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	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 	No Charge	Subject to deductible and coinsurance:
 See "Other Services" for additional Preventive Care information Office Visit Medical exam, office surgery Other Outpatient Care Allergy treatments and injections Short term rehabilitative therapy-physical, occupational, cardiac or speech (unlimited) 	\$15 PCP/\$30 Specialist Copay \$15 Copay	Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member Family:
 Surgery-Outpatient department of a hospital (non-site of service location) Lab-Outpatient department of a hospital (non-site of service location) CT scan, MRI, X-ray and Ultrasound 	In-Network deductible applies	\$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year
Site of Service - 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) 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 Skilled Nursing Facility and Rehabilitation Facility Care (Limited to 100 days combined maximum per member per calendar year) 	In-Network deductible applies	
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) OB/GYN care-well women exam annually 	No Charge	
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 • Outpatient services	In-Network Benefits	Out-of-Network Benefits
 Individual Therapy Office Visit Intensive Outpatient Treatment Program (IOP) 	\$15 Copay	Individual: \$1,000 deductible per member per calendar year and
 Group Therapy Inpatient services Inpatient	No Charge In-Network deductible	20% coinsurance up to \$2,000 per member
- Partial Hospitalization Program (PHP) Substance Use Disorder • Outpatient services - Individual Therapy Office Visit	applies \$15 Copay	Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar
 Intensive Outpatient Treatment Program (IOP) Group Therapy Inpatient services 	No Charge In-Network	year Some self referred benefits are
 Inpatient services Inpatient (Including medical detoxification & SA rehabilitation) Partial Hospitalization Program (PHP) 	deductible applies	subject to precertification requirements.

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. This is a taxable benefit.
- 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.					
Employee Share of the Cost (copayment)	Retail Pharmacy (days supply limit: up to a 31-days) • \$10 for each generic medication • \$25 for each preferred brand-name medication • \$40 for each non-preferred brand-name	Mail Service Pharmacy (days supply limit: up to a 90-days) • \$1 for each generic medication • \$40 for each preferred brand-name medication • \$70 for each non-preferred brand-name			
Maximums (for covered prescription costs)	 \$750 per individual per calendar year \$1,500 per family per calendar year 	medication			
	 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