COX HEALTHPLANS
CoxHealth

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

Partners 80 $3000 | PPO

Covered Services	In-Network	Out-Of-Network
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible		
Per Covered Person	$3,000	$6,000
Per Family	$6,000	$12,000
Annual Maximum Out-of-Pocket	**(Including all Deductibles, Coinsurance and Copays)**	
Per Covered Person	$6,000	$12,000
Per Family	$12,000	$24,000
Physician Services	**Copay includes services billed by physician on same date of service. All other services subject to Deductible and Coinsurance**	
Primary Care Physician (PCP) Office Visit/Telemedicine (INCLUSIVE)	$30 Copay	50%* Coins MAA**
Specialty Care Physician (SCP) Office Visit/Telemedicine (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 (INCLUSIVE - covers services billed by physician)	$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 (INCLUSIVE - covers services billed by physician)	$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		
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.

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.