Silver Connect 9
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	$7,800
Per Family	$15,600
Annual Maximum Out-of-Pocket *(Including Deductible and Co-pay / Co-insurance / Costshare)*	
Per Covered Person	$8,500
Per Family	$17,000
Physician Services	
Primary Care Physician (PCP) Office Visit/Telemedicine	$40 Co-pay
Specialty Care Physician (SCP) Office Visit/Telemedicine	$75 Co-pay
Physician Services not received in an office setting	30%**
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	30%**
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	$0
Additional immunizations not mandated by PHSA Section 2713	$12 Co-pay
Inpatient Hospital Services	
Physician Services	30%**
Hospitalization	30%**
Maternity and Newborn Care	30%**
Human Organ Transplant	30%**
Transportation and Lodging	30%**
Unrelated Donor Search	30%**
Skilled Nursing Services - Inpatient, and Physical Medicine and Rehabilitation	30%** *150 Inpatient days per Benefit Year Combined*
Outpatient Services	
Emergency Services	$200 Co-pay after Deductible
Urgent Care Services	$100 Co-pay
Outpatient Surgery & Procedures	30%**
Rehabilitation and Habilitative	
*Physical Therapy and Manipulation Therapy*** (not including Chiropractic Services)*	30%** *20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)*
*Occupational Therapy****	30%** *20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)*
Speech Therapy	30%** Unlimited

Cardiac Rehabilitation	30%** *36 visits per Benefit Year*
Pulmonary Rehabilitation	30%** *20 visits per Benefit Year*
Chiropractic Services	30%** *Prior authorization required for office visits in excess of 26 per Benefit Year*
Diagnostic Laboratory, Imaging and Radiology	30%**
Home Health Care	30%** *100 visits per Benefit Year*
Private Duty Nursing	30%** *82 visits per Benefit Year, 164 visits Lifetime Maximum*
Hospice	30%**
Ambulance Services	30%**
Educational Services	30%**
Durable Medical Equipment	30%**
Orthotics	30%**
Disposable Medical Supplies	30%**
Prosthetics	30%**
Mental Health Services	
Mental Health Office Visit	$40 Co-pay
Mental Health Services not received in an office setting	30%**
Hospital Inpatient/Residential Treatment	30%**
Substance Abuse	
Outpatient Annual Maximum Benefit (unlimited)	30%**
Inpatient/Residential Annual Maximum (unlimited)	30%**
Medical or Social Setting Detox Annual Max (unlimited)	30%**
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	30%**
Pediatric Dental *(dependent children through age 18)*	
Dental Exam	30%**
Basic Dental Care	30%**
Major Dental Care	30%**
Orthodontia (requires prior authorization)	30%**
Pediatric Vision *(dependent children through age 18)*	
Routine Eye Exam (1 visit per Calendar Year)	30%**
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Calendar Year) (1 standard frame every other Calendar Year)	30%**
Autism Services	Benefits are based on the setting in which Covered Services are Received[2]
Applied Behavior Analysis (ABA) *Requires prior authorization*	30%**
Pharmacy Services[4]	Retail (30 day supply)
Deductible	Subject to Medical Deductible (Tier 3-4)
Generic (most), Tier 1 (30 day supply)	$25 Co-pay
Preferred Brand, Tier 2 (30 day supply)	$60 Co-pay
Other Brand/Non-Formulary, Tier 3 (30 day supply)	30%**
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	30%**
Mail Order[3] (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 covered by this Plan.

[3] Mail order available on maintenance medications only for a 90 day supply.

[4] 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 Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2021)