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 • 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 • 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, services will be subject to an office visit co-pay, 3 visits per member per calendar year, unlimited for diabetes or organic disease)*	No Charge

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 (*Including medical detoxification & SA rehabilitation)* – 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 $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 **<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.		
	Retail Pharmacy (days supply limit: up to a 31-days)	**Mail Service Pharmacy (days supply limit: up to a 90-days)**
Employee Share of the Cost (copayment)	• $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
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