# Cox HealthPlans Gold Standard $1,500 Deductible

## *Individual EPO Plan Benefit Summary*

COX HEALTHPLANS
CoxHealth

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. Benefits are limited to services provided by In-Network Providers, except for Emergency Services and certain Mental Health office sessions[1].

Services provided by Out-of-Network Providers are not covered, except as specifically authorized. Please see the Covered Services section of your plan document for further information.

| Plan Features | In-Network<br>Member is responsible for: |
|---|---|
| **Essential Health Benefits** | Unlimited |
| **Lifetime Maximum Benefit** | Unlimited |
| **Deductible** | |
| *Per Covered Person* | $1,500 |
| *Per Family* | $3,000 |
| **Annual Maximum Out-of-Pocket** *(Including Deductible and Co-pay / Co-insurance / Costshare)* | |
| *Per Covered Person* | $7,800 |
| *Per Family* | $15,600 |
| **Physician Services** | |
| *Primary Care Physician (PCP) Office Visit/Telemedicine* | $30 Co-pay |
| *Specialty Care Physician (SCP) Office Visit/Telemedicine* | $60 Co-pay |
| *Physician Services not received in an office setting* | 25%** Co-ins |
| **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 |
| *Additional preventive services or treatments not mandated by PHSA Section 2713* | 25%** Co-ins |
| **Preventive Services for Children and Adolescents** | |
| *Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration* | $0 |
| **Physician office visits and laboratory tests associated with preventive checkups** | |
| *Preventive Services for Adults* | $0 |
| *Preventive care and screenings for women supported by the Health Resources and Services Administration* | $0 |
| **Immunizations Ages 0 to Adult** *(per immunization)* | |
| *As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713, and as provided by Department of Health & Senior Services regulations* | $0 |
| *Additional immunizations not mandated by PHSA Section 2713* | $12 Co-pay |
| **Inpatient Hospital Services** | |
| *Physician Services* | 25%** Co-ins |
| *Hospitalization* | 25%** Co-ins |
| *Maternity and Newborn Care* | 25%** Co-ins |
| *Human Organ Transplant* | 25%** Co-ins |
| *Transportation and Lodging* | 25%** Co-ins |
| *Unrelated Donor Search* | 25%** Co-ins |
| *Skilled Nursing Services - Inpatient, and Physical Medicine and Rehabilitation* | 25%** Co-ins<br>*150 Inpatient days per Benefit Year Combined* |
| **Outpatient Services** | |
| *Emergency Services* | 25%** Co-ins |
| *Urgent Care Services* | $45 Co-pay |
| *Outpatient Surgery & Procedures* | 25%** Co-ins |
| **Rehabilitation and Habilitative** | |
| *Physical Therapy and Manipulation Therapy*** (not including Chiropractic Services)* | $30 Co-pay<br>*20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)* |
| *Occupational Therapy**** | $30 Co-pay<br>*20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)* |
| *Speech Therapy* | $30 Co-pay<br>Unlimited |

| | |
|---|---|
| *Cardiac Rehabilitation* | 25%** Co-ins<br>*36 visits per Benefit Year* |
| *Pulmonary Rehabilitation* | 25%** Co-ins<br>*20 visits per Benefit Year* |
| *Chiropractic Services* | 25%** Co-ins<br>*Prior authorization required for office visits in excess of 26 per Benefit Year* |
| *Diagnostic Laboratory, Imaging and Radiology* | 25%** Co-ins |
| *Home Health Care* | 25%** Co-ins<br>*100 visits per Benefit Year* |
| *Private Duty Nursing* | 25%** Co-ins<br>*82 visits per Benefit Year, 164 visits Lifetime Maximum* |
| *Hospice* | 25%** Co-ins |
| *Ambulance Services* | 25%** Co-ins |
| *Educational Services* | 25%** Co-ins |
| *Durable Medical Equipment* | 25%** Co-ins |
| *Orthotics* | 25%** Co-ins |
| *Disposable Medical Supplies* | 25%** Co-ins |
| *Prosthetics* | 25%** Co-ins |
| **Mental Health Services** | |
| *Mental Health Office Visit* | $30 Co-pay |
| *Mental Health Services not received in an office setting* | 25%** Co-ins |
| *Hospital Inpatient/Residential Treatment* | 25%** Co-ins |
| **Substance Abuse** | |
| *Outpatient Annual Maximum Benefit (unlimited)* | 25%** Co-ins |
| *Inpatient/Residential Annual Maximum (unlimited)* | 25%** Co-ins |
| *Medical or Social Setting Detox Annual Max (unlimited)* | 25%** Co-ins |
| **Dental Services** *(only related to accidental injury or for certain members requiring general anesthesia)* | 25%** Co-ins |
| **Pediatric Dental** *(dependent children through age 18)* | |
| *Dental Exam* | 25%** Co-ins |
| *Basic Dental Care* | 25%** Co-ins |
| *Major Dental Care* | 25%** Co-ins |
| *Orthodontia (requires prior authorization)* | 25%** Co-ins |
| **Pediatric Vision** *(dependent children through age 18)* | |
| *Routine Eye Exam (1 visit per Calendar Year)* | 25%** Co-ins |
| *Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Calendar Year) (1 standard frame per Calendar Year)* | 25%** Co-ins |
| **Autism Services** | Benefits are based on the setting in which Covered Services are Received[2] |
| **Applied Behavior Analysis (ABA)**<br>*Requires prior authorization* | 25%** Co-ins |
| **Pharmacy Services**[3] | Retail (30 day supply) |
| ***Deductible*** | $0 Deductible |
| *Generic (most), Tier 1 (30 day supply)* | $15 Co-pay |
| *Preferred Brand, Tier 2 (30 day supply)* | $30 Co-pay |
| *Other Brand/Non-Formulary, Tier 3 (30 day supply)* | $60 Co-pay |
| *Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)* | $250 Co-pay |
| *Mail Order (90 day supply)* | 2.5× |

* 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.

[1] Covered Services include 2 Mental Health sessions per Calendar Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider acting within the scope of their license.

[2] 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, mental health, or substance abuse services covered by this Plan.

[3] 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 plan will not impose any financial requirement on Mental health or Substance use disorder benefits that is more restrictive than the predominant financial requirement that applies to substantially all Mental health or Substance use disorder benefits in the classification or sub-classification.

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: 1/1/2025)***