			SCHEDULE OF BENEFITS
Covered Medical Services when performed by a Contracted Provider	**HIGH OPTION**		Maximum Annual Benefit: $25,000. Hospital Services Excluded (Professional and Facility) Health Screen may be required / Pre-existing Condition Limitations may apply Excludes coverage for Medicare eligibles and Age 65+
PCP / Pediatrician	**10**		
Allergy Treatment (Injection / testing / therapy)	**15**	R	▪ In addition to office visit co-pay if performed in a PCP or Specialist office
Specialists	**25**	R	▪ Includes Obstetrician visits for pre/post-natal care. Obstetrical delivery and Hospital care or Birthing Center excluded
Mental Health Services (Group or Individual)	**10 / 25**	R	▪ 20 visits per Contract Year
Routine Radiology Services	**15**	R	▪ In addition to office visit co-pay if performed in a PCP or Specialist office
High Tech Radiology Services	**50**	R	▪ Including but not limited to: Bone Scan, CT Scan, MRI, and Nuclear Medicine
Laboratory Services	**0**	R	
Home Health Services	**10**	R	▪ 30 visits per Contract Year limit
Prescription Drugs ***Generic*** ***Non-Generic***	 **7** **25**		▪ $1200 per year maximum benefit (no carry-over) ▪ Maximum Plan Payment: $100. Per Month (excludes co-pay) ▪ 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.
Chiropractic Services	**25**		
Ambulatory Surgical Center (ASC)	**100**	R	▪ 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 *(Outside the Hospital)*	**25**		▪ Requires notification to the Health Plan within 24 - 48 hrs of Urgent Care visit
Out -of-Area Urgent Care *(Outside the Hospital)*	**50**		▪ 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 *(Optometrist)*	**25**		▪ 1 per Contract Year limit
Vision Services *(Glasses or Contacts)*	**0**		▪ 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**		▪ 1 per Contract Year limit
Hearing Aids	**0**		▪ Limit 1 every 2 yrs. ▪ After 6 months of continuous coverage ▪ 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 *(Physical or Occupational or Speech Therapy)*	**25**	R	▪ 30 visits per Contract Year limit
Durable Medical Equipment	**10**	R	▪ Co-pay is payable upon delivery and subsequently, if monthly maintenance is required
		"R"	***Requires referral from PCP and authorization from Plan's U/M Dept.***

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