



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.coxhealthplans.com](http://www.coxhealthplans.com) or by calling 1-800-205-7665.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$1,500</b> person/ <b>\$3,000</b> family <u>in-network provider</u> . <b>\$3,000</b> person <b>\$6,000</b> family <u>out-of-network provider</u> Doesn't apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or <u>plan</u> document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$0 for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For InNetwork <u>providers</u> <b>\$5,000</b> person/ <b>\$10,000</b> family. For Out-of-Network <u>providers</u> <b>\$20,000</b> person/ <b>\$40,000</b> family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums, balance-billed charges, and health care this plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the <u>plan</u> will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See <a href="http://www.coxhealthplans.com">www.coxhealthplans.com</a> or call 1-800-205-7665 for a list of in-network <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this <u>plan</u> doesn't cover are listed on page 5. See your policy or <u>plan</u> document for additional information about <u>excluded services</u> .

**Questions:** Call 1-800-205-7665 or visit us at [www.coxhealthplans.com](http://www.coxhealthplans.com).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-205-7665 to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <b>copay</b> /visit \$20 Mental Health <b>copay</b> /visit	40% <b>coinsurance</b>	<b>Copay</b> covers services billed by the physician for the same date of service.
	Specialist visit	\$30 <b>copay</b> /visit	40% <b>coinsurance</b>	<b>Copay</b> covers services billed by the physician for the same date of service.
	Other practitioner office visit	\$20 <b>copay</b> /visit for chiropractor	40% for chiropractor	<b>Copay</b> covers services billed by the physician for the same date of service. Limited to 26 visits per calendar year without prior authorization.
	Preventive care/screening/immunization	No Charge	40% <b>coinsurance</b>	No charge only for services recommended by the U.S. Preventive Services Task Force as mandated by PHSA Section 2713
If you have a test	Diagnostic test (x-ray, blood work)	10% <b>coinsurance</b>	40% <b>coinsurance</b>	-----None-----
	Imaging (CT/PET scans, MRIs)	10% <b>coinsurance</b>	40% <b>coinsurance</b>	-----None-----
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at <a href="http://www.coxhealthplans.com">www.coxhealthplans.com</a> .	Generic drugs	\$15 prescription retail and \$37.50 mail order	40% <b>coinsurance</b>	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	\$45 prescription retail and \$112.50 mail order	40% <b>coinsurance</b>	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	\$75 prescription retail and \$187.50 mail order	40% <b>coinsurance</b>	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Specialty drugs	\$100 prescription retail	Not Covered	Covers up to a 30-day supply (retail prescription). Mail order not covered.

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required <u>preauthorization</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required <u>preauthorization</u> .
If you need immediate medical attention	Emergency room services	150% <u>coinsurance</u>	150% <u>coinsurance</u>	-----None-----
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----None-----
	Urgent care	75% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> .
	Physician/surgeon fee	10% <u>coinsurance</u>	40% <u>coinsurance</u>	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> .
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% <u>coinsurance</u> .	40% <u>coinsurance</u> .	-----None-----
	Mental/Behavioral health inpatient services	10% <u>coinsurance</u> .	40% <u>coinsurance</u> .	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> .
	Substance use disorder outpatient services	10% <u>coinsurance</u> .	40% <u>coinsurance</u> .	-----None-----
	Substance use disorder inpatient services	10% <u>coinsurance</u> .	40% <u>coinsurance</u> .	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> .
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Delivery and all inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> .

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty may be applied without <u>preauthorization</u> .
	Rehabilitation services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical Therapy, Occupational Therapy, & Speech Therapy each limited to 60 days per calendar year. Physical/Occupational require authorization for home visits. All Speech Therapy requires authorization. 50% penalty may be applied without the required <u>preauthorization</u> .
	Habilitation services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Autism (BCBA, BCaBA specialties only) requires <u>preauthorization</u> and is limited to individuals through 18 years of age.
	Skilled nursing care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty may be applied without <u>preauthorization</u> .
	Durable medical equipment	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty may be applied without <u>preauthorization</u> .
	Hospice service	10% <u>coinsurance</u>	40% <u>coinsurance</u>	50% penalty may be applied without <u>preauthorization</u> .
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for eye exam.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check up	Not Covered	Not Covered	No coverage for dental check-up.

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
• Acupuncture	• Glasses (Child)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Dental care (Adult)	• Infertility treatment	• Routine foot care
• Dental check-up (Child)	• Long-term care	• Weight loss programs
• Eye exam (Child)		

## Excluded Services & Other Covered Services:

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (26 visits per calendar year without prior authorization)
- Cosmetic surgery (With prior authorization)
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-(800) 205-7665. You may also contact your state insurance department, the U.S. Department of Labor at [www.dol.gov/](http://www.dol.gov/), Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the insurer at 1-(800) 205-7665. You may also contact your state insurance department at 1-(800) 726-7390.

Additionally, a consumer assistance program can help you file your appeal. You may also contact them at 1-(800) 726-7390.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Non-English speaking language assistance services, free of charge, are available to you. Call 1-844-563-0782 (TTY: 1-800-735-2966).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays **\$5,220**
- Patient pays **\$2,320**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,500
Co-pays	\$20
Co-insurance	\$600
Limits or exclusions	\$200
<b>Total</b>	<b>\$2,320</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays **\$3,120**
- Patient pays **\$2,280**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,500
Co-pays	\$600
Co-insurance	\$100
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,280</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-205-7665 or visit us at [www.coxhealthplans.com](http://www.coxhealthplans.com).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-205-7665 to request a copy.



Design Name **Design\_011A**

Description **GROUP\_PPO\_PARTNERS\_AI\_RX\_DED\_MOOP\_OV\_copay\_only**

SBC Document Collection : Design\_011A

PlanID : PSXBP2766C010678651, PSXBP2767C010678661, PSXBP3830C010754471

EffectiveDateEnd : 12/31/2078

EffectiveDateStart : 01/01/2015

PharmacyCode : X1503TB50pAO2X, X1C3TB50pAN2X, X1C3TB50pO

Plan Name : PlanName\_043

PlanID : PSXBP2685C010652501, PSXBP2786C010696681

CoPays and CoInsurance : CHP249

PlanID : PSXBP2786C010696681

SBCEffectiveDate : 01/01/2016

SBCTermDate : 12/31/2078