

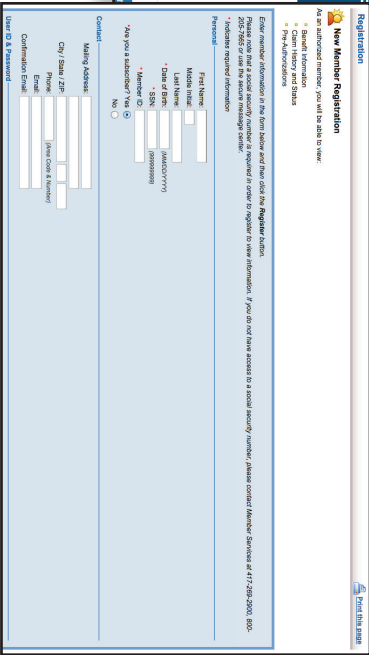
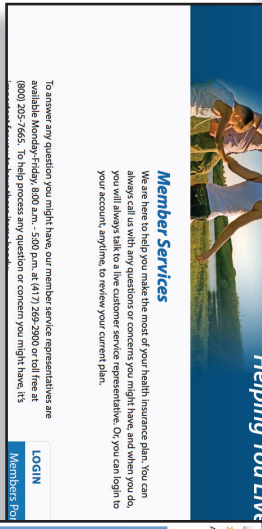
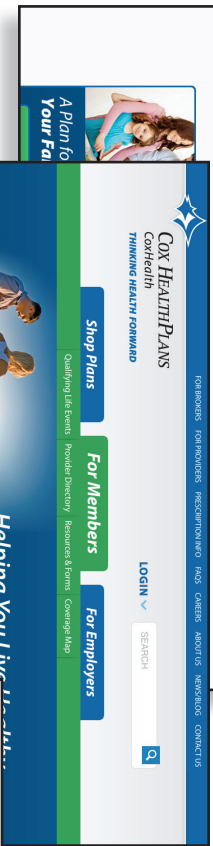


THINKING HEALTH FORWARD

Cox HealthPlans Member Online Access

Member Online Access provides you access to your plan 24 hours a day:

- Benefit Information/Schedule of Benefits
- Claims Status/Claims Payment information
- Identification card ordering and temporary card generation
- Benefit accumulations to date (Deductible/Coinsurance/Family totals)
- Provider search by specialty or by location
- Pre-Authorization information
- Secure messaging to/from CHP



How to Access Your Member Online Access:

• Go to the "For Members" page at CoxHealthPlans.com/for-members to register your account. Once you are registered, you can login to find all of your information. Please have the following information ready for your initial registration:


- Member ID
- Social Security Number
- Date of Birth





EPO HDHP 100

Coverage for: Employee + 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 1-800-205-7665 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 ?	\$4,000 person/ \$8,000 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 deductible ?	Yes. <u>Preventive care</u> 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	\$4,000 person/ \$8,000 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 out-of-pocket limit ?	<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 network provider ?	Yes. See www.coxhealthplans.com or call 1-800-205-7665 for a list of in- <u>network providers</u> .	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 referral to see a specialist ?	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	0% coinsurance	Not covered	Cost sharing does not apply for preventive services .
	Specialist visit	0% coinsurance	Not covered	
	Preventive care/screening/immunization	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)	0% coinsurance	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	0% 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)	0% coinsurance	Not covered	Must meet medical deductible first. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order for maintenance medications only). 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)	0% coinsurance	Not covered	
	Non-preferred brand drugs (Tier 3)	0% coinsurance	Not covered	
	Specialty drugs (Tier 4)	0% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% 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 preventive services .
	Physician/surgeon fees	0% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	-----None-----
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	0% coinsurance	0% 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)	0% <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	0% <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	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Covered services include 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	0% <u>coinsurance</u>	Not covered	All Inpatient Services requires <u>preauthorization</u> . <u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you are pregnant	Office visits	0% <u>coinsurance</u>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>preventive services</u>
	Childbirth/delivery professional services	0% <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). <u>Cost sharing</u> does not apply for <u>preventive services</u>
	Childbirth/delivery facility services	0% <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). <u>Cost sharing</u> does not apply for <u>preventive services</u>

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	0% <u>coinsurance</u>	Not covered	50% penalty may be applied without <u>preauthorization</u> .
	Rehabilitation services	0% <u>coinsurance</u>	Not covered	Physical Therapy, Occupational Therapy, & Speech Therapy each limited to 60 days per calendar year. Physical/Occupational require <u>preauthorization</u> for home visits. All Speech Therapy requires <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> .
	Habilitation services	0% <u>coinsurance</u>	Not covered	Applied behavior analysis (BCBA, BCaBA specialties only) requires <u>preauthorization</u> . 50% penalty may be applied without <u>preauthorization</u> .
	Skilled nursing care	0% <u>coinsurance</u>	Not covered	50% penalty may be applied without <u>preauthorization</u> .
	Durable medical equipment	0% <u>coinsurance</u>	Not covered	50% penalty may be applied without <u>preauthorization</u> .
	Hospice services	0% <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	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing (Home Health setting only, 82 visits per benefit year, 164 visits lifetime) 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Chiropractic care (26 visits per calendar year without <u>preauthorization</u>) 	<ul style="list-style-type: none"> • Hearing aids (newborns) 	

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 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 1-800-205-7665. 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? 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 (Español): Para obtener asistencia en Español, 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.

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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	\$4,000	■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000
■ Specialist coinsurance	0%	■ Specialist coinsurance	0%	■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%
■ 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	\$4,000	Deductibles	\$4,000	Deductibles	\$2,800
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	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	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$4,060	The total Joe would pay is	\$4,060	The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.