

Summary of KeystoneBlue HMO Benefits

KeystoneBlue is an HMO product that does not require referrals although selection of a PCP is still necessary. Except for emergencies, all covered services must be received from a Keystone Health Plan West network provider. Below are specific benefit levels that apply during your benefit period.

Benefit	Network
Benefit Period ⁽¹⁾	Contract Year
Deductible (per benefit period)	
Individual	None
Family	None
Plan Payment Level – Based on the provider’s reasonable charge (PRC)	100%
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)	
Individual	None
Family	None
Lifetime Maximum (per person)	Unlimited
Primary Care Physician Office Visits	100% after \$20 copayment
Specialist Office Visits	100% after \$20 copayment
Preventive Care	
<i>Adult</i>	
Routine physical exams	100% after \$20 copayment
Adult Immunizations	100%
Colorectal Cancer Screening	
Basic Diagnostic Services	100%
Medical Surgical	100%
Routine gynecological exams, including a Pap Test	100% after \$20 copayment
Mammograms, annual routine and medically necessary	100%
<i>Pediatric</i>	
Routine physical exams	100% after \$20 copayment
Pediatric immunizations	100%
Emergency Room Services	100% after \$100 copayment (waived if admitted)
Spinal Manipulations	100% after \$20 copayment Limit: 20 visits/benefit period
Physical Medicine	100% after \$20 copayment Limit: 20 visits/benefit period
Speech Therapy	100% after \$20 copayment Limit: 20 visits/benefit period
Occupational Therapy	100% after \$20 copayment Limit: 20 visits/benefit period
Allergy Extracts and Injections	100%
Ambulance	100%
Assisted Fertilization Procedures	Not Covered
Dental Services Related to Accidental Injury	100%
Diabetes Treatment	100%
Diagnostic Services (including routine)	
<i>Advanced Imaging</i> (MRI, CAT Scan, PETscan, etc.)	100%
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%
Durable Medical Equipment, Orthotics and Prosthetics	100%
Enteral Formulae	100%
Home Infusion Therapy	100%
Home Health Care	100%
Hospice	100%
Hospital Services – Inpatient	100% after \$250 deductible (Admissions primarily for Physical Medicine, Speech Therapy, and/or Occupational Therapy Services are limited to a combined total of sixty (60) calendar days, per course of treatment, for the same condition, beginning on the date of the rehabilitation admission)
Hospital Services – Outpatient	100%
Infertility Counseling, Testing and Treatment ⁽²⁾	100%
Maternity (facility & professional services)	100%

Benefit	Network
Medical/Surgical Expenses (except office visits)	100%
Mental Health – Inpatient (3)	100% after \$250 deductible
Mental Health – Outpatient (3)	100%
Private Duty Nursing	100%
Respiratory Therapy	100%
Skilled Nursing Facility Care	100% Limit: 100 days/benefit period
Substance Abuse	
Inpatient Detoxification	100% after \$250 deductible
Inpatient Rehabilitation	100% after \$250 deductible
Outpatient	100%
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%
Transplant Services	100%
Precertification Requirements	Performed by Provider
Prescription Drug Deductible	
Individual	None
Family	None
Premier Prescription Drug Program Mandatory Generic(4) <i>Defined by Premier Pharmacy Network - Not Physician Network.</i> <i>Prescriptions filled at a non-network pharmacy are not covered.</i>	Retail Drugs (31/60/90 day supply) \$8/\$16/\$24 generic copayment \$30/\$60/\$90 brand copayment Maintenance Drugs through Mail Order (90-day Supply) \$16 generic copayment \$60 brand copayment

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's renewal date. Contact your employer to determine the renewal date applicable to your program.
- (2) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (3) State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)
- (4) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your doctor must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.