Cox HealthPlans CoxHealth

Partners 80 Gold 1000

Coverage for: Employee + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-205-7665 or visit www.coxhealthplans.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-205-7665 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person/ **$2,000** family in-network **provider**. **$2,000** person **$4,000** family out-of-network **provider** Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or **plan** document to see when the **deductible** 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 **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care, Emergency Room, Urgent Care and Office Visit services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the annual **deductible** amount, but a **deductible**, **copay**, or **coinsurance** may apply. For example this**plan** covers certain preventive services without cost-sharing before you meet your **deductible**. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For in-network **providers** **$6,000** person/ **$12,000** family. For out-of-network **providers** **$20,000** person/ **$40,000** family	The **out-of-pocket limit** 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 out-of-pocket limit?	**Premiums**, **balance-billed** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.coxhealthplans.com** or call **1-800-205-7665** for a list of in-network **providers**.	If you use an in-network doctor or other health care **provider**, this **plan** 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit $20 Mental Health copay/visit	50% coinsurance	Copay covers services billed by the physician for the same date of service.
	Specialist visit	$40 copay/visit	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	50% coinsurance	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)	20% coinsurance	50% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.coxhealthplans.com	Generic drugs (Tier 1)	$15 prescription retail and $37.50 mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs (Tier 2)	$45 prescription retail and $112.50 mail order	50% coinsurance	
	Non-preferred brand drugs (Tier 3)	$75 prescription retail and $187.50 mail order	50% coinsurance	
	Specialty drugs (Tier 4)	$100 prescription retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required preauthorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$75 copay/visit	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	50% coinsurance.	----------None----------
	Inpatient services	20% coinsurance.	50% coinsurance.	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers.
If you are pregnant	Office visits	$20 copay	50% coinsurance	Copay covers services billed by the physician for the same date of service.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	50% penalty may be applied without preauthorization.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits per calendar year. 50% penalty may be applied without preauthorization.
	Rehabilitation services	20% coinsurance	50% coinsurance	Therapies, excluding speech, each limited to 20 visits per calendar year. 50% penalty may be applied without preauthorization for additional visits or speech therapy.
	Habilitation services	20% coinsurance	50% coinsurance	Applied behavior analysis (BCBA, BCaBA specialties only) requires preauthorization and is limited to individuals through 18 years of age.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 150 inpatient days per calendar year. 50% penalty may be applied without preauthorization.
	Durable medical equipment	20% coinsurance	50% coinsurance	50% penalty may be applied without preauthorization.
	Hospice services	20% coinsurance	50% coinsurance	50% penalty may be applied without preauthorization.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	Limited to one visit per calendar year for individuals up to 19 years of age.
	Children's glasses	20% coinsurance	20% coinsurance	Limited to one pair of glasses (lenses and frames) per calendar year for individuals up to 19 years of age. Requires preauthorization.
	Children's dental check-up	20% coinsurance	20% coinsurance	Limited to one visit per calendar year for individuals up to 19 years of age.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (26 visits per calendar year without prior authorization)
- Cosmetic surgery (With prior authorization)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Home Health setting only)

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/, Employee Benefits Security Administration at 1-866-444-3272 or 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.

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 plan provide Minimum Essential Coverage? **Yes.**
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 plan meet Minimum Value Standards? **Yes.**
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.**

Language Access Services:
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 section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Primary care doctor copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,640

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,290
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,718

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$830
Copayments	$320
Coinsurance	$207
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,357

The plan would be responsible for the other costs of these EXAMPLE covered services.