CeltiCare Premier

Annual Out-of-Pocket Expenses per benefit year	Maximum amount
Per Person	Unlimited
Family total	Unlimited
Annual Deductible	**Maximum amount**
Per person	None
Family total	None

Covered Benefit	Co-Payment
Outpatient Medical Care	
Community Health Center Visits (Primary Care and Specialist) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	$20/$30
Office Visits (PCP/Specialists) (No Co-payment for adult routine physical, annual GYN exam and well-child care.)	$20/$30
Outpatient Surgery (Hospital and Ambulatory Surgery Centers)	$150 per surgery
Diagnostic X-rays/Labs	$25/$25
Diagnostic CT/MRI/MRA/PET scan	$100/$100/$100/$100
Nuclear Cardiac Imaging	$100
Inpatient Medical and Maternity Care	$150 per admission
Prescription Drugs	
Medication via Pharmacy (1 month supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	•Generic* $15 •Preferred $30 •Non-preferred $50
Medication via Mail Order (90 day supply) *Generics for treatment of high blood pressure, high cholesterol, and diabetes	•Generic* $30 •Preferred $60 •Non-preferred $150
Emergency Care (waived if admitted)	$75
Mental Health *(biological based)*	-
Office visits	$20
Inpatient Admission	$150 per admission
Mental Health *(non-biological based)*	-
Office visits	$20
Inpatient Admission	$150 per admission
Substance Abuse	
Oupatient Office Visits and rehabilitation	$20
Oupatient detoxification	$20
Inpatient Admission (rehabilitation)	$150 per admission
Inpatient Admission (detoxification)	$150 per admission
Rehabilitation Services	
Cardiac Rehabilitation	$25
Home Health Care	$0

Benefit	Cost
Inpatient Rehabilitation Services	
Skilled Nursing Facility (Up to 100 days per benefit year)	$150 per admission
Inpatient Rehabilitation or Chronic Disease Hospital (Up to 60 days per benefit year)	$150 per admission
Short-term outpatient rehabilitation (Physical and Occupational Therapies up to a combined limit of 60 visits per benefit year)	$25 per visit
Speech Therapy (no limits other than medical necessity.)	$25 per visit
Other Benefits	
Ambulance (Emergency covered. Non-emergent covered only when prior authorized.)	$0
Durable Medical Equipment, Supplies, Prosthetics, Orthotics, Oxygen & Respiratory Therapy Equipment. • Combined limit of $1,000 per benefit year. • No limit for DME provided during a Home Health Care Service visit. • No limit on Diabetic Supplies.	$0
Hospice	$0
Routine foot care (for diabetics)	$0
Vision (exam and glasses every 12 months)	$30
Wellness (Family Planning, Nutritional Counseling, Prenatal, Nurse Midwife)	$0