

**APPENDIX G**  
**Point of Service (POS) Health Plan**  
**Active Employees POS**

Service Received	Your Share of the Cost	
	In-Network Benefits	Out-of-Network Benefits
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Immunization (including travel), lead screening, PSA (prostate screening)</li> </ul>	No Charge	Covered up to MAB
<ul style="list-style-type: none"> <li>Routine physical exam and well baby care</li> <li>Routine hearing screening</li> <li>Routine prenatal and postpartum care</li> <li>Preventive colonoscopy</li> <li>Family planning</li> </ul> <i>See "Other Services" for additional Preventive Care information</i>	No Charge	Subject to deductible and coinsurance:  <b>Individual:</b> \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  <b>Family:</b> \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year
<b>Office Visit</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery</li> </ul>	\$15 PCP/\$30 Specialist Copay	
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Allergy treatments and injections</li> <li>Short term rehabilitative therapy-physical, occupational, cardiac or speech (<i>unlimited</i>)</li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Surgery-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>Lab-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>CT scan, MRI, X-ray and Ultrasound</li> </ul>	In-Network deductible applies	
<b>Site of Service</b> <ul style="list-style-type: none"> <li>Surgery rendered at independent Ambulatory Surgery Center</li> <li>Lab rendered at an independent facility</li> </ul>	No Charge	Some self referred benefits are subject to precertification requirements.
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> <li>Maternity care-Delivery</li> </ul>	In-Network deductible applies	
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <ul style="list-style-type: none"> <li>(<i>Limited to 100 days combined maximum per member per calendar year</i>)</li> </ul>		
<b>Other Services</b> <ul style="list-style-type: none"> <li>Routine vision exam (<i>one exam every calendar year</i>)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Chiropractic visit (<i>24 visit maximum per member per calendar year</i>)</li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Infertility (tests, counseling)</li> <li>Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	\$30 Copay	
<ul style="list-style-type: none"> <li>Hearing aids—birth to age 18; 19 and over hearing aid maximum of \$1500 for each ear every 60 months</li> <li>Nutritional Counseling (<i>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</i>)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>OB/GYN care-well women exam annually</li> </ul>		
<ul style="list-style-type: none"> <li>Mammogram and pap smear</li> </ul>	No Charge	Covered up to MAB

<b>Hospital Emergency Room (ER)/Urgent Care Facility</b> <ul style="list-style-type: none"> <li>ER charge (<i>copay waived if admitted</i>)</li> <li>Urgent Care</li> <li>Walk In Center</li> </ul>	\$100 Copay	\$100 Copay
	\$50 Copay	\$50 Copay
	\$30 Copay	Deductible and coinsurance apply
<ul style="list-style-type: none"> <li>ER physician fee, lab, medical supplies</li> </ul>	No Charge	No Charge
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	No Charge	No Charge
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> ( <i>unlimited</i> )	No Charge	Deductible and coinsurance apply

**No PCP referral required for these services. All Inpatient care must be authorized in advance by the Medical Plan Behavioral Health Administrator.**

<b>Mental Health</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
<ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> </ul>	\$15 Copay	Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year  Some self referred benefits are subject to precertification requirements.
<ul style="list-style-type: none"> <li>Group Therapy</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient</li> <li>Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	In-Network deductible applies	
<b>Substance Use Disorder</b> <ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> <li>Group Therapy</li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient (<i>Including medical detoxification &amp; SA rehabilitation</i>)</li> <li>Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	In-Network deductible applies	

**In-Network Deductible**

- \$500 per member no more than \$1000 per family per calendar year

**Copay/Out-of-Network/In-Network Maximums (for covered medical costs)**

	<b>Copay Maximum</b>	<b>In-Network Deductible Maximum</b>	<b>In-Network Out of Pocket Maximum</b>	<b>Out-of-Network Out of Pocket Maximum</b>
<ul style="list-style-type: none"> <li>Individual Out-of-Pocket Maximum</li> </ul>	\$500 per member per calendar year	\$500 per member per calendar year	\$1000 per member per calendar year	\$3000 per member per calendar year
<ul style="list-style-type: none"> <li>Family Out-of-Pocket Maximum</li> </ul>	\$1000 per family per calendar year	\$1000 per family for Calendar year	\$2000 per family per calendar year	\$6000 per family per calendar year
<ul style="list-style-type: none"> <li>Life Time Benefit Maximum</li> </ul>	Unlimited			

**Other**

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

**Prescription Drugs**

Prescription drug benefits are administered through the State’s Pharmacy Benefit Manager.

	<b>Retail Pharmacy (days supply limit: up to a 31-days)</b>	<b>Mail Service Pharmacy (days supply limit: up to a 90-days)</b>
Employee Share of the Cost (copayment)	<ul style="list-style-type: none"> <li>• \$10 for each generic medication</li> <li>• \$25 for each preferred brand-name medication</li> <li>• \$40 for each non-preferred brand-name medication</li> </ul>	<ul style="list-style-type: none"> <li>• \$1 for each generic medication</li> <li>• \$40 for each preferred brand-name medication</li> <li>• \$70 for each non-preferred brand-name medication</li> </ul>
Maximums (for covered prescription costs)	<ul style="list-style-type: none"> <li>• \$750 per individual per calendar year</li> <li>• \$1,500 per family per calendar year</li> </ul>	
	<ul style="list-style-type: none"> <li>• Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out.</li> <li>• Exclusive Specialty Pharmacy</li> <li>• Quantity Limits</li> </ul>	<ul style="list-style-type: none"> <li>• Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered “Dispense as Written”)</li> <li>• Traditional Generic Step Therapy</li> <li>• Pharmacy Adviser</li> </ul>

End