COX HEALTHPLANS
CoxHealth

Benefit Summary
Cox Health Systems Insurance Company
for Ozarks Technical Community College
PPO Group Health Plan

Partners 80 (Base Plan)

Covered Services	In-Network	Out-Of-Network
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible		
Per Covered Person	$1,000	$1,000
Per Family	$2,000	$2,000
Annual Maximum Out-of-Pocket	**(Including all Deductibles, Coinsurance and Copays)**	
Per Covered Person	$3,000	$5,000
Per Family	$6,000	$10,000
Physician Services		
Primary Care Physician (PCP) Office Visit	20%* Coins	40%* Coins U&C**
Specialty Care Physician (SCP) Office Visit	20%* Coins	40%* Coins U&C**
Physician eVisit	20%* Coins	40%* Coins U&C**
Physician Telehealth Visit	20%* Coins	40%* Coins U&C**
Physician Services not received in an office setting	20%* Coins	40%* Coins U&C**
Diagnostic Laboratory, Imaging and Radiology	20%* Coins	40%* Coins U&C**
Inpatient Hospitalization	20%* Coins	40%* Coins U&C**
Outpatient Hospital Services	20%* Coins	40%* Coins U&C**
Hospital Emergency Room Services	$200 Copay	
Urgent Care Facility	$100 Copay	40%* Coins U&C**
Urgent Care Physician Services	$100 Copay	40%* Coins U&C**
Emergency Ambulance Services	20%* Coins	
Maternity & Childbirth Expenses	20%* Coins	40%* Coins U&C**
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	40%* Coins U&C**
Additional preventive services or treatments not mandated by PHSA Section 2713	20%* Coins	40%* Coins U&C**
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	40%* Coins U&C**
Physician office visits and laboratory tests associated with preventive checkups	$0	40%* Coins U&C**
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	40%* Coins U&C**
Immunizations Ages 0 to Adult (per immunization)		
As recommended by Advisory Committee on Immunization Practices of the CDC as mandated by PHSA Section 2713	$0	$12 Copay
Additional immunizations not mandated by PHSA Section 2713	$12 Copay	$12 Copay
Home Health Care	20%* Coins	40%* Coins U&C**
Skilled Nursing Facility	20%* Coins	40%* Coins U&C**
Hospice Care	20%* Coins	40%* Coins U&C**
Durable Medical Equipment	20%* Coins	40%* Coins U&C**
Disposable Medical Supplies	20%* Coins	40%* Coins U&C**
Prosthetics	20%* Coins	40%* Coins U&C**
Orthotics	40%* Coins	40%* Coins U&C**
Chiropractic Services (Spinal Manipulation)	**Prior Authorization required for office visits in excess of 26 per benefit year**	
Office Visit	20%* Coins	40%* Coins U&C**
Other Services	20%* Coins	40%* Coins U&C**

Covered Services	In-Network		Out-Of-Network
Therapy Services (Not Including Chiropractic Services)****			
Physical Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
Occupational Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
Speech Therapy	20%* Coins		40%* Coins U&C**
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)		
Autism Services	**Benefits are based on the setting in which Covered Services are Received *******		
Applied Behavior Analysis (ABA)	20%* Coins		40%* Coins U&C**
(dependent children through age 18)	Requires prior authorization		
Dental Anesthesia	20%* Coins		40%* Coins U&C**
Mental Illness/Substance Use Disorder Services			
Office Visit	20%* Coins		40%* Coins U&C**
Other Services	20%* Coins		40%* Coins U&C**
Outpatient Treatment	20%* Coins		40%* Coins U&C**
Hospital Inpatient Treatment	20%* Coins		40%* Coins U&C**
Residential Treatment	20%* Coins		40%* Coins U&C**
Covered Education	20%* Coins		40%* Coins U&C**
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	40%* Coins U&C**
Tier 2 - Preferred Brand (30 day supply)	$30 Copay	2.5 x Retail Copay	40%* Coins U&C**
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	$50 Copay	2.5 x Retail Copay	40%* Coins U&C**
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.

** U&C is used as an abbreviation for Usual and Customary.

*** 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.

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.

"You Pay"	
EE	**$0.00**
ES	**$546.00**
EC	**$203.00**
FA	**$778.05**