

Individual HMO

Benefits at a glance



**Independence
Blue Cross**

HMO \$20 Copay	
Benefits per calendar year	Coverage
Deductible, individual/family	None
Coinsurance, after deductible	None
Out-of-pocket maximum, individual/family (does not include deductible or copays)	None
Preventive services	
Mammogram (referral) Pediatric immunizations (subject to office visit copay) Nutrition counseling (6 visits per year) Outpatient lab/Pathology	\$0
Physician services	
Primary care office visit	\$20
Specialist office visit	\$30
Routine gynecological exam/Pap (no referral, 1 per year)	\$30
Routine eye care (once every two years)	
Exam	\$30
Reimbursement for glasses/contacts	\$35
Spinal manipulations (20 visits per year) Physical/Occupational therapy (30 visits per year) Routine radiology/Diagnostic	\$30
MRI/MRA, CT/CTA scan, PET scan	\$60
Biotech/Specialty injectables	\$100
Hospital/Other medical services	
Inpatient hospital services Maternity hospitalization	\$400*
Outpatient surgery	\$400
Emergency room (not waived if admitted)	\$100
Ambulance	\$0
Durable medical equipment (each year, you have coverage up to \$1,000)	50%
Mental health/Substance abuse	Not covered
Prescription drug	
Prescription deductible, individual/family	\$250/\$750
Generic formulary copay	\$15, after prescription deductible
Brand formulary copay	\$25, after prescription deductible
Non-formulary brand copay	\$35, after prescription deductible
Prescription mail-order	Available
Maximum prescription drug benefit, individual/family	Each year, you have coverage up to \$2,500/\$5,000

*There is a maximum of five copayments for inpatient hospital admissions, including maternity hospitalization.

(over)

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 non-preventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- immunizations for travel or employment;
- service 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.

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 described in this summary. 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.