Cox HealthPlans CoxHealth

**Silver Connect 9.3 AI/AN Limited Cost Sharing**

Coverage for: **Individual+Family** | Plan Type: **EPO**

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 1-800-869-1093 or visit www.thinkinghealthforward.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 healthcare.gov or call 1-800-869-1093 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $0 at Indian Health Care provider (IHCP) or with IHCP referral at non-IHCP; or $6,000 individual / $12,000 family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, 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 deductible amount. But a copayment or coinsurance may apply. For example this plan covers certain preventive services without cost sharing and 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 network providers $7,000 individual/ $14,000 family; Out-of-network not covered. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Copayments for certain services, premiums, balance-billing 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.thinkinghealthforward.com or call 1-800-869-1093 for a list of in-network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

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 |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No Charge | $40 copay/visit deductible does not apply. | Not covered | Cost sharing waived at non-IHCP with IHCP referral. |
| | Specialist visit | No Charge | $75 copay/visit deductible does not apply. | Not covered | |
| | Preventive care/ screening/immunization | No Charge | No Charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 30% coinsurance | Not covered | Cost sharing waived at non-IHCP with IHCP referral. |
| | Imaging (CT/PET scans, MRIs) | No charge | 30% coinsurance | Not covered | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.thinkinghealthforward.com | Generic drugs (Tier 1) | No Charge | $25 prescription retail and $62.50 mail order | Not covered | Medical deductible must be met before Tiers 3 - 4 prescription retail services apply. Deductible does not apply to Tiers 1 - 2. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order for maintenance medications only). Mail order not covered for Tier 4 drugs. Certain drugs may have a 50% penalty without preauthorization. Cost sharing waived at non IHCP with IHCP referral. |
| | Preferred brand drugs (Tier 2) | No Charge | $60 prescription retail and $150 mail order | Not covered | |
| | Non-preferred brand drugs (Tier 3) | No Charge | 30% coinsurance | Not covered | |
| | Specialty drugs (Tier 4) | No Charge | 30% coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 30% coinsurance | Not covered | Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge | 30% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | No Charge | $200 copay/visit after deductible is met | $200 copay/visit after deductible is met | Must meet deductible first on emergency room care. Deductible does not apply to Urgent Care. Cost sharing waived at non- IHCP with IHCP referral. |
| | Emergency medical transportation | No Charge | 30% coinsurance | 30% coinsurance | |
| | Urgent care | No Charge | $100 copay/visit | $100 copay/visit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 30% coinsurance | Not covered | Preauthorization is required. Cost sharing waived at non-IHCP with IHCP referral. |
| | Physician/surgeon fees | No charge | 30% coinsurance | Not covered | Preauthorization is required. Cost sharing waived at non- IHCP with IHCP referral. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | $40 Mental Health copay/visit Deductible does not apply for office visit and 30% coinsurance for other outpatient services. | Not covered | Covered services include two 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. Cost sharing does not apply for preventive services. |
| | Inpatient services | No Charge | 30% coinsurance | Not covered | All Inpatient Services require preauthorization. Cost sharing does not apply for preventive services. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | No charge | 30% coinsurance | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge | 30% coinsurance | Not covered | All Inpatient Services require preauthorization. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | No charge | 30% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No Charge | 30% coinsurance | Not covered | 100 visits per Benefit Year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Rehabilitation services | No Charge | 30% coinsurance | Not covered | Physical Therapy & Occupational Therapy each limited to 20 visits per Benefit Year. Speech Therapy unlimited. Cost sharing waived at non-IHCP with IHCP referral. |
| | Habilitation services | No Charge | 30% coinsurance | Not covered | Physical Therapy & Occupational Therapy each limited to 20 visits per Benefit Year. Speech Therapy unlimited. Cost sharing waived at non-IHCP with IHCP referral. |
| | Skilled nursing care | No Charge | 30% coinsurance | Not covered | Skilled nursing, Physical Medicine, and Rehabilitation limited to 150 combined inpatient days per Benefit year. Cost sharing waived at non-IHCP with IHCP referral. |
| | Durable medical equipment | No Charge | 30% coinsurance | Not covered | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Cost sharing waived at non-IHCP with IHCP referral. |
| | Hospice services | No Charge | 30% coinsurance | Not covered | Preauthorization is required. Cost sharing waived at non-IHCP with IHCP referral. |
| If your child needs dental or eye care | Children's eye exam | No charge | 30% coinsurance | Not covered | Limited to one visit per calendar year for individuals up to 19 years of age. |
| | Children's glasses | No charge | 30% coinsurance | Not covered | Limited to one pair of standard eyeglass lenses or contact lenses per 1 standard frame every other year for individuals up to 19 years of age. Requires preauthorization. |
| | Children's dental check-up | No charge | 30% coinsurance | Not covered | 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.)**

- Abortion (except when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic 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 preauthorization)
- Non-emergency care when traveling outside the U.S.
- Hearing aids (Newborns)
- Private-duty nursing (Outpatient only, 82 visits per benefit year/164 visits per lifetime)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Missouri Department of Commerce and Insurance, P.O. Box 690, Jefferson City, MO 65102, phone: 800-726-7390 or fax: 573-526-4536. You may also contact Cox HealthPlans at www.thinkinghealthforward.com or call 800-869-1093. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-869-1093. You may also contact the Missouri Department of Commerce & Insurance at 1-800-726-7390.

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?** **Not Applicable**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Espanol): Para obtener assistencia an Espanol, llame al 1-844-563-0782.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-563-0782.
Chinese ( 中文): 如果需要中文的帮助, 请拨打这个号码 1-844-563-0782.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-563-0782.

*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 | **$6,000** |
| Specialist copayment | **$75** |
| Hospital (facility) coinsurance | **30%** |
| 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 | $12,700 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $0 |

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

| | |
|---|---|
| The plan's overall deductible | **$6,000** |
| Specialist copayment | **$75** |
| Hospital (facility) coinsurance | **30%** |
| 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 | $5,600 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Joe would pay is | $0 |

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

| | |
|---|---|
| The plan's overall deductible | **$6,000** |
| Specialist copayment | **$75** |
| Hospital (facility) coinsurance | **30%** |
| 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 | $2,800 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $0 |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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

## We speak your language

If you or someone you're helping needs assistance you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Member Services number on the back of your card, or 844-563-0782, TTY: 1-800-735-2966 if you are a member.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Cox HealthPlans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 844-563-0782, TTY: 1-800-735-2966.

如果您，或您正在幫助的人，有關於 Cox HealthPlans 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電844-563-0782, TTY: 1-800-735-2966.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Cox HealthPlans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 844-563-0782, TTY: 1-800-735-2966.

To aan, malla goɗɗo mo mballata, e yama dow Cox HealthPlans a woodi baawɗe heɓuki habaru malla wallireeki wolde maaɗa naa maa a yoɓii. Mbolda e pirtoowo, nodda 844-563-0782, TTY: 1-800-735-2966.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Cos HealthPlan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 844-563-0782 an, TTY: 1-800-735-2966.

ب خ صروص أ س ئ لِة ئ ساعده شخص ل دى أو ل دي ك ك ان إن ) Cox HealthPlans (، ك لدي ئ ال حق ئ ي ال م ساعدة ع لى ال ح صول ئ ك ل نقة اي ة دون حن ب ل غ نك ال ضروري ة وال م ع لومات. ب ان صل م نرجم مع ل ل ئ حدث ) 844-563-0782, TTY: 1-800-735-2966.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Cox HealthPlans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 844-563-0782, TTY: 1- 800-735-2966 로 전화하십시오.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Cox HealthPlans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 844-563-0782, TTY: 1-800-735-2966.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Cox HealthPlans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 844-563-0782, TTY: 1-800-735-2966.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Cox HealthPlans may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 844-563-0782, TTY: 1-800-735-2966.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Cox HealthPlans, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 844-563-0782, TTY: 1-800-735-2966 uffrufe.

در سروال ، م ې ک ن ډ ک هک او ب ه شما ک ه ک سی ې ا شما، اګ ر مورد Cox HealthPlans مک دارې د اې زرا حق ب ا ش ډ دا ش ئه ، دري ان ت راې ګان طور مب را خود زب ان مب اطالعات و ک هک ن ماې ډ 844-563-0782, TTY: 1-800-735-2966 ن ماس ن ماې ډ حا صل

Isin yookan namni biraa isin deeggartan Cox HealthPlans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 844-563-0782, TTY: 1-800-735-2966 tiin bilbilaa.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Cox HealthPlans você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 844-563-0782, TTY: 1-800-735-2966.

Cox HealthPlans የፌደራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆዳ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልም።844-563-0782, TTY: 1-800-735-2966.

Cox HealthPlans complies with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Cox HealthPlans and CoxHealth Network provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 844-563-0782, TTY: 1-800-735-2966, if you are not already a member. If you believe that Cox HealthPlans and CoxHealth Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or online with: Missouri Department of Insurance Financial Institutions & Professional Registration, P.O. Box 690, Jefferson City, MO 65102, fax: 573-526-4536, phone: 800-726-7390, online at www.insurance.mo.gov. If you need help filing a grievance, the Division of Consumer Affairs is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html