Keystone Point of Service Plan Design Comparison

Medical Benefits

	2025 Plan Design		2026 Plan Design	
	In-Network	**Out of Network**	**In Network**	**Out- of-Network**
Deductible (Embedded) Individual/Family	$0	$500 / $1,500	**$200 / $400**	**$600/$1,200**
Maximum Out-of-Pocket responsibility (Embedded) Individual/Family	$2,000 / $4,000	$3,000 / $9,000	**$3,000 / $6,000**	**$6,000 / $12,000**
Coinsurance	0%	30%	0%	30%
Preventive Services				
Preventive Care	No charge	30% no deductible	No charge	30% no deductible
Preventive Colonoscopy				
Preventive Plus Providers	No charge	30% no deductible	No charge	Not covered
Hospital Based	No charge	30% no deductible	No charge	30% no deductible
Physician Services				
Primary Care Physician (PCP)				
Office Visit	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Telemedicine Visit	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Specialist				
Office Visit	$40 copay per visit	30% after deductible	$40 copay per visit	30% after deductible
Telemedicine Visit	$40 copay per visit	30% after deductible	$40 copay per visit	30% after deductible
Teladoc Virtual Care Option				
Telemedicine	No charge	Not covered	No charge	Not covered
Teledermatology	No charge	Not covered	No charge	Not covered
Telebehavioral Health	No charge	Not covered	No charge	Not covered
Therapy Services				
Physical Therapy (30 visits/year)				
Freestanding	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Hospital Based	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Occupational Therapy				
Freestanding	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Hospital Based	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Speech Therapy (20 visits/year)	$20 copay per visit	30% after deductible	$20 copay per visit	30% after deductible
Emergency Services				
Emergency Room (copay waived if admitted)	$250 copay	Covered at In-Network level	$250 copay	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level	**No charge after deductible**	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Hospital Services				
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)	$100/day; max of 5 copays per admission	30% after deductible	$100/day; max of 5 copays per admission	30% after deductible
Observation Services	$250 copay	30% after deductible	$250 copay	30% after deductible
Maternity Hospital Services	$100/day; max of 5 copays per admission	30% after deductible	$100/day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Outpatient Surgery				
Freestanding	$50 copay	30% after deductible	$50 copay	30% after deductible
Hospital Based	$50 copay	30% after deductible	$50 copay	30% after deductible
Outpatient Professional Services	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Outpatient Diagnostics				
Diagnostic Medical (EKG)	$20 copay	30% after deductible	$20 copay	30% after deductible
Routine Radiology (X-Ray)				
Freestanding	$20 copay	30% after deductible	$20 copay	30% after deductible
Hospital Based	$20 copay	30% after deductible	$20 copay	30% after deductible
Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)				
Freestanding	$80 copay	30% after deductible	$80 copay	30% after deductible
Hospital Based	$80 copay	30% after deductible	$80 copay	30% after deductible
Outpatient Lab and Pathology				
Freestanding	No charge	30% after deductible	**$20 copay**	30% after deductible
Hospital Based	No charge	30% after deductible	**$20 copay**	30% after deductible
Other Medical Services				
Spinal Manipulations (20 visits/year)	$20 copay	30% after deductible	$20 copay	30% after deductible
Acupuncture (18 visits/year)	$40 copay	30% after deductible	$40 copay	30% after deductible
Standard Injectables	$20 copay	30% after deductible	$20 copay	30% after deductible
Allergy Injections	$20 copay	30% after deductible	$20 copay	30% after deductible
Biotech/Specialty Injectables				
Home Office	$100 copay	30% after deductible	$100 copay	30% after deductible
Outpatient	$100 copay	30% after deductible	$100 copay	30% after deductible
Chemotherapy	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Dialysis	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Skilled Nursing Facility (In-Network: 120 days/year; Out-of-Network: 60 days/year)	$50/day; max of 5 copays per admission	30% after deductible	$50/day; max of 5 copays per admission	30% after deductible
Home Health	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Hospice	No charge	30% after deductible	**No charge after deductible**	30% after deductible
Durable Medical Equipment	30% coinsurance	30% after deductible	30% coinsurance	30% after deductible
Mental Health - Outpatient (includes mental illness and substance abuse)				
Office Visit	$20 copay	30% after deductible	$20 copay	30% after deductible
All Other Services	$20 copay	30% after deductible	$20 copay	30% after deductible
Mental Health - Inpatient (includes serious mental illness and substance abuse)	$100/day; max of 5 copays per admission	30% after deductible	$100/day; max of 5 copays per admission	30% after deductible

Prescription Drug Benefits

	2025 Plan Design		2026 Plan Design	
Benefits per Calendar Year	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible Individual/Family	$0	$0	$0	$0
Maximum Out-of-Pocket Individual/Family	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
Retail Pharmacy				
Generic	$10	30% Reimbursement	**$15**	30% Reimbursement
Preferred	$30	30% Reimbursement	**$35**	30% Reimbursement
Non-Preferred	$50	30% Reimbursement	**$55**	30% Reimbursement
Specialty	N/A	N/A	**$75**	**30% Reimbursement**
Dispensing Limits	30 day supply max	30 day supply max	30 day supply max	30 day supply max
Mail Order Pharmacy				
Generic	$20	Not covered	**$30**	Not covered
Preferred	$60	Not covered	**$70**	Not covered
Non-Preferred	$100	Not covered	**$110**	Not covered
Specialty	N/A	N/A	**N/A - Specialty Drugs dispensed in 30 day supply only**	**Not covered**
Dispensing Limits	90 day supply max	90 day supply max	90 day supply max	90 day supply max