Partners 100 Bronze 6550

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	$6,550	$13,100
Per Family	$13,100	$26,200
Annual Maximum Out-of-Pocket *(includes all deductibles, co-pays and co-insurance)*		
Per Covered Person	$6,550	$20,000
Per Family	$13,100	$40,000
Physician Services		
Primary Care Physician (PCP)	0%**	30%** U&C*
Specialty Care Physician (SCP)	0%**	30%** U&C*
Physician eVisit	0%**	30%** U&C*
Physician Telehealth Visit	$45	30%** U&C*
Physician Services not received in an office setting	0%**	30%** U&C*
Preventive Health Services		
Services with an "A" or "B" rating form the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0	30%** U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	0%**	30%** 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	30%** U&C*
Physician office visits and laboratory tests associated with preventive checkups	$0	30%** U&C*
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	30%** 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	0%**	30%** U&C*
Hospitalization	0%**	30%** U&C*
Maternity and Newborn Care	0%**	30%** U&C*
Human Organ Transplant	0%**	30%** U&C*
Transportation and Lodging	0%**	Not Covered
Unrelated Donor Search	0%**	
Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient	0%**	30%** U&C*
	150 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	0%**	0%**
Urgent Care Services	0%**	30%** U&C*
Outpatient Surgery & Procedures	0%**	30%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	0%**	30%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	0%**	30%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Speech Therapy	0%**	30%** U&C*
	Unlimited	

Cardiac Rehabilitation	0%**	30%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	0%**	30%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	0%**	30%** U&C*
	Prior authorization required for office visits in excess of 26 per benefit year	
Diagnostic Laboratory, Imaging and Radiology	0%**	30%** U&C*
Home Health Care	0%**	30%** U&C*
	100 visits per Benefit Year	
Private Duty Nursing	0%**	30%** U&C*
	82 visits per Benefit Year, 164 visits Lifetime Maximum	
Hospice	0%**	30%** U&C*
Ambulance Services	0%**	0%**
Educational Services	0%**	30%** U&C*
Durable Medical Equipment	0%**	30%** U&C*
Orthotics	0%**	30%** U&C*
Disposable Medical Supplies	0%**	30%** U&C*
Prosthetics	0%**	30%** U&C*
Mental Health Services		
Mental Health Office Visit	0%**	30%** U&C*
Mental Health Services not received in an office setting	0%**	30%** U&C*
Hospital Inpatient / Residential Treatment	0%**	30%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	0%**	30%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	0%**	30%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	0%**	30%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	0%**	30%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	0%**	
Basic Dental Care	0%**	
Major Dental Care	0%**	
Orthodontia (requires prior authorization)	0%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	0%**	
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)	0%**	
Autism Services	Benefits are based on the setting in which Covered Services are received****	
Applied Behavior Analysis (ABA) *Requires prior authorization*	0%**	30%** U&C*
Pharmacy Services		
Deductible	Subject to Medical Deductible and Co-insurance	
Generic (most), Tier 1 (30 day supply)	0%**	30%** U&C*
Preferred Brand, Tier 2 (30 day supply)	0%**	30%** U&C*
Other Brand / Non-Formulary, Tier 3 (30 day supply)	0%**	30%** U&C*
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	0%**	N/A
Mail Order (90 day supply)	2.5×	N/A

*U&C is used as an abbreviation for Usual and Customary.

**Co-pays/Co-insurance/Costshare applies after Deductible is met.

***Co-pays/Co-insurance/Costshare for Physical Therapy or 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/Costshare 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 Small Group Health Plan Certificate of Coverage is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2018)

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