Appendix F Network Health Plan Effective 11/01/2011

Active Employees HMO

Service Received	Employee 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 (through age 18) *See "Other Services" for additional Preventive Care information*	No charge
Office Visit • Medical Exam, family planning, 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 in hospital outpatient department or ambulatory surgery center • Lab, X-ray and ultrasound • CT scan and MRI, outpatient facility fees	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	No Charge
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 days combined per member, per calendar year)*	No Charge
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 – birth through age 18 *(one exam every year)* • Routine vision exam – age 19 and over *(one exam every two years)*	No Charge
• Chiropractic visits ***(limited to 20 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 (performed by an OB/GYN provider) - Well Women exam (1 per year) - Maternity care (routine prenatal, delivery and postpartum)	No Charge
• Mammogram and Pap smear	
• Hearing aids – birth to age 18 • Nutritional Counseling –(*if billed as an office visit, service will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)*	
These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.	
Hospital Emergency Room (ER)/ Urgent Care Facility • Urgent Care charge (waived if admitted) • ER charge *(waived if admitted)* • ER physician fee, CT scan, MRI, medical supplies, etc.	$50 copay $100 copay No Charge
Ambulance (medically necessary emergency transport only)	No Charge

Service Received	Employee Share of the Cost
For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral Health Administrator	
Mental Health (MH) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	$15 copay
- Group Therapy	No Charge
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	No Charge
Substance Abuse (SA) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	$15 copay
- Group Therapy	No Charge
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	No Charge

Maximums (For covered medical costs)*

- Individual Out-Of Pocket Maximum $500
- Family Out-of-Pocket Maximum $1000
- Life Time Benefit Maximum 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**
- [1]**Fitness Equipment Reimbursement:** $200 per employee per calendar year **OR 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).

**This is a taxable benefit.

Prescription Drugs

	Retail Pharmacy	Mail Service Pharmacy
Employee Share of the Cost	• **$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
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

- 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

[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.