

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) |
| Preventive Care <ul style="list-style-type: none"> Immunization (including travel), lead screening, PSA (prostate screening) | No Charge | Covered up to MAB |
| <ul style="list-style-type: none"> Routine physical exam and well baby care Routine hearing screening Routine prenatal and postpartum care Preventive colonoscopy Family planning <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. |
| Office Visit <ul style="list-style-type: none"> Medical exam, office surgery | \$15 PCP/\$30 Specialist Copay | |
| Other Outpatient Care <ul style="list-style-type: none"> Allergy treatments and injections Short term rehabilitative therapy- physical, occupational, cardiac or speech (<i>unlimited</i>) | \$15 Copay | |
| <ul style="list-style-type: none"> Surgery – Outpatient department of a hospital (<i>non-site of service location</i>) | In-Network deductible applies | |
| <ul style="list-style-type: none"> Lab – Outpatient department of a hospital (<i>non-site of service location</i>) | | |
| <ul style="list-style-type: none"> CT scan , MRI, X-ray and ultrasound | | |
| <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> 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 | In-Network deductible applies | |
| Skilled Nursing Facility and Rehabilitation Facility Care <ul style="list-style-type: none"> <i>(Limited to 100 days combined maximum per member per calendar year)</i> | | |
| Other Services <ul style="list-style-type: none"> Routine vision exam (<i>one exam every calendar year</i>) | No Charge | |
| <ul style="list-style-type: none"> Chiropractic visit (<i>24 visit maximum per member per calendar year</i>) | \$15 Copay | |
| <ul style="list-style-type: none"> Infertility (<i>tests, counseling</i>) Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>) | \$30 Copay | |
| <ul style="list-style-type: none"> Hearing aids – Birth to age 18. 19 and over hearing aid maximum of \$1500 for each ear every 60 months 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>) OB/GYN care – Well Women exam annually | No Charge | |

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| • Mammogram and pap smear | No Charge | Covered up to MAB |
|--|--|---|
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| Hospital Emergency Room (ER)/ Urgent Care Facility | | |
| • 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 |
| Ambulance (<i>medically necessary emergency transport only</i>) | No Charge | No Charge |
| Durable Medical Equipment (DME) and External Prosthetic Devices (<i>unlimited</i>) | 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 Therapy | \$15 Copay | Individual: \$1,000 deductible per member per calendar year and 20% coinsurance up to \$2,000 per member |
| - Intensive Outpatient Treatment Program (IOP) | No Charge | |
| - Group Therapy | No Charge | |
| • Inpatient services | In-Network deductible applies No Charge | Family: \$2,000 per family per calendar year and 20% coinsurance up to \$4,000 per family per calendar year |
| - Inpatient | | |
| - Partial Hospitalization Program (PHP) | | |
| Substance Abuse (SA) | | |
| • Outpatient services | | |
| - Individual Therapy | \$15 Copay | Some self referred benefits are subject to precertification requirements. Refer to your Benefit Booklet for details. Call 1-800-531-4450 to precertify. |
| - Intensive Outpatient Treatment Program (IOP) | No Charge | |
| - Group Therapy | No Charge | |
| • Inpatient services | In-Network deductible applies | |
| - Inpatient (<i>Including medical detoxification & SA rehabilitation</i>) | | |
| - 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 | | |
| <ul style="list-style-type: none"> Health Education Reimbursement: \$150 per family per calendar year** Fitness Equipment Reimbursement or Health Club Benefit: N/A Eyewear benefits: N/A <p style="margin-left: 40px;">**This is a taxable benefit.</p> | | |
| Prescription Drugs | | |
| | Retail Pharmacy | Mail Service Pharmacy |
| Employee Share of the Cost | <ul style="list-style-type: none"> \$10 for each generic medication \$25 for each preferred brand-name medication \$40 for each non-preferred brand-name medication | <ul style="list-style-type: none"> \$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) | | |
| <ul style="list-style-type: none"> \$750 per individual per calendar year \$1,500 per family per calendar year | | |
| Other | | |
| <ul style="list-style-type: none"> Mandatory Mail Order (for Maintenance Drugs after three (3) retail purchases per prescription, with employee opt out. Exclusive Specialty Pharmacy Quantity Limits | <ul style="list-style-type: none"> Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered “Dispense as Written”) Traditional Generic Step Therapy Pharmacy Adviser | |

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