Gold

Care Guide Blue HMO 500

Care Guide Blue HMO 500 offers greater coverage and more predictable costs when you receive care from selected providers. Here's how: Some people plan to use a lot of medical services and want fixed, predictable costs when they get care. With Care Guide Blue HMO 500, you have a fixed copay for some services, like doctor visits and emergency room visits, prior to meeting the deductible. For less common services, you pay 100% of costs of most covered services until the deductible of $500 for individuals or $1,000 for families has been reached. After that, you pay copays and coinsurance until you reach the out-of-pocket maximum for the year. That amount is $5,000 for individuals or $10,000 for families. Then, Keystone Health Plan West covers all your medical expenses when you receive covered health care services from network providers.

Where to turn for help

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

HighmarkBCBS.com

P3161PSFront WPA 26073 (09/13)

Care Guide Blue HMO 500 Explained

KEYSTONE HEALTH PLAN WEST
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Plan Details	Network		Out-of-Network	
	Plan Pays	You Pay[1]	Plan Pays	You Pay
Deductible – Individual	N/A	$500	N/A	N/A
Deductible – Family[2]	N/A	$1,000	N/A	N/A
Coinsurance plan pays after deductible	80%	20%	N/A	N/A
Out-of-Pocket Limit – Individual	N/A	$5,000	N/A	N/A
Out-of-Pocket Limit – Family	N/A	$10,000	N/A	N/A
Preventive Care[3] – Annual deductible and coinsurance do not apply to the Preventive Care services listed below				
Routine Annual Physical Exam	100%	0%	Not Covered	100%
Routine Annual Gynecological Exam	100%	0%	Not Covered	100%
Immunizations – Adult and Pediatric	100%	0%	Not Covered	100%
Routine Mammogram Screenings	100%	0%	Not Covered	100%
Preventive Medications[4]	100%	0%	Not Covered	100%
Illness or Injury Care				
Primary Care Office/Clinic Visit	100% after copay	$15 copay	Not Covered	100%
Specialist Office/Urgent Care Visit	100% after copay	$40 copay	Not Covered	100%
Emergency Room Visit	100% after copay	$100 copay	100% after copay	$100 copay
Prescription Drugs[5]	100% after copay	Generic: $8 Brand: $45	Not Covered	100%
Maternity Services	80% after deductible	20% after deductible	Not Covered	100%
Ambulance Services	80% after deductible	20% after deductible	80% after in-network deductible	20% after in-network deductible
Inpatient Hospital Services	80% after deductible	20% after deductible	Not Covered	100%
Medical/Surgical Expenses	80% after deductible	20% after deductible	Not Covered	100%
Diagnostic Services[6] (Lab, X-ray and other services)	Lab, X-Ray and Radiology: 100% after copay	Lab: $15 copay; X-Ray: $40 copay; Radiology: $80 copay	50% after deductible	50% after deductible
Therapy and Rehabilitation Services[7]	100% after copay	$40 copay	Not Covered	100%
Spinal Manipulations[8]	100% after copay	$50 copay	Not Covered	100%
Skilled Nursing Facility Care	80% after deductible	20% after deductible	Not Covered	100%
Mental Health/Substance Abuse Services	Outpatient: 100% after copay; Inpatient: 80% after deductible	Outpatient: $40 copay; Inpatient: 20% after deductible	Not Covered	100%
Routine Eye Exam (Every 24 months)	100%	0%	Not Covered	100%
Pediatric Dental	Exam/Cleaning: 100%; All other benefits: 50%	Exam/Cleaning: 0%; All other benefits: 50%	Not Covered	100%
Pediatric Vision	Exam: 100%; Frames/Lenses: 100%	Exam: 0%; Frames/Lenses: 0%	Not Covered	100%

[1]You are responsible for out-of-pocket costs each Benefit Period up to a maximum amount shown. Thereafter, the Plan pays 100% of the Provider's Allowable Charge during the remainder of the Benefit Period. This amount does not include amounts in excess of the Provider's Allowable Charge.
[2]Care Guide Blue HMO Family Deductible: For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for Covered Services for that Member for the remainder of the Benefit Period, whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. No individual Member may satisfy the entire family Deductible.
[3]The Highmark Preventive Service Schedule is reviewed and updated periodically based on the requirements of the Patient Protection and Affordable Care Act of 2010, as amended, and the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association and Medical Consultants. Accordingly, the frequency and eligibility of services is subject to change.
[4]Certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes.
[5]Prescription drug copays for a 34-day supply (Retail): $8 generic; $45 brand; $95 non-formulary brand and non-formulary generic; specialty drug copays vary. The plan has a four-tier structure and utilizes the HCR Progressive Formulary on the Premier 2012 network. Mail order available.
[6]Basic Diagnostic Services include four types of service: Standard Imaging Services, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. Basic Diagnostic Services require one copayment per date of service and type of service. Additional Basic Diagnostic Services are subject to deductible and coinsurance. Advanced Diagnostic Services include but are not limited to CAT Scan, CTA, MRI, MRA, PET Scan and PET/CT Scan.
[7]Therapy visit limits include in and out-of-network visits. Physical medicine is limited to 30 visits per contract year combined for Rehabilitative and Habilitative services. Speech therapy and occupational therapy are a combined 30 visit limit per contract year combined for Rehabilitative and Habilitative services.
[8]Spinal manipulations are limited to 20 services per contract year in and out-of-network.

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