APPENDIX F
Network Health Plan
Active Employees HMO

Service Received	Employee Share of the Cost
These services MUST be provided by or referred by your Primary Care Provider (PCP).	
Preventive Care • Immunization (including travel), lead screening, PSA (prostate screening) • 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
Office Visit • Medical Exam, office surgery	$15 PCP /$30 Specialist Copay
Other Outpatient Care • Short term rehabilitative therapy- physical, occupational, cardiac or speech *(unlimited)* • Allergy treatment and injections	$15 Copay
• Surgery – Outpatient department of a hospital (*non-site of service location*)	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	Deductible applies
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 days combined per member, per calendar year)*	
Durable Medical Equipment (DME) and External Prosthetic Devices *(unlimited)*	No Charge
These services DO NOT require a PCP referral as long as you use designated network providers.	
Other Services • Routine vision exam *(one exam every calendar year)*	No Charge
• Chiropractic visit *(limited to 24 visits per member per calendar year)*	$15 Copay
• Infertility office visits (*tests, counseling*) • Treatment for surgical and non-surgical TMJ *(excluding appliances and orthodontic treatment)*	$30 Copay
• OB/GYN care – Well Women exam annually	No Charge
• Mammogram and pap smear	
• 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)*	

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These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.	
Hospital Emergency Room (ER)/ Urgent Care Facility • ER charge *(copayment waived if admitted)* • Urgent Care • Walk In Center • ER physician fee, lab, medical supplies • CT scan, MRI, X-ray and ultrasound	 $100 Copay $50 Copay $30 Copay No Charge Deductible Applies
Ambulance (*medically necessary emergency transport only*)	No Charge

For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral Health Administrator	
Mental Health (MH) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	 $15 Copay No Charge
- Group Therapy	No Charge
• Inpatient services - Inpatient - Partial Hospitalization Program (PHP)	 Deductible Applies No Charge
Substance Abuse (SA) • Outpatient services - Individual Therapy - Intensive Outpatient Treatment Program (IOP)	 $15 Copay No Charge
- Group Therapy	No Charge
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)* - Partial Hospitalization Program (PHP)	 Deductible applies

Deductible Maximum (For covered medical costs)

- $500 per member no more than $1,000 per family per calendar year.

Co-Pay Maximum (For covered medical costs)

- Individual Out-of-Pocket Maximum $500 per member per calendar year
- Family Out-of-Pocket Maximum $1,000 per family per calendar year

Lifetime Dollar Limit

Unlimited

Other

- **Health Education Reimbursement: $150 per family per calendar year
- **Fitness Equipment Reimbursement: $200 per employee per calendar year **OR** Health Club Benefit: $450 per employee per calendar year*
- Eyewear benefits: $100 every two years per family member (Includes eyeglasses (frames and lenses) and contact lenses).

*__Married State Employees.__ If two state employees are married, each employee is entitle to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.
**This is a taxable benefit.

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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~