Cox HealthPlans Silver Standard American Indian Individual EPO Plan Benefit Summary



The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. Benefits are limited to services provided by In-Network Providers, except for Emergency Services and certain Mental Health office sessions'.

Services provided by Out-of-Network Providers are not covered, except as specifically authorized. Please see the Covered Services section of your plan document for further information.

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Dutpatient Services	0%** Co-ins
-	150 Inpatient days per Benefit Year Combined
mergency Services	
	0%** Co-ins
Urgent Care Services	0%** Co-ins
Outpatient Surgery & Procedures	
Rehabilitation and Habilitative	0%** Co-ins
Physical Therapy and Manipulation Therapy*** Inot including Chiropractic Services) 20	0%** Co-ins
Dccupational Therapy*** 20	0%** Co-ins 0%** Co-ins
Speech Therapy	0%** Co-ins 0%** Co-ins risits per Benefit Year (not including Autism/Applied Behavioral Analysis)

Cardiac Rehabilitation	0%** Co-ins
	36 visits per Benefit Year
Pulmonary Rehabilitation	0%** Co-ins
, 	20 visits per Benefit Year
Chiropractic Services	0%** Co-ins
	Prior authorization required for office visits in excess of 26 per Benefit Year
Diagnostic Laboratory, Imaging and Radiology	0%** Co-ins
Home Health Care	0%** Co-ins
nome nearth Care	100 visits per Benefit Year
Private Duty Nursing	0%** Co-ins
	82 visits per Benefit Year, 164 visits Lifetime Maximum
Hospice	0%** Co-ins
Ambulance Services	0%** Co-ins
Educational Services	0%** Co-ins
Durable Medical Equipment	0%** Co-ins
Orthotics	0%** Co-ins
Disposable Medical Supplies	0%** Co-ins
Prosthetics	0%** Co-ins
Mental Health Services	
Mental Health Office Visit	\$0 Со-рау
Mental Health Services not received in an office setting	0%** Co-ins
Hospital Inpatient/Residential Treatment	0%** Co-ins
Substance Abuse	
Outpatient Annual Maximum Benefit (unlimited)	0%** Co-ins
Inpatient/Residential Annual Maximum (unlimited)	0%** Co-ins
Medical or Social Setting Detox Annual Max (unlimited)	0%** Co-ins
Dental Services (only related to accidental injury or for certain members requiring general anesthesia) 0%** Co-ins	
Pediatric Dental (dependent children through age 18)	
Dental Exam	0%** Co-ins
Basic Dental Care	0%** Co-ins
Major Dental Care	0%** Co-ins
Orthodontia (requires prior authorization)	0%** Co-ins
Pediatric Vision (dependent children through age 18)	070 CO IIIS
Routine Eye Exam (1 visit per Calendar Year)	0%** Co-ins
Eye Glasses (1 pair standard eyeglass lenses or contact lenses per Calendar Year)	070 00 ms
(1 standard frame per Calendar Year)	0%** Co-ins
Autism Services	Benefits are based on the setting in which Covered Services are Received ²
Applied Behavior Analysis (ABA)	
Requires prior authorization	0%** Co-ins
Pharmacy Services ³	Retail (30 day supply)
Deductible	\$0
Generic (most), Tier 1 (30 day supply)	\$0 Co-pay
Preferred Brand, Tier 2 (30 day supply)	\$0 Co-pay
Other Brand/Non-Formulary, Tier 3 (30 day supply)	0%** Co-ins
Specialty Formulary Brand/Non-Formulary, Tier 4 (30 day supply)	0%** Co-ins
Mail Order (90 day supply)	2.5×

* U&C is used as an abbreviation for Usual and Customary.

** Co-pays/ Co-insurance/ Costshare applies after Deductible is met.

***Co-pays/ Co-insurance/ Costshare for Physical Therapy or Occupational Therapy will not exceed the physician office visit once the Deductible is met.

Covered Services include 2 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.
 Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/ Co-pay/ Co-insurance/ Costshare than is applicable to other physical health care services, mental health, or substance abuse services covered by this Plan.

³ If a Provider, Pharmacy, or any third party payer waives, discounts, reduces, or indirectly pays the required cost sharing for a particular claim; the waived portion, discounted portion, reduced portion, or indirectly paid portion of the cost share will not apply to or reduce any Deductible or Out-of-Pocket applicable to the Plan.

This plan will not impose any financial requirement on Mental health or Substance use disorder benefits that is more restrictive than the predominant financial requirement that applies to substantially all Mental health or Substance use disorder benefits in the classification or sub-classification. This is only a brief summary of benefits which is not intended to be comprehensive. Your Individual Health Plan Policy is the governing document for benefit information.

All Plans Are Qualified Health Plans

(Plans Available Beginning: 1/1/2025)