



Flex Series Copay Options Benefit Guide

Keystone Health Plan East HMO

Members' Primary Care Physician coordinates all of their care. Referrals are required for all specialty care.

Keystone Point-of-Service

Members may receive care coordinated by their Primary Care Physician or obtain care directly. Benefits are maximized when members get referrals to network specialists.

Keystone Direct POS

Members must select a Primary Care Physician but can obtain most health care services in or out-of-network without a referral. *Referrals are required for spinal manipulation, routine X-ray, physical/occupational therapy, and podiatry.*

Personal Choice®

Members have the freedom to obtain care in or out-of-network without a referral.

OFFICE/OUTPATIENT CARE	C1	C2	C3	C4
Primary care office visit	\$10	\$15	\$20	\$30
OB-GYN office visit	\$10	\$15	\$20	\$30
Specialist office visit	\$20	\$30	\$40	\$50
Physical and occupational therapy 30 visits per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Spinal manipulations 20 visits per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Speech therapy 20 visits per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Cardiac rehab - 36 sessions per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Pulmonary rehab - 36 sessions per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Orthoptic/pleoptic therapy - 8 sessions per lifetime (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Outpatient laboratory/pathology (outpatient facility & lab)	\$0	\$0	\$0	\$0
Outpatient x-ray/radiology/diagnostic services				
Routine Radiology/Diagnostic	\$20	\$30	\$40	\$50
MRI/MRA, CT/CTA scans/PET scans*	\$40	\$60	\$80	\$100
(No copay applicable when service performed in an ER or office setting)				
Outpatient mental health* 20 visits per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Outpatient substance abuse* 60 visits per calendar year (combined with PPO out-of-network max) 120 visits per lifetime (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Outpatient serious mental illness* 60 visits per calendar year (combined with PPO out-of-network max)	\$20	\$30	\$40	\$50
Routine gyn exam/pap 1 per calendar year regardless of age (combined with PPO out-of-network max)	\$10	\$15	\$20	\$30
Mammography	\$0	\$0	\$0	\$0
Nutrition counseling for weight management 6 visits per calendar year (combined with PPO out-of-network max)	\$0	\$0	\$0	\$0
Pediatric immunizations	\$0	\$0	\$0	\$0
Injectable medications				
Standard injectables (ex. steroids, antibiotics)	\$0	\$0	\$0	\$0
Biotech/Specialty injectables*	\$50	\$75	\$100	\$125
Maternity 1st visit	\$10	\$15	\$20	\$30
Chemotherapy/radiation/infusion therapy (pre-authorization required for Infusion Therapy)	\$0	\$0	\$0	\$0

* Preauthorization required. Personal Choice® members may be held responsible for financial penalties if they do not preauthorize services when using a BlueCard® PPO provider or an out-of-network provider. Keystone Point-of-Service and Keystone Direct POS members may be held responsible for financial penalties if they do not preauthorize inpatient/outpatient services when using their self-referred/out-of-network benefits. Members will be subject to 20% reduction in benefits if prior approval is not obtained for inpatient/outpatient treatment services for Direct POS and PPO out-of-network/POS self-referred care.

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Flex Series

FACILITY/ANCILLARY	F1	F2	F3	F4	F5
Hospital inpatient* Unlimited days in-network/referred Copay waived for new admissions within 90 days of prior admission (any diagnosis)	\$0	\$100/day Max. 5 copays/admission (\$500)	\$150/day Max. 5 copays/admission (\$750)	\$250/day Max. 5 copays/admission (\$1250)	\$400/day Max. 5 copays/admission (\$2000)
Outpatient surgery*	\$0	\$50	\$75	\$125	\$200
Anesthesia	\$0	\$0	\$0	\$0	\$0
Surgeon/assistant surgeon	\$0	\$0	\$0	\$0	\$0
Skilled nursing facility* 120 days per calendar year (combined with PPO out-of-network max) Copay not waived if admitted from inpatient hospital stay	\$0	\$50/day Max. 5 copays/admission (\$250)	\$75/day Max. 5 copays/admission (\$375)	\$125/day Max. 5 copays/admission (\$625)	\$200/day Max. 5 copays/admission (\$1000)
Home health care*	\$0	\$0	\$0	\$0	\$0
Hospice*	\$0	\$0	\$0	\$0	\$0
Inpatient mental health* 30 days per calendar year (combined with PPO out-of-network max)	\$0	\$100/day Max. 5 copays/admission (\$500)	\$150/day Max. 5 copays/admission (\$750)	\$250/day Max. 5 copays/admission (\$1250)	\$400/day Max. 5 copays/admission (\$2000)
Inpatient substance abuse* 30 days per calendar year (combined with PPO out-of-network max) 90 days per lifetime (combined with PPO out-of-network max)	\$0	\$100/day Max. 5 copays/admission (\$500)	\$150/day Max. 5 copays/admission (\$750)	\$250/day Max. 5 copays/admission (\$1250)	\$400/day Max. 5 copays/admission (\$2000)
Inpatient serious mental illness* 30 days per calendar year (combined with PPO out-of-network max)	\$0	\$100/day Max. 5 copays/admission (\$500)	\$150/day Max. 5 copays/admission (\$750)	\$250/day Max. 5 copays/admission (\$1250)	\$400/day Max. 5 copays/admission (\$2000)
Emergency room (Copay NOT WAIVED, if admitted)	\$100	\$100	\$100	\$100	\$125
Ambulance transport* (elective non-emergency)	\$0	\$0	\$0	\$0	\$0
Dialysis	\$0	\$0	\$0	\$0	\$0
Outpatient private duty nursing* 360 hours per calendar year (combined with PPO out-of-network max)	90%	90%	85%	85%	80%
Durable medical equipment* (purchase items more than \$500 including, repairs and replacements, and all rentals except oxygen, diabetic supplies and unit dose medication for nebulizer)	70%	70%	50%	50%	50%
Prosthetics* (purchase items over \$500, including repairs and replacements, except ostomy supplies)	70%	70%	50%	50%	50%

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For groups under 100, C4 may be paired only with F3, F4 and F5. F5 may be paired with C3 and C4. For PPO and POS plan designs, F5 may be paired with O2.

OUT-OF-NETWORK BENEFITS** - FOR PPO, POS and Direct POS products only	O1	O2
Deductible individual/family	\$500/\$1,500	\$1,500/\$4,500
Coinsurance	70% of plan allowance	50% of plan allowance
Out-of-pocket individual/family	\$3,000/\$9,000	\$10,000/\$30,000
Overall lifetime maximum	\$1,000,000	\$500,000
OFFICE VISIT		
Primary care and specialist office visit	70%	50%
Physical and occupational therapy PPO: 30 visits per calendar year (combined with in-network max) Direct POS/POS: 30 visits per calendar year (out-of-network/self-referred)	70%	50%
Spinal manipulations PPO: 20 visits per calendar year (combined with in-network max) Direct POS/POS: 20 visits per calendar year (out-of-network/self-referred)	70%	50%
Speech therapy PPO: 20 visits per calendar year (combined with in-network max) Direct POS/POS: 20 visits per calendar year (out-of-network/self-referred)	70%	50%
Cardiac rehab PPO: 36 sessions per calendar year (combined with in-network max) Direct POS/POS: 36 sessions per calendar year (out-of-network/self-referred)	70%	50%
Pulmonary rehab PPO: 36 sessions per calendar year (combined with in-network max) Direct POS/POS: 36 sessions per calendar year (out-of-network/self-referred)	70%	50%
Orthoptic/Pleoptic therapy PPO: 8 sessions per lifetime (combined with in-network max) Direct POS/POS: 8 sessions per lifetime (out-of-network/self-referred)	70%	50%
Outpatient Laboratory/Pathology (outpatient facility and lab)	70%	50%
Outpatient x-ray/radiology/diagnostic services Routine Radiology/Diagnostic MRI/MRA, CT/CTA Scans, PET Scans*	70%	50%
Outpatient mental health* PPO: 20 visits per calendar year out-of-network (part of overall in-network max) Direct POS/POS: 20 visits per calendar year (out-of-network/self-referred)	50%	50%
Outpatient substance abuse* 60 visits per calendar year (combined with PPO in-network max) 120 visits per lifetime (combined with PPO in-network max)	70%	50%
Outpatient serious mental illness* 60 visits per calendar year (combined with PPO in-network max)	50%	50%
Routine gyn exam/pap 1 per calendar year regardless of age (combined with PPO in-network max)	70%, no deductible	50%, no deductible
Mammography	70%, no deductible	50%, no deductible
Nutrition counseling for weight management 6 visits per calendar year (combined with PPO out-of-network max)	70%	50%
Pediatric immunizations	70%, no deductible	50%, no deductible
Injectable medications*	70%	50%
Maternity*	70%	50%
Chemotherapy/radiation/infusion therapy (pre-authorization required for Infusion Therapy)	70%	50%

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** Out-of-network providers may bill members for any difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

For groups under 100, C4 may be paired only with F3, F4 and F5. F5 may be paired with C3 and C4. For PPO and POS plan designs, F5 may be paired with O2.

OUT-OF-NETWORK BENEFITS** - FOR PPO, POS, and Direct POS products only	01	02
Hospital inpatient* 70 days out-of-network/self-referred	70%	50%
Outpatient surgery*	70%	50%
Anesthesia	70%	50%
Surgeon/assistant surgeon fees	70%	50%
Skilled nursing facility* PPO: 120 days per calendar year (combined with in-network max) Direct POS/POS: 60 days per calendar year (out-of-network/self-referred)	70%	50%
Home health care*	70%	50%
Hospice*	70%	50%
Inpatient mental health* PPO: 20 days per calendar year out-of-network (part of overall in-network/referred max) Direct POS/POS: 20 days per calendar year (out-of-network/self-referred)	70%	50%
Inpatient substance abuse* 30 days per calendar year (combined with PPO in-network max) 90 days per lifetime (combined with PPO in-network max)	70%	50%
Inpatient serious mental illness* 30 days per calendar year (combined with PPO in-network max)	70%	50%
Emergency room (Copay not waived, if admitted)	Covered at in-network level	Covered at in-network level
Ambulance transport* (elective non-emergency)	70%	50%
Dialysis	70%	50%
Outpatient private duty nursing* PPO: 360 hours per calendar year (combined with in-network max) Direct POS/POS: 360 hours per calendar year (out-of-network/self-referred)	70%	50%
Durable medical equipment* (purchase items more than \$500 including, repairs and replacements, and all rentals except oxygen, diabetic supplies and unit dose medication for nebulizer)	50% \$2,500 benefit maximum per calendar year	50% \$2,500 benefit maximum per calendar year
Prosthetics* (purchase items over \$500, including repairs and replacements, except ostomy supplies)	50%	50%

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