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| **Benefit** | **All Providers – In-Network / Out-of-Network** |
| Deductible | $1,500 Individual / $4,500 Family |
| Member Co-Insurance | 20% |
| Out of Pocket Maximum (Inc. Deductible) | $3,750 Individual / $11,250 Family |
| Deductible and Out-Of-Pocket Accumulation is on Calendar Year basis, |
| **Physician Based Services - Medical** |
| Primary Care Physician Office Visits | $25 Co-Pay; Deductible Does not apply |
| Specialist Office Visits | $50 Co-Pay; Deductible Does not apply |
| Allergy Testing | $50 Co-Pay; Deductible Does not apply |
| Chiropractic Care – 25 visits per Calendar Year | $50 Co-Pay; Deductible Does not apply |
| Dermatology | $50 Co-Pay; Deductible Does not apply |
| Maternity / Newborn Care (co-pay 1st visit only) | $25 Co-Pay; Deductible Does not apply |
| Telehealth / Virtual Office Visits | Subject to PCP/Specialist Co-Pay |
| Preventive Care – Adult, Infant, Pediatric | $0 Co-Pay; Deductible Does not apply |
| **Physician Based Outpatient Services** |
| Dialysis / Hemodialysis | $50 Co-Pay; Deductible Does not apply |
| Home Visits | $50 Co-Pay; Deductible Does not apply |
| Home Health Care Services – 60 visits per Calendar Year | $50 Co-Pay; Deductible Does not apply |
| Mental Health | $50 Co-Pay; Deductible Does not apply |
| Second Opinion - Surgical | $50 Co-Pay; Deductible Does not apply |
| Substance Abuse  | $50 Co-Pay; Deductible Does not apply |
| Urgent Care | $50 Co-Pay; Deductible Does not apply |
| **Therapy Services** |
| All Therapy - 30 visits per therapy per Calendar Year | $50 Co-Pay; Deductible Does not apply |
| **Other Services** |
| Prosthetic Devices and Durable Medical Equipment (includes Diabetic Supplies) | 50% Co-Insurance after Deductible |
| **Facility Based Services** |
| **Inpatient Services** |
| Pre-Surgical / Pre-Admission Testing | 20% Co-Insurance after deductible |
| Inpatient Hospital Stay:Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab |
| Inpatient Physician Services |
| Inpatient Mental Health / Substance Abuse |
| Skilled Nursing – 60 day maximum per Calendar Year |
| **Emergency Services** |
| Emergency Care  | $300 Co-Pay; Deductible does not apply |
| Emergency Medical Transportation | $300 Co-Pay; Deductible does not apply |
| **Outpatient Services** |
| Chemotherapy  | $50 Co-Pay; Deductible does not apply |
| Hospice | 20% Co-Insurance after deductible |
| Outpatient Surgery | 20% Co-Insurance after deductible |
| **Benefit** | **All Providers – In-Network / Out-of-Network** |
| **Lab and Radiology** |
| Lab and Pathology | $0 co-pay; Deductible does not apply |
| Radiology – X-Rays | $0 co-pay; Deductible does not apply |
| Lab and Radiology – Hospital Setting | 20% Co-Insurance after deductible |
| Advanced Radiology (MRI, CT, PET)  | $200 co-pay; Deductible does not apply |
| Advanced Radiology – Hospital Setting | 20% Co-Insurance after deductible |
| **Prescription Drug** |
| **Benefit** | **In-Network** | **Out-Of-Network** |
| Generic | $5 Co-Pay; Deductible does not apply | Not Covered |
| Brand  | $40 Co-Pay; Deductible does not apply | Not Covered |
| Non-Preferred | $60 Co-pay; Deductible does not apply | Not Covered |
| Specialty | $100 Co-pay; Deductible does not apply | Not Covered |
| **90 day Mail Order is available for 2x co-pay** |  |

**PRESCRIPTION DRUG NOTES**

1. **Coverage for Over‐the‐Counter (OTC) items are limited to items which require prescription as mandated by State or Federal law. Please check with MedTipster (877.226.2378) before ordering.**
2. **The Plan will cover charges for the first fill of specialty drugs and injectables when filled at the facility providing treatment. All subsequent fills need to be Pre‐Certified and will be provided under the Pharmacy Benefits**

**Network Utilization**

Physician based services utilize the MultiPlan PHCS Practitioner and Ancillary network

Facility based services reimburse providers based on a Medicare fee schedule

Prescription Drug uses MedTipster participating pharmacies

**Excluded Services**

In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan:

* Acupuncture
* Advanced Infertility Services including Artificial Insemination and InVitro Fertilization
* Bariatric Surgery
* Cosmetic Surgery
* Dental Care (Routine)
* Foot Care (Routine)
* Hearing Aids
* Maternity Care coverage for dependent daughters
* Private Duty Nursing
* TMJ Treatment
* Vision Hardware (limited coverage on examination)
* Voluntary Sterilization
* Weight Loss Programs

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| **PRE-CERTIFICATION REQUIREMENTS****The plan has a 50% penalty for failure to pre-cert a service that requires preauthorization** ***Pre-Authorization through Health Care Strategies (HCS) at 800-764-3433.*** ***Member, patient or provider MUST CALL.*** |
| Member, Patient or Provider must obtain pre‐ treatment authorization for the following services at least 48 hours in advance:* Inpatient Admissions (including partial hospitalization and intensive out‐patient programs for mental health conditions and substance abuse), other than an inpatient admission related to Emergency Services. In event of admission related to Emergency Services, pre-authorization required within 3 days.
* Outpatient Surgery (except if performed in a physician’s office)
* All Complex Imaging MRA’s, MRI’s, PET Scans, CT Scans
* Air Ambulance
* Chemotherapy/Radiation Therapy
* Dialysis / Hemodialysis
* Durable Medical Equipment with a purchase price over $1,500
* Genetic Testing
* Hyperbaric Oxygen Therapy
* I.V. Therapy
* Home Health Care
* Hospice
* Mental health and substance abuse - intensive care outpatient and partial hospitalization only
* Nuclear Medicine
* Physical therapy, Occupational therapy, Speech therapy and Cardiac rehabilitation services
* Skilled Nursing Facility
* Sleep Studies
* Specialty Drugs and Injectables
* Transplants
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