Appendix G Point of Service Health Plan Effective 11/01/2011
Active Employees POS

Service Received	Your Share of the Cost	
Preventive Care	**In-Network Benefits**	**Out-Of-Network Benefits**
• Immunization (including travel), lead screening, PSA (prostate screening)	No charge	Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening (*through age 18)* *See "Other Services" for additional Preventive Care information*	No charge	Subject to deductible and coinsurance: Individual: $150 deductible per member per calendar year and 20% coinsurance up to $1350 per member Family: $450 per family per calendar year and 20% coinsurance up to $2,550 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details.
Office Visit • Medical exam, family planning, and office surgery	$15 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injections • Short term rehabilitative therapy- physical, occupational, cardiac or speech	$15 Copay	
• Lab, X-ray and ultrasound • CT scan and MRI, outpatient facility fees • Surgery in hospital outpatient department or ambulatory surgery center	No charge	
Inpatient Care (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	No charge	
Skilled Nursing Facility and Rehabilitation Facility Care *(Limited to 30 days combined maximum per member per calendar year)*	No charge	
Other Services • Routine vision exam – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)*	No Charge	
• Chiropractic visit *(20 visit maximum per calendar year)*	$15 copay	
• Infertility diagnosis and treatment • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay	
• Hearing aids – birth to age 18 • Nutritional Counseling – *(if billed as an office visit, services will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)* • OB/GYN care (performed by an OB/GYN provider) - Well Women Exam (1 per year)) - Maternity care (routine prenatal, delivery and postpartum)	No charge	
• mammogram and pap smear	No charge	Covered up to MAB
Hospital Emergency Room (ER) /Urgent Care Facility • ER charge (waived if admitted)	$100 per visit	$100 per visit
• ER physician fee	No charge	No charge
• Urgent Care charge (waived if admitted)	$50 per visit	$50 per visit
Ambulance *(medically necessary emergency transport only)*	No charge	No charge
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No charge	$100 deductible, then 20% coins

For these services, ALL care must be authorized in advance by Behavioral Health. You will pay less if you utilize a network provider.

Mental Health (MH)	Network Benefits	Out-of-Network Benefits
• Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$15 Copay	Individual: $150 deductible per member per calendar year and 20% coinsurance up to $1,350 per member Family: $450 per family per calendar year and 20% coinsurance up to $2,550 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details.
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	No charge	
Substance Abuse (SA) • Outpatient services - Individual Therapy - Group Therapy - Intensive Outpatient Treatment Program (IOP)	$15 Copay	
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	No charge	

Maximums (For covered medical costs)

	Network Benefits*	Out-of-Network Benefits*
• Individual Out-Of Pocket Maximum	$500 per person per calendar year	$1500 per person per calendar year
• Family Out-of-Pocket Maximum	$1000 per family per calendar year	$3000 per family per calendar year
• Life Time Benefit Maximum	Unlimited	Unlimited

* Individual and Family Out-of-Pocket Maximums accumulated between 01/01/2011 through 10/31/2011 shall be applied to the period 11/01/2011 through 12/31/2011 for calendar year 2011 only. Effective 01/01/2012 Out-of-Pocket Maximums will reset to $0.

Other

- Health Education Reimbursement: $150 per family per calendar year**
- [1]Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

**This is a taxable benefit.

Prescription Drugs

	Retail Pharmacy	Mail Service Pharmacy
Employee Share of the Cost	• **$10** for each generic medication • **$25** for each preferred brand-name medication • **$40** for each non-preferred brand-name medication	• **$1** for each generic medication • **$40** for each preferred brand-name medication • **$70** for each non-preferred brand-name medication
Days Supply Limit	Up to a **31**-day supply	Up to a **90**-day supply

Maximums (for covered prescription costs)[2]

- $750 per individual per calendar year
- $1500 per family per calendar year

Other

- Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out.
- Exclusive Specialty Pharmacy
- Quantity Limits
- Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered "Dispense as Written")
- Traditional Generic Step Therapy
- Pharmacy Adviser

[1] **Married State Employees.** If two State employees are married, each employee is entitled to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.

[2] Individual and Family Out-of-Pocket Maximums accumulated between 01/01/2011 through 10/31/2011 shall be applied to the period 11/01/2011 through 12/31/2011 for calendar year 2011 only. Effective 01/01/2012 Out-of-Pocket Maximums will reset to $0.