

**APPENDIX F**  
**Network Health Plan**  
**Active Employees HMO**

Service Received	Employee Share of the Cost
<b>These services MUST be provided by or referred by your Primary Care Provider (PCP).</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Immunization (including travel), lead screening, PSA (prostate screening)</li> <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
<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>• Short term rehabilitative therapy- physical, occupational, cardiac or speech (<i>unlimited</i>)</li> <li>• Allergy treatment and injections</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> <li>• Lab – Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>• CT scan, MRI, X-ray and ultrasound</li> </ul>	Deductible applies
<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>	Deductible applies
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days combined per member, per calendar year)</i>	
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> <i>(unlimited)</i>	No Charge
<b>These services DO NOT require a PCP referral as long as you use designated network providers.</b>	
<b>Other Services</b> <ul style="list-style-type: none"> <li>• Routine vision exam (<i>one exam every calendar year</i>)</li> <li>• Chiropractic visit (<i>limited to 24 visits per member per calendar year</i>)</li> <li>• Infertility office visits (<i>tests, counseling</i>)</li> <li>• Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> <li>• OB/GYN care – Well Women exam annually</li> <li>• Mammogram and pap smear</li> <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> </ul>	No Charge

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<b>These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.</b>	
<b>Hospital Emergency Room (ER)/ Urgent Care Facility</b> <ul style="list-style-type: none"> <li>• ER charge (<i>copayment waived if admitted</i>)</li> <li>• Urgent Care</li> <li>• Walk In Center</li> <li>• ER physician fee, lab, medical supplies</li> <li>• CT scan, MRI, X-ray and ultrasound</li> </ul>	\$100 Copay \$50 Copay \$30 Copay No Charge Deductible Applies
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	No Charge
<b>For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral Health Administrator</b>	
<b>Mental Health (MH)</b> <ul style="list-style-type: none"> <li>• Outpatient services               <ul style="list-style-type: none"> <li>- Individual Therapy</li> <li>- Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> <li>- Group Therapy</li> </ul>	\$15 Copay No Charge  No Charge
<ul style="list-style-type: none"> <li>• Inpatient services               <ul style="list-style-type: none"> <li>- Inpatient</li> <li>- Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	Deductible Applies No Charge
<b>Substance Abuse (SA)</b> <ul style="list-style-type: none"> <li>• Outpatient services               <ul style="list-style-type: none"> <li>- Individual Therapy</li> <li>- Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> <li>- Group Therapy</li> </ul>	\$15 Copay No Charge No Charge
<ul style="list-style-type: none"> <li>• Inpatient services               <ul style="list-style-type: none"> <li>- Inpatient (<i>Including medical detoxification &amp; SA rehabilitation</i>)</li> <li>- Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	Deductible applies
<b>Deductible Maximum (For covered medical costs)</b>	
<ul style="list-style-type: none"> <li>• \$500 per member no more than \$1,000 per family per calendar year.</li> </ul>	
<b>Co-Pay Maximum (For covered medical costs)</b>	
<ul style="list-style-type: none"> <li>• Individual Out-of-Pocket Maximum      \$500 per member per calendar year</li> <li>• Family Out-of-Pocket Maximum        \$1,000 per family per calendar year</li> </ul>	
<b>Lifetime Dollar Limit</b>	
<b>Unlimited</b>	
<b>Other</b>	
<ul style="list-style-type: none"> <li>• **Health Education Reimbursement: \$150 per family per calendar year</li> <li>• **Fitness Equipment Reimbursement: \$200 per employee per calendar year <b>OR</b> Health Club Benefit: \$450 per employee per calendar year*</li> <li>• Eyewear benefits: \$100 every two years per family member (Includes eyeglasses (frames and lenses) and contact lenses).</li> </ul> <p style="margin-left: 40px;">*<b>Married State Employees.</b> If two state employees are married, each employee is entitled to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.</p> <p style="margin-left: 40px;">**This is a taxable benefit.</p>	

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<b>Prescription Drugs</b>		
<b>Employee Share of the Cost</b>	<b>Retail Pharmacy</b>	<b>Mail Service Pharmacy</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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