

## 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.

### Allegheny County Schools Health Insurance Consortium

7-1-2008

Benefit	Network
<b>Benefit Period</b> <sup>(1)</sup>	Calendar 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%
<b>Specialist Office Visits</b>	100% after \$15 copayment
<b>Preventive Care</b>	
<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%
<b>Emergency Room Services</b>	100% after \$35 copayment (waived if admitted)
<b>Spinal Manipulations</b>	100% after \$15 copayment Unlimited visits/benefit period
<b>Physical Medicine</b>	100% Unlimited visits/benefit period
<b>Speech Therapy</b>	100% Unlimited visits/benefit period
<b>Occupational Therapy</b>	100% Unlimited visits/benefit period
<b>Allergy Extracts and Injections</b>	100%
<b>Ambulance</b>	100%
<b>Assisted Fertilization Procedures</b>	\$15,000 family maximum per lifetime
<b>Dental Services Related to Accidental Injury</b>	100%
<b>Diabetes Treatment</b>	100%
<b>Diagnostic Services (including routine)</b>	
<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%  (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>Benefit</b>	<b>Network</b>
<b>Medical/Surgical Expenses</b> (Except Office Visits)	100%
<b>Mental Health – Inpatient</b> (3)	100% Unlimited days/benefit period
<b>Mental Health – Outpatient</b> (3)	100% Unlimited visits/benefit period
<b>Private Duty Nursing</b>	100%
<b>Respiratory Therapy</b>	100%
<b>Skilled Nursing Facility Care</b>	100%
<b>Substance Abuse – Inpatient Detoxification</b>	100% Limit: 7 days/admission; 4 admissions/lifetime
<b>Substance Abuse – Inpatient Rehabilitation</b>	100% Limit: 30 days/benefit period; 90 days/lifetime
<b>Substance Abuse – Outpatient</b>	100% Limit: 60 visits/benefit period; 120 visits/lifetime
<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 Family	None None
<b>Premier Prescription Drug Program</b>	<i>Defined by Premier Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</i> <b>Retail Drugs(5) (34-day Supply)</b> \$5 generic copayment \$25 brand copayment \$40 non-formulary brand copayment  <i>Maintenance Drugs through Mail Order(5) (90-day Supply)</i> \$5 generic copayment \$25 brand copayment \$40 non-formulary brand copayment

## **Questions? Call 1-800-215-7865**

**Reference Code: E0408003**

*(Please have your Reference Code ready when you call)*

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (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) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your doctor and you elect to purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

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