Retail Health Clinic Visit	$20 no deductible	Not covered
Urgent Care Visit	$50 no deductible	Not covered
Virtual Care[3]	**Referred**	**Out-of-Network**
Telemedicine	$10 no deductible	Not covered
Teledermatology	$10 no deductible	Not covered
Telebehavioral Health	$10 no deductible	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Occupational Therapy (30 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Speech Therapy (20 visits/year)	$40 no deductible	Not covered
Emergency Services	**Referred**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$200 no deductible	Covered at In-Network level
Emergency Ambulance	No charge after deductible	Covered at In-Network level
Non-Emergency Ambulance	No charge after deductible	Not covered
Hospital Services	**Referred**	**Out-of-Network**
Inpatient Hospital Services	$250/Admission after deductible	Not covered
Observation Services (copay waived if admitted)	$200 after deductible	Not covered

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Maternity Hospital Services	$250/Admission after deductible	Not covered
Inpatient Professional Services (includes Maternity)	No charge after deductible	Not covered
Outpatient Surgery	**Referred**	**Out-of-Network**
Freestanding	$100 after deductible	Not covered
Hospital Based	$100 after deductible	Not covered
Outpatient Professional Services	No charge after deductible	Not covered
Outpatient Diagnostics	**Referred**	**Out-of-Network**
Diagnostic Medical (EKG)	$20 no deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	$20 no deductible	Not covered
Hospital Based	$20 no deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Outpatient Lab and Pathology	**Referred**	**Out-of-Network**
Freestanding	No charge no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Other Medical Services	**Referred**	**Out-of-Network**
Spinal Manipulations (20 visits/year)	$40 no deductible	Not covered
Acupuncture (18 visits/year)	$40 no deductible	Not covered
Standard Injectables	No charge no deductible	Not covered
Allergy Injections	No charge no deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	No charge after deductible	Not covered
Outpatient	No charge after deductible	Not covered
Chemotherapy	No charge no deductible	Not covered
Dialysis	No charge no deductible	Not covered
Skilled Nursing Facility (120 days/year)	$250/Admission after deductible	Not covered
Home Health	No charge after deductible	Not covered
Hospice	No charge no deductible	Not covered
Durable Medical Equipment (DME)	30% after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$20 no deductible	Not covered
All Other Services	$20 no deductible	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$250/Admission after deductible	Not covered
Routine Eye Care	$40 no deductible	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 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.

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4 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**

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.

Telugu: శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిస్తాయి. 1-800-275-2583 (TTY: 711) కు కాల్ చేయండి.

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។

Taglines as of 11/4/2024

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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - — Qualified sign language interpreters
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - — Qualified interpreters
  - — Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: civilrightscoordinator@1901market.com.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at the following website: **www.healthinsurancehosting.com/notices**.