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	No Charge			
Preventive colonoscopy				
Family planning				
See "Other Services" for additional Preventive Care information				
Office Visit	\$15 PCP /\$30 Specialist Copay			
Medical exam, office surgery Other Output Core	1 1 2			
Other Outpatient Care				
Short term rehabilitative therapy-physical, occupational, cardiac or speech (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	27 01			
Surgery rendered at independent Ambulatory Surgery Center L. L	No Charge			
Lab rendered at an independent facility				
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	Deductible			
Maternity care-Delivery	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	No Charge			
(unlimited)	No Charge			
These services DO NOT require a PCP referral as long as you use designated no	otwork providens			
Other Services	etwork providers.			
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)	φιο σοραγ			
 Treatment for surgical and non-surgical TMJ (excluding appliances and 	\$30 Copay			
orthodontic treatment)	ψου σορ α ς			
OB/GYN care-well women exam annually				
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)	\$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. <u>All care must be authorized in advance by the Behavioral Health Administrator.</u>

Mental Health		
Outpatient services	\$15 Copay	
 Individual Therapy Office Visit 	ф13 Сора у	
 Intensive Outpatient Treatment Program (IOP) 		
Group Therapy	No Charge	
Inpatient services		
Inpatient	Deductible Applies	
 Partial Hospitalization Program (PHP) 		
Substance Use Disorder		
Outpatient services	\$15 Congy	
 Individual Therapy Office Visit 	ndividual Therapy Office Visit \$15 Copay	
 Intensive Outpatient Treatment Program (IOP) 		
Group Therapy	No Charge	
Inpatient services		
 Inpatient (Including medical detoxification & SA rehabilitation) 	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. This is a taxable benefit.
- Fitness Equipment Reimbursement: \$200 per employee per calendar year **OR** Health Club Benefit: \$450 per employee per calendar year.* This is a taxable benefit.
- 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.

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