HMO 10 Copay

Keystone HEALTH PLAN EAST

Benefits per calendar year	You pay
Deductible, individual/family	None
Coinsurance, after deductible	
Out-of-pocket maximum, individual/family	

Preventive services

Mammogram (no referral required)	$0
Pediatric immunizations	
Nutrition counseling (6 visits per year)	
Routine gynecological exam/Pap test (no referral required, 1 per year)	

Physician services

Primary care office visit	$10
Specialist office visit	$20
Routine eye exam (once every two years)	
Eyeglasses or contact lenses (once every two years)	$35 benefit*
Spinal manipulations (20 visits per year)	$20
Physical/occupational therapy (30 visits per year)	

Hospital/other medical services

Inpatient hospital services	$100†
Maternity hospitalization	
Emergency room (not waived if admitted)	$100
Outpatient surgery	
Ambulance	$0
Outpatient lab/pathology	
Routine radiology/diagnostic	$20
MRI/MRA, CT/CTA scan, PET scan	$40
Biotech/specialty injectables	$50
Durable medical equipment	50%
Mental health/substance abuse/serious mental illness treatment	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay
Prescription deductible, individual/family	$100/$300
Generic formulary copay	$10, after prescription deductible
Brand formulary copay	30% coinsurance, $250 maximum copay, after prescription deductible
Non-formulary copay	40% coinsurance, $250 maximum copay, after prescription deductible
Prescription mail order	Available
Maximum prescription drug benefit, individual/family	None

*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.

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;
- Self-injectable drugs are excluded under medical programs. However, they are covered under the prescription drug benefit.
- 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. If you have been continuously insured for 12 months by a participating Blue Cross® or Blue Shield® plan, or the past 18 months by another plan (without a break in coverage of more than 63 days prior to the current application), you may be able to receive credit for all or part of the 12 month exclusion. To learn more about preexisting condition exclusions and how they can be reduced through creditable coverage, visit www.ibx4you.com/importantinfo (Does not apply to members under age 19).

Note: Dependent children are generally covered to age 26. 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 and/or subscriber agreement carefully to determine which health care services are covered. If you need more information, please call 1-800-263-1410.

Independence Blue Cross®

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