

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

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

| Mental Health | In-Network Benefits | Out-of-Network Benefits |
|---|-------------------------------|--|
| <ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> 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. |
| <ul style="list-style-type: none"> Group Therapy | No Charge | |
| <ul style="list-style-type: none"> Inpatient services <ul style="list-style-type: none"> Inpatient Partial Hospitalization Program (PHP) | In-Network deductible applies | |
| Substance Use Disorder <ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> Individual Therapy Office Visit Intensive Outpatient Treatment Program (IOP) Group Therapy | \$15 Copay | |
| <ul style="list-style-type: none"> Inpatient services <ul style="list-style-type: none"> Inpatient (<i>Including medical detoxification & SA rehabilitation</i>) 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 |
|--|-------------------------------------|--------------------------------------|---|---|
| <ul style="list-style-type: none"> 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 |
| <ul style="list-style-type: none"> 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 |
| <ul style="list-style-type: none"> 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) | <ul style="list-style-type: none"> • \$10 for each generic medication • \$25 for each preferred brand-name medication • \$40 for each non-preferred brand-name medication | <ul style="list-style-type: none"> • \$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) | <ul style="list-style-type: none"> • \$750 per individual per calendar year • \$1,500 per family per calendar year | |
| | <ul style="list-style-type: none"> • Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out. • Exclusive Specialty Pharmacy • Quantity Limits | <ul style="list-style-type: none"> • Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered “Dispense as Written”) • Traditional Generic Step Therapy • Pharmacy Adviser |

End