Nexus Health Management
Summary of Benefits – Plan B (Gold)
Effective Date: 1/1/2027 – 12/31/2027

Benefit	All Providers – In-Network / Out-of-Network
Deductible	$4,000 Individual. / $8,000 Family
Member Co-Insurance	20%
Out of Pocket Maximum (Inc. Deductible)	$7,000 Individual. / $14,000 Family
Deductible and Out-Of-Pocket Accumulation is on a Plan 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 benefit period	$50 Co-Pay; Deductible does not apply
Dermatology	$50 Co-Pay; Deductible does not apply
Maternity / Newborn Care (co-pay 1st visit only) ***NOTE:*** *Preventive care charges for pregnancy are covered under the Preventive Care benefit.*	$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 Benefit Period	$50 Co-Pay; Deductible does not apply
Mental Health Refer to SPD for covered services for ABA Therapy	$50 Co-Pay; Deductible does not apply
Substance Abuse	$50 Co-Pay; Deductible does not apply
Second Opinion - Surgical	$50 Co-Pay; Deductible does not apply
Urgent Care	$40 Co-Pay; Deductible does not apply
Therapy Services	
All Therapy – 30 visits per therapy per Benefit Period; Nutrition therapy limited to 12 visits	$50 Co-Pay; Deductible does not apply
Other Services	
Prosthetic Devices and Durable Medical Equipment (includes Diabetic Supplies)	20% 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 Benefit Period	20% Co-Insurance after Deductible
Emergency Services	
Emergency Care	$750 Co-Pay; Deductible does not apply
Emergency Medical Transportation	20% Co-Insurance after Deductible
Outpatient Services	
Chemotherapy	$40 Co-Pay; Deductible does not apply
Hospice	20% Co-Insurance after Deductible
Outpatient Surgery	20% Co-Insurance after Deductible

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Lab and Radiology		
Lab and Pathology - Office	20% Co-Insurance after Deductible	
X-Rays - Office	20% Co-Insurance after Deductible	
Lab & X-Rays – Hospital / Free-Standing Facility	20% Co-insurance after Deductible	
Advanced Radiology (MRI, CT, PET etc.)	20% Co-insurance after Deductible	
Prescription Drug		
	In-Network	**Out-Of-Network**
Generic	$10 Co-Pay; Deductible does not apply	Not Covered
Brand	$40 Co-Pay; Deductible does not apply	Not Covered
Non-Preferred	$85 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 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 Prime Health Services 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 Plan Exclusions of the SPD, 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 (except to the extent required by the Affordable Care Act)
- Hearing Aids
- Maternity Care Coverage for dependent daughters (except for Preventive Care services as required by the Affordable Care Act)
- 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 (except for FDA-approved female sterilization procedures as required by Affordable Care Act)
- 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, 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 Hospitalizations only
- Nuclear Medicine
- Physical therapy, Occupational therapy, Speech therapy and Cardiac rehabilitation services. Pre-Cert required starting from the 13th visit.
- Sleep Studies
- Specialty Drugs and Injectables
- Transplants