

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 <ul style="list-style-type: none"> • 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 <i>See "Other Services" for additional Preventive Care information</i>	No Charge
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"> • Short term rehabilitative therapy- physical, occupational, cardiac or speech (<i>unlimited</i>) • Allergy treatment and injections 	\$15 Copay
<ul style="list-style-type: none"> • Surgery – Outpatient department of a hospital (<i>non-site of service location</i>) • Lab – Outpatient department of a hospital (<i>non-site of service location</i>) • CT scan, MRI, X-ray and ultrasound 	Deductible applies
<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 	Deductible applies
Skilled Nursing Facility and Rehabilitation Facility Care <i>(limited to 100 days combined per member, per calendar year)</i>	
Durable Medical Equipment (DME) and External Prosthetic Devices <i>(unlimited)</i>	No Charge
These services DO NOT require a PCP referral as long as you use designated network providers.	
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>limited to 24 visits per member per calendar year</i>) 	\$15 Copay
<ul style="list-style-type: none"> • Infertility office visits (<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"> • OB/GYN care – Well Women exam annually • Mammogram and pap smear 	No Charge
<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>) 	No Charge

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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 <ul style="list-style-type: none"> • ER charge (<i>copayment waived if admitted</i>) • 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 (<i>medically necessary emergency transport only</i>)	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) <ul style="list-style-type: none"> • Outpatient services <ul style="list-style-type: none"> - Individual Therapy - Intensive Outpatient Treatment Program (IOP) - Group Therapy 	\$15 Copay No Charge No Charge
<ul style="list-style-type: none"> • Inpatient services <ul style="list-style-type: none"> - Inpatient - Partial Hospitalization Program (PHP) 	Deductible Applies No Charge
Substance Abuse (SA) <ul style="list-style-type: none"> • Outpatient services <ul style="list-style-type: none"> - Individual Therapy - Intensive Outpatient Treatment Program (IOP) - Group Therapy 	\$15 Copay No Charge No Charge
<ul style="list-style-type: none"> • Inpatient services <ul style="list-style-type: none"> - Inpatient (<i>Including medical detoxification & SA rehabilitation</i>) - Partial Hospitalization Program (PHP) 	Deductible applies
Deductible Maximum (For covered medical costs)	
<ul style="list-style-type: none"> • \$500 per member no more than \$1,000 per family per calendar year. 	
Co-Pay Maximum (For covered medical costs)	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • **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). <p style="margin-left: 40px;">*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.</p> <p style="margin-left: 40px;">**This is a taxable benefit.</p>	

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