Partners 70
Benefit Summary

COX HEALTHPLANS
CoxHealth

Plan Features	In-Network *Member is responsible for:*	Out-of-Network *Member is responsible for:*
Essential Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible Options *Family Maximum = 3x Individual*	$1000, $1500, $2000, $2500, $3500, $5000, $7500 or $10,000	2× in-network
Out-of-Pocket Maximum Options *(does not include deductible)* *Family Maximum = 2x Individual*	$3000, $4000 or $5000	2.5× in-network
Physician Services		
Physician Office Visit	$20, $30, or $40 Copay per visit*	50% U&C**
Physician Services	30%	50% U&C**
Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology	30%	50% U&C**
Inpatient Hospitalization	30%	50% U&C**
Outpatient Hospital Services	30%	50% U&C**
Hospital Emergency Room Services Options	30% or $200 Copay per visit	30% or $200 Copay per visit
Urgent Care Services Options	30% or $75 Copay per visit	50% U&C**
Ambulance Services	20%	20% U&C**
Maternity & Childbirth Expenses	30%	50% U&C**
Preventive Health Services *Services as mandated by PHSA Section 2713*		
Services recommended by the U.S. Preventive Task Force	$0	50% U&C**
Preventive office visits & lab associated with checkups	$0	50% U&C**
Additional office services not mandated by PHSA Section 2713	Copay is same as Physician Office Visit	50% U&C**
Immunizations *(per immunization)*		
Ages 0 through Adult as mandated by PHSA Section 2713	$0 Copay	$12 Copay
Additional immunizations not mandated by PHSA Section 2713	$12 Copay	$12 Copay
Home Health Care	30%	50% U&C**
Skilled Nursing Facility	30%	50% U&C**
Hospice Care	30%	50% U&C**
Durable Medical Equipment	30%	50% U&C**
Disposable Medical Equipment	30%	50% U&C**
Chiropractic Services (Limited to 26 per calendar year without prior authorization)		
Chiropractic Office Visit	Copay is same as Physician Office Visit	50% U&C**
Other Chiropractic Services	30%	50% U&C**
Mental Health/Substance Abuse		
Mental Health Provider Office Visit	Copay is same as Physician Office Visit	50% U&C**
Inpatient Services	30%	50% U&C**
Outpatient Services	30%	50% U&C**
Outpatient Prescription Drugs Options After satisfaction of $0, $100, or $250 Rx Deductible		
Tier 1– Most Generics[1] (30-day supply)	$10 or $10	50%
Tier 2 – Preferred Brand (30-day supply)	$20 $35	50%
Tier 3 – Non-Preferred Formulary Brand (30-day supply)	$40 $75	50%
Tier 4 – Specialty (30-day supply)	$100 $100	N/A
Mail Order (90-day supply)	2.5× Retail Copay	N/A

*Copay applies **only** to office visit cost; all diagnostics, x-rays, and treatment will be subject to deductible and coinsurance. eVisits subject to $10 copay.
**Usual and customary charges.
[1]Generics could fall into any tier. Please consult the formulary.
No benefit combination to equal more than 30% difference between In-Network and Out-of Network coinsurances.
This is only a brief summary of benefits, which is not to be comprehensive. Your Evidence of Coverage is the governing document for benefit information.

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