Cox HealthPlans Silver Standard $5,900 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 Member is responsible for:
Essential Health Benefits	Unlimited
Lifetime Maximum Benefit	Unlimited
Deductible	
Per Covered Person	$5,900
Per Family	$11,800
Annual Maximum Out-of-Pocket *(Including Deductible and Co-pay / Co-insurance / Costshare)*	
Per Covered Person	$9,100
Per Family	$18,200
Physician Services	
Primary Care Physician (PCP) Office Visit/Telemedicine	$40 Co-pay
Specialty Care Physician (SCP) Office Visit/Telemedicine	$80 Co-pay
Physician Services not received in an office setting	40%** 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	40%** 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	40%** Co-ins
Hospitalization	40%** Co-ins
Maternity and Newborn Care	40%** Co-ins
Human Organ Transplant	40%** Co-ins
Transportation and Lodging	40%** Co-ins
Unrelated Donor Search	40%** Co-ins
Skilled Nursing Services - Inpatient, and Physical Medicine and Rehabilitation	40%** Co-ins *150 Inpatient days per Benefit Year Combined*
Outpatient Services	
Emergency Services	40%** Co-ins
Urgent Care Services	$60 Co-pay
Outpatient Surgery & Procedures	40%** Co-ins
Rehabilitation and Habilitative	
*Physical Therapy and Manipulation Therapy*** (not including Chiropractic Services)*	$40 Co-pay *20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)*
*Occupational Therapy****	$40 Co-pay *20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)*
Speech Therapy	$40 Co-pay Unlimited

Cardiac Rehabilitation	40%** Co-ins *36 visits per Benefit Year*
Pulmonary Rehabilitation	40%** Co-ins *20 visits per Benefit Year*
Chiropractic Services	40%** Co-ins *Prior authorization required for office visits in excess of 26 per Benefit Year*
Diagnostic Laboratory, Imaging and Radiology	40%** Co-ins
Home Health Care	40%** Co-ins *100 visits per Benefit Year*
Private Duty Nursing	40%** Co-ins *82 visits per Benefit Year, 164 visits Lifetime Maximum*
Hospice	40%** Co-ins
Ambulance Services	40%** Co-ins
Educational Services	40%** Co-ins
Durable Medical Equipment	40%** Co-ins
Orthotics	40%** Co-ins
Disposable Medical Supplies	40%** Co-ins
Prosthetics	40%** Co-ins
Mental Health Services	
Mental Health Office Visit	$40 Co-pay
Mental Health Services not received in an office setting	40%** Co-ins
Hospital Inpatient/Residential Treatment	40%** Co-ins
Substance Abuse	
Outpatient Annual Maximum Benefit (unlimited)	40%** Co-ins
Inpatient/Residential Annual Maximum (unlimited)	40%** Co-ins
Medical or Social Setting Detox Annual Max (unlimited)	40%** Co-ins
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	40%** Co-ins
Pediatric Dental *(dependent children through age 18)*	
Dental Exam	40%** Co-ins
Basic Dental Care	40%** Co-ins
Major Dental Care	40%** Co-ins
Orthodontia (requires prior authorization)	40%** Co-ins
Pediatric Vision *(dependent children through age 18)*	
Routine Eye Exam (1 visit per Calendar Year)	40%** Co-ins
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Calendar Year) (1 standard frame per Calendar Year)	40%** Co-ins
Autism Services	Benefits are based on the setting in which Covered Services are Received[2]
Applied Behavior Analysis (ABA) *Requires prior authorization*	40%** Co-ins
Pharmacy Services[3]	Retail (30 day supply)
Deductible	Subject to Medical Deductible (Tier 3-4)
Generic (most), Tier 1 (30 day supply)	$20 Co-pay
Preferred Brand, Tier 2 (30 day supply)	$40 Co-pay
Other Brand/Non-Formulary, Tier 3 (30 day supply)	$80 Co-pay
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	$350 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: 1/1/2024)