COX HEALTHPLANS
CoxHealth

Benefit Summary
Cox Health Systems Insurance Company
for Ozark Schools
EPO Group Health Plan

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, Urgent Care Services and certain Mental Health office sessions[1]. 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.

HDHP

Covered Services	In-Network
Essential Health Benefits	Unlimited
Lifetime Maximum Benefit	Unlimited
Deductible	
Per Covered Person	$4,000
Per Family	$8,000
Annual Maximum Out-of-Pocket	**(Including all Deductibles, Coinsurance and Copays)**
Per Covered Person	$4,000
Per Family	$8,000
Physician Services	**Copay covers the physician consultation fee. All other services subject to deductible and coinsurance.**
Primary Care Physician (PCP) Office Visit/Telemedicine	0%* Coins
Specialty Care Physician (SCP) Office Visit/Telemedicine	0%* Coins
Physician Services not received in an office setting	0%* Coins
Diagnostic Laboratory, Imaging and Radiology	0%* Coins
Inpatient Hospitalization	0%* Coins
Outpatient Hospital Services	0%* Coins
Hospital Emergency Room Services	0%* Coins
Urgent Care Facility	0%* Coins
Urgent Care Physician Services	0%* Coins
Emergency Ambulance Services	0%* Coins
Maternity & Childbirth Expenses	0%* Coins
Preventive Health Services (Ages 0 to adult)	
Services with an "A" or "B" rating from the U.S. Preventive Services Task Force as mandated by PHSA Section 2713	$0
Additional preventive services or treatments not mandated by PHSA Section 2713	0%* Coins
Preventive Health Services for Children and Adolescents	
Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration	$0
Physician office visits and laboratory tests associated with preventive checkups	$0
Preventive Services for Adults	
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0
Immunizations Ages 0 to Adult (per immunization)	
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713, and as specified by the MO Department of Health and Senior Services regulations	$0
Additional immunizations not mandated by PHSA Section 2713, or the MO Department of Health and Senior Services regulations	0%* Coins
Home Health Care	0%* Coins
Skilled Nursing Facility	0%* Coins
Hospice Care	0%* Coins
Durable Medical Equipment	0%* Coins

Covered Services	In-Network	
Disposable Medical Supplies	0%* Coins	
Prosthetics	0%* Coins	
Orthotics	0%* Coins	
Chiropractic Services (Spinal Manipulation)	**Prior Authorization required for office visits in excess of 26 per benefit year**	
Office Visit	0%* Coins	
Other Services	0%* Coins	
Therapy Services (Not Including Chiropractic Services)****		
Physical Therapy	0%* Coins Annual Benefit of 60 visits (not including Applied Behavioral Analysis)	
Occupational Therapy	0%* Coins Annual Benefit of 60 visits (not including Applied Behavioral Analysis)	
Speech Therapy	0%* Coins Annual Benefit of 60 visits (not including Applied Behavioral Analysis)	
Autism Spectrum Disorder (ASD) Services	**Benefits are based on the setting in which Covered Services are Received *******	
No limit to the number of visits for prior authorized ASD Services. The Therapy Services Annual Benefit of 60 visits does not apply to Autism Spectrum Disorder.		
Applied Behavior Analysis (ABA), Required prior authorization	0%* Coins	
No limit to the number of visits for prior authorized ABA. The Therapy Services Annual Benefit of 60 visits does not apply to Applied Behavioral Analysis.		
Dental Services (only related to accidental injury or for certain members requiring general anesthesia)	0%* Coins	
Mental Illness/Substance Use Disorder Services		
Office Visit[1]	0%* Coins	
Other Services	0%* Coins	
Outpatient Treatment	0%* Coins	
Hospital Inpatient Treatment	0%* Coins	
Residential Treatment	0%* Coins	
Covered Education	0%* Coins	
Outpatient Prescription Drugs******	**Retail (30 day supply)**	**Mail*****
Prescription Drug Deductible	$4,000 Medical Deductible	
Tier 1 - Most Generics (30 day supply)	0%* Coins	0%* Coins
Tier 2 - Preferred Brand (30 day supply)	0%* Coins	0%* Coins
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	0%* Coins	0%* Coins
Tier 4 - Specialty Formulary Brand (30 day supply)	0%* Coins	Not available
Tier 5 - Preventive	$0	$0

[1] 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.

* Coinsurance applies after Deductible is met.

** MAA is used as an abbreviation for Maximum Allowable Amount.

*** Mail order available on maintenance medications only for a 90 day supply (Copay will be 2.5x Retail)

****Copays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

***** Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible/Co-pay/Co-insurance than is applicable to other physical health care services covered by this Plan.

****** 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 is only a brief summary of benefits, which is not intended to be comprehensive. Your Certificate of Coverage is the governing document for benefit information.