Bronze 6500
Individual 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	$6,500	$13,000
Per Family	$13,000	$26,000
Annual Maximum Out-of-Pocket *(including deductible and co-pay)*		
Per Covered Person	$7,150	$20,000
Per Family	$14,300	$40,000
Physician Services		
Primary Care Physician (PCP)	1st 5 Visits $45 co-pay; subsequent visits Deductible/Co-insurance	50%** U&C*
Specialty Care Physician (SCP)	40%**	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	40%**	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	40%**	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		
Preventive Services for Adults	$0	50%** U&C*
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	40%**	50%** U&C*
Hospitalization	40%**	50%** U&C*
Maternity and Newborn Care	40%**	50%** U&C*
Human Organ Transplant	40%**	50%** U&C*
Transportation and Lodging	40%**	Not Covered
Unrelated Donor Search	40%**	
Skilled Nursing Services - Inpatient, and Physical Medicine and Rehabilitation	40%**	50%** U&C*
	150 Inpatient days per Benefit Year Combined	
Outpatient Services		
Emergency Services	40%**	40%**
Urgent Care Services	$75 co-pay	50%** U&C*
Outpatient Surgery & Procedures	40%**	50%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	40%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	40%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	

Speech Therapy	40%**	50%** U&C*
	Unlimited	
Cardiac Rehabilitation	40%**	50%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	40%**	50%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	40%**	50%** U&C*
	26 visits per Benefit Year without prior approval	
Diagnostic Laboratory, Imaging and Radiology	40%**	50%** U&C*
Home Health Care	40%**	50%** U&C*
	100 visits per Benefit Year	
Private Duty Nursing	40%**	50%** U&C*
	82 visits per Benefit Year, 164 visits Lifetime Maximum	
Ambulance Services	40%**	40%**
Educational Services	40%**	50%** U&C*
Durable Medical Equipment	40%**	50%** U&C*
Orthotics	40%**	50%** U&C*
Disposable Medical Supplies	40%**	50%** U&C*
Prosthetics	40%**	50%** U&C*
Mental Health Services		
Mental Health Office Visit	1st 5 Visits $45 co-pay; subsequent visits Deductible/Co-insurance	50%** U&C*
Mental Health Services not received in an office setting	40%**	50%** U&C*
Hospital Inpatient / Residential Treatment	40%**	50%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	40%**	50%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	40%**	50%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	40%**	50%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	40%**	50%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	40%**	
Basic Dental Care	40%**	
Major Dental Care	40%**	
Orthodontia (requires prior authorization)	40%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	40%**	
Eye Glasses (1 pair of glasses (lenses and frames) per Benefit Year)	40%**	
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*	40%**	50%** U&C*
Pharmacy Services		
Deductible	$650 (Tier 2-4)	
Generic (most), Tier 1 (30 day supply)	$20	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)	2.5×	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 Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2017)

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