Palm Beach Health Partners
(Premier Management)
Employee Benefit Summary – Base Plan
Effective Date: 1/1/2023

Benefit	All Providers – In-Network / Out-of-Network
Deductible	$5,000 Individual. / $10,000 Family
Member Co-Insurance	30%
Out of Pocket Maximum (Inc. Deductible)	$7,000 Individual. / $14,000 Family
Deductible and Out-Of-Pocket Accumulation is on Plan Year basis.	
Physician Based Services - Medical	
Primary Care Physician Office Visits	$35 Co-Pay; Deductible Does not apply
Specialist Office Visits	$65 Co-Pay; Deductible Does not apply
Allergy Testing	$65 Co-Pay; Deductible Does not apply
Chiropractic Care – 25 visits per benefit period	$65 Co-Pay; Deductible Does not apply
Dermatology	$65 Co-Pay; Deductible Does not apply
Maternity / Newborn Care (co-pay 1st visit only)	$35 Co-Pay; Deductible Does not apply
Telehealth / Virtual Office Visits	Subject to PCP/Specialist Co-Pay
COVID-19 – Testing / Related Office visit Testing for presence of COVID-19 Serological Antibody testing if medical necessity	$0 Co-Pay; Deductible Does not apply
Preventive Care – Adult, Infant, Pediatric	$0 Co-Pay; Deductible does not apply
Physician Based Outpatient Services	
Dialysis / Hemodialysis	$65 Co-Pay; Deductible Does not apply
Home Visits	$65 Co-Pay; Deductible Does not apply
Home Health Care Services – 60 visits per Benefit Period	$65 Co-Pay; Deductible Does not apply
Mental Health	$65 Co-Pay; Deductible Does not apply
Second Opinion - Surgical	$65 Co-Pay; Deductible Does not apply
Substance Abuse	$65 Co-Pay; Deductible Does not apply
Urgent Care	$65 Co-Pay; Deductible Does not apply
Therapy Services	
All Therapy – 30 visits per therapy per Benefit Period; Nutrition therapy limited to 12 visits	$65 Co-Pay; Deductible Does not apply
Other Services	
Prosthetic Devices and Durable Medical Equipment (includes Diabetic Supplies)	30% Co-Insurance after deductible
Facility Based Services	
Inpatient Services	
Pre-Surgical / Pre-Admission Testing	30% 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 Benefit Period	30% Co-Insurance after deductible
Emergency Services	
Emergency Care	$500 Co-Pay; Deductible does not apply
Emergency Medical Transportation	30% Co-Insurance after deductible

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Benefit	All Providers – In-Network / Out-of-Network	
Outpatient Services		
Chemotherapy	$65 Co-Pay; Deductible does not apply	
Hospice	30% Co-Insurance after deductible	
Outpatient Surgery	30% Co-Insurance after deductible	
Lab and Radiology		
Lab and Pathology	$35 Co-Pay; Deductible Does not apply	
X-Rays	$65 Co-Pay; Deductible Does not apply	
Advanced Radiology (MRI, CT, PET etc.)	30% Co-Insurance after deductible	
Prescription Drug		
	In-Network	**Out-Of-Network**
Generic	$15 Co-Pay; Deductible does not apply	Not Covered
Brand	$60 Co-Pay; Deductible does not apply	Not Covered
Non-Preferred	$100 Co-pay; Deductible does not apply	Not Covered
Specialty	Not Covered	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 MagellanRx (877.647.4026) before ordering.**
2. **The Plan will cover charges for the first fill of 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 utilizes MagellanRx participating pharmacies

Excluded Services

In addition to exclusions listed in the Summary Plan 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)
- Genetic Testing unless medically necessary
- Hearing Aids
- Maternity Care Coverage for dependent daughters
- Non-Emergency Services outside of United States
- Non-Emergency Services in Emergency Room setting
- 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 $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.
- Sleep Studies
- Specialty Drugs and Injectables
- Transplants