Ozark School District

Effective Date: 7/1/2025

Carrier	Cox Health Plans (CHP)		Cox Health Plans (CHP)		Cox Health Plans (CHP)		Cox Health Plans (CHP)	
Plan Name	H S A $4,000 ***(EPO Network)***		H S A $4,000 ***(PPO Network)***		Partners 80 $3,000		Partners 80 $1,500	
Network	CHP EPO (Cox/Barnes BJC Only)		CHP PPO/First Health Network		CHP PPO/First Health Network		CHP PPO/First Health Network	
Deductible								
In-network individual (family)	$4,000 ($8,000)		$4,000 ($8,000)		$3,000 ($6,000)		$1,500 ($4,500)	
Out-of-network individual (family)	$8,000 ($16,000)		$8,000 ($16,000)		$6,000 ($12,000)		$3,000 ($9,000)	
Co-insurance								
In-network	100%		100%		80%		80%	
Out-of-network	70%		70%		50%		50%	
In-network out-of-pocket maximum (includes deductible)								
Individual (family)	$4,000 ($8,000)		$4,000 ($8,000)		$6,000 ($12,000)		$4,000 ($9,500)	
Doctor co-pay								
Primary care	Deductible		Deductible		$30		$30	
Specialist	Deductible		Deductible		$30		$30	
Lab								
Physician's Office	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance	
Facility/Hospital	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance	
X-ray *Except complex high dollar radiology*								
Physician's Office	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance	
Facility/Hospital	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance	
Preventive care								
In-network	100% for Federally Mandated Services		100% for Federally Mandated Services		100% for Federally Mandated Services		100% for Federally Mandated Services	
Urgent Care	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		$75		$75	
ER	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		$200		$200	
Prescription drug								
Retail (up to 30 day supply)	Subject to Deductible & Coinsurance		Subject to Deductible & Coinsurance		$10/$35/$75/$100 after $100 Rx Deductible		$10/$35/$75/$100 after $100 Rx Deductible	
Remarks	***Preventive RX at No Cost***		***Preventive RX at No Cost***					
IMPORTANT: THE HSA EPO PLAN OPTION WILL ONLY COVER EMERGENCY AND URGENT CARE SERVICES IF RENDERED OUT OF THE EPO SPECIFIC NETWORK								
Monthly Rates - 7/1/2025-12/31/2025	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE
HSA Contribution/Month	$99		$35		Not Applicable		Not Applicable	
EE Only	**$0**	$575	**$0**	$639	**$0**	$674	**$37**	$711
EE + Spouse	**$604**	$1,179	**$671**	$1,310	**$708**	$1,382	**$785**	$1,459
EE + Child(ren)	**$401**	$976	**$446**	$1,085	**$472**	$1,146	**$536**	$1,210
Family	**$1,091**	$1,666	**$1,213**	$1,852	**$1,279**	$1,953	**$1,387**	$2,061
IMPORTANT: THE HSA EPO PLAN OPTION WILL ONLY COVER EMERGENCY AND URGENT CARE SERVICES IF RENDERED OUT OF THE EPO SPECIFIC NETWORK								
Monthly Rates - 1/1/2026-12/31/2026	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE	EE COST	PREMIUM/RETIREE
HSA Contribution/Month	$106		$37		Not Applicable		Not Applicable	
EE Only	**$0**	$618	**$0**	$687	**$0**	$724	**$41**	$765
EE + Spouse	**$649**	$1,267	**$721**	$1,408	**$761**	$1,485	**$844**	$1,568
EE + Child(ren)	**$432**	$1,050	**$479**	$1,166	**$508**	$1,232	**$576**	$1,300
Family	**$1,173**	$1,791	**$1,303**	$1,990	**$1,375**	$2,099	**$1,492**	$2,216

The benefits noted above are a summary only. Refer to the quotes and/or benefit summaries for detailed plan benefits.