APPENDIX G
Network Health Plan
Active Employees POS

Service Received	Employee Share of the Cost	
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening)	**In-Network Benefits** No Charge	**Out-Of-Network Benefits (OON)** Covered up to MAB
• Routine physical exam and well baby care • Routine hearing screening • Routine prenatal and postpartum care • Preventive colonoscopy • Family planning *See "Other Services" for additional Preventive Care information*	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 • Medical exam, office surgery	$15 PCP/$30 Specialist Copay	
Other Outpatient Care • Allergy treatments and injections • 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** 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) • 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 • (*Limited to 100 days combined maximum per member per calendar year*)		
Other Services • 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*) • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay	
• Hearing aids – Birth to age 18. 19 and over hearing aid maximum of $1500 for each ear every 60 months • 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)* • 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: $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		
- 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	In-Network deductible applies	
- Inpatient (*Including medical detoxification & SA rehabilitation)*		
- 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 • **$25** for each preferred brand-name medication • **$40** for each non-preferred brand-name medication	• **$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)

- $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~