THE HMO THAT GIVES YOU MORE
KEYSTONE BLUE
KEYSTONE BLUE WELCOMES YOU

Keystone Blue℠ HMO – a health maintenance organization from Keystone Health Plan West – gives you a wide choice of care providers. Its physician network is made up of more than 2,600 Primary Care Physicians (PCPs), over 6,400 specialists and most hospitals in the area – more than any other HMO in western Pennsylvania.

Keystone Blue HMO covers a broad range of care. You’re covered for routine and preventive care, specialty care, hospital care, women’s care, emergency care, and even out-of-area care. That’s comprehensive care.

Finally, Keystone Blue HMO gives you unmatched member service support. Highmark goes “above and beyond” to serve members effectively and respectfully.

We encourage you to take a few minutes to review this information. When you consider the experience, quality, convenience and comprehensive benefits we provide, we think you’ll feel comfortable with the many advantages this HMO offers.
HOW KEYSTONE BLUE HMO WORKS

As an HMO, Keystone Blue utilizes a network of health care providers to deliver care. Keystone Blue’s physician network includes PCPs, obstetricians/gynecologists and other specialists.

To deliver an exceptional range of care, network hospitals range from advanced teaching and research facilities to local community medical centers. Many of the area’s finest, most renowned hospitals are part of Keystone Blue’s network.

As a Keystone Blue member, you and each of your dependents will choose a primary care physician (PCP). When you select your PCP, you and each covered family member can choose from the following types of physicians: family practitioners, general practitioners, internists and pediatricians…so you and your loved ones can get the care you need. Your PCP must provide certain services, such as routine adult physicals, routine pediatric physicals and routine pediatric immunizations.

For you to receive the best available care, you and your PCP should establish a relationship based on honesty and mutual respect. Your Keystone Blue PCP should give you considerate, courteous and confidential care, clear treatment and diagnosis information, and access to appropriate medical services. In turn, you need to take an active role in maintaining your own health care, talk openly and honestly with your PCP, ask questions, and follow your PCP’s treatment and recommendations.

If for any reason you would like to change your PCP, it’s an easy process. You may make your new selection by calling or writing our Member Service department. Or, once you’ve become a Keystone Blue member, you can make the change online by logging onto our website, www.highmarkbcbs.com. The change will become effective the first of the following month if it is received between the 1st and the 15th of the month. Otherwise, it will become effective the first day of the second month after it is received. You’ll also be sent a new ID card with your new PCP’s name and telephone number on it.

For all specialty services, Keystone Blue gives you the flexibility you want to go directly to any network specialist without a referral from your PCP. Keystone Blue network specialists represent some of the finest experts in their field.

The important thing for you to remember is that Keystone Blue monitors all participating network physicians to ensure that they meet established professional standards…and that you get the best possible care for yourself and your family.

To locate a network provider near you, or to learn whether your current physician is in the Keystone Blue network, go to www.highmarkbcbs.com and click on the “Find a doctor, hospital or other medical provider.”
BLUE DISTINCTION®: THE SIGN OF QUALITY SPECIALTY CARE

If you’re facing a serious medical procedure or surgery, look for the Blue Distinction designation of quality. The Blue Cross and Blue Shield Association awards the Blue Distinction designation to hospitals that deliver superior outcomes for high-risk, high-cost procedures, such as cardiac care, complex/rare cancers, knee/hip replacements, spine surgery and transplants.

Blue Distinction Centers are available nationwide, so you can find quality care wherever you live, work or travel.

To find a Blue Distinction Center, use the online address or Member Service number found on the back of your Member ID card, or go to [www.bcbs.com/bluedistinction/bdcfinder](http://www.bcbs.com/bluedistinction/bdcfinder).

NOTE: Designation as Blue Distinction Centers® means these facilities’ overall experience and aggregate data met objective criteria established in collaboration with expert clinicians’ and leading professional organizations’ recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please contact your local Blue Cross and/or Blue Shield Plan; and call your provider before making an appointment, to verify the most current information on its Network participation and Blue distinction status. Neither Blue Cross and Blue Shield Association nor any of its Licensees are responsible for any damages, losses, or non-covered charges that may result from using Blue Distinction or other provider finder information or receiving care from a Blue Distinction or other provider. To find out more, contact your local Blue Plan.

Blue Distinction is registered service mark of the Blue Cross and Blue Shield Association.
YOU GET A RANGE OF COVERED CARE

*Keystone Blue* provides comprehensive health care coverage. You’re covered for everything from sick care to inpatient and outpatient hospital care. The following are some of your coverage highlights:

**Preventive Care**
This vital care can help you stay on top of your medical needs and establish a healthy lifestyle. That’s why we encourage members to take advantage of *Keystone Blue*’s excellent preventive care benefits. Women are also covered for routine gynecological exams and Pap tests. Refer to your *Summary of Benefits* for the specifics on your coverage.

**Emergency Care**
More than anything, you want the reassurance of knowing that you’re covered when you need care most. *Keystone Blue* covers emergency care received within or outside the *Keystone Blue* provider network. Emergency care received at an out-of-network provider is covered at the network level. This flexibility is critical when you need care *immediately*. So in true emergency situations when you must be treated immediately, go directly to your nearest hospital emergency room or urgent care center, or call “911” or your area’s emergency number.

*You should use emergency services only when appropriate.* In some situations, such as strains or sprains, fevers and sore throats, it may make sense to contact a network doctor, go to the nearest urgent care center or go to your local network retail health clinic (typically found in pharmacies).

**Worldwide Care**
It’s reassuring to know that no matter where you travel, you are covered for your critical and urgent care. *Keystone Blue* provides all of the services of the BlueCard Worldwide® Program. These services include access to a worldwide network of care providers. Medical assistance services are included as well. You access these services by calling 1-800-810-BLUE. Remember, the Cross and Shield symbols on your ID card are recognized around the world - that’s important protection.

**Please note:** Some services are not covered under this program. You may be financially responsible for total payment to the provider for any services not covered by your program. Please refer to the information that you will receive after you enroll for a detailed list of services covered and not covered under your program.
YOU GET SERVICE & SUPPORT WHENEVER YOU NEED IT

Make the most of your health coverage and make strides towards real health improvement! Take advantage of the many tools and resources available to you.

MAKE INFORMED CARE DECISIONS AND LIVE A HEALTHY LIFESTYLE: GET THE INFORMATION YOU NEED ONLINE OR BY PHONE

WebMD®
Begin by logging into www.highmarkbcbs.com.

Enjoy a healthier lifestyle with resources powered by WebMD, a trusted name in online health and wellness.

- **Wellness Profile** – Take a few minutes to take this comprehensive health assessment on your member website. This confidential questionnaire covers all aspects of your health, including nutrition, weight management, physical activity, stress, injury prevention, skin protection, immunizations, and health measures such as blood pressure and cholesterol. Data from the profile is used to generate a personalized action plan that helps you to identify areas in need of health improvement and includes online health and wellness programs and activities.

- **Health and Wellness Programs** – You have a wide selection of online programs to help you lead a healthy lifestyle. Check out all your available programs to help you eat healthy, get active, manage stress, lose weight, and quit smoking. And if you have a chronic health condition, such as asthma and diabetes, there are programs to help you better manage all aspects of your condition.

- **Health Education Tools** – You have thousands of online educational resources! You can look up articles on health conditions, surgeries, procedures, medications and more. You can review care treatment options, check out a comprehensive health library and connect to recent health news articles.

- **Compare Costs and Save** – The Care Cost Estimator lets you compare prices and quality for different health care providers. You can research 359 procedures, including inpatient, outpatient, surgical, laboratory and diagnostics. Do side-by-side comparisons for quality ratings, convenience and cost-effectiveness.
The cost estimates include all services related to a procedure – like a physician fees, supplies and medications. It uses your own specific coverage to calculate what your out-of-pocket costs will be. Your own deductible, coinsurance and copay amounts are taken into account.

Other online health tools help you make informed health care decisions. With reliable cost and quality information, they are easy to find and simple to understand.

- **Personal Health Record** pulls together your history of health conditions, office visits, procedures, tests, medications and immunizations in one location.

- **Compare Prescription Costs** shows you how to save money by using generics.

- **The Provider Directory** helps you select health care professionals based on their quality, experience, location and more.

- **Patient Experience Ratings** let you see how other people rate doctors and medical facilities.

- **Online Plan Activity Statement** combines the claims information with spending account information into one, user-friendly document.

- Coming in 2014, an **interactive, online experience** that consolidates medical, dental, vision and pharmacy activity and spending account summaries. Everything is in one place on the member website, making it easy to track claims and medical spending.

- **Member Discounts** – As a member, you’ll enjoy discounts on a wide range of health-related products and services, fitness club memberships, plus over-the-counter medications. You can save money on diet programs, and even wellness therapies. Just log onto your member website for all the details.

- **Not Yet Registered on your Member Website?**
If you are not yet registered on your member website, take a few minutes to establish your password and register online.

- **Want to “Go Mobile”?**
If you have a web-enabled phone you can access many of the same online features via phone. Use the same registration process and the same member ID and password. Just type [www.highmarkbcbs.com](http://www.highmarkbcbs.com) in your mobile browser to be directed to the site.

**Tell us more about you!**
As part of your health care coverage, you’re eligible for lots of “extras” to help you make sure you get all the information you need – in the way you prefer – by telling us about your preferences and other important member and family information. Go to
www.highmarkbcbs.com to tell us which phone number is best for us to call, and give us your preferences for other communications. If you need special help, because English is not your native language or you belong to a racial, ethnic or cultural group that has not always received the appropriate quality of care, let us know.

The race, ethnicity and language information you provide won’t affect your benefits or coverage, how much you pay or how we pay your claims. We are committed to protecting your personal information and handling it with respect and integrity. Providing this information is voluntary, but we encourage you to consider helping us help you to take charge of your health.

IF YOU ARE PREGNANT, ENROLL IN BABY BLUEPRINTS®

If you are pregnant, you’ll want to join the free Baby Blueprints® Maternity Education and Support Program. Enrolling in Baby Blueprints gives you access to online information on all aspects of pregnancy and childbirth. And you’ll receive individualized support from a nurse Health Coach throughout your pregnancy and after your child is born. To enroll in Baby Blueprints, just call toll-free 1-866-918-5267.
ENGLISH
If you need benefit information in a language other than English or someone to interpret, we're here to help! If you are a member, call the number on the back of your identification card. The language assistance services are free. A printed copy is available for request.

FRENCH
Si vous avez besoin d’informations concernant les prestations dans une langue autre que l’anglais ou si vous souhaitez faire appel à un interprète, nous sommes là pour vous aider ! Si vous êtes membre, veuillez composer le numéro de téléphone qui figure au dos de votre carte d’identification. Les services d’aide linguistique sont gratuits. Une copie imprimée est disponible sur demande.

ARABIC
إذا كنت بحاجة إلى معلومات عن مناقع بلغة غير الإنجليزية أو كنت بحاجة إلى شخص يقوم بالترجمة، نحن هنا للمساعدة! إذا كنت عضوا، أتصل بالرقم الموجود على ظهر بطاقة هويتك. تقدم خدمات المساعدة اللغوية مجانا. توجد نسخة مطبوعة متاحة عند الطلب.

GERMAN
Wenn Sie Informationen über die Versicherungsleistungen in anderen Sprachen als Englisch wünschen oder einen Dolmetscher benötigen, helfen wir Ihnen gerne weiter! Mitglieder rufen die auf der Rückseite der Ausweiskarte aufgeführte Telefonnummer an. Die Übersetzungsdienste stehen kostenlos zur Verfügung. Eine gedruckte Ausfertigung ist auf Anfrage erhältlich.

GREEK
Εάν χρειάζεστε πληροφορίες για παροχές ασφάλισης σε μια άλλη γλώσσα εκτός από τα αγγλικά, ή χρειάζεσθε διερμηνέα, είμαστε εδώ να σας εξυπηρετήσουμε! Εάν είστε μέλος, καλέστε τον αριθμό που βρίσκεται στο πίσω μέρος της κάρτας συνδρομής σας. Οι υπηρεσίες γλωσσικής υποστήριξης είναι δωρεάν. Διατίθενται σε έντυπη μορφή κατόπιν αιτήματος.

GUJARATI
જો તમને લાભો સંબંધિત માહિતી અંગ્રેજી સિવાય કોઈ લાભની જોઈની હોય અથવા કોઈ વ્યક્તિ તમને માહિતીનું અર્થધાર્ય કરી આપે તેવું ચક્કતા હો, તો અમે માદક્રૂપ થવા અમિશ હજાર છીએ! જો તમે સક્ષ્ય હો, તો તમારા અલગાપાયા (એલ.ડી. કડીની) પાણી આપેલા નંબર પર કોન કરો. ભાષા સહાયતા સેવાઓ મદ્દત આપવામાં આવે છે. વિનંતી કરવાથી છાપેલી નકલ ઉપલબ્ધ છે.
यदि आपको लाभों के संबंध में जानकारी अंग्रेजी के अलावा किसी अन्य भाषा में चाहिए या समझने के लिए कोई व्यक्ति चाहिए, तो हम आपकी सेवा में उपस्थित हैं। यदि आप एक सदस्य हैं तो अपने पहचान-पत्र के पीछे दिए गए नंबर पर फोन करें। भाषा सहायता सेवा निशुल्क दी जाती है। अनुरोध करने पर छपी हुई प्रति उपलब्ध है।
Se avete bisogno di informazioni in italiano o di qualcuno che vi faccia da interprete, siamo qui per aiutarvi! Se siete soci, chiamate il numero sul retro della vostra tessera identificativa. I servizi di assistenza linguistica sono gratuiti. Una copia stampata è disponibile su richiesta.

Если Вам необходима информация на русском языке о льготах или нужна помощь переводчика, то мы Вам поможем! Если Вы уже являетесь участником нашей программы, позвоните по номеру телефона, приведенному на обороте Вашей идентификационной карточки участника. Услуги языковой помощи бесплатны. Письменный экземпляр предоставляется по запросу.

Nếu quý vị cần thông tin về quyền lợi bằng tiếng Việt hoặc cần một người thông dịch, chúng tôi có mặt để giúp quý vị! Nếu quý vị là hội viên, hãy gọi số ghi ở phía sau thẻ ID của quý vị. Dịch vụ hỗ trợ ngôn ngữ là miễn phí. Có sẵn bản in nếu yêu cầu.

If you need information in additional languages or require the assistance of a translator, we are here to help you! If you are a member, please call the number on the back of your identification card. Language assistance services are free. A printed copy is available upon request.

اگر آپ کو بیفت (وظیفہ) سے متعلق معلومات انگریزی کی علاوہ کسی دوسروں زبان میں دکھا یا بی ہے سمجھئے کی لیے کسی شخص کی ضرورت ہے تو، لمد کی لیے موجود ہیں! اگر آپ ممبر بن گئے تو، اپنی شناختی کارڈ کی یہ جگہ بھی درج نمیر پر کال کریں۔ زبان سے متعلق لمد کی خدمات مفت ہے۔ درخواست کرئے پر اپک پچھی بونی کاپی دستیاب ہے۔
ADDITIONAL IMPORTANT INFORMATION

DETERMINING YOUR CARE COVERAGE

For benefits to be paid under your program, services and supplies must be considered “Medically Necessary and Appropriate.”

Medical Management + Policy (MM&P) is responsible for determining that care is medically necessary and provided in the appropriate setting.

MM+P will review your care to assure it is “medically necessary and appropriate,” that is:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

CARE & CASE MANAGEMENT

Care Management Process
Recognizing each member has different needs at different times, Care Management represents an integrated, comprehensive approach to providing care support and assuring care is responsive and appropriate. Services listed below are part of a total care management program:

- **Pre-certification Review**, which begins once treatment information is received, is designed to:
  - verify member eligibility for services and benefits;
  - assess medical necessity and appropriateness of care;
  - establish care is being rendered at an appropriate site by an appropriate provider;
  - initiate alternative levels of care when feasible;
  - identify members who will benefit from case management or condition management.
• **Concurrent Review**, which may occur during the course of ongoing treatment, is designed to:
  - evaluate a member’s current medical status to determine need for service continuation;
  - evaluate appropriate level of care for treatment;
  - identify any potential quality of care concerns;
  - identify situations that require a physician consultation;
  - identify cases that may benefit from case management or condition management;
  - update and/or revise the discharge plan.

• **Discharge Planning**, an integral part of the inpatient review process, often begins prior to a scheduled admission and continues throughout the course of treatment to:
  - promote, when appropriate, the use of alternative levels of care;
  - arrange for the provision of care in an appropriate setting;
  - provide early identification of members who may benefit from case management or condition management programs;
  - collaboratively develop and implement appropriate discharge plans.

• **Retrospective Review**, the process of assessing the appropriateness of medical services after the services have been provided, is based solely on the medical information available to the attending physician or ordering provider.

**Case Management**
Case Management helps members to better navigate the health care system and make more informed care decisions:

• **Outreach Case Management** focuses on addressing gaps and/or barriers to care either prior to an inpatient admission or following discharge from a hospital. The case manager educates members on care coordination, support systems, medication knowledge, health and wellness, and on understanding and managing their condition.

• **Intensive Case Management** supports members who may have experienced a serious injury or illness. The case manager collaborates with members, their families, significant others and providers to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual’s health needs using assessment tools, education and community resources.
HOW WE PROTECT YOUR RIGHT TO CONFIDENTIALITY

We have established policies and procedures to protect the privacy of our members’ protected health information from unauthorized or improper use.

As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members’ health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas. You have the right to access the information your doctor has been keeping in your medical records and any such request should be directed first to your network physician.

You have the right to access the information your doctor has been keeping in your medical records and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with doctors, hospitals, vendors and other health care providers.

We provide aggregate information to employer groups whenever possible. In those instances where protected health information is required, the employer group will be required to sign an agreement before the information is released.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to doctors’ offices. It’s all part of assuring that your protected health information is kept confidential.
MEMBER RIGHTS & RESPONSIBILITIES

You have the right to:

1. Receive information about Highmark Blue Cross Blue Shield, its products and services, and members’ rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
5. Voice a complaint or appeal about your Plan or the care provided, and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Members’ Rights and Responsibilities policies.

You have the responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.
OUT-OF-AREA CARE

Keystone Blue HMO covers your out-of-area care. In emergency situations, handle your care just as you would at home. For urgent or follow-up care while you are traveling on business or vacation, you can get access to the country’s largest network of providers through the Blue Cross and Blue Shield Association’s BlueCard® program.

Urgent care is an unexpected illness or injury that cannot wait to be treated until you return home. You do not need to contact your PCP or network specialist for the initial urgent care visit. However, if the out-of-area physician you receive care from recommends you return for an additional visit or recommends that you go to another physician or facility for non-emergency care, you must coordinate this care through your PCP or network specialist before receiving services.

Follow-up care consists of ongoing services started before you left home that you require while traveling. Follow-up care must be coordinated with your PCP or network specialist prior to traveling.

To receive out-of-area urgent or follow-up care, Keystone Blue HMO members should call the BlueCard Provider Access number at 1-800-810-BLUE. You can call 24 hours a day, seven days a week. When you call, you will be given the names of Blue Cross and/or Blue Shield participating physicians in the area where you are traveling. You just call one of these physicians to schedule an appointment. You can also find a provider online at www.bcbs.com, the BlueCard Doctor and Hospital Finder website.

Along with the BlueCard Program for urgent and follow-up care, you can use the service of BlueCard Worldwide to locate providers outside the U.S. by calling the same number, 1-800-810-BLUE. Should you receive care out of the country, call your PCP when you return home to inform him or her about your care. To file for reimbursement, save your medical receipts and call a Member Service representative who will assist you with your claims filing.

Away From Home Care® Guest Membership
For long-term travelers, separated families or students living out of the service area for 90 days or more, Keystone Blue HMO also allows members to receive benefits through the Away From Home Care Guest Membership Program. Through this program, members residing in another plan area for at least 90 days are able to become guest members in the area’s local Blue Cross and/or Blue Shield HMO if one is available. This service can be especially valuable for members who have ongoing health needs that require care while they are away, or for college students living away from home. For more information on this Guest Membership program, call the phone number listed in your enrollment information.
NON-COVERED COVERED SERVICES

Some services are not covered under your Keystone Blue HMO program. These services include, but are not limited to, those listed below. Covered and non-covered services may also vary by employer plan.

- Personal or comfort/convenience items
- Operations for cosmetic purposes done to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except as otherwise provided by your program; other exceptions include: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment, which results from a covered disease or injury
- Custodial care
- For treatment directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as described in your Subscriber Agreement which you receive after you enroll
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma
- Services that are experimental/investigative in nature
- Routine eye examinations (may be covered for some groups)
- Eyeglasses or contact lenses
- Palliative or cosmetic foot care
- Hair growth stimulants; hair replacement surgery or wigs
- Immunizations for foreign travel or employment
- Services which are not medically necessary and appropriate
- Care related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change
- Services eligible for coverage under motor vehicle insurance, Pennsylvania Motor Vehicle Financial Responsibility Act, Workers’ Compensation Act, Occupational Disease Law or similar type legislation
- For complementary alternative care services such as, but not limited to, acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments, and naturopathic services
- Routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel which are not medically necessary and appropriate
- For methadone hydrochloride treatment for which no functional progress is expected to occur
- Services rendered by a provider who is a member of the patient’s immediate family
- Vision correction services related to myopia, hyperopia or presbyopia
- Reversal of voluntary sterilization
- Court-ordered services when not medically necessary and appropriate
- Any treatment leading to or in connection with transsexual surgery, except for sickness or illness resulting from such treatment as surgery
- Weight reduction programs, including weight reduction drugs
- All or some assisted fertilization procedures
- Routine hearing exams and hearing devices
- Private duty nursing when provided in an inpatient setting
• Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared
• Outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate
• Nicotine cessation support programs and/or classes
• Blood storage except when done in preparation for a scheduled surgical procedure
• Normal deliveries outside the service area which could have been foreseen, and non-medical fees associated with maternity services
• Benefits provided to members of the armed forces while on active duty or to patients in Veteran’s Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay
• Services required by a member related to organ donation where the member serves as the organ donor
• Care for conditions that federal, state or local law require to be treated in a public facility
• Respite care, that is, short-term care for a terminally ill member provided by a facility provider to relieve a person (caregiver) who is caring for the member at home free of charge.

This managed care plan may not cover all of your health care expenses. Once you are enrolled, you should read your Keystone Blue HMO Subscriber Agreement carefully to determine which health care services are covered. If you have any questions, please call the toll-free number in the accompanying materials. Also, keep in mind you could be financially responsible for total payment to the provider for any received services not covered by this plan.
TRANSITION OF CARE

If you are receiving medical care from an out-of-network provider at the time of your effective date of coverage, which is not otherwise covered by your prior coverage, you may, at your option, continue an ongoing course of treatment with that provider for a period of up to 60 days from the effective date of your enrollment in Keystone Blue HMO.

Keystone Health Plan West must be notified of your request to continue an ongoing course of treatment for the Transition of Care period. To receive Transition of Care coverage, call the phone number provided with your enrollment materials to request a Transition of Care Form. All requests must be submitted prior to the date your new plan goes into effect.

CONTINUITY OF CARE

If, at the time you are receiving medical care from a network provider, notice is received from Keystone Health Plan West that it intends to terminate or has terminated the contract of that network provider for reasons other than cause you may, at your option, continue an ongoing course of treatment with that provider for a period of up to 90 days from the date of notification of the termination or pending termination. If the network provider is terminated for cause and you continue to seek treatment from that provider, Keystone Health Plan West will not be liable for payment for health care services provided to you following the date of termination.

Both the Transition of Care period and the Continuity of Care period may be extended if determined to be medically necessary and appropriate by Keystone Health Plan West following consultation with you and your provider. In the case of a member who is in the second or third trimester of pregnancy on the effective date of coverage or at the time notice of the termination or pending termination is received, care may continue with the provider through postpartum care related to delivery. Any continuing care services authorized for Transition of Care or Continuity of Care will be covered in accordance with the same terms and conditions as applicable to network providers. Nothing in this section shall require Keystone Health Plan West to pay benefits for health care services that are not otherwise provided under the terms and conditions of your KeystoneBlue HMO Subscriber Agreement.
TO RECEIVE ADDITIONAL INFORMATION ABOUT KEYSTONE HEALTH PLAN WEST

You may receive information on any of the following subjects…

- A list of the names, business addresses and official positions of Keystone Health Plan West’s Board of Directors and Plan Officers.
- The procedures adopted to protect the confidentiality of medical records and other member information.
- A description of the credentialing process for health care providers.
- A list of the participating health care providers affiliated with a specific hospital—please include the name of the hospital for which you want this information.
- Whether a specific drug is included or excluded from your coverage.
- A description of the process by which a health care provider can prescribe a medication that is not included in the prescription drug formulary of Keystone Health Plan West.
- A description of how Keystone Health Plan West determines if a medical technology or drug is experimental.
- A summary of the methods used to reimburse plan providers.
- A description of the Keystone Health Plan West quality assurance program.

Please send your written request along with your name, address and phone number to:

Keystone Health Plan West
Member Information, P.O. Box 226
120 Fifth Avenue, Pittsburgh, PA 15230

Please note that this address is for these requests only – other requests will not be handled through this address.