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

| Service Received | Employee Share of the Cost | |
|---|---|---|
| **Preventive Care**<br>• Immunization (including travel), lead screening, PSA (prostate screening) | **In-Network Benefits**<br>No Charge | **Out-Of-Network Benefits (OON)**<br>Covered up to MAB |
| • Routine physical exam and well baby care<br>• Routine hearing screening<br>• Routine prenatal and postpartum care<br>• Preventive colonoscopy<br>• Family planning<br>*See "Other Services" for additional Preventive Care information* | No Charge | Subject to deductible and coinsurance:<br><br>Individual:<br>$1,000 deductible per member per calendar year and<br>20% coinsurance up to<br>$2,000 per member<br><br>Family:<br>$2,000 per family per calendar year and 20% coinsurance up to $4,000 per family per calendar year<br><br>Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify. |
| **Office Visit**<br>• Medical exam, office surgery | $15 PCP/$30 Specialist Copay | |
| **Other Outpatient Care**<br>• Allergy treatments and injections<br>• Short term rehabilitative therapy- physical, occupational, cardiac or speech *(unlimited)* | $15 Copay | |
| • Surgery – Outpatient department of a hospital (*non-site of service location*) | In-Network deductible applies | |
| • Lab – Outpatient department of a hospital (*non-site of service location*) | | |
| • CT scan , MRI, X-ray and ultrasound | | |
| • **Site of Service**<br>Surgery rendered at independent Ambulatory Surgery Center<br>(if labs associated with surgery are sent to a non-site of service location deductible will apply)<br>Lab rendered at an independent facility | No Charge | |
| **Inpatient Care** (as a bed patient in an acute care hospital)<br>• Semi-private room and board<br>• Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy<br>• Maternity care-delivery | In-Network deductible applies | |
| **Skilled Nursing Facility and Rehabilitation Facility Care**<br>• (*Limited to 100 days combined maximum per member per calendar year*) | | |
| **Other Services**<br>• Routine vision exam *(one exam every calendar year)* | No Charge | |
| • Chiropractic visit *(24 visit maximum per member per calendar year)* | $15 Copay | |
| • Infertility (*tests, counseling*)<br>• Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)* | $30 Copay | |
| • Hearing aids – Birth to age 18.<br>19 and over hearing aid maximum of $1500 for each ear every 60 months<br>• 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)*<br>• OB/GYN care – Well Women exam annually | No Charge | |

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| | | |
|---|---|---|
| • Mammogram and pap smear | No Charge | Covered up to MAB |

| Service Received | Employee Share of the Cost | |
|---|---|---|
| **Hospital Emergency Room (ER)/ Urgent Care Facility** | | |
| • ER charge *(copayment waived if admitted)* | $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 |
| **Ambulance** *(medically necessary emergency transport only)* | No Charge | No Charge |
| **Durable Medical Equipment (DME) and External Prosthetic Devices** *(unlimited)* | No Charge | Deductible and Coinsurance apply |

**For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral Health Administrator**

| **Mental Health (MH)** | **In-Network Benefits** | **Out-of-Network Benefits** |
|---|---|---|
| • Outpatient services | | Individual:<br>$1,000 deductible per member per calendar year and<br>20% coinsurance up to $2,000 per member<br><br>Family:<br>$2,000 per family per calendar year and 20% coinsurance up to $4,000 per family per calendar year<br><br>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 | | |
| - Inpatient | In-Network deductible applies | |
| - Partial Hospitalization Program (PHP) | No Charge | |
| **Substance Abuse (SA)** | | |
| • Outpatient services | | |
| - Individual Therapy | $15 Copay | |
| - Intensive Outpatient Treatment Program (IOP) | No Charge | |
| - Group Therapy | No Charge | |
| • Inpatient services | | |
| - Inpatient (*Including medical detoxification & SA rehabilitation)* | In-Network deductible applies | |
| - Partial Hospitalization Program (PHP) | | |

**In-Network Deductible Maximum (For covered medical costs)**

- $500 per member no more than $1000 per family per calendar year

**Co-Pay/OON Maximums (For covered medical costs)**

| | **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 |

**Lifetime Dollar Limit**

**Unlimited**

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## Other

- Health Education Reimbursement: $150 per family per calendar year**
- Fitness Equipment Reimbursement or Health Club Benefit: N/A
- Eyewear benefits: N/A

**This is a taxable benefit.

## Prescription Drugs

| | Retail Pharmacy | Mail Service Pharmacy |
|---|---|---|
| **Employee Share of the Cost** | • **$10** for each generic medication<br>• **$25** for each preferred brand-name medication<br>• **$40** for each non-preferred brand-name medication | • **$1** for each generic medication<br>• **$40** for each preferred brand-name medication<br>• **$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~**