Keystone 65 (KS65) Plan Change Form 1

2008 Rates

Please check off desired option and return via fax (215-761-0335) no later than October 5, 2007

Benefit Summary	KS65 Discount Drug Only ❑	KS65 Rx III ❑
Monthly Premium	$114.14	$241.16
Family Physician/ Specialist Copay	$15/$35	$15/$30
Emergency Room Copayment	$50 (**Not waived** if admitted)	$50 (**Not waived** if admitted)
Ambulance	$100	$50
Inpatient Hospital Copayment (Unlimited days each benefit period) Using Tier 1 hospitals members incur less out of pocket costs. Directory is available with new member kit.	Tier I: $150/day - $1,500 per stay Tier II: $250/day - $2,500 per stay	$150/day/$1,500 Annual Maximum (Tiering does not apply)
Inpatient Mental Health	$150 day/$1,500 per stay. Separate Mental Health Out of Pocket Maximum	$150/$1,500 Annual Maximum. Separate Mental Health Out of Pocket Maximum
Outpatient Surgery Copayment	15%	$150
Skilled Nursing Facility	$25 per day 100 days per benefit period	$25 per day 100 days per benefit period
Physical, Speech & Occupational Therapy Copayment	$35	$30
Vision Reimbursement Maximum	$100 every 2 calendar years	$100 every 2 calendar years
Durable Medical Equipment	20%	20%
Dental Copayment	$15 Value Dental	$15 Value Dental
Out of Network	N/A	N/A
Prescription Drugs	Discount Only H071, #M42, QN, Y	No deductible; $5/$20/$40 up to $2,500 Initial Coverage Limit (ICL), $5 generic copay until $4,050 TrOOP, 100% member liability of brand until $4,050. Then the greater of $2.25/$5.60 coinsurance. One copay for mail order. H070, #496, QN, Y

All Premium Rates shown above are pending approval from CMS.

NOTE: MEMBERS MUST BE ENROLLED IN PART D THROUGH KEYSTONE 65 IN ORDER TO TAKE ADVANTAGE OF THESE RATES. BY ELECTING ONE OF THESE OPTIONS, THE GROUP ALSO GIVES KEYSTONE 65 APPROVAL TO AUTO ENROLL ITS MEMBERS INTO PART D.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independent Blue Cross- Independent licensees of the Blue Cross and Blue Shield Association. Details of Benefits in Evidence of Coverage (EOC).

Group Name _____Group/Account Number(s) _____Customer Email Address_____

Customer Signature _____ Date _____ Customer Phone # _____