

Partners 80 Gold 1500

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>	\$1,500	\$3,000
<i>Per Family</i>	\$3,000	\$6,000
Annual Maximum Out-of-Pocket <i>(includes all deductibles, co-pays and co-insurance)</i>		
<i>Per Covered Person</i>	\$5,500	\$20,000
<i>Per Family</i>	\$11,000	\$40,000
Physician Services		
<i>Primary Care Physician (PCP)</i>	\$25 Co-pay	50%** Co-insurance U&C*
<i>Specialty Care Physician (SCP)</i>	\$50 Co-pay	50%** Co-insurance U&C*
<i>Physician eVisit</i>	\$10 Co-pay	50%** Co-insurance U&C*
<i>Physician Telehealth Visit</i>	\$10 Co-pay	50%** Co-insurance U&C*
<i>Physician Services not received in an office setting</i>	20%** Co-insurance	50%** Co-insurance 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%** Co-insurance U&C*
<i>Additional preventive services or treatments not mandated by PHSA Section 2713</i>	20%** Co-insurance	50%** Co-insurance 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%** Co-insurance U&C*
<i>Physician office visits and laboratory tests associated with preventive checkups</i>	\$0	50%** Co-insurance U&C*
Preventive Services for Adults		
<i>Preventive care and screenings for women supported by the Health Resources and Services Administration</i>	\$0	50%** Co-insurance 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>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Hospitalization</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Maternity and Newborn Care</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Human Organ Transplant</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Transportation and Lodging</i>	20%** Co-insurance	Not Covered
<i>Unrelated Donor Search</i>		20%** Co-insurance
<i>Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>150 Inpatient days per Benefit Year</i>
Outpatient Services		
<i>Emergency Services</i>	\$250 Co-pay	\$250 Co-pay
<i>Urgent Care Services</i>	\$100 Co-pay	50%** Co-insurance U&C*
<i>Outpatient Surgery & Procedures</i>	20%** Co-insurance	50%** Co-insurance U&C*
Rehabilitation and Habilitative		
<i>Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)</i>
<i>Occupational Therapy***</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)</i>
<i>Speech Therapy</i>	20%** Co-insurance	50%** Co-insurance U&C*
		Unlimited

<i>Cardiac Rehabilitation</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>36 visits per Benefit Year</i>
<i>Pulmonary Rehabilitation</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>20 visits per Benefit Year</i>
<i>Chiropractic Services</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>Prior authorization required for office visits in excess of 26 per Benefit Year</i>
<i>Diagnostic Laboratory, Imaging and Radiology</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Home Health Care</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>100 visits per Benefit Year</i>
<i>Private Duty Nursing</i>	20%** Co-insurance	50%** Co-insurance U&C*
		<i>82 visits per Benefit Year, 164 visits Lifetime Maximum</i>
<i>Hospice</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Ambulance Services</i>	20%** Co-insurance	20%** Co-insurance
<i>Educational Services</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Durable Medical Equipment</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Orthotics</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Disposable Medical Supplies</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Prosthetics</i>	20%** Co-insurance	50%** Co-insurance U&C*
Mental Health Services		
<i>Mental Health Office Visit</i>	\$25 Co-pay	50%** Co-insurance U&C*
<i>Mental Health Services not received in an office setting</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Hospital Inpatient/Residential Treatment</i>	20%** Co-insurance	50%** Co-insurance U&C*
Substance Abuse		
<i>Outpatient Annual Maximum Benefit (unlimited)</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Inpatient/Residential Annual Maximum (unlimited)</i>	20%** Co-insurance	50%** Co-insurance U&C*
<i>Medical or Social Setting Detox Annual Maximum (unlimited)</i>	20%** Co-insurance	50%** Co-insurance U&C*
Dental Services (only related to accidental injury or for certain members requiring general anesthesia)	20%** Co-insurance	50%** Co-insurance U&C*
Pediatric Dental (dependent children through age 18)		
<i>Dental Exam</i>		20%** Co-insurance
<i>Basic Dental Care</i>		20%** Co-insurance
<i>Major Dental Care</i>		20%** Co-insurance
<i>Orthodontia (requires prior authorization)</i>		20%** Co-insurance
Pediatric Vision (dependent children through age 18)		
<i>Routine Eye Exam (1 visit per Benefit Year)</i>		20%** Co-insurance
<i>Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)</i>		20%** Co-insurance
Autism Services Benefits are based on the setting in which Covered Services are received****		
Applied Behavior Analysis (ABA) (requires prior authorization)	20%** Co-insurance	50%** Co-insurance U&C*
Pharmacy Services*****		
Deductible		\$0 Deductible
<i>Generic (most), Tier 1 (30 day supply)</i>	\$10 Co-pay	50%** Co-insurance U&C*
<i>Preferred Brand, Tier 2 (30 day supply)</i>	\$35 Co-pay	50%** Co-insurance U&C*
<i>Other Brand/Non-Formulary, Tier 3 (30 day supply)</i>	\$75 Co-pay	50%** Co-insurance U&C*
<i>Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)</i>	\$100 Co-pay	N/A
<i>Mail Order (90 day supply)</i>	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 and Occupational 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.

*****If a Provider, Pharmacy, or any third party payer waives, discounts, reduces, or indirectly pays the required cost sharing for a particular claim, the waived portion, discounted portion, reduced portion, or indirectly paid portion of the cost share will not apply to or reduce any Deductible or Out-of-Pocket applicable to the 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: 1/1/2019)

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