

Company Name	Keystone VIP	
Plan Premium, Deductible, and Maximum Out of Pocket		
Monthly Plan Premium	\$0.00	You must continue to pay your Medicare Part B premium, if not paid for by Medicaid or another third party.
Deductible	\$0.00	The Plan has no deductible.
MOOP Responsibility	\$9,350.00	(Limit for services received from in-network providers) In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility. If you reach the MOOP you keep getting covered hospital and medical services and the plan will pay the full cost for the rest of the year.
Covered Medical and Hospital Coverage		
Inpatient Hospital Coverage	\$0.00	(Per stay) Prior Authorization is required.
Outpatient Hospital Coverage	\$0.00	This includes medically necessary services for diagnosis or treatment of an illness or injury. Not all outpatient preventive or diagnostic services will require authorization.
Ambulatory Surgical Center	\$0.00	Prior authorization required.
Doctor Visits		
Primary Care	\$0.00	Copay per visit
Annual Wellness Visits	\$0.00	Copay per visit
Specialists	\$0.00	Copay per visit
Preventative		
Preventative Care	\$0.00	Abdominal aortic aneurysm screening, Alcohol misuse counseling, Bone mass measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screening, Cervical and vaginal cancer screening, Colorectal Cancer Screening (colonoscopy, fecal occult blood test flexible sigmoidoscopy), Depression screening, Diabetes screening, Diabetes management, Dementia screening, Eye health screening, Glaucoma screening, Hearing screening, Lung cancer screening, Mammography, Medical nutrition therapy, Medicare Diabetes Prevention Program (MDPP), Obesity screening and counseling, Prostate cancer screening (PSA), Papillary thyroid cancer screening, Pap smear, Pneumococcal vaccination, Smoking cessation, Tuberculosis screening, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Four additional face-to-face PCP visits for smoking/tobacco cessation annually, Vaccines, including flu shots, hepatitis B shots, pneumococcal shots, COVID-19 vaccines, Vision care, Welcome to Medicare preventative Visit (one time)
Emergency and Urgent Care		
Emergency Care	\$0.00	Cost-sharing for necessary emergency services furnished out of network is the same as that for such services furnished in-network.
Urgently Needed Services	\$0.00	This includes services needed to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Cost sharing for necessary urgently needed services furnished out of network is the same as that for such services furnished in-network.
Diagnostic Services/ Lab Imaging		
Diagnostic Services/Lab Imaging (including diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	\$0.00	Covered services include, but are not limited to: Diagnostic tests and procedures, Laboratory tests, Diagnostic radiology services (such as magnetic resonance imaging [MRI], magnetic resonance
Hearing Services		
Hearing Services	\$0.00	For up to one routine hearing exam every year.
	\$0.00	For up to three fittings for a hearing aid every three years.
	\$0.00	For 80 batteries per aid for non-rechargeable models every three years.
	\$2,000.00	For hearing aids every three years (limit one hearing aid per ear).
		Each TruHearing® branded hearing aid purchase includes one year of follow-up provider visits for fitting and adjustments. These visits are available for 12 months following TruHearing® branded hearing aid purchase and only with the purchase of a TruHearing® branded hearing aid.
Dental Services		
Preventive:		
Oral Exams	\$0.00	One every six months
Cleaning	\$0.00	One every six months
Fluoride treatment	\$0.00	One every six months
X-rays	\$0.00	Four every year
Comprehensive	\$5,000.00	Plan coverage limit for every year.
Vision Services		
Treatment	\$0.00	For Medicare-covered diagnosis and treatment for diseases and conditions of the eye.
Routine Eye Exam	\$0.00	For up to one exam every year
Eye Wear	\$500.00	Every year towards Eyeglasses or contact lenses
Mental Health Services		
Inpatient Visit	\$0.00	
Outpatient Group Therapy Visit	\$0.00	
Outpatient Individual Therapy Visit	\$0.00	
Skilled Nursing Facility and Therapy		
Skilled Nursing Facility (SNF)	\$0.00	Plan covers up to 100 days in SNF per admission. Prior authorization is required.
Physical Therapy	\$0.00	Prior authorization is required.
Ambulance and Non-Emergency Transportation		
Ambulance	\$0.00	Prior authorization is required for non-emergency ambulance services.
Transportation	\$0.00	35 one-way trips to plan-approved locations every year (e.g., doctor's office, pharmacy, and hospital). Prior authorization is required for trips that exceed 50 miles one way. Other prior authorization and scheduling rules apply.
Medicare Part B Drugs		
Drugs	\$0.00	Chemotherapy drugs, Other Part B drugs.
Prior authorization is required.		
Part D Prescription Drugs		
Yearly Deductible	No Deductible	For Part D covered drugs.
Initial Coverage	\$0.00	Per prescription for all Part D covered drugs.
Catastrophic Coverage	\$0.00	Per prescription.
30, 60, or 100-day supply of drugs available at retail pharmacy and 61 to 100-day supply using mail-order prescription.		
Additional Covered Benefits		
Acupuncture	\$0.00	The plan covers acupuncture for chronic low back pain for a specified number of visits when reasonable and necessary. Four additional face-to-face primary care provider visits for smoking/tobacco cessation annually. This is in addition to Medicare's eight covered visits, for a total of 12 visits in a 12-month period.
Additional Smoking and Tobacco Use Cessation	\$0.00	The plan covers manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).
Chiropractic Care	\$0.00	SilverSneakers is a free fitness benefit which includes access to participating SilverSneakers fitness facilities, online wellness resources, and classes.
Gym Benefit	\$0.00	Covered services include, but are not limited to, Part-time or intermittent skilled nursing and home health aide services (To receive care under the home health aide services, you must be skilled nursing and home health aide services combined must total fewer than 8 hours per day and 36 hours per week). Physical therapy, occupational therapy, and speech therapy, Medical and social services, Medical equipment and supplies.
Home Health Care	\$0.00	The post-discharge benefit covers 14 days over the course of one week for qualified homestbound members after each discharge from an inpatient facility or a skilled nursing facility. Up to four times per year.
Meal Benefit, post-discharge	\$0.00	A referral is required.
Medical Equipment/Supplies	\$0.00	Prosthetics (e.g., braces, artificial limbs, and breast prostheses). Prior authorization may be required.
Opioid Treatment Program Services	\$0.00	Substance use counseling, individual and group therapy, toxicology testing, Cardiac (heart) rehabilitation services, Occupational therapy visit.
Outpatient Rehabilitation	\$0.00	Physical therapy and speech and language therapy visit.
Over-the-counter Items (OTC)	\$0.00	\$220 per month to use for Over-The-Counter (OTC) items included in the OTC catalog, online ordering portal and qualifying purchases at participating retail settings via a registered smart debit card. Members also qualify on account-based (ASB) plans based on the number of items purchased towards qualifying food & produce at participating retail locations and/or mail-order (item limits may apply), qualifying rent, utility services (including internet), transportation for non-medical needs, pest control, and/or pet supplies.
Podiatry Services	\$0.00	Six routine foot care visits every year.
Telemedicine	\$0.00	MOLIVE offers all members access 24 hours a day, 7 days a week, throughout the year to a participating doctor via telephone, desktop, or mobile device. Members can immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time.
Worldwide Emergency/Urgent Coverage	\$0.00	\$50,000 combined annual maximum plan benefit amount for worldwide emergency coverage, worldwide urgent coverage, and worldwide transportation services.
24/7 Nurse Call Line	\$0.00	The 24/7 Nurse Call Line is a service available to all members 24 hours a day, seven days a week. The service is designed to provide members with a resource to answer health-related questions and to recommend the appropriate level of care.