# **APPENDIX F**

## Network (HMO) Health Plan Active Employees HMO

Service Received	Your 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)					
<ul><li>Routine physical exam and well-baby care</li><li>Routine hearing screening</li></ul>					
<ul> <li>Routine prenatal and postpartum care</li> <li>Preventive colonoscopy</li> </ul>	No Charge				
<ul> <li>Freventive colonoscopy</li> <li>Family planning</li> <li>See "Other Services" for additional Preventive Care information</li> </ul>					
Office Visit  • Medical exam, office surgery	\$15 PCP /\$30 Specialist Copay				
Other Outpatient Care					
<ul> <li>Short term rehabilitative therapy-physical, occupational, cardiac or speech (unlimited)</li> <li>Allergy treatment and injections</li> </ul>	\$15 Copay				
<ul> <li>Surgery-Outpatient department of a hospital (non-site of service location)</li> <li>Lab-Outpatient department of a hospital (non-site of service location)</li> </ul>	Deductible				
CT scan, MRI, X-ray and ultrasound	Applies				
<ul> <li>Site of Service</li> <li>Surgery rendered at independent Ambulatory Surgery Center</li> <li>Lab rendered at an independent facility</li> </ul>	No Charge				
<ul><li>Inpatient Care (as a bed patient in an acute care hospital)</li><li>Semi-private room and board</li></ul>					
<ul> <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				
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				
<ul> <li>Infertility office visits (tests, counseling)</li> <li>Treatment for surgical and non-surgical TMJ (excluding appliances and orthodontic treatment)</li> </ul>	\$30 Copay				
OB/GYN care-well women exam annually	No Charge				
<ul> <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 (if billed as an office visit, services will be subject to an efficient in the service of the latest and the services of the latest and the latest are subject.</li> </ul>	No Charge				
office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)	Tio Chago				

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 (copay waived if admitted)	\$100 Copay		
Urgent Care	\$50 Copay		
Walk In Center	\$30 Copay		
ER physician fee, lab, medical supplies	No Charge		
Ambulance (medically necessary emergency transport only)	No Charge		

# No PCP referral required for these services. $\underline{All}$ care must be authorized in advance by the Behavioral Health Administrator.

Mental Health		
Outpatient services	\$15 Copay	
<ul> <li>Individual Therapy Office Visit</li> </ul>	\$13 Copay	
<ul> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul>		
Group Therapy	No Charge	
Inpatient services		
<ul> <li>Inpatient</li> </ul>	Deductible Applies	
<ul> <li>Partial Hospitalization Program (PHP)</li> </ul>		
Substance Use Disorder		
Outpatient services	\$15 Copey	
<ul> <li>Individual Therapy Office Visit</li> </ul>	Office Visit \$15 Copay	
<ul> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul>		
Group Therapy	No Charge	
Inpatient services		
<ul> <li>Inpatient (Including medical detoxification &amp; SA rehabilitation)</li> </ul>	Deductible Applies	
Partial Hospitalization Program (PHP)	11	

#### **Deductible**

• \$500 per member no more than \$1000 per family per calendar year

## Copay Maximums (for covered medical costs)

•	Individual Out-of-Pocket Copay Maximum	\$500 per member per calendar year
•	Family Out-of-Pocket Copay Maximum	\$1000 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 entitled to receive the Fitness Equipment Reimbursement OR the Health Club Benefit per calendar year.
  - \*\*This is a taxable benefit.

Prescription Drugs				
Prescription drug benefits are administered through the State's Pharmacy Benefit Manager.				
Employee Share of the Cost (copayment)	Retail Pharmacy (days supply limit: up to a 31-days)  • \$10 for each generic medication  • \$25 for each preferred brand-name medication  • \$40 for each non-preferred brand-name medication	Mail Service Pharmacy (days supply limit: up to a 90-days)  • \$1 for each generic medication • \$40 for each preferred brand-name medication • \$70 for each non-preferred brand-name medication		
Maximums (for covered prescription costs)	<ul> <li>\$750 per individual per calendar year</li> <li>\$1,500 per family per calendar year</li> </ul>			
	<ul> <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> <li>Mandatory Generic Substitution with DAW 2         <ul> <li>(i.e., the only exception is physician ordered</li></ul></li></ul>		

End