

# Partners 80 Gold 2000

## Small Group Plan Benefit Summary



Plan Features	In-Network Member is responsible for:	Out-of-Network Member is responsible for:
<b>Essential Health Benefits</b>		Unlimited
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>Deductible</b>		
Per Covered Person	\$2,000	\$4,000
Per Family	\$4,000	\$8,000
<b>Annual Maximum Out-of-Pocket</b> (includes all deductibles, copays and coinsurance)		
Per Covered Person	\$3,000	\$20,000
Per Family	\$6,000	\$40,000
<b>Physician Services</b>		
Primary Care Physician (PCP)	\$30 copay	50%** U&C*
Specialty Care Physician (SCP)	\$50 copay	50%** U&C*
Physician eVisit	\$10 copay	50%** U&C*
Physician Services not received in an office setting	20%**	50%** U&C*
<b>Preventive Health Services</b>		
Services recommended by the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	\$0	50%** U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	20%**	50%** U&C*
<b>Preventive Services for Children and Adolescents</b>		
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	\$0	50%** U&C*
Physician office visits and laboratory tests associated with preventive checkups	\$0	50%** U&C*
<b>Preventive Services for Adults</b>		
Preventive care and screenings for women supported by the Health Resources and Services Administration	\$0	50% U&C*
<b>Immunizations Ages 0 to Adult</b> (per immunization)		
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713	\$0	\$12 copay
Additional immunizations not mandated by PHSA Section 2713	\$12 copay	\$12 copay
<b>Inpatient Hospital Services</b>		
Physician Services	20%**	50%** U&C*
Hospitalization	20%**	50%** U&C*
Maternity and Newborn Care	20%**	50%** U&C*
Human Organ Transplant	20%**	50%** U&C*
Transportation and Lodging	20%**	Not Covered
Unrelated Donor Search		20%**
Skilled Nursing Services - Inpatient	20%**	50%** U&C*
		90 Inpatient days per Benefit Year
Physical Medicine and Rehabilitation	20%**	50%** U&C*
		60 Inpatient days per Benefit Year
<b>Outpatient Services</b>		
Emergency Services	\$200 copay	\$200 copay
Urgent Care Services	\$75 copay	50%** U&C*
Outpatient Surgery & Procedures	20%**	50%** U&C*
<b>Rehabilitation and Habilitative</b>		
Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***	20%**	50%** U&C*
		20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)
Occupational Therapy	20%**	50%** U&C*
		20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)

Speech Therapy	20%**	Unlimited	50%** U&C*
Cardiac Rehabilitation	20%**	36 visits per Benefit Year	50%** U&C*
Pulmonary Rehabilitation	20%**	20 visits per Benefit Year	50%** U&C*
Chiropractic Services	20%**	26 visits per Benefit Year without prior approval	50%** U&C*
Diagnostic Laboratory, Imaging and Radiology	20%**		50%** U&C*
Home Health Care	20%**	90 visits per Benefit Year	50%** U&C*
Private Duty Nursing	20%**		50%** U&C*
Hospice	20%**		50%** U&C*
Ambulance Services	20%**		20%**
Educational Services	20%**		50%** U&C*
Durable Medical Equipment	20%**		50%** U&C*
<b>Hearing Aids (newborns only)</b>	20%**		50%** U&C*
Orthotics	20%**		50%** U&C*
Disposable Medical Supplies	20%**		50%** U&C*
Prosthetics	20%**		50%** U&C*
<b>Mental Health Services</b>			
Mental Health Office Visit	\$30 copay		50%** U&C*
Mental Health Services not received in an office setting	20%**		50%** U&C*
Hospital Inpatient / Residential Treatment	20%**		50%** U&C*
<b>Substance Abuse</b>			
Outpatient Annual Maximum Benefit (unlimited)	20%**		50%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	20%**		50%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	20%**		50%** U&C*
<b>Applied Behavior Analysis (ABA)</b>			
<b>Applied Behavior Analysis</b> (dependent children through age 18) Requires prior authorization	20%**		50%** U&C*
<b>Dental Services</b> (only related to accidental injury or for certain members requiring general anesthesia)	20%**		50%** U&C*
<b>Pediatric Dental</b> (dependent children through age 18)			
Dental Exam		20%**	
Basic Dental Care		20%**	
Major Dental Care		20%**	
Orthodontia (requires prior authorization)		20%**	
<b>Pediatric Vision</b> (dependent children through age 18)			
Routine Eye Exam (1 visit per Benefit Year)		20%**	
Eye Glasses (1 pair of glasses, lenses and frames, per Benefit Year)		20%**	
<b>Pharmacy Services</b>			
<b>Deductible</b>		\$0	
Generic (most), Tier 1 (30 day supply)	\$10		50%** U&C*
Preferred Brand, Tier 2 (30 day supply)	\$35		50%** U&C*
Other Brand / Non-Formulary, Tier 3 (30 day supply)	\$75		50%** U&C*
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	\$100		N/A
Mail Order (90 day supply)	2.5x		N/A

\*U&C is used as an abbreviation for Usual and Customary.

\*\*Coinsurance applies after Deductible is met.

\*\*\*Co-pays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

This is only a brief summary of benefits, which is not intended to be comprehensive.

Your Small Group Health Plan Certificate of Coverage is the governing document for benefit information.

**All Plans Are Qualified Health Plans**  
(Plans Available Beginning: 1/1/2016)