APPENDIX G
Point of Service (POS) Health Plan
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 • Routine prenatal and postpartum care • Preventive colonoscopy • Family planning *See "Other Services" for additional Preventive Care information*	No Charge	Subject to deductible and coinsurance: 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.
Office Visit • Medical exam, office surgery	$15 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injections • Short term rehabilitative therapy-physical, occupational, cardiac or speech *(unlimited)*	$15 Copay	
• Surgery-Outpatient department of a hospital *(non-site of service location)*	In-Network deductible applies	
• Lab-Outpatient department of a hospital *(non-site of service location)*		
• CT scan, MRI, X-ray and Ultrasound		
Site of Service - Surgery rendered at independent Ambulatory Surgery Center - Lab rendered at an independent facility	No Charge	
Inpatient Care (as a bed patient in an acute care hospital) • Semi-private room and board • Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy • Maternity care-Delivery	In-Network deductible applies	
Skilled Nursing Facility and Rehabilitation Facility Care • *(Limited to 100 days combined maximum per member per calendar year)*		
Other Services • Routine vision exam *(one exam every calendar year)*	No Charge	
• Chiropractic visit *(24 visit maximum per member per calendar year)*	$15 Copay	
• Infertility (tests, counseling) • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay	
• Hearing aids–birth to age 18; 19 and over hearing aid maximum of $1500 for each ear every 60 months • 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)*	No Charge	
• OB/GYN care-well women exam annually		
• Mammogram and pap smear	No Charge	Covered up to MAB

Hospital Emergency Room (ER)/Urgent Care Facility • ER charge *(copay waived if admitted)* • Urgent Care • Walk In Center	\$100 Copay \$50 Copay \$30 Copay	\$100 Copay \$50 Copay Deductible and coinsurance apply
• ER physician fee, lab, medical supplies	No Charge	No Charge
Ambulance *(medically necessary emergency transport only)*	No Charge	No Charge
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No Charge	Deductible and coinsurance apply

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

Mental Health	**In-Network Benefits**	**Out-of-Network Benefits**
• Outpatient services – Individual Therapy Office Visit – Intensive Outpatient Treatment Program (IOP)	\$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.
• Group Therapy	No Charge	
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	In-Network deductible applies	
Substance Use Disorder • Outpatient services – Individual Therapy Office Visit – Intensive Outpatient Treatment Program (IOP)	\$15 Copay	
• Group Therapy	No Charge	
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	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)

	Copay Maximum	**In-Network Deductible Maximum**	**In-Network Out of Pocket Maximum**	**Out-of-Network Out of Pocket Maximum**
• Individual Out-of-Pocket Maximum	\$500 per member per calendar year	\$500 per member per calendar year	\$1000 per member per calendar year	\$3000 per member per calendar year
• Family Out-of-Pocket Maximum	\$1000 per family per calendar year	\$1000 per family for Calendar year	\$2000 per family per calendar year	\$6000 per family per calendar year
• Life Time Benefit Maximum	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.		
	Retail Pharmacy (days supply limit: up to a 31-days)	**Mail Service Pharmacy (days supply limit: up to a 90-days)**
Employee Share of the Cost (copayment)	• $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
Maximums (for covered prescription costs)	• $750 per individual per calendar year • $1,500 per family per calendar year	
	• 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

End