

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: \$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 & 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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