

<b>SCHEDULE OF BENEFITS</b> Covered Medical Services when performed by a Contracted Provider	<b>HIGH OPTION \$ Co-Pay</b>		Maximum Annual Contract Benefit: \$25,000 Hospital Services Excluded (Professional and Facility) Pre-existing Condition Limitations may apply Excludes coverage for Medicare eligibles and Age 65+
<b>PCP / Pediatrician</b>	<b>\$10</b>		<ul style="list-style-type: none"> <li>Includes immunizations and vaccines recommended by Advisory Committee on Immunization Practices, American Academy of Pediatrics and the American Academy of Family Physicians; <b>except those</b> related to occupation or travel.</li> </ul>
<b>Allergy Treatment</b> <i>(Injection / testing / therapy)</i>	<b>\$15</b>	R	<ul style="list-style-type: none"> <li>In addition to office visit co-pay if performed in a PCP or Specialist office</li> <li>\$1200. per year maximum benefit (Excludes co-pay, No carry-over)</li> <li>Maximum Plan Payment \$100. per Month (Excludes co-pay, No carry-over)</li> </ul>
<b>Specialists</b>	<b>\$25</b>	R	<ul style="list-style-type: none"> <li>Includes Obstetrician visits for pre/post-natal care. Obstetrical delivery and Hospital care or Birthing Center excluded.</li> </ul>
<b>Mental Health Services</b> <i>(Group or Individual)</i>	<b>\$10/\$25</b>	R	<ul style="list-style-type: none"> <li>20 visits per Contract Year</li> </ul>
<b>Routine Radiology Services</b>	<b>\$15</b>	R	<ul style="list-style-type: none"> <li>In addition to office visit co-pay if performed in a PCP or Specialist office</li> </ul>
<b>High Tech Radiology Services</b>	<b>\$50</b>	R	<ul style="list-style-type: none"> <li>Including but not limited to: Bone Scan, CT Scan, MRI, and Nuclear Medicine</li> </ul>
<b>Laboratory Services</b>	<b>\$0</b>	R	
<b>Home Health Services</b>	<b>\$10</b>	R	<ul style="list-style-type: none"> <li>30 visits per Contract Year limit</li> </ul>
<b>Prescription Drugs</b>			<ul style="list-style-type: none"> <li>\$1200 per year maximum benefit (Excludes co-pay, no carry-over)</li> <li>Maximum Plan Payment: \$100. Per Month (Excludes co-pay, no carry-over)</li> <li>Coverage includes Oral Contraceptive under generic co-pay only</li> <li>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.</li> </ul>
	<i>Generic</i>	<b>\$7</b>	
	<i>Non-Generic</i>	<b>\$25</b>	
<b>Non-Pharmacy Drugs</b>	<b>\$0</b>		<ul style="list-style-type: none"> <li>Injectibles, intravenous medications and any other non-pharmacy drugs and non-pharmacy medications.</li> <li>\$1200. per year maximum benefit. (Excludes co-pay, No carry-over)</li> <li>Maximum Plan Payment \$100. Per Month (Excludes co-pay, No carry-over)</li> <li>Immunizations and vaccines addressed under <i>PCP/Pediatrician</i> above not subject to this maximum benefit.</li> </ul>
<b>Chiropractic Services</b>	<b>\$25</b>		
<b>Ambulatory Surgical Center (ASC)</b>	<b>\$100</b>	R	<ul style="list-style-type: none"> <li>Surgical procedures performed in a contracted ASC are a covered medical benefit</li> <li>Maximum Plan Payment (after co-pay): \$750. Per Episode - excluding physician charges</li> </ul>
<b>Urgent Care Center</b> <i>(Outside the Hospital)</i>	<b>\$25</b>		<ul style="list-style-type: none"> <li>Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit.</li> </ul>
<b>Out-of-Area Urgent Care Center</b> <i>(Outside the Hospital)</i>	<b>\$50</b>		<ul style="list-style-type: none"> <li>Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit</li> <li>Rendered outside of the service area by a non-contracted provider</li> <li>Maximum Plan Payment (after co-pay): High Option- \$100. Per Episode / Low Option—\$75. Per Episode</li> </ul>
<b>Eye Examination / Refraction</b> <i>(Optometrist)</i>	<b>\$25</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> </ul>
<b>Vision Services</b> <i>(Glasses or Contacts)</i>	<b>\$0</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> <li>After 6 months of continuous coverage</li> <li>Maximum Plan Payment: High Option- \$100 Per Year / Low Option—\$50. Per Year</li> </ul>
<b>Hearing Services</b>	<b>\$25</b>		<ul style="list-style-type: none"> <li>1 per Contract Year limit</li> </ul>
<b>Hearing Aids</b>	<b>\$0</b>		<ul style="list-style-type: none"> <li>After 6 months of continuous coverage</li> <li>Limit 1 every 2 yrs.</li> <li>Adult: Maximum Plan Payment: High Option- \$100. Per Year / Low Option—\$50. Per Year</li> <li>Pediatric: Maximum Plan Payment: High Option- \$200. Per Year / Low Option—\$100. Per Year</li> </ul>
<b>Rehabilitative Services</b> <i>(Physical or Occupational or Speech Therapy)</i>	<b>\$25</b>	R	<ul style="list-style-type: none"> <li>30 visits per Contract Year limit</li> </ul>
<b>Durable Medical Equipment</b>	<b>\$10</b>	R	<ul style="list-style-type: none"> <li>Co-pay is payable upon delivery and subsequently, if monthly maintenance is required.</li> </ul>
		"R"	<b>Requires referral from PCP and / or authorization from Plan's U/M Dept.</b>