

## 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.

<b>Benefit</b>	<b>Network</b>
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year
<b>Deductible</b> (per benefit period)	
Individual	None
Family	None
<b>Plan Payment Level</b> – Based on the provider’s reasonable charge (PRC)	100%
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)	
Individual	None
Family	None
<b>Lifetime Maximum</b> (per person)	Unlimited
<b>Primary Care Physician Office Visits</b>	100% after \$20 copayment
<b>Specialist Office Visits</b>	100% after \$20 copayment
<b>Preventive Care</b>	
<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%
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)
<b>Spinal Manipulations</b>	100% after \$20 copayment Limit: 20 visits/benefit period
<b>Physical Medicine</b>	100% after \$20 copayment Limit: 20 visits/benefit period
<b>Speech Therapy</b>	100% after \$20 copayment Limit: 20 visits/benefit period
<b>Occupational Therapy</b>	100% after \$20 copayment Limit: 20 visits/benefit period
<b>Allergy Extracts and Injections</b>	100%
<b>Ambulance</b>	100%
<b>Assisted Fertilization Procedures</b>	Not Covered
<b>Dental Services Related to Accidental Injury</b>	100%
<b>Diabetes Treatment</b>	100%
<b>Diagnostic Services</b> (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%
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%
<b>Enteral Formulae</b>	100%
<b>Home Infusion Therapy</b>	100%
<b>Home Health Care</b>	100%
<b>Hospice</b>	100%
<b>Hospital Services – Inpatient</b>	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)
<b>Hospital Services – Outpatient</b>	100%
<b>Infertility Counseling, Testing and Treatment</b> <sup>(2)</sup>	100%
<b>Maternity</b> (facility & professional services)	100%
<b>Medical/Surgical Expenses</b> (except office visits)	100%

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