

Partners HRA Gold 2500

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		
<i>Per Covered Person</i>	\$2,500	\$5,000
<i>Per Family</i>	\$5,000	\$10,000
Annual Maximum Out-of-Pocket <i>(includes all deductibles, co-pays and co-insurance)</i>		
<i>Per Covered Person</i>	\$5,000	\$20,000
<i>Per Family</i>	\$10,000	\$40,000
Physician Services		
<i>Primary Care Physician (PCP)</i>	\$30 co-pay	50%** U&C*
<i>Specialty Care Physician (SCP)</i>	\$50 co-pay	50%** U&C*
<i>Physician eVisit</i>	\$10 co-pay	50%** U&C*
<i>Physician Telehealth Visit</i>	\$10 co-pay	50%** U&C*
<i>Physician Services not received in an office setting</i>	30%**	50%** U&C*
Preventive Health Services		
<i>Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713</i>	\$0	50%** U&C*
<i>Additional preventive services or treatments not mandated by PHSA Section 2713</i>	30%**	50%** U&C*
Preventive Services for Children and Adolescents		
<i>Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration</i>	\$0	50%** U&C*
<i>Physician office visits and laboratory tests associated with preventive checkups</i>	\$0	50%** U&C*
Preventive Services for Adults		
<i>Preventive care and screenings for women supported by the Health Resources and Services Administration</i>	\$0	50%** U&C*
Immunizations Ages 0 to Adult <i>(per immunization)</i>		
<i>As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713</i>	\$0	\$12 co-pay
<i>Additional immunizations not mandated by PHSA Section 2713</i>	\$12 co-pay	\$12 co-pay
Inpatient Hospital Services		
<i>Physician Services</i>	30%**	50%** U&C*
<i>Hospitalization</i>	30%**	50%** U&C*
<i>Maternity and Newborn Care</i>	30%**	50%** U&C*
<i>Human Organ Transplant</i>	30%**	50%** U&C*
<i>Transportation and Lodging</i>	30%**	Not Covered
<i>Unrelated Donor Search</i>		30%**
<i>Skilled Nursing Services - Inpatient, Physical Medicine and Rehabilitation</i>	30%**	50%** U&C*
	<i>150 Inpatient days per Benefit Year Combined</i>	
Outpatient Services		
<i>Emergency Services</i>	\$200 co-pay	\$200 co-pay
<i>Urgent Care Services</i>	\$75 co-pay	50%** U&C*
<i>Outpatient Surgery & Procedures</i>	30%**	50%** U&C*
Rehabilitation and Habilitative		
<i>Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***</i>	30%**	50%** U&C*
	<i>20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)</i>	
<i>Occupational Therapy</i>	30%**	50%** U&C*
	<i>20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)</i>	
<i>Speech Therapy</i>	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*
Mental Health Services		
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*
Substance Abuse		
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*
Dental Services (only related to accidental injury or for certain members requiring general anesthesia)	30%**	50%** U&C*
Pediatric Dental (dependent children through age 18)		
Dental Exam		30%**
Basic Dental Care		30%**
Major Dental Care		30%**
Orthodontia (requires prior authorization)		30%**
Pediatric Vision (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%**
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	30%**	50%** U&C*
Pharmacy Services		
Deductible		\$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.

**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)