Cox HealthPlans CoxHealth

Silver Preferred 16.2AI/AN Zero 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 healthcare 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	See the Common Medical Events charts below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount.
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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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	No charge	Not covered	----------None----------
	Specialist visit	No charge	No charge	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	No charge	Not covered	No cost sharing at in-network non-IHCP providers
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.thinkinghealthforward.com	Generic drugs (Tier 1)	No charge	No charge	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	No charge	No charge	Not covered	
	Non-preferred brand drugs (Tier 3)	No charge	No charge	Not covered	
	Specialty drugs (Tier 4)	No charge	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. No cost sharing at in-network non-IHCP providers.
	Physician/surgeon fees	No charge	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	----------None----------
	Emergency medical transportation	No charge	No charge	No charge	
	Urgent care	No charge	No charge	No charge	

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		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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	Preauthorization is required. If you don't get Preauthorization benefits could be reduced by 50% of the total cost of the service.No cost sharing at in-network IHCP providers.
	Physician/surgeon fees	No charge	No charge	Not covered	Preauthorization is required. If you don't get Preauthorization benefits could be reduced by 50% of the total cost of the service. No cost sharing at in-network IHCP providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Not covered	Preauthorization is required. 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.
	Inpatient services	No charge	No charge	Not covered	Preauthorization is required. 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.
If you are pregnant	Office visits	No charge	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. No cost sharing at in-network IHCP providers.
	Childbirth/delivery professional services	No charge	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. No cost sharing at in-network IHCP providers.
	Childbirth/delivery facility services	No charge	No charge	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	No charge	Not covered	100 visits per Benefit Year.
	Rehabilitation services	No Charge	No charge	Not covered	Physical Therapy & Occupational Therapy each limited to 20 visits per Benefit Year. Speech Therapy unlimited. No cost sharing at in-network non-IHCP providers.
	Habilitation services	No Charge	No charge	Not covered	Physical Therapy & Occupational Therapy each limited to 20 visits per Benefit Year. Speech Therapy unlimited. No cost sharing at in-network non-IHCP providers.
	Skilled nursing care	No Charge	No charge	Not covered	Skilled nursing, Physical Medicine, and Rehabilitation limited to 150 combined inpatient days per Benefit year. No cost sharing at in-network non-IHCP providers.
	Durable medical equipment	No Charge	No charge	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. No cost sharing at in-network non-IHCP providers.
	Hospice services	No Charge	No charge	Not covered	Preauthorization is required. No cost sharing at in-network non-IHCP providers.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Coverage limited to one exam per calendar year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No charge	No charge	Not covered	Coverage limited to one pair of glasses per calendar year. Cost sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	No charge	No charge	Not covered	One diagnostic exam every six months beginning before age one. Cost sharing waived at non-IHCP with IHCP referral.

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
- 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.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.

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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)

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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'sType 2 Diabetes
(a year of routine in-networkof a well-controlled conditiocna)re

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including diseaseeducation*)
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 an d follow up care)

The plan's overall deductible	$0
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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**

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 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.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Cox HealthPlans، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 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.

اگر شما، یا کسی که شما به او کمک می کنید، در مورد Cox HealthPlans، سؤال داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای صحبت با مترجم با 844-563-0782, TTY: 1-800-735-2966 تماس حاصل نمایید

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 ኣያገልም።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