Gold 1500
Individual 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 *(including Deductible and Co-pay / Co-insurance)*		
Per Covered Person	$6,000	$20,000
Per Family	$12,000	$40,000
Physician Services		
Primary Care Physician (PCP)	$30 Co-pay	40%** U&C*
Specialty Care Physician (SCP)	$50 Co-pay	40%** U&C*
Physician eVisit	$10 Co-pay	40%** U&C*
Physician Telehealth Visit	$10 Co-pay	40%** U&C*
Physician Services not received in an office setting.	10%**	40%** 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	40%** U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	10%**	40%** 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	40%** U&C*
Physician office visits and laboratory tests associated with preventive checkups		
Preventive Services for Adults	$0	40%** U&C*
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	40%** 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	10%**	40%** U&C*
Hospitalization	10%**	40%** U&C*
Maternity and Newborn Care	10%**	40%** U&C*
Human Organ Transplant	10%**	40%** U&C*
Transportation and Lodging	10%**	Not Covered
Unrelated Donor Search	10%**	
Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient	10%**	40%** U&C*
	150 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	$200 Co-pay	$200 Co-pay
Urgent Care Services	$75 Co-pay	40%** U&C*
Outpatient Surgery & Procedures	10%**	40%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	10%**	40%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Occupational Therapy	10%**	40%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	

Speech Therapy	10%**	40%** U&C*
	Unlimited	
Cardiac Rehabilitation	10%**	40%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	10%**	40%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	10%**	40%** U&C*
	Prior authorization required for office visits in excess of 26 per Benefit Year	
Diagnostic Laboratory, Imaging and Radiology	10%**	40%** U&C*
Home Health Care	10%**	40%** U&C*
	100 visits per Benefit Year	
Private Duty Nursing	10%**	40%** U&C*
	82 visits per Benefit Year, 164 visits Lifetime Maximum	
Hospice	10%**	40%** U&C*
Ambulance Services	10%**	10%**
Educational Services	10%**	40%** U&C*
Durable Medical Equipment	10%**	40%** U&C*
Orthotics	10%**	40%** U&C*
Disposable Medical Supplies	10%**	40%** U&C*
Prosthetics	10%**	40%** U&C*
Mental Health Services		
Mental Health Office Visit	$30 Co-pay	40%** U&C*
Mental Health Services not received in an office setting.	10%**	40%** U&C*
Hospital Inpatient/Residential Treatment	10%**	40%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	10%**	40%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	10%**	40%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	10%**	40%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	10%**	40%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	10%**	
Basic Dental Care	10%**	
Major Dental Care	10%**	
Orthodontia (requires prior authorization)	10%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	10%**	
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)	10%**	
Autism Services	Benefits are based on the setting in which Covered Services are received****	
Applied Behavior Analysis (ABA) *Requires prior authorization*	10%**	40%** U&C*
Pharmacy Services		
Deductible	$0	
Generic (most), Tier 1 (30 day supply)	$15 Co-pay	40%** U&C*
Preferred Brand, Tier 2 (30 day supply)	$45 Co-pay	40%** U&C*
Other Brand/Non-Formulary, Tier 3 (30 day supply)	$75 Co-pay	40%** U&C*
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	$100 Co-pay	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 Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2018)

P.O. Box 5750 • Springfield, Missouri 65801-5750 • (417) 269-4679 • (800) 664-1244 • Fax: (417) 269-4667 • coxhealthplans.com