Partners 90 Gold 2500

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	$2,500	$5,000
Per Family	$5,000	$10,000
Annual Maximum Out-of-Pocket *(includes all deductibles, co-pays and co-insurance)*		
Per Covered Person	$7,900	$20,000
Per Family	$15,800	$40,000
Physician Services		
Primary Care Physician (PCP)	$20 Co-pay	40%** Co-insurance U&C*
Specialty Care Physician (SCP)	10%** Co-insurance	40%** Co-insurance U&C*
Physician eVisit	$10 Co-pay	40%** Co-insurance U&C*
Physician Telehealth Visit	$10 Co-pay	40%** Co-insurance U&C*
Physician Services not received in an office setting	10%** Co-insurance	40%** Co-insurance 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%** Co-insurance U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	10%** Co-insurance	40%** Co-insurance 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%** Co-insurance U&C*
Physician office visits and laboratory tests associated with preventive checkups	$0	40%** Co-insurance U&C*
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	40%** Co-insurance 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%** Co-insurance	40%** Co-insurance U&C*
Hospitalization	10%** Co-insurance	40%** Co-insurance U&C*
Maternity and Newborn Care	10%** Co-insurance	40%** Co-insurance U&C*
Human Organ Transplant	10%** Co-insurance	40%** Co-insurance U&C*
Transportation and Lodging	10%** Co-insurance	Not Covered
Unrelated Donor Search	10%** Co-insurance	
Skilled Nursing Services/Physical Medicine and Rehabilitation - Inpatient	10%** Co-insurance	40%** Co-insurance U&C*
	150 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	10%** Co-insurance	10%** Co-insurance
Urgent Care Services	10%** Co-insurance	40%** Co-insurance U&C*
Outpatient Surgery & Procedures	10%** Co-insurance	40%** Co-insurance U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	10%** Co-insurance	40%** Co-insurance U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)	
*Occupational Therapy****	10%** Co-insurance	40%** Co-insurance U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavior Analysis)	
Speech Therapy	10%** Co-insurance	40%** Co-insurance U&C*
	Unlimited	

Cardiac Rehabilitation	10%** Co-insurance	40%** Co-insurance U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	10%** Co-insurance	40%** Co-insurance U&C*
	20 visits per Benefit Year	
Chiropractic Services	10%** Co-insurance	40%** Co-insurance U&C*
	Prior authorization required for office visits in excess of 26 per Benefit Year	
Diagnostic Laboratory, Imaging and Radiology	10%** Co-insurance	40%** Co-insurance U&C*
Home Health Care	10%** Co-insurance	40%** Co-insurance U&C*
	100 visits per Benefit Year	
Private Duty Nursing	10%** Co-insurance	40%** Co-insurance U&C*
	82 visits per Benefit Year, 164 visits Lifetime Maximum	
Hospice	10%** Co-insurance	40%** Co-insurance U&C*
Ambulance Services	10%** Co-insurance	10%** Co-insurance
Educational Services	10%** Co-insurance	40%** Co-insurance U&C*
Durable Medical Equipment	10%** Co-insurance	40%** Co-insurance U&C*
Orthotics	10%** Co-insurance	40%** Co-insurance U&C*
Disposable Medical Supplies	10%** Co-insurance	40%** Co-insurance U&C*
Prosthetics	10%** Co-insurance	40%** Co-insurance U&C*
Mental Health Services		
Mental Health Office Visit	$20 Co-pay	40%** Co-insurance U&C*
Mental Health Services not received in an office setting	10%** Co-insurance	40%** Co-insurance U&C*
Hospital Inpatient/Residential Treatment	10%** Co-insurance	40%** Co-insurance U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	10%** Co-insurance	40%** Co-insurance U&C*
Inpatient/Residential Annual Maximum (unlimited)	10%** Co-insurance	40%** Co-insurance U&C*
Medical or Social Setting Detox Annual Maximum (unlimited)	10%** Co-insurance	40%** Co-insurance U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	10%** Co-insurance	40%** Co-insurance U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	10%** Co-insurance	
Basic Dental Care	10%** Co-insurance	
Major Dental Care	10%** Co-insurance	
Orthodontia (requires prior authorization)	10%** Co-insurance	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	10%** Co-insurance	
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Benefit Year) (1 standard frame every other Benefit Year)	10%** Co-insurance	
Autism Services	Benefits are based on the setting in which Covered Services are received****	
Applied Behavior Analysis (ABA) *(requires prior authorization)*	10%** Co-insurance	40%** Co-insurance U&C*
Pharmacy Services***		
Deductible	Subject to Medical Deductible and Co-insurance (Tier 2-4)	
Generic (most), Tier 1 (30 day supply)	$5 Co-pay	40%** Co-insurance U&C*
Preferred Brand, Tier 2 (30 day supply)	10%** Co-insurance	40%** Co-insurance U&C*
Other Brand/Non-Formulary, Tier 3 (30 day supply)	10%** Co-insurance	40%** Co-insurance U&C*
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	10%** Co-insurance	N/A
Mail Order (90 day supply)	2.5×	N/A

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

**Co-insurance applies after Deductible is met.

***Co-pays/Co-insurance for Physical Therapy and 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 than is applicable to other physical health care services covered by this Plan.

*****If a Provider, Pharmacy, or any third party payer waives, discounts, reduces, or indirectly pays the required cost sharing for a particular claim, the waived portion, discounted portion, reduced portion, or indirectly paid portion of the cost share will not apply to or reduce any Deductible or Out-of-Pocket applicable to the 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: 1/1/2019)

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