2014 - 2015 HMO Schedule of Benefits for CVS Caremark

PROFESSIONAL SERVICES	***COPAYMENT***
Visit to Physician, Physician Assistant or Nurse Practitioner at PPG.	$30 pcp/$45 specialist
Performed at a CVS Minute Clinic.	$0
Periodic health evaluations. Includes routine, preventive care/annual preventive physicals.	
--Birth through 24 months (until age 2).	100% covered
--Ages 2 and older.	100% covered
Vision and hearing examinations.	$30
Specialist consultations.	$45
OB/GYN services excluding Well Woman (see Periodic health evaluations for Well Woman benefit)	$30
Physician visit to member's home (at discretion of physician) .	**10%**
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	100% covered
Other immunizations (except foreign travel/occupational-see below).	100% covered
Immunizations for occupational/travel purposes.	100% covered
Allergy testing.	$30 pcp/$45 specialist
Allergy serum.	100% covered
Allergy injection services (serum not included).	100% covered
All other injections.	**10%**
Surgeon/assistant surgeon in hospital or PPG.	**10%**
Administration of anesthetics.	**10%**
X-ray and laboratory procedures.	**10%**
Complex Radiology (CT/MRI/PET/SPECT)	$250
Rehabilitation therapy services (outpatient physical, occupational, respiratory, and cardiac therapy.) Provided as long as significant improvement is expected.	$45
Chiropractic - must be authorized and provided by PPG	$45
Speech Therapy	$45
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	***COPAYMENT***
Prenatal and postnatal office visit.	100% covered (initial office visit copay only)
Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician.	**10%**
Complications of pregnancy, including medically necessary abortions.	100% covered
Elective abortions.	$150
Genetic testing of fetus.	100% covered
Circumcision of newborn.	100% covered
FAMILY PLANNING (professional services only)	***COPAYMENT***
Contraceptive devices.	100% covered
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable).	Not covered
Sterilization of females.	100% covered
Sterilization of males.	$100
Reversal of sterilization.	No

OTHER SERVICES	***COPAYMENT***
Medical social services.	100% covered
Patient education.	100% covered
Ground ambulance	**10%**
Air ambulance	**10%**
Durable medical equipment. $5000 plan year max	**10% - no dollar max**
Orthotics (braces and supports)	100% covered
Custom footwear.	No
Diabetic supplies (except footwear)	100% covered
Diabetic footwear	100% covered
Hearing aids. Combined with Durable Medical Equipment plan year max	100% covered
Prosthesis (replacing body parts).	100% covered
Blood, blood plasma, blood factors and blood derivatives.	**10%**
Nuclear medicine (professional services only).	100% covered
Organ and bone marrow transplants (non-experimental and non-investigative. Professional services only).	100% covered
Chemotherapy (professional services only).	100% covered
Renal dialysis (professional services only).	100% covered
Home health visit. 100 visits per plan year.	$30
Hospice care	**10%**
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	***COPAYMENT***
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders.	**$350 + 10% per admission**
Confinement in a skilled nursing facility. 100 days per plan year	10%/100 days per year
Maternity care. Includes routine nursery charges.	**$350 + 10% per admission**
Outpatient services, excluding surgery.	**10%**
Outpatient surgery at hospital or ambulatory surgical center.	**10%**
EMERGENCY CARE/URGENTLY NEEDED CARE	***COPAYMENT***
The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.	
Use of emergency room (facility and professional services).	90% covered
Use of urgent care center (facility and professional services).	$45
OUT OF POCKET MAXIMUM	***COPAYMENT***
Single contract.	$2,000
Two-party contract.	$4,000
Family contract.	$6,000
CHEMICAL DEPENDENCY REHABILITATION and CARE for MENTAL DISORDERS	***COPAYMENT***
Severe Mental Illnesses (1)	
Outpatient	
Outpatient copay	$30
Maximum visits per calendar year	Unlimited
Inpatient	
Inpatient care in hospital or residential treatment facility	**$350 + 10% per admission**
Maximum days per calendar year	Unlimited
Physician visit to hospital or residential treatment facility	100% covered
Other Mental Illnesses	
Outpatient	
Outpatient copay	$30
Maximum visits per calendar year	Unlimited

Inpatient	
Inpatient care in hospital or residential treatment facility	**$350 + 10% per admission**
Maximum days per calendar year	Unlimited
Physician visit to hospital or residential treatment facility	100% covered
Chemical Dependency Rehabilitation	
Outpatient	
Individual therapy session	$30
Group therapy session	$15
Maximum visits per calendar year	Unlimited
Detoxification	**$350 + 10% per admission**
Inpatient	
Chemical dependency rehabilitation	**$350 + 10% per admission**
Maximum days per calendar year	n/a
Health Care Reform (Non-Granfathered)	
Dependent Age Limit	26
Lifetime Limits	n/a

April 1, 2014