APPENDIX F
Network (HMO) Health Plan
Active Employees HMO

*Benefits apply when care is **medically necessary.** Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. Services must be provided by a network provider.*

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)*	
• Imaging, including but not limited to, CT scan, MRI, X-ray and ultrasound	
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) • 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/UC physician fee, lab, medical supplies	$100 Copay $50 Copay $30 Copay No Charge
• Imaging, including but not limited to, CT scan, MRI, X-ray and ultrasound	Deductible applies
Ambulance *(medically necessary emergency transport only)*	No Charge

No PCP referral required for these services. <u>All Inpatient</u> care must be authorized in advance by the Medical Plan Behavioral Health Administrator.	
Mental Health • Outpatient services • Individual Therapy Office Visit	$15 Copay
• Group Therapy • Intensive Outpatient Treatment Program (IOP) • Partial Hospitalization Program (PHP)	No Charge
• Inpatient services - Inpatient	Deductible Applies
Substance Use Disorder • Outpatient services - Individual Therapy Office Visit	$15 Copay
• Group Therapy • Intensive Outpatient Treatment Program (IOP) • Partial Hospitalization Program (PHP)	No Charge
• Inpatient services - Inpatient (*Including medical detoxification & SA rehabilitation)*	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).

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