

**Citadel Care Centers**  
**Employee Benefit Summary – Plan D (NY/Union)**  
**Effective Date: 5/1/2023**



<b>Benefit</b>	<b>All Providers – In-Network / Out-of-Network</b>
Deductible- Plan Year	\$1,000 Individual / \$2,000 Family
Member Co-Insurance	0%
Out of Pocket Maximum (Inc. Deductible)	\$7,000 Individual. / \$14,000 Family
<b>Physician Based Services - Medical</b>	
Primary Care Physician Office Visits	\$25 Co-Pay; Deductible Does not apply
Specialist Office Visits	\$45 Co-Pay; Deductible Does not apply
Allergy Testing	\$45 Co-Pay; Deductible Does not apply
Chiropractic Care – 25 visits per benefit period	\$45 Co-Pay; Deductible Does not apply
Dermatology	\$45 Co-Pay; Deductible Does not apply
Maternity / Newborn Care (co-pay 1 <sup>st</sup> visit only)	\$25 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
<b>Physician Based Outpatient Services</b>	
Dialysis / Hemodialysis	\$45 Co-Pay; Deductible Does not apply
Home Visits	\$45 Co-Pay; Deductible Does not apply
Home Health Care Services – 60 visits per Benefit Period	\$45 Co-Pay; Deductible Does not apply
Mental Health	\$45 Co-Pay; Deductible Does not apply
Second Opinion - Surgical	\$45 Co-Pay; Deductible Does not apply
Substance Abuse	\$45 Co-Pay; Deductible Does not apply
Urgent Care	\$45 Co-Pay; Deductible Does not apply
<b>Therapy Services</b>	
All Therapy – 30 visits per therapy per Benefit Period; Nutrition therapy limited to 12 visits	\$45 Co-Pay; Deductible Does not apply
<b>Other Services</b>	
Prosthetic Devices and Durable Medical Equipment (includes Diabetic Supplies)	0% Co-Insurance after Deductible
<b>Facility Based Services</b>	
<b>Inpatient Services</b>	
Pre-Surgical / Pre-Admission Testing	0% 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	0% co-insurance after deductible
<b>Emergency Services</b>	
Emergency Care	\$150 Co-Pay; Deductible Does not apply
Emergency Medical Transportation	\$150 Co-Pay; Deductible Does not apply

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<b>Outpatient Services</b>		
Chemotherapy	\$45 Co-Pay; Deductible does not apply	
Hospice	0% Co-Insurance after Deductible	
Outpatient Surgery	0% Co-Insurance after Deductible	
<b>Lab and Radiology</b>		
Lab and Pathology	\$0 Co-Pay; Deductible does not apply	
X-Rays	\$0 Co-Pay; Deductible does not apply	
Advanced Radiology (MRI, CT, PET etc.)	\$100 Co-Pay; Deductible does not apply	
<b>Prescription Drug</b>		
	In-Network	Out-Of-Network
Generic	\$10 Co-Pay; Deductible does not apply	Not Covered
Brand	\$50 Co-Pay; Deductible does not apply	Not Covered
Non-Preferred	\$80 Co-pay; Deductible does not apply	Not Covered
Specialty	\$150 Co-pay; Deductible does not apply	Not Covered
<b>90 day Mail Order is available for 2x co-pay</b>		

**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 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 MedTipster 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
- 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
- Specialty Drugs and Injectables
- Transplants