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

Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. Services from a non-network provider, under Self Referred benefits, may charge the difference between the MAB and the provider's charge.

Service Received	Your SI	nare of the Cost	
Preventive Care	<b>In-Network Benefits</b>	Out-of-Network Benefits	
• Immunization (including travel), lead screening, PSA (prostate	No Charge	Covered up to MAB	
screening)	No Charge		
Routine physical exam and well baby care			
Routine hearing screening			
Routine prenatal and postpartum care	No Charge	Subject to deductible and	
Preventive colonoscopy	6	coinsurance:	
• Family planning		Individual:	
See "Other Services" for additional Preventive Care information	¢15 DCD/¢20	\$1,000 deductible per member	
Office Visit	\$15 PCP/\$30	per calendar year and	
Medical exam, office surgery	Specialist Copay	20% coinsurance up to	
Other Outpatient Care		\$2,000 per member	
Allergy treatments and injections	\$15 Copay		
• Short term rehabilitative therapy-physical, occupational, cardiac or speech <i>(unlimited)</i>		Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year	
• Surgery-Outpatient department of a hospital (non-site of service location)	In-Network		
• Lab-Outpatient department of a hospital (non-site of service	deductible		
location)	applies		
CT scan, MRI, X-ray and Ultrasound		5	
Site of Service		Some self referred benefits are	
<ul> <li>Surgery rendered at independent Ambulatory Surgery Center</li> <li>Lab rendered at an independent facility</li> </ul>	No Charge	subject to precertification requirements.	
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,	In-Network		
occupational and speech therapy	deductible		
Maternity care-Delivery	applies		
Skilled Nursing Facility and Rehabilitation Facility Care			
• (Limited to 100 days combined maximum per member per			
calendar year) Other Services			
<ul> <li>Routine vision exam (one exam every calendar year)</li> </ul>	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	\$30 Copay		
appliances and orthodontic treatment)			
• 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	

<ul> <li>Hospital Emergency Room (ER)/Urgent Care Facility</li> <li>ER charge (copay waived if admitted)</li> <li>Urgent Care</li> <li>Walk In Center</li> </ul>	\$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. All Inpatient care must be authorized in advance by the Medical Plan Behavioral Health Administrator. Mental Health In-Network **Out-of-Network Benefits** Benefits Outpatient services • Individual Therapy Office Visit \_ Individual: \_ Intensive Outpatient Treatment Program (IOP) \$1,000 deductible per member \$15 Copay per calendar year and Group Therapy No Charge • 20% coinsurance up to In-Network Inpatient services • \$2,000 per member deductible Inpatient Partial Hospitalization Program (PHP) applies Family: Substance Use Disorder \$2,000 per family per calendar Outpatient services • year and 20% coinsurance up to \$15 Copay Individual Therapy Office Visit \_ \$4,000 per family per calendar Intensive Outpatient Treatment Program (IOP) year No Charge Group Therapy ٠ • Inpatient services In-Network Some self referred benefits are subject to precertification Inpatient (Including medical detoxification & SA rehabilitation) deductible Partial Hospitalization Program (PHP) applies requirements.

## **In-Network Deductible**

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\$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> <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
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				
	oursement: \$150 per family	y per calendar year. This is a	a taxable benefit.	

- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

Prescription drug bene	fits are administered through the State's Pharmacy Be	enefit 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> <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> <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> <li>\$750 per individual per calendar year</li> <li>\$1,500 per family per calendar year</li> </ul>		
	<ul> <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> <li>Mandatory Generic Substitution with DAW (i.e., the only exception is physician ordered "Dispense as Written")</li> <li>Traditional Generic Step Therapy</li> <li>Pharmacy Adviser</li> </ul>	

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