

# Choose the plan that's right for you



We offer two types of plans — deductible and copay. Our deductible plans are a great way to keep your monthly costs low. If you tend to use only the basic services, like visits to your doctor, specialist, or OB/GYN, then a deductible plan may be right for you. Our copay plans are all about predictability. If you prefer to have more control over your budget by containing your out-of-pocket costs, then one of our copay plans may fit your needs.

Benefits per calendar year	Deductible options			Copay options		
	HMO \$5000 Deductible	HMO \$2500 Deductible	HMO \$1500 Deductible	HMO \$20 Copay	HMO \$15 Copay	HMO \$10 Copay
Deductible, individual/family	\$5,000/ \$10,000	\$2,500/ \$5,000	\$1,500/ \$3,000	None		
Coinsurance, after deductible	You pay 30%, unless otherwise noted			None		
Out-of-pocket maximum, individual/family (does not include deductible or copays)	\$7,500/ \$15,000	\$5,000/ \$10,000	\$5,000/ \$10,000	None		
<b>Preventive services</b>						
Mammogram (no referral required) Pediatric immunizations (subject to office visit copay) Nutrition counseling (6 visits per year) Outpatient lab/pathology	\$0 (deductible waived)			\$0		
<b>Physician services</b>						
Primary care office visit	\$30 (deductible waived)			\$20	\$15	\$10
Specialist office visit	\$50 (deductible waived)			\$30	\$25	\$20
Routine gynecological exam/Pap (no referral required, 1 per year)	\$30 (deductible waived)			\$30	\$25	\$20
Routine eye care (once every two years) Exam Eyeglasses or contact lenses	\$50 (deductible waived) \$35+ benefit			\$30 \$35 benefit+	\$25 \$35 benefit+	\$20 \$35 benefit+
Spinal manipulations (20 visits per year) Physical/occupational therapy (30 visits per year) Routine radiology/diagnostic	\$50 (deductible waived)			\$30	\$25	\$20
MRI/MRA, CT/CTA scan, PET scan	\$100 (deductible waived)			\$60	\$50	\$40
Biotech/specialty injectables	\$100 (deductible waived)			\$100	\$75	\$50
<b>Hospital/other medical services</b>						
Inpatient hospital services Maternity hospitalization	1) You pay the provider's charges at our discounted rate until the deductible has been met.			\$400 <sup>†</sup>	\$200 <sup>†</sup>	\$100 <sup>†</sup>
Outpatient surgery				\$400	\$200	\$100
Emergency room (not waived if admitted)	2) Once the deductible has been met, you pay 30% until the out-of-pocket maximum has been reached.			\$100		
Ambulance				3) Once you reach the out-of-pocket maximum, we pay 100%.		
Durable medical equipment (each year, you have coverage up to \$1,000)	50%, after deductible			50%		
Mental health/substance abuse	Not covered			Not covered		

\*This is a preliminary quote only. Final rate quote and approval of coverage is dependent on medical underwriting. Approval is not guaranteed, and some applications may not be approved based on medical conditions.

†Paid in-full-benefit available with select group of frames at Davis Vision participating providers.

\*Amount shown reflects the copayment per day. There is a maximum of five copayments per admission.

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	HMO \$5000 Deductible	HMO \$2500 Deductible	HMO \$1500 Deductible	HMO \$20 Copay	HMO \$15 Copay	HMO \$10 Copay
<b>Prescription drug</b>						
Prescription deductible, individual/family	None			\$250/\$750	\$100/\$300	\$100/\$300
Generic formulary copay	\$10			\$15, after prescription deductible		
Brand formulary copay	\$30			\$25, after prescription deductible		
Non-formulary brand copay	\$50			\$35, after prescription deductible		
Prescription mail order	Available			Available		
Maximum prescription drug benefit, individual/family	Each year you have coverage up to \$2,500/\$5,000			Each year, you have coverage up to \$2,500/\$5,000		

As low as \$76 a month\*

As low as \$111 a month\*

### What's not covered?

- services not medically necessary;
- any treatment of substance abuse or mental illness, including serious mental illness;
- services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- immunizations for travel or employment;
- services or supplies payable under Workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- outpatient services that are not performed by your primary care physician's designated provider;
- private duty nursing;
- charges related to any medical condition or illness for which medical advice or treatment was recommended or received in the 90 days preceding the effective date of your plan policy is excluded for the first 12 months.

NOTE: Eligible unmarried dependent children are generally covered to age 19 or age 23 (if full-time student). See contract for additional details.

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program. Benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 1-800-263-1410.

