

CARE ACCESS		SCHEDULE OF BENEFITS	
Covered Medical Services when performed by a Contracted Provider	LOW 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	20		
Allergy Treatment (Injection / testing / therapy)	30	R	<ul style="list-style-type: none"> In addition to office visit co-pay if performed in a PCP or Specialist office
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 (Group or Individual)	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 <i>Generic</i> <i>Non-Generic</i>	15 35		<ul style="list-style-type: none"> \$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	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 (Outside the Hospital)	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 (Outside the Hospital)	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 copay): High Option- \$100. Per Episode / Low Option—\$75. Per Episode
Eye Examination / Refraction (Optometrist)	35		<ul style="list-style-type: none"> 1 per Contract Year limit
Vision Services (Glasses or Contacts)	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"> 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)	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 authorization from Plan's U/M Dept.

