COX HEALTHPLANS
CoxHealth

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

## Partners 80

| Covered Services | In-Network | Out-Of-Network |
|---|---|---|
| **Essential Health Benefits** | Unlimited | |
| **Lifetime Maximum Benefit** | Unlimited | |
| **Deductible** | | |
| Per Covered Person | $1,500 | $3,000 |
| Per Family | $4,500 | $9,000 |
| **Annual Maximum Out-of-Pocket** | **(Including all Deductibles, Coinsurance and Copays)** | |
| Per Covered Person | $4,000 | $9,250 |
| Per Family | $9,500 | $21,500 |
| **Physician Services** | **Copay covers the physician consultation fee. All other services subject to deductible and coinsurance.** | |
| Primary Care Physician (PCP) Office Visit/Telemedicine (NON-INCLUSIVE) | $30 Copay | 50%* Coins MAA** |
| Specialty Care Physician (SCP) Office Visit/Telemedicine (NON-INCLUSIVE) | $30 Copay | 50%* Coins MAA** |
| Physician Services not received in an office setting | 20%* Coins | 50%* Coins MAA** |
| **Diagnostic Laboratory, Imaging and Radiology** | 20%* Coins | 50%* Coins MAA** |
| **Inpatient Hospitalization** | 20%* Coins | 50%* Coins MAA** |
| **Outpatient Hospital Services** | 20%* Coins | 50%* Coins MAA** |
| **Hospital Emergency Room Services** | $200 Copay | |
| **Urgent Care Facility** | $75 Copay | 50%* Coins MAA** |
| **Urgent Care Physician Services** | $75 Copay | 50%* Coins MAA** |
| **Emergency Ambulance Services** | 20%* Coins | |
| **Maternity & Childbirth Expenses** | 20%* Coins | 50%* Coins MAA** |
| **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 | 50%* Coins MAA** |
| Additional preventive services or treatments not mandated by PHSA Section 2713 | 20%* Coins | 50%* Coins MAA** |
| **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 | 50%* Coins MAA** |
| Physician office visits and laboratory tests associated with preventive checkups | $0 | 50%* Coins MAA** |
| **Preventive Services for Adults** | | |
| Preventive care and screenings for women supported by the Health Resources and Services Administration | $0 | 50%* Coins MAA** |
| **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 | $12 Copay |
| Additional immunizations not mandated by PHSA Section 2713, or the MO Department of Health and Senior Services regulations | $12 Copay | $12 Copay |
| **Home Health Care** | 20%* Coins | 50%* Coins MAA** |
| **Skilled Nursing Facility** | 20%* Coins | 50%* Coins MAA** |
| **Hospice Care** | 20%* Coins | 50%* Coins MAA** |
| **Durable Medical Equipment** | 20%* Coins | 50%* Coins MAA** |
| **Disposable Medical Supplies** | 20%* Coins | 50%* Coins MAA** |
| **Prosthetics** | 20%* Coins | 50%* Coins MAA** |
| **Orthotics** | 50%* Coins | 50%* Coins MAA** |
| **Chiropractic Services (Spinal Manipulation)** | **Prior Authorization required for office visits in excess of 26 per benefit year** | |
| Office Visit | $30 Copay | 50%* Coins MAA** |
| Other Services | 20%* Coins | 50%* Coins MAA** |

| Covered Services | In-Network | | Out-Of-Network |
|---|---|---|---|
| **Therapy Services (Not Including Chiropractic Services)****** | | | |
| Physical Therapy | 20%* Coins | | 50%* Coins MAA** |
| | Annual Benefit of 60 visits (not including Applied Behavioral Analysis) | | |
| Occupational Therapy | 20%* Coins | | 50%* Coins MAA** |
| | Annual Benefit of 60 visits (not including Applied Behavioral Analysis) | | |
| Speech Therapy | 20%* Coins | | 50%* Coins MAA** |
| | 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), Requires prior authorization** | 20%* Coins | | 50%* Coins MAA** |
| 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) | 20%* Coins | | 50%* Coins MAA** |
| **Mental Illness/Substance Use Disorder Services** | | | |
| Office Visit | $30 Copay | | 50%* Coins MAA** |
| Other Services | 20%* Coins | | 50%* Coins MAA** |
| Outpatient Treatment | 20%* Coins | | 50%* Coins MAA** |
| Hospital Inpatient Treatment | 20%* Coins | | 50%* Coins MAA** |
| Residential Treatment | 20%* Coins | | 50%* Coins MAA** |
| **Covered Education** | 20%* Coins | | 50%* Coins MAA** |
| **Outpatient Prescription Drugs******** | **Retail (30 day supply)** | **Mail***** | **Out-Of-Network** |
| Prescription Drug Deductible | $100 Deductible | | |
| Tier 1 - Most Generics (30 day supply) | $10 Copay | 2.5 x Retail Copay | 50%* Coins MAA** |
| Tier 2 - Preferred Brand (30 day supply) | $35 Copay | 2.5 x Retail Copay | 50%* Coins MAA** |
| Tier 3 - Non-Preferred Formulary Brand (30 day supply) | $75 Copay | 2.5 x Retail Copay | 50%* Coins MAA** |
| Tier 4 - Specialty Formulary Brand (30 day supply) | $100 Copay | Not available | Not available |
| Tier 5 - Preventive | $0 | $0 | Not available |

* Coinsurance applies after Deductible is met.

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

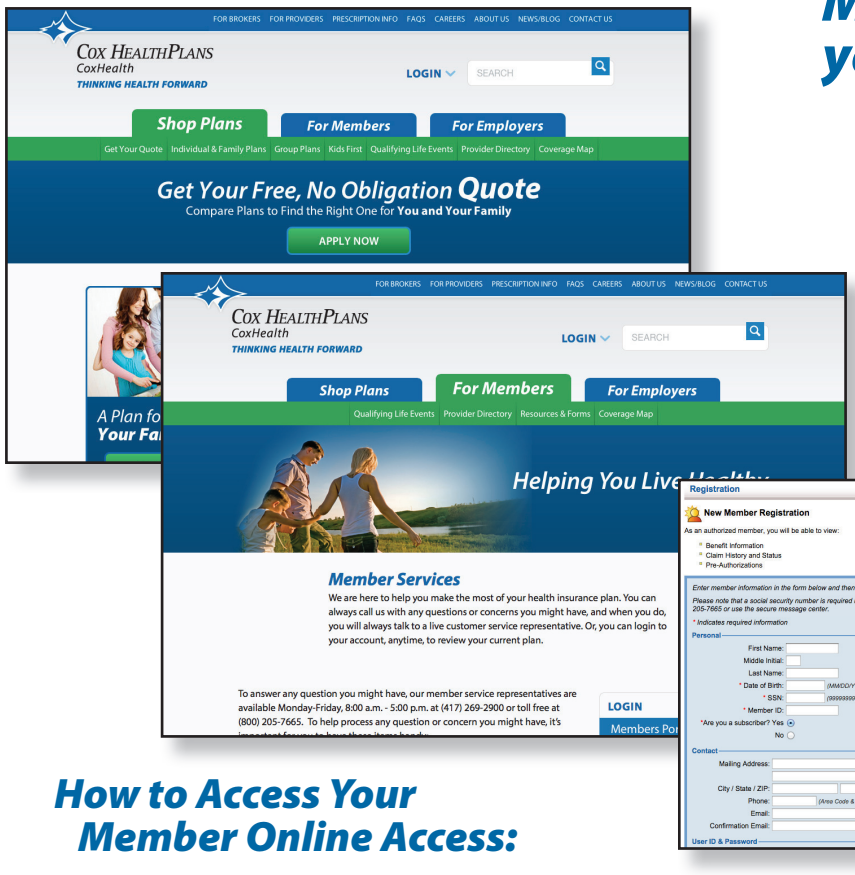
*** Mail order available on maintenance medications only for a 90 day supply (Copay will be 2.5x Retail)

****Copays/Coinsurance for Physical Therapy and Occupational 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.

# 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

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**Coverage for:** Employee + Family | **Plan Type:** PPO

**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? | $1,500 person/ $4,500 family in-network provider. $3,000 person $9,000 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, Emergency Room, Urgent Care and Office Visit 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? | Yes. $100 for prescription drug coverage. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For in-network providers $4,000 person/ $9,500 family. For out-of-network providers $9,250 person/ $21,500 family | 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 | $30 copay/visit Deductible does not apply. | 50% coinsurance | Cost sharing does not apply for preventive services. |
| | Specialist visit | $30 copay/visit Deductible does not apply. | 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) | $10 prescription retail and $25 mail order | 50% coinsurance | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order for maintenance medications only). Mail order not covered for Tier 4 drugs. Certain drugs may have a 50% penalty without preauthorization. Cost sharing does not apply for preventive services. |
| | Preferred brand drugs (Tier 2) | $35 prescription retail and $87.50 mail order | 50% coinsurance | |
| | Non-preferred brand drugs (Tier 3) | $75 prescription retail and $187.50 mail order | 50% coinsurance | |
| | Specialty drugs (Tier 4) | $100 prescription retail | 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 | |

| 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 immediate medical attention | Emergency room care | $200 copay/visit | $200 copay/visit | ----------None---------- |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | $75 copay/visit Deductible does not apply. | 50% coinsurance | |
| 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 | $30 Mental Health copay/office visit Deductible does not apply for office visit and 20% coinsurance for other outpatient services. | 50% coinsurance | 50% penalty may be applied without preauthorization. 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. Cost sharing does not apply for preventive services. |

| 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 are pregnant | Office visits | 20% coinsurance | 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of services, coinsurance may apply. Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | All Inpatient Services require preauthorization. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | 50% penalty may be applied without preauthorization. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | 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 the required preauthorization. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | Applied behavior analysis (BCBA, BCaBA specialties only) requires preauthorization. 50% penalty may be applied without preauthorization. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | 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 | 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
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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)
- Cosmetic surgery (with preauthorization)
- Hearing aids
- Non-emergency care when traveling outside the U.S.

**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 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 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.

**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 | $1,500 |
| Specialist copayment | $30 |
| 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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $2,500 |
| *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 | $1,500 |
| Specialist copayment | $30 |
| 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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $1,000 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | $3,060 |

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $30 |
| 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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments | $90 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,190 |

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