# Partners 80 Silver 3500

## Small Group Plan Benefit Summary

Cox HealthPlans
CoxHealth

| Plan Features | In-Network<br>Member is responsible for: | Out-of-Network<br>Member is responsible for: |
|---|---|---|
| **Essential Health Benefits** | Unlimited | |
| **Lifetime Maximum Benefit** | Unlimited | |
| **Deductible** | | |
| *Per Covered Person* | $3,500 | $7,000 |
| *Per Family* | $7,000 | $14,000 |
| **Annual Maximum Out-of-Pocket** *(includes all deductibles, co-pays and co-insurance)* | | |
| *Per Covered Person* | $4,000 | $20,000 |
| *Per Family* | $8,000 | $40,000 |
| **Physician Services** | | |
| *Primary Care Physician (PCP)* | 20%** | 50%** U&C* |
| *Specialty Care Physician (SCP)* | 20%** | 50%** U&C* |
| *Physician eVisit* | 20%** | 50%** U&C* |
| *Physician Telehealth Visit* | $45 | 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 form 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 Combined* | |
| **Outpatient Services** | | |
| *Emergency Services* | 20%** | 20%** |
| *Urgent Care Services* | 20%** | 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 | |

| | | |
|---|---|---|
| *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%** | 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 of glasses, (lenses and frames), per Benefit Year)* | 20%** | |
| **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* | 20%** | 50%** U&C* |
| **Pharmacy Services** | | |
| ***Deductible*** | Subject to Medical Deductible and Co-insurance | |
| *Generic (most), Tier 1 (30 day supply)* | 20%** | 50%** U&C* |
| *Preferred Brand, Tier 2 (30 day supply)* | 20%** | 50%** U&C* |
| *Other Brand / Non-Formulary, Tier 3 (30 day supply)* | 20%** | 50%** U&C* |
| *Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)* | 20%** | 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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