EPO Benefit Summary / Network Information

COX HEALTHPLANS
CoxHealth

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

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. Benefits are limited to services provided by In-Network Providers, except for Emergency Services, Urgent Care Services and certain Mental Health office sessions[1]. Services provided by Out-of-Network Providers are not covered, except as specifically authorized. Please see the Covered Services section of your plan document for further information.

HDHP

Covered Services	In-Network
Essential Health Benefits	Unlimited
Lifetime Maximum Benefit	Unlimited
Deductible	
Per Covered Person	$4,000
Per Family	$8,000
Annual Maximum Out-of-Pocket	**(Including all Deductibles, Coinsurance and Copays)**
Per Covered Person	$4,000
Per Family	$8,000
Physician Services	**Copay covers the physician consultation fee. All other services subject to deductible and coinsurance.**
Primary Care Physician (PCP) Office Visit/Telemedicine	0% after deductible
Specialty Care Physician (SCP) Office Visit/Telemedicine	0% after deductible
Physician Services not received in an office setting	0% after deductible
Diagnostic Laboratory, Imaging and Radiology	0% after deductible
Inpatient Hospitalization	0% after deductible
Outpatient Hospital Services	0% after deductible
Hospital Emergency Room Services	0% after deductible
Urgent Care Facility	0% after deductible
Urgent Care Physician Services	0% after deductible
Emergency Ambulance Services	0% after deductible
Maternity & Childbirth Expenses	0% after deductible
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
Additional preventive services or treatments not mandated by PHSA Section 2713	0% after deductible
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
Physician office visits and laboratory tests associated with preventive checkups	$0
Preventive Services for Adults	
Preventive care and screenings for women supported by the Health Resources and Services Administration	$0
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
Additional immunizations not mandated by PHSA Section 2713, or the MO Department of Health and Senior Services regulations	0% after deductible
Home Health Care	0% after deductible
Skilled Nursing Facility	0% after deductible
Hospice Care	0% after deductible
Durable Medical Equipment	0% after deductible

Covered Services	In-Network	
Disposable Medical Supplies	0% after deductible	
Prosthetics	0% after deductible	
Orthotics	50% after deductible	
Chiropractic Services (Spinal Manipulation)	**Prior Authorization required for office visits in excess of 26 per benefit year**	
Office Visit	0% after deductible	
Other Services	0% after deductible	
Therapy Services (Not Including Chiropractic Services)****		
Physical Therapy	0% after deductible	
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)	
Occupational Therapy	0% after deductible	
	Annual Benefit of 60 visits (not including Applied Behavioral Analysis)	
Speech Therapy	0% after deductible	
	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), Required prior authorization	0% after deductible	
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)	0% after deductible	
Mental Illness/Substance Use Disorder Services		
Office Visit[1]	0% after deductible	
Other Services	0% after deductible	
Outpatient Treatment	0% after deductible	
Hospital Inpatient Treatment	0% after deductible	
Residential Treatment	0% after deductible	
Covered Education	0% after deductible	
Outpatient Prescription Drugs******	**Retail (30 day supply)**	**Mail*****
Prescription Drug Deductible	$4,000 Medical Deductible	
Tier 1 - Most Generics (30 day supply)	0% after deductible	0% after deductible
Tier 2 - Preferred Brand (30 day supply)	0% after deductible	0% after deductible
Tier 3 - Non-Preferred Formulary Brand (30 day supply)	0% after deductible	0% after deductible
Tier 4 - Specialty Formulary Brand (30 day supply)	0% after deductible	Not available
Tier 5 - Preventive	$0	$0

[1] Covered Services include two Mental Health sessions per Calendar Year for the diagnosis or assessment of Mental Illness to an Out-of-Network Provider acting within the scope of their license.

* 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 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.

Cox HealthPlans

Exclusive Provider Organization (EPO)

The Cox HealthPlans EPO network offers comprehensive care within the preferred CoxHealth network. When you or your family need medical care, you can choose from doctors, health professionals, and facilities operating in our network of participating health professionals. The plans pay no benefits for out-of-network expenses except for Emergency and/or Urgent Care service situations, as well as certain mental health services.

Health Benefit Highlights:

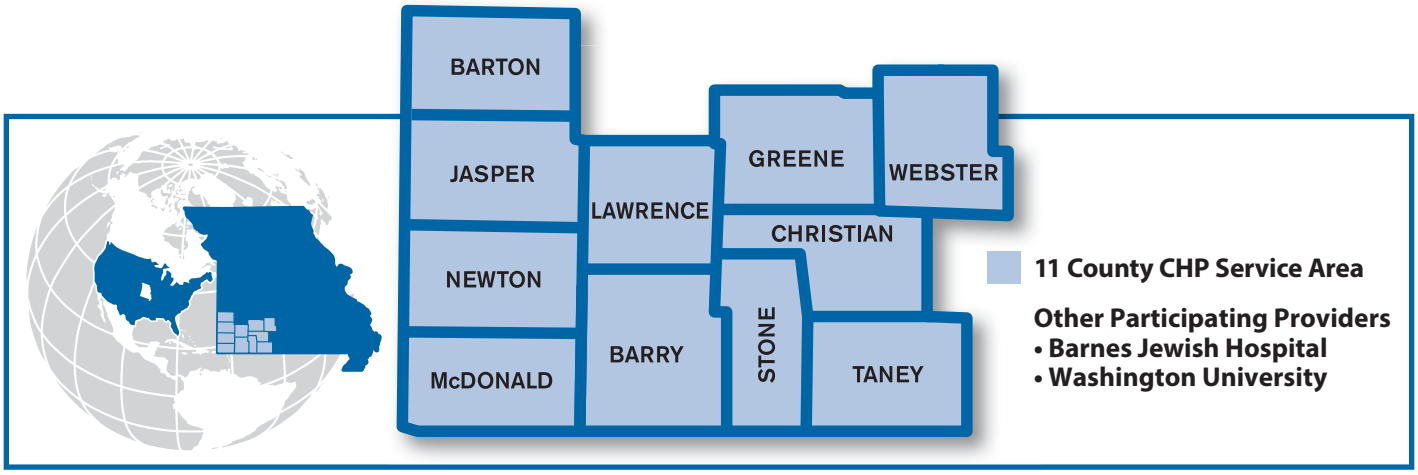
- *Preferred network of health care professionals and facilities*
- *Copays for prescription drugs, office visits, emergency and urgent care facilities*
- *Out-of-network services will not be covered, with the exception of emergency and/or urgent care service situations and certain mental health services*
- *First-dollar preventive care benefits*
- *No referrals necessary to see a specialist*
- *CoxHealth, Freeman Health System and BJC HealthCare*

EPO Provider Network:

- ***EXCLUDES** Lab Corp and Quest Diagnostics labs (providers should verify network labs)*
- ***EXCLUDES** PPO First Health Network*
- ***NETWORK PROVIDERS SHOULD BE CONFIRMED BY:***
  - *Calling Cox HealthPlans Member Services at (800) 205-7665, or (417) 269-2900, or by*
  - *Checking online at https://www.coxhealthplans.com/members-providers (Group and Individual Health Plans/EPO Directory)*

Prescription Drug Coverage:

- *EPO members use the same standard formulary as our PPO plans*
- *Any drug copay levels (tiers) or applicable pre-authorization requirements are the same as our PPO plans*
- *The EPO pharmacy network is the same as the PPO pharmacy network*



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