Cox HealthPlans CoxHealth

Individual Silver 3500

Coverage for: Individual + Family | Plan Type: HDHP

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?	$3,500 person $7,000 family in-network provider. $7,000 person $14,000 family out-of-network provider.	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 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 in-network providers $4,000 person/ $8,000 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. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
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.	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
		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% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.
	Specialist visit	20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	50% coinsurance	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)	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)	20% coinsurance	50% coinsurance	You must meet the medical deductible first. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Certain drugs may have a 50% penalty applied without preauthorization. Mail order not covered for Tier 4 drugs. Cost sharing does not apply for preventive services.
	Preferred brand drugs (Tier 2)	20% coinsurance	50% coinsurance	
	Non-preferred brand drugs (Tier 3)	20% coinsurance	50% coinsurance	
	Specialty drugs (Tier 4)	20% coinsurance	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. Cost sharing does not apply for preventive services.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	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 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. Cost sharing does not apply for preventive services.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers. Cost sharing does not apply for preventive services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.
	Inpatient services	20% coinsurance	50% coinsurance	All Inpatient Services require preauthorization. 50% penalty may be applied without preauthorization for Out-of-Network providers. Cost sharing does not apply for preventive services.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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. Habilitation services are limited to 20 days per calendar year. 50% penalty may be applied without preauthorization.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 150 inpatient days per calendar year including Physical Medicine and Rehabilitation. 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
- 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 (Home Health setting only, 82 visits per benefit year, 164 visits 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: the Department of Health and Human Services at www.HHS.gov, or Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cms.gov/cciio. You may also contact Cox HealthPlans at www.coxhealthplans.com or call 1-800-205-7665. Other coverage options may be available to you also, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 Insurance at 1-800-726-7390 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform..

Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-726-7390.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax returns unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes.**
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.]

----------*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	$3,500
Specialist coinsurance	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	$2,800
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,060

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

The plan's overall deductible	$3,500
Specialist coinsurance	20%
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	$3,200
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$4,055

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

The plan's overall deductible	$3,500
Specialist coinsurance	20%
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	$1,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,925

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