APPENDIX F
Network Health Plan Effective January 1, 2016
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 • Routine prenatal and postpartum care • Preventive colonoscopy • Family planning *See "Other Services" for additional Preventive Care information*	No Charge
Office Visit • Medical Exam, 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 – Outpatient department of a hospital (*non-site of service location*)	Deductible applies
• Lab – Outpatient department of a hospital (*non-site of service location*)	
• CT scan, MRI, X-ray and ultrasound	
• **Site of Service** Surgery rendered at independent Ambulatory Surgery Center (if labs associated with surgery are sent to a non-site of service location deductible will apply) Lab rendered at an independent facility	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 • Maternity care-delivery	Deductible applies
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 days combined per member, per calendar year)*	
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 *(one exam every calendar year)*	No Charge
• Chiropractic visit *(limited to 24 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 – Well Women exam annually	No Charge
• Mammogram and pap smear	
• Hearing aids – Birth to age 18; 19 and over hearing aid maximum of $1500 for each ear every 60 months • Nutritional Counseling (*if billed as an office visit, service will be subject to an office visit co-pay, three visits per member per calendar year, unlimited for diabetes or organic disease)*	

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Network Health Plan Effective January 1, 2016
Active Employees HMO

These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.	
Hospital Emergency Room (ER)/ Urgent Care Facility • ER charge *(copayment waived if admitted)* • Urgent Care • Walk In Center • ER physician fee, lab, medical supplies • CT scan, MRI, X-ray and ultrasound	 $100 Copay $50 Copay $30 Copay No Charge Deductible Applies
Ambulance (*medically necessary emergency transport only*)	No Charge

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 No Charge
- Group Therapy	No Charge
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	 Deductible Applies No Charge
Substance Abuse (SA) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	 $15 Copay No Charge
- Group Therapy	No Charge
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	Deductible applies

Deductible Maximum (For covered medical costs)

- $500 per member no more than $1,000 per family per calendar year.

Co-Pay Maximum (For covered medical costs)

- Individual Out-of-Pocket Maximum $500 per member per calendar year
- Family Out-of-Pocket Maximum $1,000 per family per calendar year

Lifetime Dollar Limit

Unlimited

Other

- **Health Education Reimbursement: $150 per family per calendar year
- **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).

*__Married State Employees.__ If two state employees are married, each employee is entitle to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.
**This is a taxable benefit.

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Active Employees HMO

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)
• $750 per individual per calendar year • $1,500 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

~end~