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)			
• Routine physical exam and well-baby care			
Routine hearing screening			
Routine prenatal and postpartum care	No Charge		
Preventive colonoscopy	_		
Family planning			
ee "Other Services" for additional Preventive Care information			
Office Visit	\$15 BCD /\$20 Specialist Coney		
Medical exam, office surgery	\$15 PCP /\$30 Specialist Copay		
Other Outpatient Care			
Short term rehabilitative therapy-physical, occupational, cardiac or speech	\$15 Copay		
(unlimited)	\$15 Copay		
Allergy treatment and injections			
Surgery-Outpatient department of a hospital (non-site of service location)			
Lab-Outpatient department of a hospital (non-site of service location)	Deductible		
CT scan, MRI, X-ray and ultrasound	Applies		
Site of Service			
Surgery rendered at independent Ambulatory Surgery Center	No Charge		
Lab rendered at an independent facility			
npatient 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	rippites		
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	No Charge		
unlimited)			
These services DO NOT require a PCP referral as long as you use designated net	work providers.		
Other Services	No Charge		
Routine vision exam (one exam every calendar year)			
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	\$30 Copay		
orthodontic treatment)			
OB/GYN care-well women exam annually	No Charge		
Mammogram and pap smear	no charge		
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, services will be subject to an			
office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or	No Charge		
organic disease)			

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) Urgent Care Walk In Center ER physician fee, lab, medical supplies 	\$100 Copay \$50 Copay \$30 Copay No Charge		
Ambulance (medically necessary emergency transport only)	No Charge		
No PCP referral required for these services. <u>All</u> care must be authorized in advance by the Behavioral Health Administrator.			
Mental Health Outpatient services Individual Therapy Office Visit Intensive Outpatient Treatment Program (IOP) 	\$15 Copay		
Group Therapy	No Charge		
 Inpatient services Inpatient Partial Hospitalization Program (PHP) 	Deductible Applies		
 Substance Use Disorder Outpatient services Individual Therapy Office Visit Intensive Outpatient Treatment Program (IOP) 	\$15 Copay		
Group Therapy	No Charge		
 Inpatient services Inpatient (<i>Including medical detoxification & SA rehabilitation</i>) Partial Hospitalization Program (PHP) 	Deductible Applies		
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 Family Out-of-Pocket Copay Maximum \$500 per member per calendar year \$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 <u>OR</u> 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)	 \$750 per individual per calendar year \$1,500 per family per calendar year 		
	 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