## 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			
<ul><li> Routine hearing screening</li><li> Routine prenatal and postpartum care</li></ul>	No Charge		
<ul> <li>Routine prenatar and postpartum care</li> <li>Preventive colonoscopy</li> </ul>	No Charge		
<ul> <li>Family planning</li> </ul>			
See "Other Services" for additional Preventive Care information			
Office Visit	\$15 PCP /\$30 Specialist Copay		
• Medical Exam, office surgery			
Other Outpatient Care			
• Short term rehabilitative therapy- physical, occupational, cardiac or speech	\$15 Copay		
(unlimited)	¢re copuj		
Allergy treatment and injections			
• Surgery – Outpatient department of a hospital ( <i>non-site of service location</i> )	Deductible		
Lab – Outpatient department of a hospital ( <i>non-site of service location</i> )	applies		
CT scan and MRI, x-ray and ultrasound			
Site of Service     Surgery rendered at independent Ambulatory Surgery Center	No Charge		
<ul> <li>Surgery Center</li> <li>Lab rendered at an independent facility</li> </ul>	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,	Deductible		
medical supplies, medication and physical, occupational and speech therapy	applies		
Maternity care-delivery			
Skilled Nursing Facility and Rehabilitation Facility Care			
(limited to 100 days combined per member, per calendar year)			
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> <i>(unlimited)</i>	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 ( <i>tests, counseling</i> )			
• Treatment for surgical and non-surgical TMJ (excluding appliances and	\$30 Copay		
orthodontic treatment)			
• OB/GYN care – Well Women exam annually			
Mammogram and pap smear			
• Hearing aids – Birth to age 18; 19 and over hearing aid maximum of \$1500 for each ear every 60 months	No Charge		
• Nutritional Counseling ( <i>if billed as an office visit, service will be subject to an</i>			
office visit co-pay, three visits per member per calendar year, unlimited for			
diabetes or organic disease)			

## APPENDIX F Network Health Plan Effective January 1, 2014 Active Employees HMO

Hospital Emergency Room (ER)/ Urgent Care Facility       \$100 Copay         • ER charge (copayment waived if admitted)       \$100 Copay         • Urgent Care       \$50 Copay         • Walk In Center       \$30 Copay         • Re physician fee, lab, medical supplies       No Charge         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       \$15 Copay         • Inpatient services       No Charge         • Inpatient services       Inpatient services         • Inpatient services       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Inpatient services       \$15 Copay         • Inpatient services       \$100 per family         • Inpatient services       \$1 nopaient	These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.			
• ER charge (copayment waived if admitted)       \$100 Copay         • Urgent Care       \$50 Copay         • Walk In Center       No Charge         • ER physician fee, lab, medical supplies       No Charge         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       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       Deductible applies         • Inpatient services       Deductible applies         • Inpatient services       \$15 Copay         • Inpatient services       Individual Therapy         • Outpatient services       \$15 Copay         • Inpatient       Deductible applies         Substance Abuse (SA)       \$15 Copay         • Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Individual Therapy       No Charge         • I	Hospital Emergency Room (ER)/ Urgent Care Facility			
Walk In Center     S30 Copay     ER physician fee, 1ab, medical supplies     Mo Charge     Molance (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)     Group Therapy     Intensive Outpatient or Program (PHP)     Deductible applies     S15 Copay     Individual Therapy     Intensive Outpatient Treatment Program (IOP)     Group Therapy     Intensive Outpatient Treatment Program (IOP)     Outpatient services     Inpatient     Partial Hospitalization Program (PHP)     Substance Abuse (SA)     Outpatient services     Individual Therapy     Individual Therapy     S15 Copay     Individual Therapy     S15 Copay     Individual Therapy     S15 Copay     Individual Therapy     S15 Copay     Individual Therapy     Deductible applies     Substance Abuse (SA)     Outpatient services     Inpatient (Including medical detoxification & SA rehabilitation)     Partial Hospitalization Program (PHP)     Deductible applies     Deductible Maximum (For Covered medical costs)     S500 per member no more than \$1,000 per family     S100 per member no more than \$1,000 per family		\$100 Copay		
• ER physician fee, lab, medical supplies       No Charge         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       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       No Charge         • Inpatient services       Partial Hospitalization Program (IOP)         • Inpatient services       S15 Copay         • Inpatient services       Deductible applies         Substance Abuse (SA)       •         • Outpatient services       \$15 Copay         • Individual Therapy       Deductible applies         Substance Abuse (SA)       •         • Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       S15 Copay         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Inpatient services       Belautification & SA rehabilitation         • Inpatient services       •         • Inpatient services       •         • Inpatient services       •         • Inpatie	Urgent Care	\$50 Copay		
• ER physician fee, lab, medical supplies       No Charge         Ambulance (inedically 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       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       No Charge         • Inpatient services       No Charge         • Inpatient services       Deductible applies         • Substance Abuse (SA)       Deductible applies         • Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Inpatient services       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       \$15 Copay         • Inpatient for Copy       No Charge         • Inpatient services<	Walk In Center	\$30 Copay		
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       \$15 Copay         • Intensive Outpatient Treatment Program (IOP)       No Charge         • Inpatient services       No Charge         • Inpatient services       Deductible applies         Substance Abuse (SA)       Deductible applies         • Outpatient services       \$15 Copay         • Individual Therapy       Deductible applies         Substance Abuse (SA)       No Charge         • Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Individual Therapy       No Charge         • Inpatient (including medical detoxification & SA rehabilitation)       Deductible applies         • Inpatient (including medical detoxification & SA rehabilitation)       Deductible applies         • Stoo per member no more than \$1,000 per family       Deductible applies         • \$500 per member no more than \$1,000 per family       \$500 per member per calendar year         • Individual Out-of-Pocket Maximum       \$500 per member per calendar year         • Family Out-of-Pocket Maximum       \$1,000 per family per calendar year		No Charge		
Health Administrator         Mental Health (MH)         • Outpatient services         • Individual Therapy         • Intensive Outpatient Treatment Program (IOP)         • Group Therapy         • Inpatient services         • Inpatient services         • Inpatient services         • Inpatient services         • Partial Hospitalization Program (PHP)         Substance Abuse (SA)         • Outpatient services         • Individual Therapy         • Outpatient services         • Individual Therapy         • Outpatient services         • Individual Therapy         • Outpatient services         • Inpatient (Including medical detoxification & SA rehabilitation)         • Partial Hospitalization Program (PHP)         Deductible Maximum (For Covered medical costs)         • \$500 per member no more than \$1,000 per family         • \$500 per member no more than \$1,000 per family         • Individual Out-of-Pocket Maximum \$500 per member per calendar year         • Family Out-of-Pocket Maximum \$1,000 per family per calendar year		No Charge		
• Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       Inpatient services         • Inpatient services       Deductible applies         • Outpatient services       \$15 Copay         • Inpatient services       Inpatient         • Outpatient services       Substance Abuse (SA)         • Outpatient services       \$15 Copay         • Individual Therapy       Deductible applies         • Individual Therapy       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       Inpatient services         • Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         • Partial Hospitalization Program (PHP)       Deductible applies         • Deductible Maximum (For Covered medical costs)       •         • \$500 per member no more than \$1,000 per family       •         • Individual Out-of-Pocket Maximum \$1,000 per family per calendar year       •         • Family Out-of-Pocket Maximum \$1,000 per family per calendar year       •	For these services no PCP referral is required, but ALL care must be authorized in advance by the Behavioral			
• Outpatient services       \$15 Copay         • Individual Therapy       No Charge         • Inpatient services       Inpatient services         • Inpatient services       Deductible applies         • Outpatient services       S15 Copay         • Inpatient       Deductible applies         • Outpatient services       S15 Copay         • Inpatient       Deductible applies         • Outpatient services       \$15 Copay         • Individual Therapy       Deductible applies         • Individual Therapy       No Charge         • Inpatient services       No Charge         • Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         • Partial Hospitalization Program (PHP)       Deductible applies         • Partial Hospitalization Program (PHP)       Deductible applies         • Stoto per member no more than \$1,000 per family       Co-Pay Maximum (For covered medical costs)         • Individual Out-of-Pocket Maximum \$1,000 per family per calendar year       Family Out-of-Pocket Maximum \$1,000 per family per calendar year	Mental Health (MH)			
Individual Therapy     Intensive Outpatient Treatment Program (IOP)     Group Therapy     Inpatient services     Inpatient     Partial Hospitalization Program (PHP)     Deductible applies     Substance Abuse (SA)     Outpatient services     Individual Therapy     Intensive Outpatient Treatment Program (IOP)     Outpatient services     Individual Therapy     Individual Therapy     Intensive Outpatient Treatment Program (IOP)     Outpatient services     Individual Therapy     Inpatient (Including medical detoxification & SA rehabilitation)     Partial Hospitalization Program (PHP)     Deductible Maximum (For Covered medical costs)     Stop per member no more than \$1,000 per family     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		¢15 Course		
-       Group Therapy       No Charge         •       Inpatient services       Inpatient         -       Partial Hospitalization Program (PHP)       Deductible applies         Substance Abuse (SA)       •       Outpatient services         •       Individual Therapy       \$15 Copay         •       Intensive Outpatient Treatment Program (IOP)       •         •       Group Therapy       No Charge         •       Inpatient services       \$15 Copay         •       Inpatient gendical detoxification & SA rehabilitation)       Deductible applies         •       Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         •       Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         •       Partial Hospitalization Program (PHP)       Deductible applies         •       Partial Hospitalization Program (PHP)       Deductible applies         •       \$500 per member no more than \$1,000 per family       •         •       \$500 per member no more than \$1,000 per family       •         •       Individual Out-of-Pocket Maximum       \$500 per member per calendar year         •       Family Out-of-Pocket Maximum       \$1,000 per family per calendar year	- Individual Therapy	\$15 Copay		
• Inpatient services       .       Inpatient         • Partial Hospitalization Program (PHP)       Deductible applies         Substance Abuse (SA)       .         • Outpatient services       \$15 Copay         • Intensive Outpatient Treatment Program (IOP)       .         • Group Therapy       No Charge         • Inpatient services       .         • Inpatient services       .         • Inpatient services       .         • Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         Partial Hospitalization Program (PHP)       Deductible applies         Deductible Maximum (For Covered medical costs)       .         • \$500 per member no more than \$1,000 per family       .         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       .	- Intensive Outpatient Treatment Program (IOP)			
• Inpatient services       .       Inpatient         • Partial Hospitalization Program (PHP)       Deductible applies         Substance Abuse (SA)       .         • Outpatient services       \$15 Copay         • Intensive Outpatient Treatment Program (IOP)       .         • Group Therapy       No Charge         • Inpatient services       .         • Inpatient services       .         • Inpatient services       .         • Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         Partial Hospitalization Program (PHP)       Deductible applies         Deductible Maximum (For Covered medical costs)       .         • \$500 per member no more than \$1,000 per family       .         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       .	- Group Therapy	No Charge		
- Inpatient       Deductible applies         - Partial Hospitalization Program (PHP)       Deductible applies         Substance Abuse (SA)       \$15 Copay         • Outpatient services       \$15 Copay         - Individual Therapy       No Charge         • Inpatient services       No Charge         • Inpatient services       Inpatient (Including medical detoxification & SA rehabilitation)         • Partial Hospitalization Program (PHP)       Deductible applies         Deductible Maximum (For Covered medical costs)       Deductible applies         • \$500 per member no more than \$1,000 per family       \$500 per member no more than \$1,000 per family         • Individual Out-of-Pocket Maximum \$500 per member per calendar year       • Family Out-of-Pocket Maximum \$1,000 per family per calendar year		Ť		
-       Partial Hospitalization Program (PHP)         Substance Abuse (SA)       •         •       Outpatient services         •       Individual Therapy         •       Intensive Outpatient Treatment Program (IOP)         •       Group Therapy         •       Inpatient services         •       Inpatient services         •       Inpatient (Including medical detoxification & SA rehabilitation)         •       Partial Hospitalization Program (PHP)         Deductible Maximum (For Covered medical costs)         •       \$500 per member no more than \$1,000 per family         Co-Pay Maximum (For covered medical costs)         •       Individual Out-of-Pocket Maximum         \$500 per member per calendar year         •       Family Out-of-Pocket Maximum		Deductible englise		
• Outpatient services       \$15 Copay         • Individual Therapy       \$15 Copay         • Intensive Outpatient Treatment Program (IOP)       • No Charge         • Inpatient services       • Inpatient services         • Inpatient (Including medical detoxification & SA rehabilitation)       • Deductible applies         • Partial Hospitalization Program (PHP)       • Deductible applies         • \$500 per member no more than \$1,000 per family       • \$500 per member no more than \$1,000 per family         • Individual Out-of-Pocket Maximum       \$500 per member per calendar year         • Family Out-of-Pocket Maximum       \$1,000 per family per calendar year	- Partial Hospitalization Program (PHP)	Deductible applies		
• Outpatient services       \$15 Copay         • Individual Therapy       \$15 Copay         • Intensive Outpatient Treatment Program (IOP)       • No Charge         • Inpatient services       • Inpatient services         • Inpatient (Including medical detoxification & SA rehabilitation)       • Deductible applies         • Partial Hospitalization Program (PHP)       • Deductible applies         • \$500 per member no more than \$1,000 per family       • \$500 per member no more than \$1,000 per family         • Individual Out-of-Pocket Maximum       \$500 per member per calendar year         • Family Out-of-Pocket Maximum       \$1,000 per family per calendar year	Substance Abuse (SA)			
- Individual Therapy       - Intensive Outpatient Treatment Program (IOP)         - Group Therapy       No Charge         • Inpatient services       - Inpatient (Including medical detoxification & SA rehabilitation)         - Partial Hospitalization Program (PHP)       Deductible applies         Deductible Maximum (For Covered medical costs)		¢15 Correct		
-       Group Therapy       No Charge         •       Inpatient services       Inpatient (Including medical detoxification & SA rehabilitation)       Deductible applies         •       Partial Hospitalization Program (PHP)       Deductible applies         •       S500 per member no more than \$1,000 per family         •       \$500 per member no more than \$1,000 per family         •       Individual Out-of-Pocket Maximum       \$500 per member per calendar year         •       Family Out-of-Pocket Maximum       \$1,000 per family per calendar year	- Individual Therapy	\$15 Copay		
<ul> <li>Inpatient services         <ul> <li>Inpatient (Including medical detoxification &amp; SA rehabilitation)</li> <li>Partial Hospitalization Program (PHP)</li> </ul> </li> <li>Deductible Maximum (For Covered medical costs)         <ul> <li>\$500 per member no more than \$1,000 per family</li> <li>Co-Pay Maximum (For covered medical costs)</li> <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> </li> </ul>	- Intensive Outpatient Treatment Program (IOP)			
<ul> <li>Inpatient (Including medical detoxification &amp; SA rehabilitation)</li> <li>Partial Hospitalization Program (PHP)</li> <li>Deductible Maximum (For Covered medical costs)</li> <li>\$500 per member no more than \$1,000 per family</li> <li>Co-Pay Maximum (For covered medical costs)</li> <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>	- Group Therapy	No Charge		
- Partial Hospitalization Program (PHP)       Deductible applies         Deductible Maximum (For Covered medical costs)         • \$500 per member no more than \$1,000 per family         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	Inpatient services			
- Faitial Hospitalization Flogram (FHF)         Deductible Maximum (For Covered medical costs)         • \$500 per member no more than \$1,000 per family         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		Deductible applies		
<ul> <li>\$500 per member no more than \$1,000 per family</li> <li>Co-Pay Maximum (For covered medical costs)</li> <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>	- Partial Hospitalization Program (PHP)	Deductione applies		
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	Deductible Maximum (For Covered medical costs)			
<ul> <li>Individual Out-of-Pocket Maximum</li> <li>Family Out-of-Pocket Maximum</li> <li>\$500 per member per calendar year</li> <li>\$1,000 per family per calendar year</li> </ul>	• \$500 per member no more than \$1,000 per family			
Family Out-of-Pocket Maximum \$1,000 per family per calendar year	Co-Pay Maximum (For covered medical costs)			
Family Out-of-Pocket Maximum \$1,000 per family per calendar year	Individual Out-of-Pocket Maximum     \$500 per member per calendar year			
Lifetime Dollar Limit				
Unlimited				
Other	Other			
**Health Education Reimbursement: \$150 per family per calendar year				
<ul> <li>**Fitness Equipment Reimbursement: \$200 per employee per calendar year</li> <li>OR Health Club Benefit: \$450 per employee per calendar</li> </ul>				
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.				

## APPENDIX F Network Health Plan Effective January 1, 2014 Active Employees HMO

Retail Pharmacy		Mail Service Pharmacy
Employee Share of the Cost	<ul> <li>\$10 for each generic medication</li> <li>\$25 for each preferred brand-namedication</li> <li>\$40 for each non-preferred brandmedication</li> </ul>	medication
Days Supply Limit	Up to a 31-day supply	Up to a 90-day supply
Maximums (for co	wered prescription costs)	
-	ividual per calendar year amily per calendar year	
Other		
three (3) retail purchases per prescription, with employee opt out.on W• Exclusive Specialty Pharmacy• Tr		<ul> <li>Mandatory Generic Substitution with DAW 2 (i.e., th only exception is physician ordered "Dispense as Written")</li> <li>Traditional Generic Step Therapy</li> <li>Pharmacy Adviser</li> </ul>

~end~