

Summary of KeystoneBlue 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.

Municipal Employers Insurance Trust (MEIT)

Benefit	Network
Benefit Period ⁽¹⁾	Calendar 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	N/A
Family	N/A
Lifetime Maximum (per person)	Unlimited
Primary Care Physician Office Visits	100%
Specialist Office Visits	100%
Preventive Care	
<i>Adult</i>	
Routine physical exams	100%
Adult Immunizations	100%
Routine gynecological exams, including a PAP Test	100%
Mammograms, annual routine and medically necessary	100%
<i>Pediatric</i>	
Routine physical exams	100%
Pediatric immunizations	100%
Emergency Room Services	100%
Spinal Manipulations	100%
Physical Medicine	100%
Speech Therapy	100%
Occupational Therapy	100%
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, PET scan, 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%
	(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% after 50% copayment up to a \$200 maximum per plan of treatment

Benefit	Network
Maternity (facility & professional services)	100%
Medical/Surgical Expenses (Except Office Visits)	100%
Mental Health – Inpatient (3)	100% Limit: 30 days/benefit period
Mental Health – Outpatient (3)	100% after \$25 copayment Limit: 20 visits/benefit period
Private Duty Nursing	100%
Respiratory Therapy	100%
Skilled Nursing Facility Care	100% Limit: 100 days/benefit period
Substance Abuse – Inpatient Detoxification	100% Limit: 7 days/admission; 4 admissions/lifetime
Substance Abuse – Inpatient Rehabilitation	100% Limit: 30 days/benefit period; 90 days/lifetime
Substance Abuse – Outpatient	100% after copayment Limit: 60 visits/benefit period; 120 visits/lifetime
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%
Transplant Services	100%
Precertification Requirements	Performed by Provider
Prescription Drug Deductible Individual Family	Per Calendar Year None None
Premier Prescription Drug Program	<i>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</i> Retail Drugs \$3 generic copayment \$5 brand copayment Mandatory Generic (4) 31-day Supply Maintenance Drugs through Mail Order \$6 generic copayment \$10 brand copayment Mandatory Generic (4) 90-day Supply

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective 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 benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- (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, the physician must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, the member is responsible for the payment differential when a generic drug is available and the doctor or patient specifies a brand name drug. The member payment is the price difference between the brand drug and the generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

12/05

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.