# 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 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<br>• Routine hearing screening<br>• Routine prenatal and postpartum care<br>• Preventive colonoscopy<br>• Family planning<br>*See "Other Services" for additional Preventive Care information* | No Charge | Subject to deductible and coinsurance:<br><br>Individual:<br>$1,000 deductible per member per calendar year and 20% coinsurance up to $2,000 per member<br><br>Family:<br>$2,000 per family per calendar year and 20% coinsurance up to $4,000 per family per calendar year<br><br>Some self referred benefits are subject to precertification requirements. |
| **Office Visit**<br>• Medical exam, office surgery | $15 PCP/$30 Specialist Copay | |
| **Other Outpatient Care**<br>• Allergy treatments and injections<br>• 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**<br>- Surgery rendered at independent Ambulatory Surgery Center<br>- Lab rendered at an independent facility | No Charge | |
| **Inpatient Care** (as a bed patient in an acute care hospital)<br>• Semi-private room and board<br>• Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy<br>• Maternity care-Delivery | In-Network deductible applies | |
| **Skilled Nursing Facility and Rehabilitation Facility Care**<br>• *(Limited to 100 days combined maximum per member per calendar year)* | | |
| **Other Services**<br>• 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)<br>• 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<br>• 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**<br>• ER charge *(copay waived if admitted)*<br>• Urgent Care<br>• Walk In Center | \$100 Copay<br>\$50 Copay<br>\$30 Copay | \$100 Copay<br>\$50 Copay<br>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<br>– Individual Therapy Office Visit<br>– Intensive Outpatient Treatment Program (IOP) | \$15 Copay | Individual:<br>\$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member<br><br>Family:<br>\$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year<br><br>Some self referred benefits are subject to precertification requirements. |
| • Group Therapy | No Charge | |
| • Inpatient services<br>- Inpatient<br>- Partial Hospitalization Program (PHP) | In-Network deductible applies | |
| **Substance Use Disorder**<br>• Outpatient services<br>– Individual Therapy Office Visit<br>– Intensive Outpatient Treatment Program (IOP) | \$15 Copay | |
| • Group Therapy | No Charge | |
| • Inpatient services<br>- Inpatient (*Including medical detoxification & SA rehabilitation)*<br>- 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. 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. | | |
| | **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<br>• $25 for each preferred brand-name medication<br>• $40 for each non-preferred brand-name medication | • $1 for each generic medication<br>• $40 for each preferred brand-name medication<br>• $70 for each non-preferred brand-name medication |
| Maximums (for covered prescription costs) | • $750 per individual per calendar year<br>• $1,500 per family per calendar year | |
| | • Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out.<br>• Exclusive Specialty Pharmacy<br>• Quantity Limits | • Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered "Dispense as Written")<br>• Traditional Generic Step Therapy<br>• Pharmacy Adviser |

End