Independence

PAISBOA HEALTH BENEFIT TRUST

Medical Benefit Highlights

HBT HMO $30 $50

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**Referred**	**Out-of-Network**
Deductible		
Individual/Family	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1]		
Individual/Family	$6,350/$12,700	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	$30	Not covered
Specialist Office Visit	$50	Not covered
Retail Health Clinic Visit	$30	Not covered
Telemedicine	Not covered	Not covered
Urgent Care Visit	$50	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[2]		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Occupational Therapy (30 visits/year)[2]		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Speech Therapy (20 visits/year)	$50	Not covered
Emergency Services	**Referred**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$150	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	Not covered
Hospital Services	**Referred**	**Out-of-Network**
Inpatient Hospital Services	$400/Day; max of 5 copays per admission	Not covered
Maternity Hospital Services	$400/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	Not covered
Outpatient Surgery	**Referred**	**Out-of-Network**
Freestanding	$200	Not covered
Hospital Based	$200	Not covered

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Outpatient Professional Services	No charge	Not covered
Outpatient Diagnostics	**Referred**	**Out-of-Network**
Diagnostic Medical (EKG)	$50	Not covered
Routine Radiology (X-Ray)		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$100	Not covered
Hospital Based	$100	Not covered
Outpatient Lab and Pathology	**Referred**	**Out-of-Network**
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Other Medical Services	**Referred**	**Out-of-Network**
Spinal Manipulations (20 visits/year)	$50	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables	$100	Not covered
Chemotherapy	No charge	Not covered
Dialysis	No charge	Not covered
Skilled Nursing Facility (120 days/year)	$200/Day; max of 5 copays per admission	Not covered
Home Health	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment (DME)	50%	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)	$50	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$400/Day; max of 5 copays per admission	Not covered

[1] Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

[2] Cognitive Therapy, Occupational Therapy, and Physical Therapy combined visit limit.

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, please call the phone number listed on the back of your identification card, or log into your member portal account at www.ibxpress.com

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.ibx.com/preapproval** or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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