APPENDIX B
NON EXEMPT CLASSIFICATIONS

APPENDIX B WAS NOT AVAILABLE AS OF THE PRINTING DATE. THE SEIU 1984 WEBSITE WILL BE UPDATED WHEN APPENDIX B IS AVAILABLE: WWW.SEIU1984.ORG

APPENDIX C

LAW ENFORCEMENT, NON-STANDARD, and FIRE PROTECTION CLASSIFICATIONS

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APPENDIX D
Active Employee Dental Plan

1. **Benefit Period:** January 1 through December 31

2. **Eligibility Period:** First day of the month following completion of one (1) month continuous employment

3. **Eligible Persons:** Full-time employees, their spouses, and qualified dependent children up to age 26.

4. **Selected Benefits and Percentage Paid by Dental Administrator:**

Diagnostic & Preventive (Coverage A)	100%
Basic Restorative (Coverage B)	80%
Major (Prosthodontics) (Coverage C)	50%
Orthodontics (Coverage D)	50%

5. **Maximum Calendar Year Benefits:** The maximum amount the plan will pay is $2000 per person per benefit period (Coverages A, B, and C) excluding Orthodontics. Orthodontic (Coverage D) benefits have a separate lifetime maximum of $1200 per eligible adult and dependent child.

6. **Deductibles:** $25 benefit period deductible per person per Calendar Year, applied to Major benefits only (Coverage C). Any expense incurred during the last 3 months of a calendar year which is applied against an individual's deductible will also reduce his/her deductible for the next year.

7. **Office Visit Copayments:** None

8. **Waiting Periods:**
   Basic Benefits: No waiting period.
   Major Benefits: No waiting period.
   Orthodontic Benefits: No waiting period.

COVERAGE A BENEFITS

Diagnostic:

- Evaluations to determine required dental treatment
- Limited oral evaluation
- Comprehensive oral evaluation – one complete comprehensive evaluation per specialist or General Dentist in a lifetime
- Periodic Evaluation – once in any period of six (6) consecutive months. This can be by a specialist or a general dentist.
- Radiographs (x-rays) – complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) twice per calendar year; films (x-rays) of individual teeth as necessary

Preventive:

- Specific procedures employed to prevent the occurrence of dental disease
- Prophylaxis (cleaning) – three (3) per calendar year (child prophylaxis up to thirteenth (13)) birthday; adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance procedures (Coverage B).
- Fluoride treatment – twice per calendar year up to age nineteen (19).
- Space maintainers
- Sealants

COVERAGE B BENEFITS

Palliative Treatment:

- Minor treatment for the relief of pain

Restorative:

- Amalgam (silver) and/or resin (white) restorations.

Endodontics:

- Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy

Periodontics:

- Treatment of diseased tissue supporting the teeth and periodontal maintenance procedures.
- Prophylaxis (cleaning) – twice per calendar year. This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance procedures (Coverage B).

Oral Surgery:

- Extractions and covered surgical procedures

Injection Drugs

Denture Repair:

- Repair of removable denture

Denture Rebase And Reline:

- Rebase and Reline of complete and partial dentures

Crown and fixed partial Denture repair:

- Repair of crown or fixed partial denture to its original condition

Anesthesia:

- General anesthesia administered in conjunction with an extraction, tooth reimplantation, surgical exposure of the tooth, biopsy, transseptal,fiberotomy, alveoloplasty, vestibuloplasty, incision and drainage of an abscess, and/or frenulectomy.
- General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients:

    a) A child under the age of six (6) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such a condition; or

    b) A person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician, which place the person at serious risk.

COVERAGE C BENEFITS

Restorative Crowns and Onlays:

- Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations

Implant Services:

- Surgical placements of an endosteal implant body including healing cap. An implant body including healing cap is a benefit once in a lifetime per site. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. Patient will be responsible for any additional fee.

Prosthodontics:

- Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures; core buildups; cast and prefabricated post and cores; and precision attachments.
- Implant Supported Prosthetics

COVERAGE D BENEFITS

Orthodontics:

- Necessary treatment and procedures required for the correction of malposed teeth
- Limited to $1,200 lifetime maximum for eligible adults and dependent children.

GENERAL EXCLUSIONS AND LIMITATIONS

The dental benefits provided by the dental benefit administrator shall not include the following:

a) Services for injuries or conditions compensable under Worker's compensation or Employer's liability laws.

b) Services that are determined by the dental benefit administrator to be rendered for cosmetic reasons, or to correct congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)

c) Services including, but not limited to, endodontics and prosthodontics (including crowns and removable fixed dentures), started prior to the date the Subscriber or Dependent became eligible under the Agreement.

d) Prescription drugs, premedications, and/or relative analgesia.

e) Charges for hospitalization, general anesthesia for restorative dentistry (except as noted in Section III. Coverage B Benefits

f) Charges for failure to keep a scheduled visit with the Dentist.

g) Charges for completion of forms. Such charges shall not be made to a Subscriber or Dependent by Participating Dentists.

h) Dental Care that is not necessary and customary as determined by generally accepted dental practice standards.

i) Dental Care or supplies that are not within the classification of benefits defined in the Agreement.

j) Appliances, procedures, or restorations for: (a) increasing vertical dimension; (b) altering, restoring, or maintaining occlusion; (c) replacing tooth structure lost by attrition or abrasion; (d) correcting congenital or developmental malformations; (e) esthetic purposes; or (f) implantology techniques.

k) Payments of benefits for the Subscriber and/or Dependent(s) terminate on the last day of the month after the date on which the Subscriber becomes ineligible for benefits.

l) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.

m) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to act of war, declared or undeclared.

n) Temporary services.

o) A consultation unless performed by a practitioner who is not performing further services.

p) Case presentation and treatment planning. Patient will be responsible for any additional fee.

End

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APPENDIX F
Network (HMO) Health Plan
Active Employees HMO

Service Received	Your Share of the Cost
These services MUST be provided by or referred by your Primary Care Provider (PCP).	
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening) • 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
Office Visit • Medical exam, office surgery	$15 PCP /$30 Specialist Copay
Other Outpatient Care • Short term rehabilitative therapy-physical, occupational, cardiac or speech *(unlimited)* • Allergy treatment and injections	$15 Copay
• Surgery-Outpatient department of a hospital *(non-site of service location)*	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	Deductible Applies
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 days combined per member, per calendar year)*	
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No Charge
These services DO NOT require a PCP referral as long as you use designated network providers.	
Other Services • Routine vision exam *(one exam every calendar year)*	No Charge
• Chiropractic visit *(limited to 24 visits per member per calendar year)*	$15 Copay
• Infertility office visits (tests, counseling) • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay
• OB/GYN care-well women exam annually	No Charge
• Mammogram and pap smear	
• 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

These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.	
Hospital Emergency Room (ER)/Urgent Care Facility • ER charge *(copay waived if admitted)* • Urgent Care • Walk In Center • ER physician fee, lab, medical supplies	$100 Copay $50 Copay $30 Copay No Charge
Ambulance *(medically necessary emergency transport only)*	No Charge
No PCP referral required for these services. <u>All</u> care must be authorized in advance by the Behavioral Health Administrator.	
Mental Health • Outpatient services – Individual Therapy Office Visit – Intensive Outpatient Treatment Program (IOP)	$15 Copay
• Group Therapy	No Charge
• Inpatient services – Inpatient – Partial Hospitalization Program (PHP)	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)	Deductible Applies

Deductible
• $500 per member no more than $1000 per family per calendar year

Copay Maximums (for covered medical costs)	
• Individual Out-of-Pocket Copay Maximum	$500 per member per calendar year
• Family Out-of-Pocket Copay Maximum	$1000 per family per calendar year

Lifetime Dollar Limit
• Unlimited

Other

- **Health Education Reimbursement : $150 per family per calendar year
- **Fitness Equipment Reimbursement: $200 per employee per calendar year **<u>OR</u>** Health Club Benefit: $450 per employee per calendar year*
- Eyewear benefits: $100 every two years per family member (Includes eyeglasses (frames and lenses) and contact lenses).

*__Married State Employees__: If two state employees are married, each employee is entitled to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.
**This is a taxable benefit.

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

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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

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