PerformPlus® Total Cost of Care for Primary Care Providers

Improving quality care and health outcomes

2026

Keystone First

Keystone First
200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Primary Care Provider:

Keystone First is pleased to announce that our Quality Enhancement Program (QEP) has been renamed to the PerformPlus® Total Cost of Care Program for Primary Care Providers.

We are excited to continue partnering with you through this enhanced incentive program and will work with your primary care practice so you can maximize your revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your Provider Account Executive.

Sincerely,

Lily Higgins, MD, MBA, MS
Market Chief Medical Officer

Kim Beatty
Director, Provider Network Management

www.keystonefirstpa.com

Introduction

The PerformPlus® Total Cost of Care Program is an upside only reimbursement system developed by Keystone First (the Plan) for participating primary care providers (PCPs).

The program is intended to be a fair and open system that provides incentives for high-quality and cost-effective care, member service and convenience, and submission of accurate and complete health data. Quality performance is the most important determinant of the additional compensation. As additional meaningful measures are developed and improved, the program's quality indicators will continue to be refined. The Plan reserves the right to make changes to this program at any time and shall provide written notification of any changes.

Program overview

The PerformPlus Total Cost of Care program is intended to provide financial incentives over and above a PCP practice's base compensation. Incentive payments are not based on individual performance, but rather the performance of your practice, unless you are a solo provider.

Program components can only be measured effectively for offices whose panels averaged 150 or more members at the Taxpayer Identification Number (TIN) level for a defined average enrollment period. For tax entities with fewer than 150 members, there is insufficient data to generate appropriate and consistent measures of performance. These providers are not eligible for participation in the PerformPlus Total Cost of Care Program. Additionally, a Total Cost of Care incentive will accompany the settlement for groups who performed above their peers on quality measures of the program and whose actual medical costs were lower than expected medical costs.

Performance Incentive Payment (PIP)

A Performance Incentive Payment (PIP) may be paid in addition to a practice's base compensation. The incentive payment calculation is based on how well a PCP office scores on each measure relative to established targets. The two performance components are:

1. Quality Performance
2. Electronic Quality Measures
3. Total Cost of Care Component
4. Health Equity Component

1. Quality Performance

This component is based on quality performance measures consistent with HEDIS® technical specifications and predicated on the Keystone First Preventive Health Guidelines and other established clinical guidelines.

These measures are based on services rendered during the reporting period and require accurate and complete encounter reporting. Please note that with the exception of the Plan All-Cause Readmissions - Observed/Expected Ratio measure, each measure requires participating PCP providers to have a minimum of five members who meet the HEDIS eligibility requirements detailed next to

the HEDIS measure. The Plan All-Cause Readmissions - Observed/Expected Ratio measure only requires participating PCP providers to have a minimum of one member who meets the HEDIS eligibility requirements detailed next to the HEDIS measure.

The Quality Performance measures are:

Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Asthma Medication Ratio (AMR)	The percentage of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	Members ages 5 – 64 as of December 31 of the measurement year. Report the following age stratifications and total rate: • 5 – 11 years. • 12 – 18 years. • 19 – 50 years. • 51 – 64 years. • Total.	The total is the sum of the age stratifications for each product line.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage during each year of continuous enrollment.
Child and Adolescent Well-Care Visits (WCV)	The percentage of members who had at least one comprehensive well-care visit with a PCP or an OB/GYN provider during the measurement year.	3 – 21 years as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (e.g., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).
Controlling High Blood Pressure (CBP) <140/90 mm Hg	The percentage of members ages 18 to 85 with a documented outpatient diagnosis of hypertension with a most recent blood pressure reading of <140/90 mm Hg. Results are based on reporting of appropriate CPT II codes.	Members ages 18 to 85 as of December 31 during the applicable measurement year.	The measurement year.	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
Developmental Screening in the First 3 Years	The percentage of children screening for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of measurement year.	Children who are enrolled continuously for 12 months prior to the child's first, second, or third birthday.	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a one-month gap in coverage (i.e., a beneficiary whose coverage lapses for two months or 60 days is not considered continuously enrolled).

(continued on page 6)

Quality Performance measures (*continued from page 5*)

Measure	Measure description/ rate calculation	Eligible members	Continuous enrollment	Allowable gap
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at Glycemic Status >9.0%.	Members with diabetes ages 18 – 75 as of December 31 of the measurement year.	The measurement year.	No more than one gap in enrollment of up to 45 days during the measurement year.
Lead Screening	The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	Children who turn 2 years old during the measurement year.	12 months prior to the child's second birthday.	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Plan All-Cause Readmissions — Observed/ Expected Ratio	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. For the Observed to Expected Ratio calculation, the rate will be represented by the count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals.	Members ages 18 to 64 as of the Index Discharge Date.	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months: Well-Child Visits in the First 15 Months: six or more well visits.	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.	31 days old to 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth.	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (e.g., a member whose coverage lapses for two months [60 days] is not considered enrolled).

Overall score calculation

Results will be calculated for each of the aforementioned Quality Performance measures for each tax entity and then compared to the established targets in each payment cycle. Providers who meet the established targets will qualify for a per member, per month (PMPM) payment for that particular measure.

Quality Performance Incentive

This incentive is paid quarterly on a fixed PMPM basis, based on the number of Keystone First members on your panel as of the first of each month during the quarter. PMPM amounts will be calculated based on meeting established target rates as illustrated below. (See quarterly targets table below.) There is no adjustment for the age or sex of the member.

2026 Incentive Timeline

Payment cycle	Measurement period	Claims period	Total cost of care period	Payment date
1	1/1/2026 – 6/30/2026	1/1/2026 – 3/31/2026	4/1/2025 – 3/31/2026	September 2026
2	1/1/2026 – 9/30/2026	4/1/2026 – 6/30/2026	7/1/2025 – 6/30/2026	December 2026
3	1/1/2026 – 12/31/2026	7/1/2026 – 9/30/2026	10/1/2025 – 9/30/2026	March 2027
4	1/1/2026 – 12/31/2026 + runout	10/1/2026 – 12/31/2026	1/1/2026 – 12/31/2026	June 2027

The following table is an example of potential earnings based on the program's past payment history. The dollar amounts reflected in the table are for illustration purposes and may vary from cycle to cycle.

2026 Quality Measure PMPM Examples

Quality measure targets achieved	Open office (PMPM)	Current patients only (PMPM)	Closed (PMPM)
8	$0.40	$0.20	$0.00
7	$0.35	$0.175	$0.00
6	$0.30	$0.15	$0.00
5	$0.25	$0.125	$0.00
4	$0.20	$0.10	$0.00
3	$0.15	$0.075	$0.00
2	$0.10	$0.05	$0.00
1	$0.05	$0.025	$0.00

Open office: Accepting all new patients (includes Providers who have reached panel maximum).
Current patients only: Open only to current patients or their relatives.
Closed: Not accepting new patients.

Note: The submission of accurate and complete encounters is critical to ensure your practice receives the correct calculation, based on the services performed for Keystone First members.

Note: If you do not submit encounters reflecting the measures shown on the above pages (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.

Target Rates — Cycles 1 – 4

2026				
Quality measures	Q1	Q2	Q3	Q4
Asthma Medication Ratio	81.64%	76.37%	78.15%	78.95%
Child & Adolescent Well-Care Visits (WCV)	30.48%	49.23%	64.68%	65.11%
Controlling High Blood Pressure	58.51%	68.02%	70.96%	71.34%
Developmental Screening in First Three Years	72.83%	80.92%	81.82%	81.82%
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%)	43.88%	31.91%	25.93%	25.93%
Lead Screening	*****	*****	*****	93.33%
Plan All Cause Readmission - Count of Observed/ Expected Ratio	*****	*****	*****	1.243
Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 Months: six or more well visits)	69.23%	75.63%	78.08%	76.92%
Controlling High Blood Pressure - LAB Result Submission	*****	*****	*****	75th Percentile
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) - LAB Result Submission	*****	*****	*****	75th Percentile
Controlling High Blood Pressure – Health Equity Black American Population	*****	*****	*****	75th Percentile
Controlling High Blood Pressure – Health Equity Hispanic/Latino American Population	*****	*****	*****	75th Percentile
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) – Health Equity Black American Population	*****	*****	*****	75th Percentile
Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%) – Health Equity Hispanic/Latino American Population	*****	*****	*****	75th Percentile
Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 Months: six or more well visits) – Health Equity Black American Population	*****	*****	*****	75th Percentile
Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 Months: six or more well visits) – Health Equity Hispanic/Latino American Population	*****	*****	*****	75th Percentile
Developmental Screening in First Three Years – Health Equity Hispanic/Latino American Population	*****	*****	*****	75th Percentile

2. Electronic Quality Measures

Providers will receive an additional incentive during the fourth and final settlement by submitting result data throughout the program year for the following HEDIS measures:

- Controlling High Blood Pressure (<140/90 mm Hg)
- Glycemic Status Assessment for Patients with Diabetes (GSD) (>9%)

Electronic submission of data can be achieved through integration with the health information exchange (HIE) or through direct data integration with Keystone First through a data aggregator.

For more details on how to initiate data integration, please contact your assigned Provider Account Executive.

3. Total Cost of Care Component

The Total Cost of Care component for the program represents an actual versus expected medical cost analysis that determines an efficient use of services based on the population being served. This efficient use of services calculation is what ultimately establishes a shared savings pool that is then made available to providers based on their quality performance across the state-mandated measures in the program.

Total Cost of Care — efficient use of services calculation

Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend (as determined using the 3M™ Clinical Risk Groups [CRG]) in the measurement year. By comparing the actual cost to the expected cost, Keystone First calculates an actual versus expected cost ratio.

The actual versus expected cost ratio is the ratio of the actual medical and pharmacy cost to the expected cost. A practice's panel whose actual medical cost is exactly equal to the expected medical cost would have an actual versus expected cost ratio of 1, or 100%, indicating that the panel cost is exactly as expected for the health mix of the attributed population. An actual versus expected cost ratio of less than 100% indicates a lower-than-expected spend and therefore a savings. The savings percentage is then calculated using the difference between 100% and the practice's actual versus expected cost ratio. This savings percentage is capped at 10%. If the result of this calculation is greater than 10%, 10% will be used. The shared savings pool will be equal to the savings percentage multiplied by the practice's reimbursement for services rendered during the claims period and then multiplied by a factor to increase the earning potential for high performers.

Total Cost of Care — provider performance earnings example

For example, Provider X had an actual medical cost of $950,000 versus an expected medical cost of $1,000,000. This results in a 95% efficient use of services score, with a margin of 5%. The provider also billed $100,000 in claims during this time, which would result in establishing a shared savings pool of $5,000 [provider spend × margin × factor] available to the provider to earn through this program.

The amount of dollars earned from this shared savings pool is then determined by how well the providers performed across the eight state-mandated measures in the program when compared to their peers. Points are earned per measure based on the percentile ranking achieved for the year:

- 60th percentile and higher = 3 points.
- 55th – 59th percentile = 2 points.
- 50th – 54th percentile = 1 point.

The total earned points across all eligible measures divided by the potential points available per measure determines the percentage of the shared savings pool to be incentivized to the provider. For example, of the eight HEDIS measures, Provider X had an adequate sample size for seven of them, and performed among the other providers in the program within the above-illustrated percentile rankings to earn 15 of a total potential of 21 points. Earned points divided by potential points equals 71%, and that percentage times the previously established $5,000 shared savings pool via the Total Cost of Care component of the program would result in a $3,571 incentive earned.

Similar to the quality performance incentive payment, the Total Cost of Care incentive payment is also based your current panel status. If a provider is "open" they are eligible for 100% of the earned incentive. If a panel is "current patients only," they are eligible for 50% of the earned incentive. If a panel is "closed" the provider is not eligible for an incentive.

4. Health Equity Component

PCP providers who meet or exceed established targets will be awarded an additional increase in their total earned PMPM with regard to the following measures for their Black American and Hispanic/Latino populations: Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes (GSD) (>9.0%), and Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 Months: six or more well visits).

Additionally, PCP providers who meet or exceed established targets will be awarded an additional increase in their total earned PMPM with regard to the following measure for their Hispanic/Latino population: Developmental Screening in First Three Years.

5. Sample Scorecard

Keystone First

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

PerformPlus® Total Cost of Care (TCOC)

1 **Payment Cycle: 4**

2 **Claims Cycle: January 2025 through December 2025**

Claims Paid Through: March 31, 2026

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Tax Name: GENERAL PRACTICE
Tax ID: 999999999
Panel_Status: 1_OPEN

Panel Average Enrollment: 5,956
Member Months: 17,868
PSMI Members: 77

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Quality Measures	Rate		4th Cycle Target	Target Achieved	TCOC% Rank	TCOC % Points
Child and Adolescent Well Care Visits (WCV)	*70.67%*	(2,171/3,072)	*65.11%*	✓	*82.42%*	*3*
Lead Screening (LEAD)	*93.12%*	(176/189)	*93.33%*	✓	*72.29%*	*3*
Controlling High Blood Pressure (CBP)	*N/A*	(N/A/N/A)	*71.34%*	N/A	*N/A*	*0*
Asthma Medication Ratio (AMR)	*84.78%*	(39/46)	*78.95%*	✓	*82.46%*	*3*
Well-Child Visits in the 1st 30 Months (W30)	*81.44%*	(136/167)	*76.92%*	✓	*87.80%*	*3*
Developmental Screening in 1st 3 Years (DVS)	*85.98%*	(460/535)	*81.82%*	✓	*86.41%*	*3*
Inverse Measures (Lower Rate is Better)						
Glycemic Status Assessment (GSD) (>9%)	*85.71%*	(6/7)	*25.93%*	✗	*1.33%*	*0*
Plan All-Cause Readmissions O/E	*N/A*	(0/0.27)	*1.243*	N/A	*N/A*	*0*

N/A Measure does not meet minimum sample size requirements (5 and/or 1 for PCR) and is therefore excluded from calculations

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Quality Incentive Summary

Targets Met / Potential: *5 / 6*
Earned /Potential PMPM: *$2.450 / $2.940*
Target Payment: *$43,776.60*

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Total Cost of Care Component

***Percent Category Legend**
≥60% = 3 Points
55%-59% =2 Points
50%-54% = 1 Points
<50% = 0 Points

Actual Cost	Expected Cost	Margin	Claims Paid	Potential Pool
$17,800,166.71	*$17,893,915.97*	*0.52%*	*$128,383.86*	*$2,002.80*

Total Points Earned/ Total Potential Points	Percentage Point	TCOC Payout
15 / 18	*83.33%*	*$1,608.12*

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Electronic Results Submission

Measures	Rate		Rank	Target Rank	Target Met	Payment
Controlling High Blood Pressure (CBP)	*N/A*	(N/A/N/A)	*N/A*	*75th %*	*N*	*$0.00*
Glycemic Status Assessment (GSD) (>9%)	*14.29%*	(1/7)	*4.00%*	*75th %*	*N*	*$0.00*

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Health Equity Component

Measures	Rate		Rank	Target Rank	Target Met	Payment
Controlling High Blood Pressure (CBP)	*N/A*	(N/A/N/A)	*N/A*	*75th %*	*N*	*$0.00*
Well-Child Visits in the 1st 30 Months (W30)	*83.33%*	(35/42)	*90.91%*	*75th %*	*Y*	*$3,601.20*
Developmental Screening in 1st 3 Years (Hisp/Lat only)	*N/A*	(1/1)	*N/A*	*75th %*	*N*	*$0.00*
Inverse Measures (Lower Rate is Better)						
Glycemic Status Assessment (GSD) (>9%)	*N/A*	(1/1)	*N/A*	*75th %*	*N*	*$0.00*

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Total Incentive Earned

Earned/Potential PMPM: ***$2.590 / $5.200*** **Total Payment / Potential Payment:** ***$48,985.92 / $98,329.20***

Understanding your 2026 PerformPlus® TCOC Scorecard

① PAYMENT CYCLE

This represents the current incentive bonus payment cycle, where each "cycle" (1 – 4) represents a quarter of the year.

② CLAIMS CYCLE / CLAIMS PAID THROUGH

This represents the claim dates-of-service used to determine your practice's performance in the program. "Claims Paid Through" represents the amount of "run-out" time allotted for claims paid outside of the claims cycle.

③ TAX INFORMATION

This is basic information about your practice, including your tax name and tax ID number. It also includes the average number of members enrolled with your tax ID during the payment cycle, the persistent severe mental illness (PSMI) members within that enrollment, and the panel status as of the last day of the claims paid through date. Please note that the impact of your panel status on your total per member per month (PMPM) payment is as follows: OPEN = 100%; RESTRICTED = 50%; CLOSED = 0% earnings.

④ QUALITY MEASURES

This section contains your tax ID's performance detail for the state-mandated quality performance metrics during the payment cycle. The results of each rate are then compared to the established targets for the particular payment cycle. If the cycle targets are achieved, then your practice will earn the allocated PMPM funding associated with the number of targets achieved during the cycle.

⑤ TOTAL COST OF CARE RANK / TOTAL COST OF CARE POINTS EARNED

These columns contain both the total cost of care (TCOC) ranking and points earned.

⑥ QUALITY INCENTIVE SUMMARY

This section contains a snapshot of incentive earnings by your tax ID.

⑦ ELECTRONIC RESULTS SUBMISSION (4th cycle scorecard ONLY)

This section contains the Electronic Results Submission calculations and earning detail. Please note that this section will only appear on the 4th cycle scorecard.

⑧ HEALTH EQUITY COMPONENT

This section contains the Health Equity component calculations and earning detail.

⑨ TOTAL COST OF CARE

This section contains the TCOC measure that demonstrates your tax ID's performance based on an actual versus expected medical cost calculation that indicates how well you performed during the cycle.

⑩ TOTAL INCENTIVE EARNED

This is the comparison of your tax ID's actual PMPM earned based on performance and the maximum potential PMPM for the payment cycle.

⑪ GROUP DETAIL

This is the breakdown of how each practice within a tax ID earns their portion of the total paid to the tax ID. The final group payment is based on the earned PMPM for the tax ID and the member months of the practice.

⑫ INFORMATION MEASURES

This section reflects inverse measures including the actual hospital admissions versus the expected Potentially Preventable Admissions (PPAs), the actual hospital ER visits versus the expected Potentially Preventable ER Visits (PPVs), Use of Opioids at High Dosage, and Use of Opioids from Multiple Providers.

Please note that a lower rate for these inverse measures indicates better performance. For example, a PPA actual rate of 105% is 5% over the max expected PPAs. The desired result is a lower rate since a score of 100% or above is showing a complete failure in providing quality care for this measure.

PPAs are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. PPAs are essentially ambulatory-sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often help avoid the need for admission. The occurrence of high rates of PPAs represents a failure of ambulatory care provided to the patient.

PPVs are emergency room visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory-sensitive conditions (e.g., asthma), which means that adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate the need for ER services.

Use of Opioids at High Dosage is the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

Use of Opioids from Multiple Providers is for members 18 years and older receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

1. Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
2. Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
3. Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator-compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

Your TCOC reports and Care Gap reports can be accessed via NaviNet. Please contact your Provider Account Executive for further details.

Provider appeal of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be made in writing.
- The written appeal must be addressed to the Market Chief Medical Officer of the Plan and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from the Plan.
- The appeal will be forwarded to the Plan's PerformPlus Total Cost of Care Program Review Committee for review and determination.
- If the PerformPlus Total Cost of Care Program Review Committee determines that a ranking correction is warranted, an adjustment will appear on the next payment cycle following committee approval.

Important notes and conditions

1. The sum of the incentive payments for the program will not exceed 33% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.
2. The Quality Performance measures are subject to change at any time upon written notification. The Plan will continuously improve and enhance its quality management and quality assessment systems. As a result, new quality variables may be periodically added, and criteria for existing quality variables may be modified.
3. For computational and administrative ease, no retroactive adjustments will be made to incentive payments. All PMPM payments will be paid according to the membership known at the beginning of each month.

Keystone First

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

Our Mission

We help people get care, stay well,
and build healthy communities.

www.keystonefirstpa.com

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