

**APPENDIX F**  
**Network (HMO) Health Plan**  
**Active Employees HMO**

Service Received	Your Share of the Cost
<b>These services MUST be provided by or referred by your Primary Care Provider (PCP).</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Immunization (including travel), lead screening, PSA (prostate screening)</li> <li>• Routine physical exam and well-baby care</li> <li>• Routine hearing screening</li> <li>• Routine prenatal and postpartum care</li> <li>• Preventive colonoscopy</li> <li>• Family planning</li> </ul> <i>See "Other Services" for additional Preventive Care information</i>	No Charge
<b>Office Visit</b> <ul style="list-style-type: none"> <li>• Medical exam, office surgery</li> </ul>	\$15 PCP /\$30 Specialist Copay
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>• Short term rehabilitative therapy-physical, occupational, cardiac or speech (<i>unlimited</i>)</li> <li>• Allergy treatment and injections</li> </ul>	\$15 Copay
<ul style="list-style-type: none"> <li>• Surgery-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>• Lab-Outpatient department of a hospital (<i>non-site of service location</i>)</li> <li>• CT scan, MRI, X-ray and ultrasound</li> </ul>	Deductible Applies
<b>Site of Service</b> <ul style="list-style-type: none"> <li>• Surgery rendered at independent Ambulatory Surgery Center</li> <li>• Lab rendered at an independent facility</li> </ul>	No Charge
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>• Semi-private room and board</li> <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
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days combined per member, per calendar year)</i>	
<b>Durable Medical Equipment (DME) and External Prosthetic Devices</b> <i>(unlimited)</i>	No Charge
<b>These services DO NOT require a PCP referral as long as you use designated network providers.</b>	
<b>Other Services</b> <ul style="list-style-type: none"> <li>• Routine vision exam (<i>one exam every calendar year</i>)</li> <li>• Chiropractic visit (<i>limited to 24 visits per member per calendar year</i>)</li> <li>• Infertility office visits (tests, counseling)</li> <li>• Treatment for surgical and non-surgical TMJ (<i>excluding appliances and orthodontic treatment</i>)</li> </ul>	No Charge
<ul style="list-style-type: none"> <li>• OB/GYN care-well women exam annually</li> <li>• Mammogram and pap smear</li> </ul>	No Charge
<ul style="list-style-type: none"> <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 (<i>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</i>)</li> </ul>	No Charge

**These services DO NOT require a PCP referral for medical emergencies as defined by your Benefit Booklet.**

<b>Hospital Emergency Room (ER)/Urgent Care Facility</b>	
<ul style="list-style-type: none"> <li>ER charge (<i>copay waived if admitted</i>)</li> <li>Urgent Care</li> <li>Walk In Center</li> <li>ER physician fee, lab, medical supplies</li> </ul>	<p>\$100 Copay \$50 Copay \$30 Copay No Charge</p>
<b>Ambulance</b> ( <i>medically necessary emergency transport only</i> )	No Charge

**No PCP referral required for these services. All care must be authorized in advance by the Behavioral Health Administrator.**

<b>Mental Health</b>	
<ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> <li>Group Therapy</li> </ul>	<p>\$15 Copay No Charge</p>
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient</li> <li>Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	Deductible Applies
<b>Substance Use Disorder</b>	
<ul style="list-style-type: none"> <li>Outpatient services <ul style="list-style-type: none"> <li>Individual Therapy Office Visit</li> <li>Intensive Outpatient Treatment Program (IOP)</li> </ul> </li> <li>Group Therapy</li> </ul>	<p>\$15 Copay No Charge</p>
<ul style="list-style-type: none"> <li>Inpatient services <ul style="list-style-type: none"> <li>Inpatient (<i>Including medical detoxification &amp; SA rehabilitation</i>)</li> <li>Partial Hospitalization Program (PHP)</li> </ul> </li> </ul>	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 **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.

	<b>Retail Pharmacy (days supply limit: up to a 31-days)</b>	<b>Mail Service Pharmacy (days supply limit: up to a 90-days)</b>
Employee Share of the Cost (copayment)	<ul style="list-style-type: none"> <li>• \$10 for each generic medication</li> <li>• \$25 for each preferred brand-name medication</li> <li>• \$40 for each non-preferred brand-name medication</li> </ul>	<ul style="list-style-type: none"> <li>• \$1 for each generic medication</li> <li>• \$40 for each preferred brand-name medication</li> <li>• \$70 for each non-preferred brand-name medication</li> </ul>
Maximums (for covered prescription costs)	<ul style="list-style-type: none"> <li>• \$750 per individual per calendar year</li> <li>• \$1,500 per family per calendar year</li> </ul>	
	<ul style="list-style-type: none"> <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 style="list-style-type: none"> <li>• Mandatory Generic Substitution with DAW 2 (i.e., the only exception is physician ordered “Dispense as Written”)</li> <li>• Traditional Generic Step Therapy</li> <li>• Pharmacy Adviser</li> </ul>

End