# Partners 90
## Benefit Summary

Cox HealthPlans
CoxHealth

| Plan Features | In-Network<br>*Member is responsible for:* | Out-of-Network<br>*Member is responsible for:* |
|---|---|---|
| **Essential Benefits** | Unlimited | |
| **Lifetime Maximum Benefit** | Unlimited | |
| **Deductible Options**<br>*Family Maximum = 3x Individual* | $250, $500, $750, $1000, $1500, $2500 or $5000 | 2× in-network |
| **Out-of-Pocket Maximum Options** *(does not include deductible)*<br>*Family Maximum = 2x Individual* | $1500, $2000, $2500, $3000, $4000 or $5000 | 2× in-network |
| **Physician Services** | | |
| *Physician Office Visit* | $20, $30, or $40 Copay per visit* | 40% U&C** |
| *Physician Services* | 10% | 40% U&C** |
| **Diagnostic X-Ray, Lab, Echo, EEG, EKG, Pathology** | 10% | 40% U&C** |
| **Inpatient Hospitalization** | 10% | 40% U&C** |
| **Outpatient Hospital Services** | 10% | 40% U&C** |
| **Hospital Emergency Room Services Options** | $100 or $200 Copay per visit | $100 or $200 Copay per visit |
| **Urgent Care Services Options** | $75 Copay per visit | 40% U&C** |
| **Ambulance Services** | 20% | 20% U&C** |
| **Maternity & Childbirth Expenses** | 10% | 40% U&C** |
| **Preventive Health Services** *Services as mandated by PHSA Section 2713* | | |
| *Services recommended by the U.S. Preventive Task Force* | $0 | 40% U&C** |
| *Preventive office visits & lab associated with checkups* | $0 | 40% U&C** |
| *Additional office services not mandated by PHSA Section 2713* | Copay is same as Physician Office Visit | 40% 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** | 10% | 40% U&C** |
| **Skilled Nursing Facility** | 10% | 40% U&C** |
| **Hospice Care** | 10% | 40% U&C** |
| **Durable Medical Equipment** | 10% | 40% U&C** |
| **Disposable Medical Equipment** | 10% | 40% U&C** |
| **Chiropractic Services** (Limited to 26 per calendar year without prior authorization) | | |
| *Chiropractic Office Visit* | Copay is same as Physician Office Visit | 40% U&C** |
| *Other Chiropractic Services* | 10% | 40% U&C** |
| **Mental Health/Substance Abuse** | | |
| *Mental Health Provider Office Visit* | Copay is same as Physician Office Visit | 40% U&C** |
| *Inpatient Services* | 10% | 40% U&C** |
| *Outpatient Services* | 10% | 40% U&C** |
| **Outpatient Prescription Drugs Options** After satisfaction of $0, $50, $100, or $250 Rx Deductible | | |
| *Tier 1– Most Generics[1] (30-day supply)* | $10 or $10 | 40% |
| *Tier 2 – Preferred Brand (30-day supply)* | $20 $35 | 40% |
| *Tier 3 – Non-Preferred Formulary Brand (30-day supply)* | $40 $75 | 40% |
| *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.

**COHEP-120 (REV. 052013)**

P.O. Box 5750 • Springfield, Missouri 65801-5750 • (417) 269-2900 • (800) 205-7665 • Fax: (417) 269-2925 • coxhealthplans.com