

2014-2015 POS 80 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 service line.	\$30 pcp/\$45 specialist	\$55	50%
Performed at a CVS Minute Clinic.	\$0	No	See HMO Benefit
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.	\$30	No	No
Specialist consultations.	\$45	\$55	50%
Visit to an OB/GYN (not including well woman services).	\$30	\$55	50%
Physician visit to member's home (at discretion of physician).	\$30	No	No
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	\$0	40%	50%
Other immunizations (except foreign travel).	\$0	\$0	No
Immunizations for foreign travel.	No	No	No
Allergy testing.	\$30 pcp/\$45 specialist	40%	50%
Allergy serum.	\$0	40%	50%
Allergy injection services.	\$0	40%	50%
Injections for treatment of infertility.	No	No	No
All other injections.			
--Office-based injectable medications.	\$0	40%	50%
--Self-administered injectable medications (per up to 30 day prescription).	30%	40% ¹	50% ¹
Surgeon/Assistant Surgeon in hospital or PPG.	20%	40% ¹	50% ¹
Administration of anesthetics.	20%	40%	50%
X-ray and laboratory procedures. Specified procedures through PPO/SELECT 2 and OON/SELECT 3 require prior certification.	20%	40%	50%
-- Complex radiology (CT, SPECT, MRI, MUGA and PET)	20%	40% ¹	50% ¹
Rehabilitation therapy (outpatient physical, occupational and respiratory therapy). Provided as long as significant improvement is expected.	\$45	40%/60 visits per plan year (PPO/OON)	50%/60 visits per plan year (PPO/OON)
Chiropractic care	\$45	40%/15 visits per plan year (PPO/OON)	50%/15 visits per plan year (PPO/OON)
Speech Therapy	\$45	40%/40 visits per plan year (PPO/OON)	50%/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	40%	50%
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	40%	50%
Normal delivery, cesarean section. Includes newborn inpatient professional care.	20%	40% ¹	50% ¹
Complications of pregnancy, including medically necessary abortions.	20%	40% ¹	50% ¹
Elective abortions.	\$150	40%	50%
Genetic testing of fetus.	\$0	40%	50%

Circumcision of newborn.	\$0	40%	50%
FAMILY PLANNING (Professional Services Only)			
	Tier 1	Tier 2	Tier 3
Contraceptive devices.	0%	\$0	Not Covered
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs).	No	No	No
Sterilization of females.	\$0	\$0	Not Covered
Sterilization of males.	\$75	50%	50%
Reversal of sterilization.	No	No	No
CHEMICAL DEPENDENCY REHABILITATION and CARE for MENTAL DISORDERS			
	Tier 1	Tier 2	Tier 3
Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient substance abuse rehabilitation facility.	\$30	\$55	50%
Residential care in a hospital or residential substance abuse care facility.	20% + \$500 per admission	40% ¹	50% ¹
Detoxification (acute care for substance abuse).	20% + \$500 per admission	40% ¹	50% ¹
Outpatient mental health consultation.	\$30	\$55	50%
Inpatient care for mental disorders.	20% + \$500 per admission	40% ¹	50% ¹
Physician mental health visit to hospital or skilled nursing facility.	\$0	40%	50%
OTHER SERVICES			
	Tier 1	Tier 2	Tier 3
Medical social services.	\$0	40%	50%
Patient education.	\$0	No	No
Air ambulance. \$750 maximum removed for each incident through PPO/OON combined.	\$0	40%¹	50%
Ground ambulance.	\$0	40%	50%
Durable medical equipment. (\$5000 annual max removed)	20%	40%	50%
Orthotics (braces and supports)	\$0	40%	50%
Diabetic supplies (except footwear; see below)	\$0	40%	50%
Diabetic footwear	\$0	40%	50%
Hearing aids. (\$5000 annual max no longer combined with DME)	20%	40%	50%
Prosthesis (replacing body parts) A prescription is required for the provision of initial and future prosthetics through PPO.	\$0	40% ¹	50%
Blood, blood plasma, blood factors and blood derivatives.	20%	40%	50%
Nuclear medicine (professional services only).	\$0	40%	50%
Organ and bone marrow transplants (nonexperimental and noninvestigative, professional services only).	20%	40% ¹	No
Travel/Lodging -Deductible is waived for travel on Tier 2	not covered	\$0	not covered
Chemotherapy (professional services only).	\$0	\$55	50%
Renal dialysis (professional services only).	\$0	\$55	50% ¹
Home health visit.	\$30 / 100 visits per plan year	40% ¹ / 50 visits (PPO/OON)	50% ¹ / 50 visits (PPO/OON)
Hospice care (elected by member).	\$0	40% ¹	50% 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.	20% + \$500 per admission	40% ¹	50% ¹
Inpatient deductible			\$500
-- Confinement for infertility services.	not covered	not covered	not covered
Confinement in a skilled nursing facility. Day limits are for each member during the plan year.	20%/100 days	40% / 50 days (PPO/OON)	50% / 50 days (PPO/OON)
Maternity care (includes routine nursery charges).	20% + \$500 per admission	40% ¹	50% ¹

Inpatient deductible			\$500
Outpatient services other than surgery.	20%	40% ¹	50% ¹
Outpatient surgery at hospital or ambulatory surgical center.	20%	40% ¹	50% ¹
Outpatient Ambulatory Surgical Center maximum payable			\$350
EMERGENCY or URGENTLY NEEDED CARE			
	Tier 1	Tier 2	Tier 3
<i>The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.</i>			
Professional Services	\$0	40%	50%
Use of Emergency Room (facility only).	20%	40%	50%
Use of Urgent Care Center (facility only).	\$45	40%	50%
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 50%).			
Out-Of-Network (OON/SELECT 3) deductible	N/A	\$1500/Mbr \$3000/Fam (PPO/OON)	\$2000/Mbr \$4000/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.	\$2,500	\$5000 (PPO/OON)	\$5000 (PPO/OON)
Two-party contract.	\$5,000	\$10,000 (PPO/OON)	\$10,000 (PPO/OON)
Family contract (3 or more members).	\$7,500	\$12500 (PPO/OON)	\$12500 (PPO/OON)
LIFETIME BENEFIT MAXIMUM (medical and mental health/substance abuse)			
	Tier 1	Tier 2	Tier 3
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 charged.

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.

June 1, 2014