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)

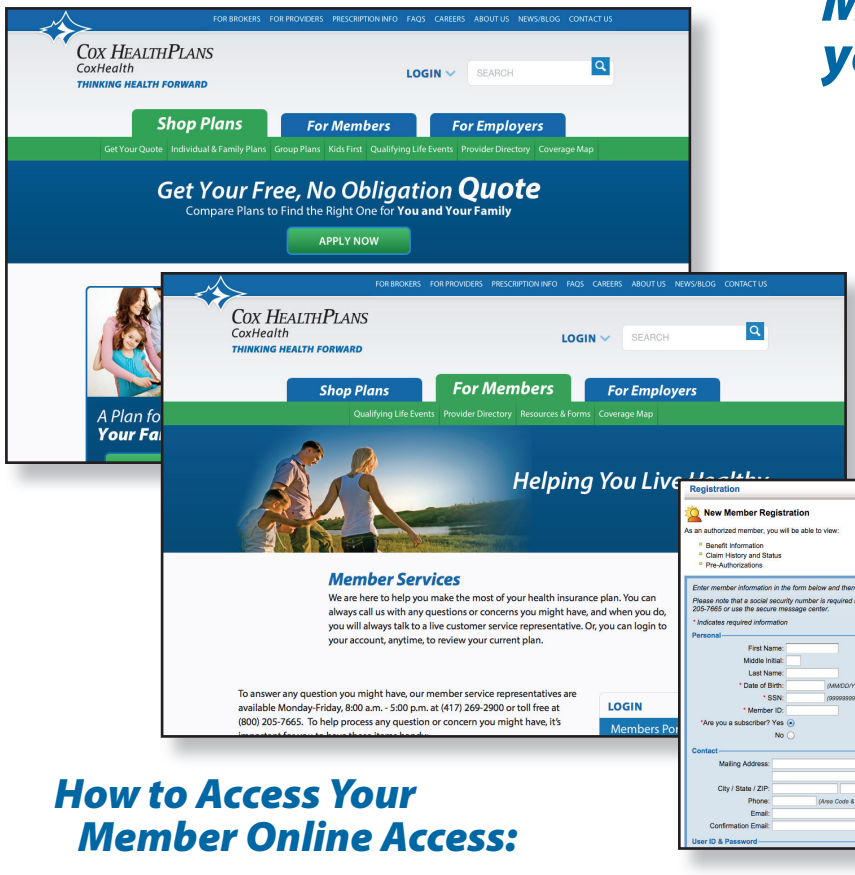
****Copays/Coinsurance for Physical Therapy will not exceed the physician office visit once the deductible is met.

***** 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.

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

Cox HealthPlans CoxHealth

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 https://www.healthcare.gov/sbc-glossary/ 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. Out-of-network providers not covered.	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?	$4,000 person/ $8,000 family. Out-of-Network providers not covered.	The out-of-pocket limit is the most you could pay in a year for 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-billing 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	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% coinsurance	Not covered	All Inpatient Services require preauthorization. Cost sharing does not apply for preventive services.
	Physician/surgeon fees	0% coinsurance	Not covered	All Inpatient Services require preauthorization. Cost sharing does not apply for preventive services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	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. Cost sharing does not apply for preventive services.
	Inpatient services	0% coinsurance	Not covered	All Inpatient Services requires preauthorization. Cost sharing does not apply for preventive services.
If you are pregnant	Office visits	0% coinsurance	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
	Childbirth/delivery professional services	0% coinsurance	Not covered	All Inpatient Services require preauthorization. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services
	Childbirth/delivery facility services	0% coinsurance	Not covered	

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% coinsurance	Not covered	50% penalty may be applied without preauthorization.
	Rehabilitation services	0% coinsurance	Not covered	Physical Therapy, Occupational Therapy, & Speech Therapy each limited to 60 days per calendar year. Physical/Occupational require preauthorization for home visits. All Speech Therapy requires preauthorization. 50% penalty may be applied without preauthorization.
	Habilitation services	0% coinsurance	Not covered	Applied behavior analysis (BCBA, BCaBA specialties only) requires preauthorization. 50% penalty may be applied without preauthorization.
	Skilled nursing care	0% coinsurance	Not covered	50% penalty may be applied without preauthorization.
	Durable medical equipment	0% coinsurance	Not covered	50% penalty may be applied without preauthorization.
	Hospice services	0% coinsurance	Not covered	50% penalty may be applied without preauthorization.
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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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)
- 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 (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.

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	$4,000
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	$4,000
Copayments	$0
Coinsurance	$0
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	$4,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$4,060

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

The plan's overall deductible	$4,000
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

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