Partners 70 Silver 3000

Small Group Plan Benefit Summary

Cox HealthPlans
CoxHealth

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	$3,000	$6,000
Per Family	$6,000	$12,000
Annual Maximum Out-of-Pocket *(includes all deductibles, copays and coinsurance)*		
Per Covered Person	$6,350	$20,000
Per Family	$12,700	$40,000
Physician Services		
Primary Care Physician (PCP)	$30 copay	50%** U&C*
Specialty Care Physician (SCP)	$50 copay	50%** U&C*
Physician eVisit	$10 copay	50%** U&C*
Physician Services not received in an office setting	30%**	50%** U&C*
Preventive Health Services		
Services recommended by 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*
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 copay
Additional immunizations not mandated by PHSA Section 2713	$12 copay	$12 copay
Inpatient Hospital Services		
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	30%**	50%** U&C*
	90 Inpatient days per Benefit Year	
Physical Medicine and Rehabilitation	30%**	50%** U&C*
	60 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	30%**	30%**
Urgent Care Services	30%**	50%** U&C*
Outpatient Surgery & Procedures	30%**	50%** U&C*
Rehabilitation and Habilitative		
*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)	

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Speech Therapy	30%**	50%** U&C*
	Unlimited	
Cardiac Rehabilitation	30%**	50%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	30%**	50%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	30%**	50%** U&C*
	26 visits per Benefit Year without prior approval	
Diagnostic Laboratory, Imaging and Radiology	30%**	50%** U&C*
Home Health Care	30%**	50%** U&C*
	90 visits per Benefit Year	
Private Duty Nursing	30%**	50%** U&C*
Hospice	30%**	50%** U&C*
Ambulance Services	30%**	30%**
Educational Services	30%**	50%** U&C*
Durable Medical Equipment	30%**	50%** U&C*
Hearing Aids (newborns only)	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 copay	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*
Applied Behavior Analysis (ABA)		
Applied Behavior Analysis *(dependent children through age 18) Requires prior authorization*	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%**	
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.
**Coinsurance applies after Deductible is met.
***Co-pays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.
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: 1/1/2016)

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