2012 POS 90 Schedule of Benefits for CVS Caremark

PROFESSIONAL SERVICES	Tier 1	Tier 2	Tier 3
Visit to a physician, physician assistant or nurse practitioner. Specialists do not include visit to an OB/GYN-see specific OB/GYN line.	$25 pcp/$35 specialist (MinuteClinic: $0)	$50	40%
Periodic health evaluation / Preventive care (to age 18). Includes newborn care (infant through 30 days of life) and well-baby care, annual preventive physicals.	$0	$0	No
Periodic health evaluations / Preventive care (age 18 and older). Includes well woman exams and annual preventive physicals.	$0	$0	No
Vision and hearing examinations.	$25	No	No
Specialist consultations.	$35	$50	40%
Visit to an OB/GYN (not including well woman services).	$25	$50	40%
Physician visit to member's home (at discretion of physician).	$25	No	No
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0	30%	40%
Other immunizations (except foreign travel).	$0	$0	No
Immunizations for foreign travel.	No	No	No
Allergy testing.	$25 pcp/$35 specialist	30%	40%
Allergy serum.	$0	30%	40%
Allergy injection services.	$0	30%	40%
Injections for treatment of infertility.	No	No	No
All other injections.			
--Office-based injectable medications.	$0	30%	40%
--Self-administered injectable medications (per up to 30 day prescription).	30%	30% [1]	40% [1]
Surgeon/Assistant Surgeon in hospital or PPG.	10%	30%[1]	40% [1]
Administration of anesthetics.	10%	30%	40%
X-ray and laboratory procedures. Specified procedures through PPO/SELECT 2 and OON/SELECT 3 require prior certification.	10%	30%	40%
-- Complex radiology (CT, SPECT, MRI, MUGA and PET)	10%	30%[1]	40% [1]
Rehabilitation therapy (outpatient physical, occupational and respiratory therapy). Provided as long as significant improvement is expected.	$35	30%/60 visits per plan year (PPO/OON)	40%/60 visits per plan year (PPO/OON)
Chiropractic care	$35	30%/15 visits per plan year (PPO/OON)	40%/15 visits per plan year (PPO/OON)
Speech Therapy	$35	30%/40 visits per plan year (PPO/OON)	40%/40 visits per plan year (PPO/OON)
Dental services (limited to medically necessary hospital or professional services directly related to monitoring, controlling or treating a severe medical condition when excluded dental services are being performed).	$0	30%	40%
CARE FOR CONDITIONS OF PREGNANCY (Professional Services Only)	**Tier 1**	**Tier 2**	**Tier 3**
Prenatal and postnatal office visit. Note: Tier 1 office visit copay applies to initial diagnostic visit only, all other covered at 100% or $0 copay.	$0	30%	40%
Normal delivery, cesarean section. Includes newborn inpatient professional care.	10%	30%[1]	40% [1]

CARE FOR CONDITIONS OF PREGNANCY (Professional Services Only) (continued)	**Tier 1**	**Tier 2**	**Tier 3**
Complications of pregnancy, including medically necessary abortions.	10%	30%[1]	40% [1]
Elective abortions.	$150	30%	40%
Genetic testing of fetus.	$0	30%	40%
Circumcision of newborn.	$0	30%	40%
FAMILY PLANNING (Professional Services Only)	**Tier 1**	**Tier 2**	**Tier 3**
Contraceptive devices.	0%	30%	40%
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs).	No	No	No
Sterilization of females.	$150	50%	50%
Sterilization of males.	$75	50%	50%
Reversal of sterilization.	No	No	No
CHEMICAL DEPENDENCY REHABILITATION and CARE for MENTAL DISORDERS - applicable towards OOPM	**Tier 1**	**Tier 2**	**Tier 3**
Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient substance abuse rehabilitation facility.	$25	$50	40%
Residential care in a hospital or residential substance abuse care facility.	10% + $250 per admission	30% [1]	40% [1]
Detoxification (acute care for substance abuse).	10% + $250 per admission	30% [1]	40% [1]
Outpatient mental health consultation.	$25	$50	40%
Inpatient care for mental disorders.	10% + $250 per admission	30% [1]	40% [1]
Physician mental health visit to hospital or skilled nursing facility.	$0	30%	40%
OTHER SERVICES	**Tier 1**	**Tier 2**	**Tier 3**
Medical social services.	$0	30%	40%
Patient education.	$0	No	No
Air ambulance. Limited to a maximum of $750 each incident through PPO/OON combined.	$0	30%	40%
Ground ambulance.	$0	30%	40%
Durable medical equipment. The benefit limit does not apply for diabetic supplies, nebulizers, face masks and tubing used for the treatment of asthma.	10%/$5,000 plan year max	30%/$5,000 plan year max (PPO/OON)	40%/$5,000 plan year max (PPO/OON)
Orthotics (braces and supports)	$0	30%	40%
Diabetic supplies (except footwear; see below)	$0	30%	40%
Diabetic footwear	$0	30%	40%
Hearing aids. Combined with Durable Medical Equipment plan year max	10%	30%	40%
Prosthesis (replacing body parts) A prescription is required for the provision of initial and future prosthetics through PPO.	$0	30%	40%
Blood, blood plasma, blood factors and blood derivatives.	10%	30%	40%
Nuclear medicine (professional services only).	$0	30%	40%
Organ and bone marrow transplants (nonexperimental and noninvestigative, professional services only).	10%	30%	No
Deductible is waived for travel on Tier 2			
Chemotherapy (professional services only).	$0	$50	40%
Renal dialysis (professional services only).	$0	$50	40% [1]
Home health visit.	$25 / 100 visits per plan year	30% [1] / 50 visits (PPO/OON)	40% [1] / 50 visits (PPO/OON)
Hospice care (elected by member).	$0	30%[1]	40% [1]

HOSPITAL AND SKILLED NURSING FACILITY SERVICES	**Tier 1**	**Tier 2**	**Tier 3**
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders.	10% + $250 per admission	30% [1]	40% [1]
Inpatient deductible			$500
-- Confinement for infertility services.	No	No	No
Confinement in a skilled nursing facility. Day limits are for each member during the plan year.	10%/100 days	30% / 50 visits (PPO/OON)	40% / 50 visits (PPO/OON)
Maternity care (includes routine nursery charges).	10% + $250 per admission	30% [1]	40% [1]
Inpatient deductible			$500
Outpatient services other than surgery.	10%	30%[1]	40% [1]
Outpatient surgery at hospital or ambulatory surgical center.	10%	30% [1]	40% [1]
Outpatient Ambulatory Surgical Center maximum payable			$350
EMERGENCY or URGENTLY NEEDED CARE	**Tier 1**	**Tier 2**	**Tier 3**
The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.			
Professional Services	$0	30%	40%
Use of Emergency Room (facility only).	$125	30%	40%
Use of Urgent Care Center (facility only).	$35	30%	40%
PLAN YEAR DEDUCTIBLES	**Tier 1**	**Tier 2**	**Tier 3**
Both copays and the calendar year deductible are included in the OOPM			
Tier 2 and 3- the plan year deductible does not apply to those services that require a copayment (for example, $50 copayment). The plan year deductible applies to all services that require a coinsurance (for example, 30% or 40%).			
Out-Of-Network (OON/SELECT 3) deductible	N/A	$1000/Mbr $2000/Fam (PPO/OON)	$1000/Mbr $2000/Fam (PPO/OON)
OUT-OF-POCKET MAXIMUM (OOPM)	**Tier 1**	**Tier 2**	**Tier 3**
Both copays and the calendar year deductible are included in the OOPM			
Single contract.	$1,500	$5000 (PPO/OON)	$5000 (PPO/OON)
Two-party contract.	$3,000	$10,000 (PPO/OON)	$10,000 (PPO/OON)
Family contract (3 or more members).	$4,500	$15000 (PPO/OON)	$15000 (PPO/OON)
LIFETIME BENEFIT MAXIMUM (medical and mental health/substance abuse)			
Maximum payments for each member's lifetime	N/A	Unlimited	Unlimited
PENALTIES FOR NON-CERTIFICATION			
1. Services require prior certification. If prior certification is not acquired, benefits are reduced to 50% of the contracted rate through PPO/SELECT 2 and 50% of maximum allowable amount through OON/SELECT 3. In addition, a $250 deductible will be ch			
NOTE: Routine care for conditions of pregnancy do not require prior certification. However, notification of pregnancy is requested.			
NOTE: Contact Health Net for Bariatric and Transplant travel expense limitations.			