

# Partners 70 Silver 3000

## 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	\$3,000	\$6,000
Per Family	\$6,000	\$12,000
<b>Annual Maximum Out-of-Pocket</b> (includes all deductibles, co-pays and co-insurance)		
Per Covered Person	\$6,350	\$20,000
Per Family	\$12,700	\$40,000
<b>Physician Services</b>		
Primary Care Physician (PCP)	\$30 co-pay	50%** U&C*
Specialty Care Physician (SCP)	\$50 co-pay	50%** U&C*
Physician eVisit	\$10 co-pay	50%** U&C*
Physician Telehealth Visit	\$10 co-pay	50%** U&C*
Physician Services not received in an office setting	30%**	50%** U&C*
<b>Preventive Health Services</b>		
Services with an "A" or "B" rating from 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	30%**	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 co-pay
Additional immunizations not mandated by PHSA Section 2713	\$12 co-pay	\$12 co-pay
<b>Inpatient Hospital Services</b>		
Physician Services	30%**	50%** U&C*
Hospitalization	30%**	50%** U&C*
Maternity and Newborn Care	30%**	50%** U&C*
Human Organ Transplant	30%**	50%** U&C*
Transportation and Lodging	30%**	Not Covered
Unrelated Donor Search		30%**
Skilled Nursing Services - Inpatient, Physical Medicine and Rehabilitation	30%**	50%** U&C*
	150 Inpatient days per Benefit Year Combined	
<b>Outpatient Services</b>		
Emergency Services	30%**	30%**
Urgent Care Services	30%**	50%** U&C*
Outpatient Surgery & Procedures	30%**	50%** U&C*
<b>Rehabilitation and Habilitative</b>		
Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***	30%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	30%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Speech Therapy	30%**	50%** U&C*
	Unlimited	

Cardiac Rehabilitation	30%**	50%** U&C*
	<i>36 visits per Benefit Year</i>	
Pulmonary Rehabilitation	30%**	50%** U&C*
	<i>20 visits per Benefit Year</i>	
Chiropractic Services	30%**	50%** U&C*
	<i>26 visits per Benefit Year without prior approval</i>	
Diagnostic Laboratory, Imaging and Radiology	30%**	50%** U&C*
Home Health Care	30%**	50%** U&C*
	<i>100 visits per Benefit Year</i>	
Private Duty Nursing	30%**	50%** U&C*
	<i>82 visits per Benefit Year, 164 visits Lifetime Maximum</i>	
Hospice	30%**	50%** U&C*
Ambulance Services	30%**	30%**
Educational Services	30%**	50%** U&C*
Durable Medical Equipment	30%**	50%** U&C*
Orthotics	30%**	50%** U&C*
Disposable Medical Supplies	30%**	50%** U&C*
Prosthetics	30%**	50%** U&C*
<b>Mental Health Services</b>		
Mental Health Office Visit	\$30 co-pay	50%** U&C*
Mental Health Services not received in an office setting	30%**	50%** U&C*
Hospital Inpatient / Residential Treatment	30%**	50%** U&C*
<b>Substance Abuse</b>		
Outpatient Annual Maximum Benefit (unlimited)	30%**	50%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	30%**	50%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	30%**	50%** U&C*
<b>Dental Services</b> (only related to accidental injury or for certain members requiring general anesthesia)	30%**	50%** U&C*
<b>Pediatric Dental</b> (dependent children through age 18)		
Dental Exam		30%**
Basic Dental Care		30%**
Major Dental Care		30%**
Orthodontia (requires prior authorization)		30%**
<b>Pediatric Vision</b> (dependent children through age 18)		
Routine Eye Exam (1 visit per Benefit Year)		30%**
Eye Glasses (1 pair of glasses, lenses and frames, per Benefit Year)		30%**
<b>Autism Services</b>	Benefits are based on the setting in which Covered Services are received****	
<b>Applied Behavior Analysis (ABA)</b> (dependent children through age 18) Requires prior authorization	30%**	50%** U&C*
<b>Pharmacy Services</b>		
<b>Deductible</b>		\$0
Generic (most), Tier 1 (30 day supply)	\$15	50%** U&C*
Preferred Brand, Tier 2 (30 day supply)	\$45	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.

\*\*Co-insurance applies after deductible is met.

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

\*\*\*\*Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.

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: 1/1/2017)