

Appendix G Point of Service Health Plan Effective 11/01/2011
Active Employees POS

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 (<i>through age 18</i>) <i>See "Other Services" for additional Preventive Care information</i>	No charge	Subject to deductible and coinsurance: Individual: \$150 deductible per member per calendar year and 20% coinsurance up to \$1350 per member Family: \$450 per family per calendar year and 20% coinsurance up to \$2,550 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details.
Office Visit	\$15 PCP/\$30 Specialist Copay	
Other Outpatient Care	\$15 Copay	
<ul style="list-style-type: none"> Allergy treatments and injections Short term rehabilitative therapy- physical, occupational, cardiac or speech 	No charge	
<ul style="list-style-type: none"> Lab, X-ray and ultrasound CT scan and MRI, outpatient facility fees Surgery in hospital outpatient department or ambulatory surgery center 	No charge	
Inpatient Care (as a bed patient in an acute care hospital)	No charge	
<ul style="list-style-type: none"> Semi-private room and board Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy 	No charge	
Skilled Nursing Facility and Rehabilitation Facility Care	No charge	
<i>(Limited to 30 days combined maximum per member per calendar year)</i>		
Other Services	No Charge	
<ul style="list-style-type: none"> Routine vision exam – birth through age 18 (<i>one exam every year</i>) Routine vision exam – age 19 and over (<i>one exam every two years</i>) 	No Charge	
<ul style="list-style-type: none"> Chiropractic visit (<i>20 visit maximum per calendar year</i>) 	\$15 copay	
<ul style="list-style-type: none"> Infertility diagnosis and treatment 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 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>) OB/GYN care (performed by an OB/GYN provider) <ul style="list-style-type: none"> - Well Women Exam (1 per year) - Maternity care (routine prenatal, delivery and postpartum) 	No charge	
<ul style="list-style-type: none"> mammogram and pap smear 	No charge	Covered up to MAB
Hospital Emergency Room (ER) /Urgent Care Facility	\$100 per visit	\$100 per visit
<ul style="list-style-type: none"> ER charge (waived if admitted) 	No charge	No charge
<ul style="list-style-type: none"> ER physician fee 	No charge	No charge
<ul style="list-style-type: none"> Urgent Care charge (waived if admitted) 	\$50 per visit	\$50 per visit
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	\$100 deductible, then 20% coins

For these services, ALL care must be authorized in advance by Behavioral Health. You will pay less if you utilize a network provider.

Mental Health (MH)	Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> Individual Therapy Group Therapy Intensive Outpatient Treatment Program (IOP) 	\$15 Copay	Individual: \$150 deductible per member per calendar year and 20% coinsurance up to \$1,350 per member Family: \$450 per family per calendar year and 20% coinsurance up to \$2,550 per family per calendar year Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details.
<ul style="list-style-type: none"> Inpatient services <ul style="list-style-type: none"> Inpatient Partial Hospitalization Program (PHP) 	No charge	
Substance Abuse (SA) <ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> Individual Therapy Group Therapy Intensive Outpatient Treatment Program (IOP) 	\$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) 	No charge	

Maximums (For covered medical costs)

	Network Benefits*	Out-of-Network Benefits*
Individual Out-Of Pocket Maximum	\$500 per person per calendar year	\$1500 per person per calendar year
Family Out-of-Pocket Maximum	\$1000 per family per calendar year	\$3000 per family per calendar year
Life Time Benefit Maximum	Unlimited	Unlimited

* Individual and Family Out-of-Pocket Maximums accumulated between 01/01/2011 through 10/31/2011 shall be applied to the period 11/01/2011 through 12/31/2011 for calendar year 2011 only. Effective 01/01/2012 Out-of-Pocket Maximums will reset to \$0.

Other

- Health Education Reimbursement: \$150 per family per calendar year**
 - ¹Fitness Equipment Reimbursement or Health Club Benefit: N/A
 - Eyewear benefits: N/A
- **This is a taxable benefit.

Prescription Drugs

	Retail Pharmacy	Mail Service Pharmacy
Employee Share of the Cost	<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
Days Supply Limit	Up to a 31-day supply	Up to a 90-day supply

Maximums (for covered prescription costs)²

- \$750 per individual per calendar year
- \$1500 per family per calendar year

Other

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| <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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¹ **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.

² Individual and Family Out-of-Pocket Maximums accumulated between 01/01/2011 through 10/31/2011 shall be applied to the period 11/01/2011 through 12/31/2011 for calendar year 2011 only. Effective 01/01/2012 Out-of-Pocket Maximums will reset to \$0.