



 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 healthcare.gov or call 1-800-205-7665 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$5,000 person \$10,000 family in-network provider. <u>Out-of-network providers</u> not covered.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>Urgent Care</u> and Office Visit services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,250 person/ \$14,500 family. <u>Out-of-Network providers</u> not covered.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.thinkinghealthforward.com or call 1-800-869-1093 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 /office visit Deductible does not apply for office visit	Not covered	Copay covers services billed by the physician for the same date of service. Cost sharing does not apply for preventive services . 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.
	Specialist visit	\$45 copay /visit Deductible does not apply.	Not covered	
	Preventive care/screening/immunization	No Charge	No covered	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
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)	\$20 prescription retail and \$50 mail order Deductible does not apply.	Not covered	Medical deductible must be met first before Tier 3 & Tier 4 prescription retail services apply. 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 does not apply for preventive services .
	Preferred brand drugs (Tier 2)	\$45 prescription retail and \$112.50 mail order Deductible does not apply.	Not covered	
	Non-preferred brand drugs (Tier 3)	30% coinsurance	Not covered	
	Specialty drugs (Tier 4)	30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Certain outpatient procedures and/or therapies may have limitations and have a 50% penalty without required preauthorization . Cost sharing does not apply for preventative services .
	Physician/surgeon fees	30% coinsurance	Not covered	

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 immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit after <u>deductible</u> is met	\$150 <u>copay</u> /visit after <u>deductible</u> is met	Must meet <u>deductible</u> first on <u>emergency room care</u> .
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Urgent care	\$75 <u>copay</u> /visit	\$75 <u>copay</u> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	All Inpatient Services require <u>preauthorization</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	All Inpatient Services require <u>preauthorization</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /office visit <u>Deductible</u> does not apply for office visit and 30% <u>coinsurance</u> for other outpatient services.	Not covered	<u>Copay</u> covers services billed by the physician for the same date of service and includes two Mental Health sessions per calendar year for the diagnosis or assessment of Mental Illness to an <u>Out-of-Network Provider</u> acting within the scope of their license. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Inpatient services	30% <u>coinsurance</u>	Not Covered	All Inpatient Services require <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for <u>Out-of-Network providers</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you are pregnant	Office visits	30% <u>coinsurance</u>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not covered	All Inpatient Services require <u>preauthorization</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	

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	30% <u>coinsurance</u>	Not covered	100 visits per Benefit Year. 50% penalty may be applied without <u>preauthorization</u> .
	Rehabilitation services	30% <u>coinsurance</u>	Not covered	Physical Therapy & Occupational Therapy limited to 20 visits each per Benefit Year. Speech Therapy unlimited and requires <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for additional visits.
	Habilitation services	30% <u>coinsurance</u>	Not covered	Physical Therapy & Occupational Therapy limited to 20 visits each per Benefit Year. Speech Therapy unlimited and requires <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> for additional visits.
	Skilled nursing care	30% <u>coinsurance</u>	Not covered	Skilled nursing services, Physical Medicine and Rehabilitation limited to 150 inpatient days combined per Benefit Year. 50% penalty may be applied without <u>preauthorization</u> .
	Durable medical equipment	30% <u>coinsurance</u>	Not covered	50% penalty may be applied without <u>preauthorization</u> .
	Hospice services	30% <u>coinsurance</u>	Not covered	50% penalty may be applied without <u>preauthorization</u> .
If your child needs dental or eye care	Children's eye exam	30% <u>coinsurance</u>	Not Covered	Limited to one visit per calendar year for individuals up to 19 years of age.
	Children's glasses	30% <u>coinsurance</u>	Not Covered	Limited to one pair of standard eyeglass lenses or contact lenses per 1 standard frame every year for individuals up to 19 years of age. Requires <u>preauthorization</u> .
	Children's dental check-up	30% <u>coinsurance</u>	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](#))
- Hearing aids (Newborns)
- Non-emergency care when traveling outside the U.S.
- 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.coxhealthplans.com or call 800-205-7665. 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 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 1-800-205-7665. 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 (Español): Para obtener asistencia en Español, llame al 1-844-563-0782.

Tagalog (Tagalog): ung 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, kwijigo holne' 1-844-563-0782.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000	■ The plan's overall deductible	\$5,000
■ Specialist copayment	\$45	■ Specialist copayment	\$45	■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$5,000	Deductibles	\$900	Deductibles	\$2,500
Copayments	\$0	Copayments	\$1,000	Copayments	\$100
Coinsurance	\$2,300	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$7,360	The total Joe would pay is	\$1,920	The total Mia would pay is	\$2,600

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 goddo mo mballata, e yama dow Cox HealthPlans a woodi baawde hebuki habaru malla wallireeki wolde maada naa maa a yobii. 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.

Cox HealthPlans (ب خ صوص أسئلة ن ساعده شخص لى أو ل ديك ك ان إن الام ساعدة على الاح صول ن ي . الاحق ن ل ديك) ن كل نة لية دون جن ب لغ نك الا ضرورية والامع لومات ن كل نة لية دون جن ب لغ نك الا ضرورية والامع لومات (ب ا ن صول م نرجم مع ل نحدث 844-563-0782, TTY: 1-800-735-2966.

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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 helpscht, 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 سوال ، م ي كن پدك چك او به شكا كه ك سى يا شكا، انك ر مك دارى داي زرا حق باش پدداش نه ، Cox HealthPlans چورد دري انك ت راي گان طور هب را خود زب ان هب اطالعات و ك چك ن ماس 844-563-0782, TTY: 1-800-735-2966 ن م اي پد ح اصل

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 የፌዴራል ሲቪል መብቶችን መብት የሚያከብር ሲሆን ሰዎችን በዘር፡ በቆይታ ቀለም፣ በዘር ሃረግ፣ በእድሜ፣ በአካል ጉዳት ወይም በጾታ ማንኛውንም ሰው አያገልግም።844-563-0782, TTY: 1-800-735-2966.

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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>