

**APPENDIX G**  
**Network Health Plan Effective January 1, 2016**  
**Active Employees POS**

Service Received	Employee Share of the Cost	
	In-Network Benefits	Out-Of-Network Benefits (OON)
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Immunization (including travel), lead screening, PSA (prostate screening)</li> </ul>	No Charge	Covered up to MAB
<ul style="list-style-type: none"> <li>Routine physical exam and well baby care</li> <li>Routine hearing screening</li> <li>Routine prenatal and postpartum care</li> <li>Preventive colonoscopy</li> <li>Family planning</li> </ul> <i>See "Other Services" for additional Preventive Care information</i>	No Charge	Subject to deductible and coinsurance:  Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year  Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
<b>Office Visit</b> <ul style="list-style-type: none"> <li>Medical exam, office surgery</li> </ul>	\$15 PCP/\$30 Specialist Copay	
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Allergy treatments and injections</li> <li>Short term rehabilitative therapy- physical, occupational, cardiac or speech (<i>unlimited</i>)</li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Surgery – Outpatient department of a hospital (<i>non-site of service location</i>)</li> </ul>	In-Network deductible applies	
<ul style="list-style-type: none"> <li>Lab – Outpatient department of a hospital (<i>non-site of service location</i>)</li> </ul>		
<ul style="list-style-type: none"> <li>CT scan , MRI, X-ray and ultrasound</li> </ul>		
<ul style="list-style-type: none"> <li><b>Site of Service</b> 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</li> </ul>	No Charge	
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> <li>Maternity care-delivery</li> </ul>	In-Network deductible applies	
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <ul style="list-style-type: none"> <li>(<i>Limited to 100 days combined maximum per member per calendar year</i>)</li> </ul>		
<b>Other Services</b> <ul style="list-style-type: none"> <li>Routine vision exam (<i>one exam every calendar year</i>)</li> </ul>	No Charge	
<ul style="list-style-type: none"> <li>Chiropractic visit (<i>24 visit maximum per member per calendar year</i>)</li> </ul>	\$15 Copay	
<ul style="list-style-type: none"> <li>Infertility (<i>tests, counseling</i>)</li> <li>Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	\$30 Copay	
<ul style="list-style-type: none"> <li>Hearing aids – Birth to age 18. 19 and over hearing aid maximum of \$1500 for each ear every 60 months</li> <li>Nutritional Counseling – (<i>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</i>)</li> <li>OB/GYN care – Well Women exam annually</li> </ul>	No Charge	

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• Mammogram and pap smear	No Charge	Covered up to MAB
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<b>Hospital Emergency Room (ER)/ Urgent Care Facility</b>		
• ER charge ( <i>copayment waived if admitted</i> )	\$100 Copay	\$100 Copay
• Urgent Care	\$50 Copay	\$50 Copay
• Walk In Center	\$30 Copay	Deductible and Coinsurance apply
• ER physician fee, lab, medical supplies	No Charge	No Charge
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	No Charge	No Charge
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> ( <i>unlimited</i> )	No Charge	Deductible and Coinsurance apply
<b>For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral Health Administrator</b>		
Mental Health (MH)	In-Network Benefits	Out-of-Network Benefits
• Outpatient services		Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member  Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year  Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify.
- Individual Therapy	\$15 Copay	
- Intensive Outpatient Treatment Program (IOP)	No Charge	
- Group Therapy	No Charge	
• Inpatient services	In-Network deductible applies	
- Inpatient	No Charge	
- Partial Hospitalization Program (PHP)		
Substance Abuse (SA)		
• Outpatient services		
- Individual Therapy	\$15 Copay	
- Intensive Outpatient Treatment Program (IOP)	No Charge	
- Group Therapy	No Charge	
• Inpatient services	In-Network deductible applies	
- Inpatient ( <i>Including medical detoxification &amp; SA rehabilitation</i> )		
- Partial Hospitalization Program (PHP)		
<b>In-Network Deductible Maximum (For covered medical costs)</b>		
• \$500 per member no more than \$1000 per family per calendar year		
<b>Co-Pay/OON Maximums (For covered medical costs)</b>		
	In-Network Benefits	Out-of-Network Benefits
• Individual Out-Of-Pocket Maximum	\$500 per member per calendar year	\$3,000 per member per calendar year
• Family Out-of-Pocket Maximum	\$1,000 per family per calendar year	\$6,000 per family per calendar year
<b>Lifetime Dollar Limit</b>		
Unlimited		

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<b>Other</b>		
<ul style="list-style-type: none"> <li>• Health Education Reimbursement: \$150 per family per calendar year**</li> <li>• Fitness Equipment Reimbursement or Health Club Benefit: N/A</li> <li>• Eyewear benefits: N/A</li> </ul> <p style="text-align: center;">**This is a taxable benefit.</p>		
<b>Prescription Drugs</b>		
	<b>Retail Pharmacy</b>	<b>Mail Service Pharmacy</b>
<b>Employee Share of the Cost</b>	<ul style="list-style-type: none"> <li>• <b>\$10</b> for each generic medication</li> <li>• <b>\$25</b> for each preferred brand-name medication</li> <li>• <b>\$40</b> for each non-preferred brand-name medication</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$1</b> for each generic medication</li> <li>• <b>\$40</b> for each preferred brand-name medication</li> <li>• <b>\$70</b> for each non-preferred brand-name medication</li> </ul>
<b>Days Supply Limit</b>	<b>Up to a 31-day supply</b>	<b>Up to a 90-day supply</b>
<b>Maximums (for covered prescription costs)</b>		
<ul style="list-style-type: none"> <li>• \$750 per individual per calendar year</li> <li>• \$1,500 per family per calendar year</li> </ul>		
<b>Other</b>		
<ul style="list-style-type: none"> <li>• Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out.</li> <li>• Exclusive Specialty Pharmacy</li> <li>• Quantity Limits</li> </ul>		<ul style="list-style-type: none"> <li>• Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered “Dispense as Written”)</li> <li>• Traditional Generic Step Therapy</li> <li>• Pharmacy Adviser</li> </ul>

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