

InBalance EPO - C

Community Rated

	Limitations	In-network	Out-of-network
Inpatient Hospital Services performed and billed by a hospital			
Inpatient Hospital Coverage	PRECERT : YES; 365 Days Per Confinement	Deductible & Coinsurance	No Coverage
Skilled Nursing Facility Care	PRECERT : YES	Deductible & Coinsurance	No Coverage
Inpatient Admission for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)	PRECERT : YES; 30 Days Per Calendar Year	Deductible & Coinsurance	No Coverage
Hospice Care - inpatient and outpatient	PRECERT : YES; 210 Days Per Lifetime	Deductible & Coinsurance	No Coverage
Outpatient Hospital Services performed and billed by a hospital or facility			
Pre-Admission Testing		Deductible & Coinsurance	No Coverage
Ambulatory Surgery facility charge (free standing)	PRECERT : YES	Deductible & Coinsurance	No Coverage
Ambulatory Surgery facility charge (OPD hospital)	PRECERT : YES	Deductible & Coinsurance	No Coverage
Home Health Care Services	PRECERT : YES; 200 Visits Per Calendar Year	20% Coinsurance (deductible waived)	No Coverage
Diagnostic Lab /Radiology	PRECERT : YES; Required for Radiology services	Deductible & Coinsurance	No Coverage
Preventive Mammography and Pap Smear & Prostate Screening		Covered in Full	No Coverage
Medical Services performed and billed by a Physician or other Medical Provider			
Office visit and diagnostic copayment for dependent children		No copay for dependent children	No Coverage
Office visit copayment, including Outpatient clinic visits		OV Copay Charge per visit	No Coverage
Specialist Office Visits		OV Copay Charge per visit, No copay for dependent children	No Coverage
Maternity Pre-Postnatal Care		Covered in Full	No Coverage
Annual Physical Check-up (Adult)		Covered in Full	No Coverage
Preventive Mammography and Pap Smear & Prostate Screening		Covered in Full	No Coverage
Chiropractic Care		OV Copay Charge per visit, No copay for dependent children	No Coverage
Physical Therapy, Osteopathic Manipulation, Occupational Therapy	30 Visits Per Calendar Year	OV Copay Charge per visit, No copay for dependent children	No Coverage
Speech Therapy	10 Visits Per Calendar Year	OV Copay Charge per visit, No copay for dependent children	No Coverage
Outpatient Surgery	Office, Outpatient Hospital, Ambulatory Surgery Facility	Deductible & Coinsurance	No Coverage
Inpatient Surgery		Deductible & Coinsurance	No Coverage
DME:	PRECERT : YES; When the amt is > \$2000	Deductible & Coinsurance	No Coverage
Diagnostic Lab	Providers Office/ Free Standing Facility	Diagnostic Copay, No copay for dependent children	No Coverage
Diagnostic Radiology	PRECERT : YES; Providers office/ Free Standing Facility	Diagnostic Copay, No copay for dependent children	No Coverage
Well baby and Child Care			
Well baby and Well Child Care, including Immunizations		Covered in full	No Coverage
Emergency Coverage			
Emergency Room Care facility copay	ER Copay, waived if admitted	ER Facility Copay	ER Facility Copay
Inpatient Mental Health & Chemical Dependency			
Inpatient Mental Health	PRECERT : YES; 30 Days Per Calendar Year, No Limits for biologically based mental illnesses	Deductible & Coinsurance	No Coverage
Chemical Dependency: Detoxification	PRECERT : YES; 7 Days Per Calendar Year	Deductible & Coinsurance	No Coverage
Chemical Dependency: Rehabilitation	PRECERT : YES; 30 Days Per Calendar Year	Deductible & Coinsurance	No Coverage
Outpatient Mental Health & Chemical Dependency			
Outpatient Chemical Dependency	PRECERT : YES; 60 Visits Per Calendar Year, up to 20 Family Visits	OV Copay Charge per visit, No copay for dependent children	No Coverage
Outpatient Mental Health	PRECERT : YES; 30 Visits Per Calendar Year, No Limits for biologically based mental illnesses	OV Copay Charge per visit, No copay for dependent children	No Coverage
Vision			
Exam	Davis Vision Providers Only Eligibility : All ages	\$10 Office Visit Copay; One biennial (every 24 months) eye exam for all ages. Copay for adults, no copay for dependent children	No Coverage
Frames, Lenses, Contacts	Davis Vision Providers Only Eligibility : Dependent Children	\$20 Copay for lenses and frames or contacts (in lieu of frames and lenses), biennially (once every 24 months) for dependent children	No Coverage
Prescription Coverage			
Pharmacy Coverage			