

SCHEDULE OF BENEFITS	LOW OPTION \$ Co-Pay		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+
Covered Medical Services when performed by a Contracted Provider			
PCP / Pediatrician	\$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>	\$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 copay, No carry-over)
Specialists	\$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>	\$20 /\$35	R	<ul style="list-style-type: none"> 20 visits per Contract Year
Routine Radiology Services	\$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	\$100	R	<ul style="list-style-type: none"> Including but not limited to: Bone Scan, CT Scan, MRI, and Nuclear Medicine
Laboratory Services	\$0	R	
Home Health Services	\$20	R	<ul style="list-style-type: none"> 30 visits per Contract Year limit
Prescription Drugs			<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.
	Generic	\$15	
	Non-Generic	\$35	
Non-Pharmacy Drugs	\$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 <i>PCP/Pediatrician</i> above not subject to this maximum benefit.
Chiropractic Services	\$35		
Ambulatory Surgical Center (ASC)	\$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>	\$50		<ul style="list-style-type: none"> Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit.
Out-of-Area Urgent Care Center <i>(Outside the Hospital)</i>	\$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>	\$35		<ul style="list-style-type: none"> 1 per Contract Year limit
Vision Services <i>(Glasses or Contacts)</i>	\$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	\$35		<ul style="list-style-type: none"> 1 per Contract Year limit
Hearing Aids	\$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>	\$35	R	<ul style="list-style-type: none"> 30 visits per Contract Year limit
Durable Medical Equipment	\$20	R	<ul style="list-style-type: none"> Co-pay is payable upon delivery and subsequently, if monthly maintenance is required.
		"R"	Requires referral from PCP and / or authorization from Plan's U/M Dept.