

# Individual HMO

## Benefits at a glance



Copay plans include \$10, \$15, or \$20 copays for primary care physician visits. These options are ideal for containing your out-of-pocket costs for health care. Deductible options are available in amounts of \$1,500, \$2,500, or \$5,000. These options are a great way to lower your monthly premium if you tend to use only the basic medical services, like visits to your doctor, specialist, or OB/GYN.

Benefits per calendar year	Copay options			Deductible options		
	HMO \$10 Copay	HMO \$15 Copay	HMO \$20 Copay	HMO \$1500 Deductible	HMO \$2500 Deductible	HMO \$5000 Deductible
Deductible, individual/family	None			\$1,500/ \$3,000	\$2,500/ \$5,000	\$5,000/ \$10,000
Coinsurance, after deductible	None			You pay 30%, unless otherwise noted		
Out-of-pocket maximum, individual/family (does not include deductible or copays)	None			\$5,000/ \$10,000	\$5,000/ \$10,000	\$7,500/ \$15,000
<b>Preventive services</b>						
Mammogram (No referral) Pediatric immunizations (subject to office visit copay) Nutrition counseling (6 visits per year) Outpatient lab/Pathology	\$0			\$0		
<b>Physician services</b>						
Primary care office visit	\$10	\$15	\$20	\$30, no deductible		
Specialist office visit	\$20	\$25	\$30	\$50, no deductible		
Routine gynecological exam/Pap (no referral, 1 per year)	\$20	\$25	\$30	\$30, no deductible		
Routine eye care (once every two years) Exam Reimbursement for glasses/ contacts	\$20 \$35	\$25 \$35	\$30 \$35	\$50, no deductible \$35		
Spinal manipulations (20 visits per year) Physical/Occupational therapy (30 visits per year) Routine radiology/Diagnostic	\$20	\$25	\$30	\$50, no deductible		
MRI/MRA, CT/CTA scan, PET scan	\$40	\$50	\$60	\$100, no deductible		
Biotech/Specialty injectables	\$50	\$75	\$100	\$100, no deductible		
<b>Hospital/Other medical services</b>						
Inpatient hospital services Maternity hospitalization	\$100*	\$200*	\$400*	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	\$100	\$200	\$400			
Emergency room (not waived if admitted)	\$100					
Ambulance	\$0					
Durable medical equipment (each year, you have coverage up to \$1,000)	50%			50%, after deductible		
Mental health/Substance abuse	Not covered			Not covered		

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

Benefits per calendar year	Copay options			Deductible options		
	HMO \$10 Copay	HMO \$15 Copay	HMO \$20 Copay	HMO \$1500 Deductible	HMO \$2500 Deductible	HMO \$5000 Deductible
<b>Prescription drug</b>						
Prescription deductible Individual/Family	\$100/\$300	\$100/\$300	\$250/\$750	None		
Generic formulary copay	\$15, after prescription deductible			\$10		
Brand formulary copay	\$25, after prescription deductible			\$30		
Non-formulary brand copay	\$35, after prescription deductible			\$50		
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		

### 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.

