COX HEALTHPLANS
CoxHealth

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

HDHP 80

Covered Services	In-Network	Out-Of-Network
Essential Health Benefits	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Deductible (non-embedded: Individuals with Family coverage are subject to the Family deductible before Single coinsurance applies**)**		
Per Covered Person	$1,650 (EO) / $3,300 (ES/EC/FA)	$3,300 EO) / $6,600 (ES/EC/FA)
Per Family	$3,300	$6,600
Annual Maximum Out-of-Pocket (embedded)	**(Including all Deductibles and Coinsurance)**	
Per Covered Person	$5,000	$10,000
Per Family	$10,000	$20,000
Physician Services		
Primary Care Physician (PCP) Office Visit/Telemedicine	20%* Coins	40%* Coins MAA**
Specialty Care Physician (SCP) Office Visit/Telemedicine	20%* Coins	40%* Coins MAA**
Physician Services not received in an office setting	20%* Coins	40%* Coins MAA**
Diagnostic Laboratory, Imaging and Radiology	20%* Coins	40%* Coins MAA**
Inpatient Hospitalization	20%* Coins	40%* Coins MAA**
Outpatient Hospital Services	20%* Coins	40%* Coins MAA**
Hospital Emergency Room Services	20%* Coins	
Urgent Care Facility	20%* Coins	40%* Coins MAA**
Urgent Care Physician Services	20%* Coins	40%* Coins MAA**
Emergency Ambulance Services	20%* Coins	
Maternity & Childbirth Expenses	20%* Coins	40%* 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	40%* Coins MAA**
Additional preventive services or treatments not mandated by PHSA Section 2713	20%* Coins	40%* 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	40%* Coins MAA**
Physician office visits and laboratory tests associated with preventive checkups	$0	40%* Coins MAA**
Preventive Services for Adults		
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0	40%* 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	40%* Coins MAA**
Additional immunizations not mandated by PHSA Section 2713, or the MO Department of Health and Senior Services regulations	20%* Coins	40%* Coins MAA**
Home Health Care	20%* Coins	40%* Coins MAA**
Skilled Nursing Facility	20%* Coins	40%* Coins MAA**
Hospice Care	20%* Coins	40%* Coins MAA**
Durable Medical Equipment	20%* Coins	40%* Coins MAA**
Disposable Medical Supplies	20%* Coins	40%* Coins MAA**
Prosthetics	20%* Coins	40%* Coins MAA**
Orthotics	20%* Coins	40%* Coins MAA**
Chiropractic Services (Spinal Manipulation)	**Prior Authorization required for office visits in excess of 26 per benefit year**	
Office Visit	20%* Coins	40%* Coins MAA**
Other Services	20%* Coins	40%* Coins MAA**

Covered Services	In-Network		Out-Of-Network
Therapy Services (Not Including Chiropractic Services)****	**Annual Benefit of 60 visits (not including Applied Behavioral Analysis)**		
Physical Therapy	20%* Coins		40%* Coins MAA**
Occupational Therapy	20%* Coins		40%* Coins MAA**
Speech Therapy	20%* Coins		40%* Coins MAA**
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		40%* 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		40%* Coins MAA**
Mental Illness/Substance Use Disorder Services			
Office Visit	20%* Coins		40%* Coins MAA**
Other Services	20%* Coins		40%* Coins MAA**
Outpatient Treatment	20%* Coins		40%* Coins MAA**
Hospital Inpatient Treatment	20%* Coins		40%* Coins MAA**
Residential Treatment	20%* Coins		40%* Coins MAA**
Covered Education	20%* Coins		40%* Coins MAA**
Outpatient Prescription Drugs******	**Retail (30 day supply)**	**Mail*****	**Out-Of-Network**
Prescription Drug Deductible	$1,600 Medical Deductible		
Tier 1 - Most Generics (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 2 - Preferred Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	20%* Coins	20%* Coins	40%* Coins MAA**
Tier 4 - Specialty Formulary Brand (30 day supply)	20%* Coins	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.

You have enrolled in the High Deductible Health Plan with a Non-Embedded deductible.

If you have single member coverage, you are subject to the deductible in the "Per Covered Person" line on the Schedule of Benefits. Coverage for two or more members is subject to the deductible indicated in the "Per Family" line on the Schedule of benefits. The "Per Family" deductible must be met before coinsurance will apply for any member.

If you or your providers of service have questions regarding your benefits, please contact our Member Service Department at (417)269-2900 or (800)205-7665 for assistance.