Flex Series Benefit Guide

Personal Choice®, Keystone Point-of-Service and Keystone Health Plan East HMO

OFFICE/OUTPATIENT CARE	C1	C2	C3
Primary Care Office Visit	$10	$15	$20
OB-GYN Office Visit	$10	$15	$20
Specialist Office Visit	$20	$30	$40
Physical and Occupational Therapy 30 visits per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Spinal Manipulations 20 visits per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Speech Therapy 20 visits per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Cardiac Rehab - 36 sessions per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Pulmonary Rehab - 36 sessions per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Orthoptic/Pleoptic Therapy - 8 sessions per lifetime (combined with PPO out-of-network max)	$20	$30	$40
Outpatient Laboratory/Pathology (outpatient facility & lab)	$0	$0	$0
Outpatient X-Ray/Radiology/Diagnostic Services			
Routine Radiology/Diagnostic	$20	$30	$40
MRI/MRA, CT Scans/PET Scans (pre-authorization required for PET Scans)	$40	$60	$80
(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
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
Outpatient Serious Mental Illness* 60 visits per calendar year (combined with PPO out-of-network max)	$20	$30	$40
Routine Gyn Exam/Pap (1 per calendar year regardless of age)	$10	$15	$20
Mammography	$0	$0	$0
Pediatric Immunizations	$0	$0	$0
Injectable Medications			
Standard injectables (ex. steroids, antibiotics)	$0	$0	$0
Biotech/Specialty injectables* (Pre-authorization applies to certain injectables)	$50	$75	$100
Maternity 1st Visit	$10	$15	$20
Chemotherapy/Radiation/Infusion Therapy (pre-authorization required for Infusion Therapy)	$0	$0	$0

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Flex Series

FACILITY/ANCILLARY	F1	F2	F3	F4
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)
Outpatient Surgery*	$0	$50	$75	$125
Anesthesia	$0	$0	$0	$0
Surgeon/Assistant Surgeon	$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)
Home Health Care	$0	$0	$0	$0
Hospice*	$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)
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)
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)
Emergency Room (Copay NOT WAIVED, if admitted)	$100	$100	$100	$100
Ambulance Transport* (elective non-emergency)	$0	$0	$0	$0
Dialysis	$0	$0	$0	$0
Outpatient Private Duty Nursing* 360 hours per calendar year (combined with PPO out-of-network max)	90%	90%	85%	85%
Durable Medical Equipment* (repairs and replacements over $100 and all rentals)	70%	70%	50%	50%
Prosthetics* (repairs and replacements over $100 and all rentals)	70%	70%	50%	50%

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OUT-OF-NETWORK BENEFITS** - FOR PPO & 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 & Specialist Office Visit	70%	50%
Physical and Occupational Therapy PPO: 30 visits per calendar year (combined with in-network max) POS: 30 visits per calendar year (self-referred)	70%	50%
Spinal Manipulations PPO: 20 visits per calendar year (combined with in-network max) POS: 20 visits per calendar year (self-referred)	70%	50%
Speech Therapy PPO: 20 visits per calendar year (combined with in-network max) POS: 20 visits per calendar year (self-referred)	70%	50%
Cardiac Rehab PPO: 36 sessions per calendar year (combined with in-network max) POS: 36 sessions per calendar year (self-referred)	70%	50%
Pulmonary Rehab PPO: 36 sessions per calendar year (combined with in-network max) POS: 36 sessions per calendar year (self-referred)	70%	50%
Orthoptic/Pleoptic Therapy PPO: 8 sessions per lifetime (combined with in-network max) POS: 8 sessions per lifetime (self-referred)	70%	50%
Laboratory/Pathology/Xray/Radiology/Diagnostic Services	70%	50%
Outpatient Mental Health* PPO: 20 visits per calendar year out-of-network (part of overall in-network max) POS: 20 visits per calendar year (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)	70%, no deductible	50%, no deductible
Mammography	70%, no deductible	50%, no deductible
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.

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OUT-OF-NETWORK BENEFITS** - FOR PPO & POS products only	O1	O2
FACILITY/ANCILLARY		
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) POS: 60 days per calendar year (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) POS: 20 days per calendar year (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)	$100	$100
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) POS: 360 hours per calendar year (self-referred)	70%	50%
Durable Medical Equipment* (repairs and replacements over $100 and all rentals)	50% $2,500 benefit maximum per calendar year	50% $2,500 benefit maximum per calendar year
Prosthetics* (repairs and replacements over $100 and all rentals)	50%	50%

INJECTABLE MEDICATIONS SUBJECT TO THE BIOTECH/SPECIALTY INJECTABLE COPAY***:

MULTIPLE SCLEROSIS AGENTS	BOTULINUM TOXIN AGENTS	MIGRAINE AGENTS	RHEUMATOID ARTHRITIS AGENTS	HEPATITIS / INTERFERON ALFA AGENTS	ANTICOAGULANT/ LOW MOLECULAR WEIGHT HEPARIN AGENTS	ENDOCRINE / METABOLIC AGENTS	HYALURONATE AGENTS	GROWTH HORMONES	HEMATOPOIETIC AGENTS	RESPIRATORY AGENTS	MISCELLANEOUS
Avonex Copaxone Betaserone Rebif	*Botox *Myobloc	Imitrex Injection	*Enbrel *Kineret *Humira	Intron A Peg Intron Rebetron Pegasys Roferon-A Actimmune Alferone	Lovenox Fragmin Arixtra Innohep Orgaran	Lupron Zoladex Trelstar Sandostatin	Hyalgan Synvisc Supartz	*Neutropin *Neutropin AQ *Humatrope *Saizen *Serostim *Protropin *Genotropin	Epogen Procrit Neupogen Aranesp Neulasta Leukine	*Xolair *Synagis	*Amevive Fuzeon Forteo Somavert Thyrogen

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