Partners 80 Gold 1500

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	$1,500	$3,000
Per Family	$3,000	$6,000
Annual Maximum Out-of-Pocket *(includes all deductibles, co-pays and co-insurance)*		
Per Covered Person	$5,000	$20,000
Per Family	$10,000	$40,000
Physician Services		
Primary Care Physician (PCP)	$20 Co-pay	50%** U&C*
Specialty Care Physician (SCP)	$40 Co-pay	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.	20%**	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	20%**	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 Co-pay
Additional immunizations not mandated by PHSA Section 2713	$12 Co-pay	$12 Co-pay
Inpatient Hospital Services		
Physician Services	20%**	50%** U&C*
Hospitalization	20%**	50%** U&C*
Maternity and Newborn Care	20%**	50%** U&C*
Human Organ Transplant	20%**	50%** U&C*
Transportation and Lodging	20%**	Not Covered
Unrelated Donor Search	20%**	
Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient	20%**	50%** U&C*
	150 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	$200 Co-pay	$200 Co-pay
Urgent Care Services	$75 Co-pay	50%** U&C*
Outpatient Surgery & Procedures	20%**	50%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	20%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	20%**	50%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Speech Therapy	20%**	50%** U&C*
	Unlimited	

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Cardiac Rehabilitation	20%**	50%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	20%**	50%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	20%**	50%** U&C*
	Prior authorization required for office visits in excess of 26 per Benefit Year	
Diagnostic Laboratory, Imaging and Radiology	20%**	50%** U&C*
Home Health Care	20%**	50%** U&C*
	100 visits per Benefit Year	
Private Duty Nursing	20%**	50%** U&C*
	82 visits per Benefit Year, 164 visits Lifetime Maximum	
Hospice	20%**	50%** U&C*
Ambulance Services	20%**	20%**
Educational Services	20%**	50%** U&C*
Durable Medical Equipment	20%**	50%** U&C*
Orthotics	20%**	50%** U&C*
Disposable Medical Supplies	20%**	50%** U&C*
Prosthetics	20%**	50%** U&C*
Mental Health Services		
Mental Health Office Visit	$20 Co-pay	50%** U&C*
Mental Health Services not received in an office setting.	20%**	50%** U&C*
Hospital Inpatient/Residential Treatment	20%**	50%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	20%**	50%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	20%**	50%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	20%**	50%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	20%**	50%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	20%**	
Basic Dental Care	20%**	
Major Dental Care	20%**	
Orthodontia (requires prior authorization)	20%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	20%**	
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)	20%**	
Autism Services	Benefits are based on the setting in which Covered Services are received****	
Applied Behavior Analysis (ABA) *Requires prior authorization*	20%**	50%** U&C*
Pharmacy Services		
Deductible	$0	
Generic (most), Tier 1 (30 day supply)	$10	50%** U&C*
Preferred Brand, Tier 2 (30 day supply)	$35	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-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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