

Partners 80 Silver 4000

Small Group Plan Benefit Summary



Plan Features	In-Network Member is responsible for:	Out-of-Network Member is responsible for:
Essential Health Benefits		Unlimited
Lifetime Maximum Benefit		Unlimited
Deductible		
Per Covered Person	\$4,000	\$8,000
Per Family	\$8,000	\$16,000
Annual Maximum Out-of-Pocket (includes all deductibles, co-pays and co-insurance)		
Per Covered Person	\$6,000	\$20,000
Per Family	\$12,000	\$40,000
Physician Services		
Primary Care Physician (PCP)	1st 3 Visits \$10 co-pay; subsequent visits Deductible/Co-insurance	50%** U&C*
Specialty Care Physician (SCP)	20%**	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	20%**	50%** U&C*
Preventive Health Services		
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	20%**	50%** U&C*
Preventive Services for Children and Adolescents		
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*
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	\$0	50%** U&C*
Immunizations Ages 0 to Adult (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
Inpatient Hospital Services		
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, Physical Medicine and Rehabilitation	20%**	50%** U&C*
	150 Inpatient days per Benefit Year Combined	
Outpatient Services		
Emergency Services	\$450 co-pay	\$450 co-pay
Urgent Care Services	\$75 co-pay	50%** U&C*
Outpatient Surgery & Procedures	20%**	50%** U&C*
Rehabilitation and Habilitative		
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%**	50%** U&C*
	Unlimited	

Cardiac Rehabilitation	20%**	50%** U&C*
	<i>36 visits per Benefit Year</i>	
Pulmonary Rehabilitation	20%**	50%** U&C*
	<i>20 visits per Benefit Year</i>	
Chiropractic Services	20%**	50%** U&C*
	<i>26 visits per Benefit Year without prior approval</i>	
Diagnostic Laboratory, Imaging and Radiology	20%**	50%** U&C*
Home Health Care	20%**	50%** U&C*
	<i>100 visits per Benefit Year</i>	
Private Duty Nursing	20%**	50%** U&C*
	<i>82 visits per Benefit Year, 164 visits Lifetime Maximum</i>	
Hospice	20%**	50%** U&C*
Ambulance Services	20%**	20%**
Educational Services	20%**	50%** U&C*
Durable Medical Equipment	20%**	50%** U&C*
Orthotics	20%**	50%** U&C*
Disposable Medical Supplies	20%**	50%** U&C*
Prosthetics	20%**	50%** U&C*
Mental Health Services		
Mental Health Office Visit	1st 3 Visits \$10 co-pay; subsequent visits Deductible/Co-insurance	50%** U&C*
Mental Health Services not received in an office setting	20%**	50%** U&C*
Hospital Inpatient / Residential Treatment	20%**	50%** U&C*
Substance Abuse		
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*
Dental Services (only related to accidental injury or for certain members requiring general anesthesia)	20%**	50%** U&C*
Pediatric Dental (dependent children through age 18)		
Dental Exam		20%**
Basic Dental Care		20%**
Major Dental Care		20%**
Orthodontia (requires prior authorization)		20%**
Pediatric Vision (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%**
Autism Services Benefits are based on the setting in which Covered Services are received****		
Applied Behavior Analysis (ABA) (dependent children through age 18) Requires prior authorization	20%**	50%** U&C*
Pharmacy Services		
Deductible		\$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)