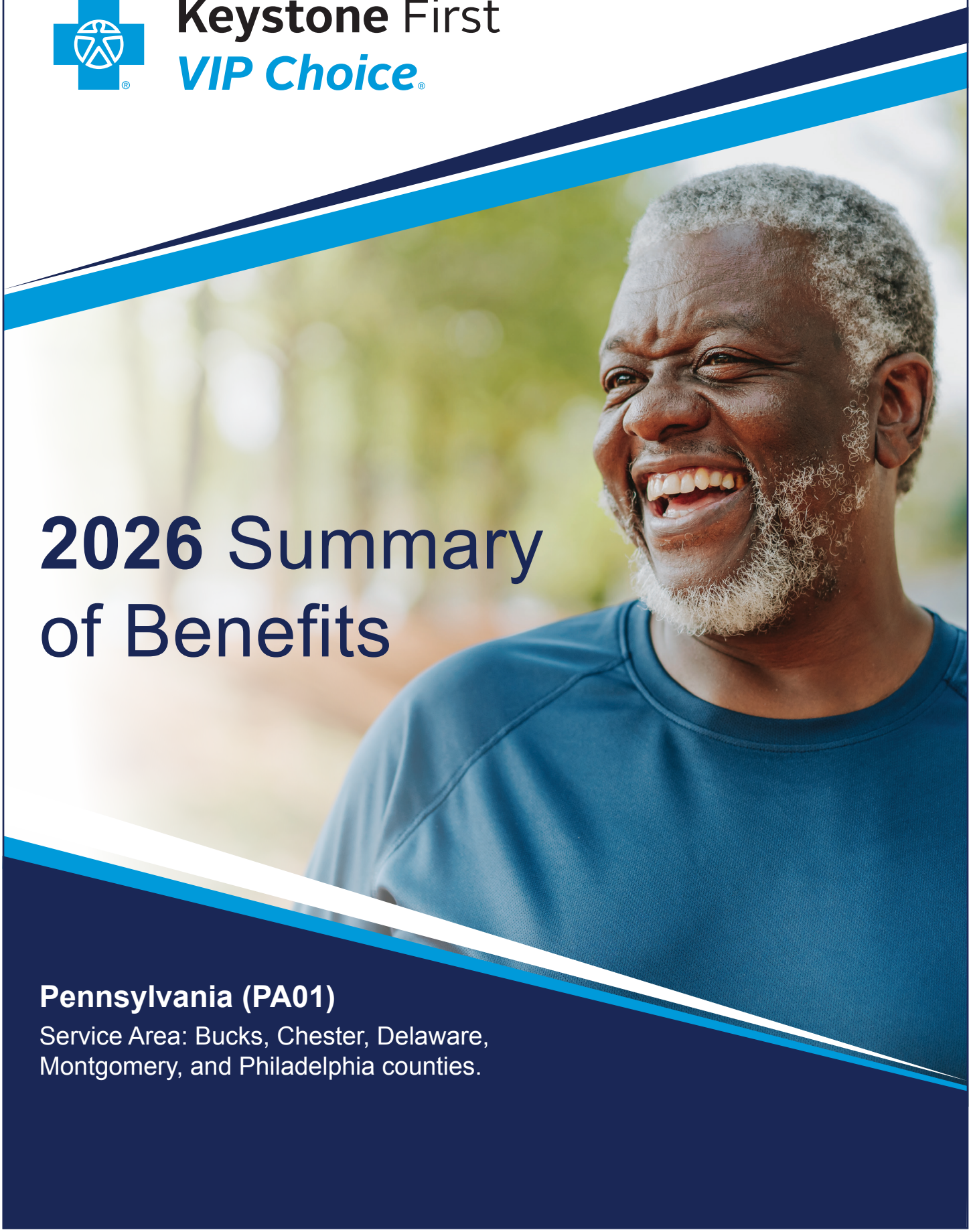
Keystone First
VIP Choice®



2026 Summary of Benefits

Pennsylvania (PA01)

Service Area: Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

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MED-MLT_254637500-1

This booklet provides you with a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage* (EOC) or visit us at https://www.keystonefirstvipchoice.com.

Who can join Keystone First VIP Choice (HMO-SNP)?

To join Keystone First VIP Choice, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and enrolled in the Pennsylvania Medical Assistance Program (Medicaid). You must qualify for Medical Assistance in one of the following categories of aid:

- Qualified Medicare Beneficiary Plus (QMB+).
- Specified Low-Income Medicare Beneficiary Plus (SLMB+).
- Full Benefit Dual Eligible (FBDE).

You must live in our service area. Our service area includes the following counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, or Philadelphia.
For prospective enrollees, if you have questions about your eligibility, call 1-855-241-3648 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday.

Which doctors, hospitals, and pharmacies can I use?

- Keystone First VIP Choice has a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. We will only pay for covered services if you go to an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. Out-of-network/non-contracted providers are under no obligation to treat Keystone First VIP Choice, members, except in emergency situations. Please call our Member Services number, 1-855-241-3648 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday. Or see your *Evidence of Coverage* (Chapter 3) for more information, including the cost-sharing that applies to out-of-network services.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can view our plan's Provider and Pharmacy Directories on our website, **https://www.keystonefirstvipchoice.com**.
- You can also call us, and we will send you a copy of the Provider and Pharmacy Directories.

What we cover

- Like all Medicare health plans, we cover everything that Original Medicare covers — and more.
  - Our plan members get all the benefits covered by Original Medicare.
  - Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.
  - You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **https://www.keystonefirstvipchoice.com**.
  - You can also call us, and we will send you a copy of the formulary.

How will I determine my drug costs?

- Our plan groups all medications into one of six tiers. The cost for your drugs will depend on the level of "Extra Help" you receive and what tier they are in.

Plan Premium, Deductible, and Maximum Out-of-Pocket (MOOP)

Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive.

Monthly Plan Premium	**You pay $0** (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.)
Deductible	**This plan does not have a deductible.**
Maximum Out-of-Pocket Responsibility	In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility. Your yearly limit(s) in this plan: **$9,250** for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.

Covered Medical and Hospital Benefits

Hospital coverage

Inpatient Hospital Coverage	**$0 copay per stay** *Prior authorization is required.*
Outpatient Hospital Coverage	**$0 copay** 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 (ASC) Services	**$0 copay** *Prior authorization may be required.*

Doctor Visits

Doctor Visits (Primary Care Providers and Specialists)	• Primary care provider (PCP) visit: **$0 copay per visit** • Annual Wellness visit: **$0 copay per visit** • Specialist care: **$0 copay per visit**

Preventive

Any additional preventive services approved by Medicare during the contract year will be covered.

Preventive Care	**$0 copay**
	• 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 self-management training • Diabetic services and supplies • Health and wellness education programs • HIV screening • Lung cancer screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screening (PSA) • Sexually transmitted infections screening and counseling • 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 preventive visit (one time)

Emergency and Urgent Care

Emergency Care	**$0 copay** 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 copay** 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, Labs and Imaging

Diagnostic Services/ Labs/Imaging (including diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	**$0 copay** 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 angiography [MRA], computed tomography [CT], and positron emission tomography [PET]) • Outpatient X-rays. *Prior authorization may be required.*

Hearing Services

Hearing Services	• **$0 copay** for up to one routine hearing exam every year. • **$2,000 allowance** for two non-implantable TruHearing branded Advanced hearing aids every three years (limit one hearing aid per ear). The allowance covers the cost of two [2] non-implantable TruHearing branded Advanced hearing aid[s] every three [3] years (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs. * You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: - First 12 months of follow-up provider visits - 60-day trial period - 3-year extended warranty - 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: Over the counter (OTC) hearing aids, ear molds, hearing aid accessories, additional provider visits, additional batteries, batteries when a rechargeable hearing aid is purchased, hearing aids that are not TruHearing-branded Advanced Aids, costs associated with loss & damage warranty claims. Costs associated with excluded items are the responsibility of the member and not covered by the plan. * Remaining costs refers to any amount more than your allowance Services not covered under any condition: Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), over the counter (OTC) hearing aids, ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).

Dental Services

Dental Services	We cover the following services: **Preventive:** • Oral exams – one every six months: **$0 copay** • Cleaning – one every six months: **$0 copay** • Fluoride treatment – one every six months: **$0 copay** • Dental X-rays – one every five years (frequency varies by service): **$0 copay** **Comprehensive:** • Minor restorations (fillings). • Simple and Surgical extractions. • Dentures (1 per arch every 5 years). • Denture repair and reline. • Oral surgery. • Periodontics/endodontics. • Crowns. • Mini-implants. **$4,250 plan coverage limit** for comprehensive dental benefits every year. *Prior authorization and limits may apply for some comprehensive dental services. You are responsible for amounts beyond the benefit limit.*

Vision Services

Vision Services	• **$0 copay** for Medicare-covered diagnosis and treatment for diseases and conditions of the eye. • **$0 copay** for up to one routine vision exam every year. • Up to **$500** every year towards eyeglasses or contact lenses. *The benefit amount (allowance) must be used to pay for vision services from an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. You are responsible for amounts beyond the benefit limit.*

Mental Health Services

Mental Health Services	**$0 copay** • Inpatient visit. • Outpatient group therapy visit. • Outpatient individual therapy visit.

Skilled Nursing Facility (SNF) and Therapy

Skilled Nursing Facility (SNF)	**$0 copay** Our plan covers up to 100 days in an SNF per admission. *Prior authorization is required.*
Physical Therapy	**$0 copay** • Occupational therapy • Speech therapy *Prior authorization is required.*

Ambulance and Non-Emergency Transportation

Ambulance	**$0 copay** *Prior authorization may be required.*
Transportation	**$0 copay** 12 one-way trips to plan-approved locations every year (e.g., doctor's office, pharmacy, and hospital. May consist of a car, shuttle, or van service, depending on appropriateness for the situation and the member's needs.) *Rides must be scheduled at least one business day in advance except in special circumstances. Limit of 50 miles per one-way trip.*

Medicare Part B Drugs

Medicare Part B Drugs	**$0 copay** • Preferred Chemotherapy drugs. • Preferred Other Part B drugs. *Prior authorization is required.* *20% coinsurance will be applied to non-preferred chemotherapy and non-preferred other Part B drugs.*

Part D Prescription Drugs

Keystone First VIP Choice covers a wide range of prescription drugs. They can include medicines you take every day to improve your health and well-being.

IMPORTANT : If you receive assistance from Medicaid or "Extra Help," you may pay less than the cost-sharing amounts listed in this document. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the *Evidence of Coverage* for additional benefit details	
Yearly Deductible stage	$615 for Tiers 1-5, only if you receive "Extra Help" from Medicare, your deductible is $0. The deductible does not apply to tier 6.
Initial Coverage stage	**-Tiers 1, 2, 3 & 5: 0-25% coinsurance** **-Tier 4: 26% coinsurance** **-Tier 6: $0 copay** -You can get a 30, 60 or up to 100-day supply of drugs at a retail pharmacy and 61 to 100-day supply of drugs using a mail-order prescription.
Catastrophic Coverage stage	**$0 copay** per prescription

To find which pharmacies are available in your network, go to **https://www.keystonefirstvipchoice.com**.

Additional Covered Benefits

Additional Smoking and Tobacco Use Cessation	**$0 copay** 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.
Chiropractic Care	**$0 copay** 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).
Fitness Benefit	**$0 copay** SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers® fitness facilities, online wellness resources, and classes.
Home Health Care	**$0 copay** Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *Prior authorization is required.*

Additional Covered Benefits continued…

Meal Benefit, post-discharge	**$0 copay** The post-discharge meal benefit covers 14 meals over the course of one week for qualified homebound members after each discharge from an inpatient facility or a skilled nursing facility. Up to four times per year. *A referral is required.*
Medical Equipment/Supplies	**$0 copay** • Durable Medical Equipment (e.g., wheelchairs and oxygen). • Prosthetics (e.g., braces, artificial limbs, and breast prostheses). *Prior authorization is required for:* • *Medicare-covered DME items over $750 for purchase.* • *Rental and rent-to-purchase items.* • *The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item* • *Enteral Nutritional Supplements* • *Non-Preferred Diabetic Supplies and Continuous Glucose Monitors (20% coinsurance will apply)*
Opioid Treatment Program Services	**$0 copay** • Substance use counseling. • Individual and group therapy. • Toxicology testing.

Additional Covered Benefits continued...

Outpatient Rehabilitation	**$0 copay** • Cardiac (heart) rehabilitation services. • Physical therapy. *Prior authorization is required.*
Over-the-counter Items (OTC)	**$55** per month to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, and more. Funds are loaded to a plan-issued debit card each month. • You can shop through the OTC catalog or at participating retail stores • No limit on the number of items or orders • Unused amounts expire at the end of each month or upon disenrollment from the plan
Podiatry Services	**$0 copay** Four routine foot care visits every year.

Additional Covered Benefits continued…

SSBCI	**SSBCI** If you qualify for SSBCI, you receive a **$65** monthly credit to help with everyday living expenses. This credit can be used for: • Healthy foods • General supports for living (e.g., rent, mortgage, utilities) • Non-medical transportation • Pest control In order to qualify for SSBCI, members must have at least one of the following chronic health conditions: cardiovascular disorders, chronic and disabling mental health conditions, chronic gastrointestinal disease (limited to end stage liver disease), chronic lung disorders (limited to chronic obstructive pulmonary disorder), congestive heart failure, connective tissue disease, dementia, diabetes mellitus, overweight, obesity, & metabolic syndrome, and stroke. In addition: The condition must be life threatening or greatly limit overall health or function of the member; the member must be at high risk of hospitalization or other adverse health outcomes; and the member must require intensive care coordination. The plan will review objective criteria to determine a member's eligibility. For more information or to check eligibility, members should contact the plan.

Additional Covered Benefits continued...

Telemedicine	**$0 copay** We offer 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 copay** **$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 copay** 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.

Appendix C
Current Pennsylvania Medicaid State Plan Benefits and Home and Community Based Services

Adult Benefit Package*	
Services	**Adult Benefit Package**
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 consecutive days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits
Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation. **Key Limitations:** Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime. Denture relines - either full or partial, limited to 1 arch every 2 calendar years. Oral exams - 1 per 180 days Dental prophylaxis - 1per 180 days Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years.

	Crowns, Periodontics and Endodontics only via approved benefit limit exception.
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits).
Targeted Case Management – Behavioral Health Only	Limited to individuals with Serious Mental Illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	

Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for first 28 days; limited to 15 days every month thereafter.
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits).
Durable Medical Equipment	No limits
Prosthetics and Orthotics	Orthopedic Shoes and Hearing Aids are not covered. Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications. Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint. Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
Eyeglass Lenses	Limited to individuals diagnosed with aphakia - 4 lenses per calendar year.
Eyeglass Frames	Limited to individuals diagnosed with aphakia - 2 frames per calendar year. Deluxe frames not included.
Contact Lenses	Limited to individuals diagnosed with aphakia - 4 lenses per calendar year.
Medical Supplies	No limits
Therapy (physical, occupational, speech) – Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Therapy (physical, occupational, speech) – Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventative/Wellness Services and Chronic Care	
Tobacco Cessation**	70, 15-minute units per calendar year

All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.

***Children's benefit plan will include all medically necessary services without limitation.**

****Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. For a full listing of preventative services beyond tobacco cessation, please contact your MCO.**

Home and Community-Based Services (HCBS)	
Services	**Services with Limits**
Adult Daily Living Services Assistive Technology Behavior Therapy Benefits Counseling Career Assessment Chore Services Cognitive Rehabilitation Therapy Community Integration Community Transition Services Counseling Employment Skills Development Home Adaptations Home Delivered Meals Home Health Aide Home Health – Nursing Home Health – Occupational Therapy Home Health – Physical Therapy Home Health – Speech and Language	**Community Integration** **Limit:** Each distinct goal may not be more than twenty-six (26) weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, OLTL retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks. **Community Transition Services** **Limit:** Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office **Employment Skills Development** **Limit:** Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval.

Therapy Job Coaching Job Finding Non-Medical Transportation Nutritional Counseling Participant-Directed Community Supports Participant-Directed Goods and Services Personal Assistance Services Personal Emergency Response System (PERS) Pest Eradication Residential Habilitation Respite Service Coordination Specialized Medical Equipment and Supplies Structured Day Habilitation TeleCare Vehicle Modifications	**Specialized Medical Equipment and Supplies Limit:** Under Specialized Medical Equipment and Supplies non-covered items include: All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream) Items covered under third party payer liability Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability Food, food supplements, food substitutes (including formulas), and thickening agents Eyeglasses, frames, and lenses Dentures Any item labeled as experimental that has been denied by Medicare and/or Medicaid Recreational or exercise equipment and adaptive devices for such

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third-party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

For more information, please contact Keystone First VIP Choice:

- **Not a member yet?**
  Contact us at 1-855-241-3648 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday.

- **Already a member?**
  Contact us at 1-800-450-1166 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday.

- Visit our website at **https://www.keystonefirstvipchoice.com**

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, seven days a week.

This information is not a complete description of benefits. Call 1-800-450-1166 (TTY 711) at the hours listed above for more information.

Keystone First VIP Choice is an HMO-DSNP plan with a Medicare contract and a contract with the Pennsylvania Medicaid program. Enrollment in Keystone First VIP Choice depends on contract renewal.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-800-450-1166 (TTY 711), October 1 – March 31, 8 a.m. – 8 p.m., seven days a week. From April 1 – September 30, call 8 a.m. – 8 p.m., Monday through Friday. The call is free.

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Keystone First VIP Choice®

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

www.keystonefirstvipchoice.com

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