High Deductible Health Plan

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	$6,850	$13,700
Per Family	$13,700	$27,400
Annual Maximum Out-of-Pocket *(includes all deductibles, copays and coinsurance)*		
Per Covered Person	$6,850	$20,000
Per Family	$13,700	$40,000
Physician Services		
Primary Care Physician (PCP)	1st 3 Visits $0 Member Costshare; subsequent visits 0%**	30%** U&C*
Specialty Care Physician (SCP)	0%**	30%** U&C*
Physician eVisit	0%**	30%** U&C*
Physician Services not received in an office setting	0%**	30%** U&C*
Preventive Health Services		
Services recommended by the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0	30%** U&C*
Additional preventive services or treatments not mandated by PHSA Section 2713	0%**	30%** 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	30%** U&C*
Physician office visits and laboratory tests associated with preventive checkups	$0	30%** U&C*
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	30%** 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 copay
Additional immunizations not mandated by PHSA Section 2713	$12 copay	$12 copay
Inpatient Hospital Services		
Physician Services	0%**	30%** U&C*
Hospitalization	0%**	30%** U&C*
Maternity and Newborn Care	0%**	30%** U&C*
Human Organ Transplant	0%**	30%** U&C*
Transportation and Lodging	0%**	Not Covered
Unrelated Donor Search	0%**	
Skilled Nursing Services - Inpatient	0%**	30%** U&C*
	90 Inpatient days per Benefit Year	
Physical Medicine and Rehabilitation	0%**	30%** U&C*
	60 Inpatient days per Benefit Year	
Outpatient Services		
Emergency Services	0%**	0%
Urgent Care Services	0%**	30%** U&C*
Outpatient Surgery & Procedures	0%**	30%** U&C*
Rehabilitation and Habilitative		
*Physical Therapy and Manipulation Therapy (not including Chiropractic Services)****	0%**	30%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	

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Occupational Therapy	0%**	30%** U&C*
	20 visits per Benefit Year (not including Autism/Applied Behavioral Analysis)	
Speech Therapy	0%**	30%** U&C*
	Unlimited	
Cardiac Rehabilitation	0%**	30%** U&C*
	36 visits per Benefit Year	
Pulmonary Rehabilitation	0%**	30%** U&C*
	20 visits per Benefit Year	
Chiropractic Services	0%**	30%** U&C*
	26 visits per Benefit Year without prior approval	
Diagnostic Laboratory, Imaging and Radiology	0%**	30%** U&C*
Home Health Care	0%**	30%** U&C*
	90 visits per Benefit Year	
Private Duty Nursing	0%**	30%** U&C*
Hospice	0%**	30%** U&C*
Ambulance Services	0%**	0%**
Educational Services	0%**	30%** U&C*
Durable Medical Equipment	0%**	30%** U&C*
Hearing Aids (newborns only)	0%**	30%** U&C*
Orthotics	0%**	30%** U&C*
Disposable Medical Supplies	0%**	30%** U&C*
Prosthetics	0%**	30%** U&C*
Mental Health Services		
Mental Health Office Visit	0%**	30%** U&C*
Mental Health Services not received in an office setting	0%**	30%** U&C*
Hospital Inpatient / Residential Treatment	0%**	30%** U&C*
Substance Abuse		
Outpatient Annual Maximum Benefit (unlimited)	0%**	30%** U&C*
Inpatient/Residential Annual Maximum (unlimited)	0%**	30%** U&C*
Medical or Social Setting Detox Annual Max (unlimited)	0%**	30%** U&C*
Applied Behavior Analysis (ABA)		
Applied Behavior Analysis *(dependent children through age 18) Requires prior authorization*	0%**	30%** U&C*
Dental Services *(only related to accidental injury or for certain members requiring general anesthesia)*	0%**	30%** U&C*
Pediatric Dental *(dependent children through age 18)*		
Dental Exam	0%**	
Basic Dental Care	0%**	
Major Dental Care	0%**	
Orthodontia	0%**	
Pediatric Vision *(dependent children through age 18)*		
Routine Eye Exam (1 visit per Benefit Year)	0%**	
Eye Glasses (1 pair of glasses, lenses and frames, per Benefit Year)	0%**	
Pharmacy Services		
Deductible	Subject to Medical Deductible and Coinsurance	
Generic (most), Tier 1 (30 day supply)	0%**	30%** U&C*
Preferred Brand, Tier 2 (30 day supply)	0%**	30%** U&C*
Other Brand / Non-Formulary, Tier 3 (30 day supply)	0%**	30%** U&C*
Specialty Formulary Brand / Non-Formulary, Tier 4 (30 day supply)	0%**	N/A
Mail Order (90 day supply)	2.5×	N/A

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

**Coinsurance applies after Deductible is met.

***Co-pays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

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: 1/1/2016)

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