

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
<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>) Lab-Outpatient department of a hospital (<i>non-site of service location</i>) CT scan, MRI, X-ray and Ultrasound 	In-Network deductible applies	
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. 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)	<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

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