

# Partners 90 Gold 1500

## 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	\$1,500	\$3,000
Per Family	\$3,000	\$6,000
<b>Annual Maximum Out-of-Pocket</b> (includes all deductibles, co-pays and co-insurance)		
Per Covered Person	\$6,500	\$20,000
Per Family	\$13,000	\$40,000
<b>Physician Services</b>		
Primary Care Physician (PCP)	\$30 Co-pay	40%** Co-insurance U&C*
Specialty Care Physician (SCP)	\$60 Co-pay	40%** Co-insurance U&C*
Physician eVisit	\$10 Co-pay	40%** Co-insurance U&C*
Physician Telehealth Visit	\$10 Co-pay	40%** Co-insurance U&C*
Physician Services not received in an office setting	10%** Co-insurance	40%** Co-insurance 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	40%** Co-insurance U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	10%** Co-insurance	40%** Co-insurance 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	40%** Co-insurance U&C*
Physician office visits and laboratory tests associated with preventive checkups	\$0	40%** Co-insurance U&C*
<b>Preventive Services for Adults</b>		
Preventive care and screenings for women supported by the Health Resources and Services Administration	\$0	40%** Co-insurance 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	10%** Co-insurance	40%** Co-insurance U&C*
Hospitalization	10%** Co-insurance	40%** Co-insurance U&C*
Maternity and Newborn Care	10%** Co-insurance	40%** Co-insurance U&C*
Human Organ Transplant	10%** Co-insurance	40%** Co-insurance U&C*
Transportation and Lodging	10%** Co-insurance	Not Covered
Unrelated Donor Search		10%** Co-insurance
Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient	10%** Co-insurance	40%** Co-insurance U&C*
		150 Inpatient days per Benefit Year
<b>Outpatient Services</b>		
Emergency Services	\$250 Co-pay	\$250 Co-pay
Urgent Care Services	\$100 Co-pay	40%** Co-insurance U&C*
Outpatient Surgery & Procedures	10%** Co-insurance	40%** Co-insurance U&C*
<b>Rehabilitation and Habilitative</b>		
Physical Therapy and Manipulation Therapy (not including Chiropractic Services)***	10%** Co-insurance	40%** Co-insurance U&C*
		20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)
Occupational Therapy***	10%** Co-insurance	40%** Co-insurance U&C*
		20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)
Speech Therapy	10%** Co-insurance	40%** Co-insurance U&C*
		Unlimited

<i>Cardiac Rehabilitation</i>	10%** Co-insurance	40%** Co-insurance U&C*
		<i>36 visits per Benefit Year</i>
<i>Pulmonary Rehabilitation</i>	10%** Co-insurance	40%** Co-insurance U&C*
		<i>20 visits per Benefit Year</i>
<i>Chiropractic Services</i>	10%** Co-insurance	40%** 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>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Home Health Care</i>	10%** Co-insurance	40%** Co-insurance U&C*
		<i>100 visits per Benefit Year</i>
<i>Private Duty Nursing</i>	10%** Co-insurance	40%** Co-insurance U&C*
		<i>82 visits per Benefit Year, 164 visits Lifetime Maximum</i>
<i>Hospice</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Ambulance Services</i>	10%** Co-insurance	10%** Co-insurance
<i>Educational Services</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Durable Medical Equipment</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Orthotics</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Disposable Medical Supplies</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Prosthetics</i>	10%** Co-insurance	40%** Co-insurance U&C*
<b>Mental Health Services</b>		
<i>Mental Health Office Visit</i>	\$30 Co-pay	40%** Co-insurance U&C*
<i>Mental Health Services not received in an office setting</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Hospital Inpatient/Residential Treatment</i>	10%** Co-insurance	40%** Co-insurance U&C*
<b>Substance Abuse</b>		
<i>Outpatient Annual Maximum Benefit (unlimited)</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Inpatient/Residential Annual Maximum (unlimited)</i>	10%** Co-insurance	40%** Co-insurance U&C*
<i>Medical or Social Setting Detox Annual Maximum (unlimited)</i>	10%** Co-insurance	40%** Co-insurance U&C*
<b>Dental Services</b> (only related to accidental injury or for certain members requiring general anesthesia)	10%** Co-insurance	40%** Co-insurance U&C*
<b>Pediatric Dental</b> (dependent children through age 18)		
<i>Dental Exam</i>		10%** Co-insurance
<i>Basic Dental Care</i>		10%** Co-insurance
<i>Major Dental Care</i>		10%** Co-insurance
<i>Orthodontia (requires prior authorization)</i>		10%** Co-insurance
<b>Pediatric Vision</b> (dependent children through age 18)		
<i>Routine Eye Exam (1 visit per Benefit Year)</i>		10%** Co-insurance
<i>Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)</i>		10%** Co-insurance
<b>Autism Services</b> Benefits are based on the setting in which Covered Services are received****		
<b>Applied Behavior Analysis (ABA)</b> (requires prior authorization)	10%** Co-insurance	40%** Co-insurance U&C*
<b>Pharmacy Services*****</b>		
<b>Deductible</b>		\$250 Deductible (Tier 1-4)
<i>Generic (most), Tier 1 (30 day supply)</i>	\$15 Co-pay	40%** Co-insurance U&C*
<i>Preferred Brand, Tier 2 (30 day supply)</i>	\$45 Co-pay	40%** Co-insurance U&C*
<i>Other Brand/Non-Formulary, Tier 3 (30 day supply)</i>	\$75 Co-pay	40%** 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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