

SCHEDULE OF BENEFITS

Covered Medical Services when performed by a Contracted Provider	HIGH OPTION \$ Co-pay	LOW OPTION \$ Co-Pay		Maximum Annual Benefit: \$25,000. Hospital Services Excluded (Professional and Facility) Health Screen may be required / Pre-existing Condition Limitations may apply
PCP / Pediatrician	10	20		<ul style="list-style-type: none"> Includes immunizations and vaccines recommended by Advisory Committee on Immunization Practices, American Academy of Pediatrics and the American Academy of Family Physicians, except those related to occupation or travel.
Allergy Treatment <i>(Injection / testing / therapy)</i>	15	30	R	<ul style="list-style-type: none"> In addition to office visit co-pay if performed in a PCP or Specialist office \$1200 per year maximum benefit (Excludes co-pay, No carry-over) Maximum Plan Payment \$100 per Month (Excludes co-pay, No carry-over)
Specialists	25	35	R	<ul style="list-style-type: none"> Includes Obstetrician visits for pre/post-natal care. Obstetrical delivery and Hospital care or Birthing Center excluded.
Mental Health Services <i>(Group or Individual)</i>	10 / 25	20 / 35	R	<ul style="list-style-type: none"> 20 visits per Contract Year
Routine Radiology Services	15	30	R	<ul style="list-style-type: none"> In addition to office visit co-pay if performed in a PCP or Specialist office
High Tech Radiology Services	50	100	R	<ul style="list-style-type: none"> Including but not limited to: Bone Scan, CT Scan, MRI, and Nuclear Medicine
Laboratory Services	0	0	R	
Home Health Services	10	20	R	<ul style="list-style-type: none"> 30 visits per Contract Year limit
Prescription Drugs	<i>Generic</i>	7		<ul style="list-style-type: none"> \$1200 per year maximum benefit (Excludes co-pay, no carry-over) Maximum Plan Payment: \$100. Per Month (Excludes co-pay, no carry-over) Coverage includes Oral Contraceptive under generic copay only Requires a prescription from a contracted provider or as a result of an out-of-area Urgent Care visit and Pharmacist will dispense generic counterpart, unless there is no generic counterpart to the brand name drug formulary.
	<i>Non-Generic</i>	25	35	
Non-Pharmacy Drugs	0	0		<ul style="list-style-type: none"> Injectibles, intravenous medications and any other non-pharmacy drugs and non pharmacy medications. \$1200 per year maximum benefit. (Excludes co-pay, No carry-over) Maximum Plan Payment \$100 Per Month (Excludes co-pay, No carry-over) Immunizations and vaccines addressed under PCP/Pediatrician above not subject to this maximum benefit.
Chiropractic Services	25	35		
Ambulatory Surgical Center (ASC)	100	200	R	<ul style="list-style-type: none"> Surgical procedures performed in a contracted ASC are a covered medical benefit Maximum Plan Payment (after co-pay): \$750. Per Episode - excluding physician charges
Urgent Care Center <i>(Outside the Hospital)</i>	25	50		<ul style="list-style-type: none"> Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit
Convenient Care/Mini Clinic	15	25		
Out -of-Area Urgent Care <i>(Outside the Hospital)</i>	50	75		<ul style="list-style-type: none"> Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit Rendered outside of the service area by a non-contracted provider Maximum Plan Payment (after co-pay): High Option- \$100. Per Episode / Low Option—\$75. Per Episode
Eye Examination/Refraction <i>(Optometrist)</i>	25	35		<ul style="list-style-type: none"> 1 per Contract Year limit
Vision Services <i>(Glasses or Contacts)</i>	0	0		<ul style="list-style-type: none"> 1 per Contract Year limit After 6 months of continuous coverage Maximum Plan Payment: High Option- \$100. Per Year / Low Option—\$50 Per Year
Hearing Services	25	35		<ul style="list-style-type: none"> 1 per Contract Year limit
Hearing Aids	0	0		<ul style="list-style-type: none"> After 6 months of continuous coverage Limit 1 every 2 yrs. Adult: Maximum Plan Payment: High Option- \$100 Per Year / Low Option—\$50. Per Year Pediatric: Maximum Plan Payment: High Option- \$200 Per Year / Low Option—\$100 Per Year
Rehabilitative Services <i>(Physical or Occupational or Speech Therapy)</i>	25	35	R	<ul style="list-style-type: none"> 30 visits per Contract Year limit
Durable Medical Equipment	10	20	R	<ul style="list-style-type: none"> Co-pay is payable upon delivery and subsequently, if monthly maintenance is required