

# HMO \$2500 Deductible



**Independence  
Blue Cross**

Benefits per calendar year	Coverage
Deductible, individual/family	\$2,500/\$5,000
Coinsurance, after deductible	You pay 30%, unless otherwise noted
Out-of-pocket maximum, individual/family (does not include deductible or copays)	\$5,000/\$10,000
<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)
<b>Physician services</b>	
Primary care office visit	\$30 (deductible waived)
Specialist office visit	\$50 (deductible waived)
Routine gynecological exam/Pap (no referral, 1 per year)	\$30 (deductible waived)
Routine eye care (once every two years) Exam Eyeglasses or contact lenses	\$50 (deductible waived) \$35 benefit*
Spinal manipulations (20 visits per year) Physical/occupational therapy (30 visits per year) Routine radiology/diagnostic	\$50 (deductible waived)
MRI/MRA, CT/CTA scan, PET scan	\$100 (deductible waived)
Biotech/specialty injectables	\$100 (deductible waived)
<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. 2) Once the deductible has been met, you pay 30% until the out-of-pocket maximum has been reached. 3) Once you reach the out-of-pocket maximum, we pay 100%.
Outpatient surgery	
Emergency room (not waived if admitted)	
Ambulance	
Durable medical equipment (each year you have coverage up to \$1,000 )	50%, after deductible
Mental health/substance abuse	Not covered
<b>Prescription drug</b>	
Prescription deductible, individual/family	None
Generic formulary copay	\$10
Brand formulary copay	\$30
Non-formulary brand copay	\$50
Prescription mail order	Available
Maximum prescription drug benefit, individual/family	Each year you have coverage up to \$2,500/\$5,000

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

(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;
- 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 are 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.