Cox Health Systems Insurance Company

Large Employer

EPO Group Health Plan

Certificate of Coverage

02/25/2021 approved version of CHSIC PPO GROUP 2021

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If you are not satisfied, return it to us within 10 days after you receive it. All premiums paid will be refunded. This Policy will then be void from its start as if no contract had been issued.

Signed for Cox Health Systems Insurance Company by:

Matthew Aug, President

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Phone: (417) 269-4679 ▪ (800) 205-7665
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SECTION 1. INTRODUCTION

Welcome to Cox Health Systems Insurance Company! We are pleased to provide Health Insurance coverage for you and your family. As a Member of Cox Health Systems Insurance Company, you will have access to one of the largest comprehensive healthcare systems in Southwest Missouri.

This book is referred to as the Certificate of Coverage (COC). The COC is regulated by the State of Missouri and is the legal document between Cox HealthPlans ("CHP", "the Plan", ''we'', "us", "our") and the Employer to provide Benefits to Covered Persons ("you", your"), subject to the terms, conditions, exclusions and limitations of the Policy. This Certificate of Coverage is issued on the basis of the Group Insurance Policy, the Employer Agreement and Group Application, the Covered Employee's Enrollment forms, and payment of the required monthly Premiums.

Please read this COC carefully, and refer to it when you require medical services. The COC explains many of the rights and responsibilities between you and Cox Health Systems Insurance Company. It also describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Reading just one or two sections may not give you the full, accurate description of your coverage. You are responsible for knowing the terms and conditions of your plan. This COC overrides and replaces any COC previously issued to you. The coverage described within this COC represents the specific benefit plan selected by your Employer. This document and any other endorsements, Amendments or Riders attached form the entire Group Contract under which Covered Services are available under your health care plan. Many words used throughout this COC have special meanings. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. To assist you in identifying the defined terms, these words or phrases are capitalized as they appear throughout the document; for example the term "Member" is capitalized throughout this document as a word defined in the "Definitions" section. Please refer to these definitions to better understand your plan.

If you have any questions about your coverage, please call the Member Services telephone number printed on your Identification (ID) Card, or access information by visiting www.coxhealthplans.com. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language line services interpreter. Our Member Service representatives are trained to make the connection to provide clear access to Benefits information.

SECTION 2. MEMBER RIGHTS & RESPONIBILITIES

As a valued Cox HealthPlans member, you are entitled to certain rights and services. As a member, there are also responsibilities in your health care. If you acquaint yourself with and follow these steps when you receive medical services, our performance as your health insurance company will be enhanced.

Cox HealthPlans is committed to administering fair practices and does not apply discriminatory enrollment processes, benefit designs, or benefit determinations.

We will not discriminate against any person on the basis of:

- race, color, national origin, or
- age, sex, religion, marital status, gender identity, sexual orientation, or
- present or predicted disability, or
- health status or conditions including expected length of life, degree of medical dependency, quality of life or other health conditions, health care needs, previous medical information, genetic information, or other status such as a victim of violence, or receipt of public assistance.

AS A MEMBER, YOU HAVE THE RIGHT TO:

- Receive information about the organization and its services, practitioners and Providers, and Member rights and responsibilities.
- Be treated with respect, consideration, recognition of your dignity, and right to privacy.
- Participate with practitioners in making decisions about your health care.
- Discuss appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be informed about, and refuse to participate in any experimental treatment.
- Be informed about applicable fees and payment policies.
- Change your Primary Care Provider (PCP). Your plan does not require the designation of a PCP; however we encourage you to select a PCP to assist in coordinating your care.
- Get information about Cox HealthPlans, our services, network providers, and the credentials of health care professionals.
- Receive complete information concerning a medical evaluation, diagnosis, treatment, and prognosis from your provider.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the Plan’s member rights and responsibilities policy.
- Receive the Benefits to which you are entitled under your Health Plan and Schedule of Benefits.
- Access wellness information to help you maintain a healthy lifestyle.
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.
- Interpretive Services as necessary. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language services interpreter.
- Privacy and confidential handling of your disclosures and records. You may approve or refuse their release, except when the release is required by law.

- Cox HealthPlans is committed to protecting the confidentiality and security of health information. A complete privacy statement is provided on an annual basis. It is also accessible at any time on our website at www.coxhealthplans.com.

AS A MEMBER, YOU HAVE THE RESPONSIBILITY TO:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Provide an accurate health history, including information about medications and over-the-counter products, dietary supplements, and allergies or sensitivities.
- Follow plans and instructions for care that you have agreed to with your practitioners.
- Take part in understanding your health problems and participate in mutually agreed-upon treatment goals, to the degree possible.
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship.
- Present your current ID Card each time you receive a medical/pharmaceutical service.
- Inform providers about living wills, medical power of attorney, or other directives affecting care.
- Treat healthcare providers, staff, and others, with respect.
- Know your Provider Network and verify the Provider’s status at your time of service.
- Follow up with your Provider to verify Preauthorization is obtained as required by your Health Plan.
- Read and understand your Health Plan and Schedule of Benefits and other materials from us concerning your health Benefits.
- Understand how to access care in routine, Emergency, and Urgent situations; and to know your health care Benefits as they relate to out-of-area coverage, Deductible/ Co-insurance/ Co-payments, etc.
- Know the limitations and exclusions of your Health Plan.
- Provide timely, accurate, and complete information to us about other health care coverage and/or insurance Benefits you may carry as it pertains to your plan.
- Accept personal fiscal responsibility for costs not covered by insurance if applicable.
- Inform us of changes affecting your coverage including but not limited to your name, address, telephone number, and family status.
- Contact our Member Services Department when you have a question concerning your coverage or experience a problem.

SECTION 3. HOW TO OBTAIN SERVICES

THIS IS A NETWORK – ONLY PLAN

Services that are not obtained from an In-Network Provider or that are not Authorized Services will be considered an Out-of-Network Service. This Plan does not provide benefits for any services you receive from an Out-of-Network Provider except:

- Emergency Care, Urgent Care, Emergency ambulance services
- Two sessions per year for the purpose of diagnosis or assessment of mental health
- Care that we approve as an Authorized Service.

In-Network Providers include Physicians, Hospitals, and other health care facilities. Check the provider directory, available at www.coxhealthplans.com, or call the number on your ID Card to determine if a Provider is In-Network.

No benefits are payable unless the Covered Person receives services from an In-Network Provider, except in the case of initial treatment and stabilization of a Medical Emergency, as indicated below under "Special Circumstances".

Benefits are provided only for those services that are Medically Necessary as defined within this Plan and for which the Covered Person has benefits. The fact that a Physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Plan document or contact us if you have any questions regarding whether services are covered.

PROVIDER NETWORK

In-Network Providers are the key to providing and coordinating your health care services. The Plan has entered into contracts with a Network of Providers to provide medical services at a reduced cost. Covered Expenses for In-Network Providers are based on Our Negotiated Rate. In-Network Providers have agreed not to charge more than our Negotiated Rates for Covered Services. In-Network Providers may charge the Covered Person for services that are not Covered Services by the Plan.

Services obtained from an Out-of-Network Provider are not Covered Services, except for Emergency Services (including those provided by an Urgent Care facility), and Mental health including two sessions per year for the purpose of diagnosis or assessment of mental health. Contact us to verify if Preauthorization is required.

In-Network Providers include other professional Providers, Hospitals, and other facility Providers who contract with us to perform services for you. Providers include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other In-Network Providers as allowed by the Plan.

- You will not be required to file any Claims for services you obtain directly from In-Network Providers. In-Network Providers will seek compensation for Covered Services rendered from us and not from you except for approved Deductibles, Co-insurance and/or Co-payments. You may be billed by your In-Network Provider(s) for any Non-Covered Services you receive or when you have not acted in accordance with this Certificate of Coverage.
- Services provided by Out-of-Network Ancillary (non-facility) providers may be considered Out-of-Network even if provided at an in-Network facility.
- Be sure to check with the Provider prior to an appointment to verify that the Provider is currently contracted with Cox HealthPlans.

Should a member receive "Unanticipated Out-of-Network care", defined as: health care services received by a patient in an In-Network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged; the Plan will coordinate reimbursement with the provider in compliance with Missouri statute §376.690.

HOW TO FIND A PROVIDER IN THE NETWORK

There are three ways you can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located.

- You may refer to your Plan's directory of In-Network Providers at www.coxhealthplans.com which lists the doctors, Providers, and Facilities that participate in this Plan's Network.
- Call our Member Services Department to ask for a list of doctors and Providers that participate in this Plan's In-Network, based on specialty and geographic area.
- Check with your doctor or Provider.

SPECIAL CIRCUMSTANCES

Covered Expenses for the services of an Out-of-Network Provider will be paid according to the In-Network Provider benefit schedule in certain circumstances as provided below:

- Hospital Emergency Services: Emergency Services for an Emergency Medical Condition will be paid at the In-Network Provider benefit schedule. Once the patient is stabilized and his/her condition permits transfer to an In-Network Hospital, services of an Out-of-Network Hospital will no longer be covered.
- Physician or other Provider Emergency Services: Covered Expenses will be paid at the In-Network Provider benefit schedule for the initial care of an Emergency Medical Condition.

NETWORK EXCEPTION

If Medically Necessary Covered Services are not available through In-Network Physicians or In-Network Providers, we will, upon the request of an In-Network Provider:

- Allow Referral to an Out-of-Network (Non-Participating) Provider; and
- Fully reimburse the Out-of-Network (Non-Participating) Provider at an agreed rate.

Prior to denying a request for referral to an Out-of-Network (Non-Participating) Provider, CHP must provide for a review conducted by a specialist of the same or similar type of specialty as the Physician or Provider to whom the referral is requested.

In the case of a second opinion for cancer diagnosis, if no specialist in that specific cancer diagnosis area is available In-Network, a referral shall be made to an Out-of-Network specialist in accordance with Missouri statute §376.1253.

CONTINUITY OF CARE

There may be instances in which your PCP or In-Network specialist ceases to be an In-Network Physician. In such cases, you may select a new PCP or In-Network specialist to continue receiving Covered Services. However, in special circumstances you may be able to continue seeing your PCP or In-Network specialist, even though he or she is no longer affiliated with CHP.

Continuity of Care allows you to receive services at In-Network coverage levels if your PCP is leaving the Network and you are receiving "Active treatment" for a condition which includes:

- An ongoing course of treatment for a life-threatening condition.
- An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits).
- The second or third trimester of pregnancy and through the postpartum period.
- An ongoing course of treatment for a health condition for which the physician or health care Provider attests that discontinuing care by the current physician or Provider would worsen your condition or interfere with anticipated outcomes.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your doctor should contact Member Services for details. Such continuity of care must be approved in advance by CHP; and your doctor

must agree to accept our reimbursement rate, and to abide by CHP's policies and procedures and quality assurance requirements. Any decision by us regarding a request for Continuity of Care is subject to the Grievance Process. There may be additional circumstances where continued care by a Provider who ceases to be a Network Provider will not be available, such as when the Provider loses his/her license to practice or retires.

RESPONSIBILITIES

RELATIONSHIP OF PARTIES (PLAN – IN-NETWORK PROVIDERS)

The relationship between the Plan and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of In-Network Providers.

The Plan shall not be responsible for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any In-Network Provider or in any In-Network Provider's facilities. To be an informed consumer, it is important for you to know what services are covered under this Certificate of Coverage. At times, an In-Network Provider may recommend that you obtain services that are not covered under this Certificate of Coverage. If you agree with the In-Network Provider to continue the services, you will be held liable for the actual charges of all such Non-Covered Services.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

The Plan is not responsible for the actual care you receive from any person. This Certificate of Coverage does not give anyone any Claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Certificate of Coverage. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider. Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for medical services they provide.

IDENTIFICATION CARD

When you receive care, you must show your Identification (ID) Card. Only a Member who has paid the Premiums under this Certificate of Coverage has the right to services or Benefits under this Certificate of Coverage. If anyone receives services or Benefits to which he/she is not entitled to under the terms of this Certificate of Coverage, he/she is responsible for the actual cost of the services or Benefits.

SECTION 4. HEALTH CARE MANAGEMENT

Health Care Management is included in your health care Benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis. Health Care Management is a process designed to promote the delivery of cost-effective medical care to Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management and through Preauthorization review requirements.

Other types of reviews may be conducted by Prior Authorization (Prior Authorization), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Preauthorization, please call Member Services at (417) 269-2900 or (800) 205-7665.

Members are entitled to receive upon request and free of charge, reasonable access to and copies of documents, records, and other information used to determine the outcome of the Member's Preauthorization request.

Your right to Benefits for Covered Services provided under this Certificate of Coverage is subject to certain policies, guidelines and limitations, including, but not limited to our clinical coverage guidelines, medical policy, and Health Care Management features listed in this section.

A description of each Health Care Management feature, its purpose, requirements and effects on Benefits is provided in this section.

PRIMARY CARE PHYSICIAN (PCP)

This EPO plan does not require the designation of a PCP; however we encourage you to select a PCP to assist in coordinating your care. You may choose a PCP from the Network of Participating (In-Network) Providers. To locate the most current directory of In-Network Providers, please visit our website at www.coxhealthplans.com.

SPECIALISTS

Your PCP is important to the coordination of your care. While this Plan does not require referrals to visit specialists, it is very important that you work with your PCP to help manage your care and keep your PCP informed of all your health care needs. Please be aware that obtaining a referral is not itself a guarantee of payment for services.

CLINICAL COVERAGE GUIDELINES

Our clinical coverage guidelines such as medical policy, preventive care clinical coverage guidelines, Preauthorization review guidelines, Concurrent Review guidelines, and Retrospective Review guidelines reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of clinical coverage guidelines is to assist in the interpretation of Medical Necessity. However, the Certificate of Coverage takes precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and we reserve the right to review and update the clinical coverage guidelines periodically including but not limited to Experimental and Investigational determinations.

PREAUTHORIZATION

Preauthorization is a Health Care Management feature that requires that an approval be obtained from us before incurring expenses for certain Covered Services. Our procedures and timeframes for making decisions for Preauthorization requests differ depending on when the request is received, the type of service that is the subject of the Preauthorization request, and the completeness of records submitted by the requesting party.

Your Primary Care Physician and other In-Network Providers have been provided detailed information on services which require Preauthorization.

- **Important note**: Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Provider for CAR-T (chimeric antigen receptor therapy), new breakthrough/novel therapies, drugs or procedures. Please be sure to contact us to determine which Hospital is a designated Network Provider.

- If a criterion is met and you are approved for service by the plan's medical management team, CAR-T, other breakthrough therapy or drug service must be performed by the plan's designated provider. The designated Provider will include hospital, clinic, and staff that are authorized through special Certification as required by the FDA (U.S. Food & Drug Administration). The designated provider has participated in the initial clinical trials of the therapy. They are authorized to provide the services and include elements to assure safe use (ETASU).
- Any requests for CAR-T, new breakthrough/novel therapies, drugs or procedures from a provider other than the designated Network Provider may be declined.

PREAUTHORIZATION PROCEDURES

Preauthorization is required for certain Covered Services as determined by the Plan. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Plan has the right to request and obtain whatever medical information it considers necessary to determine whether the service is a Covered Benefit.

Your ID Card displays the telephone number to call to seek Preauthorization.

Any new, additional or extended services not covered under the original authorization will be covered only if a new authorization is obtained. All services identified in this document are subject to all of the terms, conditions, exclusions and limitations of the Plan.

An up to date Preauthorization List is available by contacting the Plan at the telephone number listed on your ID card or by visiting the Plan's website. If there is any question concerning the procedures that require Preauthorization, contact Member Services at the phone number listed on your ID Card.

WHO IS RESPONSIBLE FOR PREAUTHORIZATION

Typically, In-Network Providers know which services require Preauthorization and will get any Preauthorization when needed or ask for a Predetermination, even though it is not required. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor ("requesting Provider") will get in touch with us to ask for a Preauthorization or Predetermination review. However, you may request a Preauthorization or Predetermination, or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 Years of age or older. The table below outlines who is responsible for Preauthorization and under what circumstances.

Network Status	Responsible Party	Guidelines
In-Network (Participating)	The Provider	The Provider must get Preauthorization when required.
Out-of-Network (Non-Participating)	Member	Member has no benefit coverage for an Out-of-Network Provider unless: ▪ The Member gets approval to use an Out-of-Network Provider before the service is given; or ▪ The Member requires an Emergency Care admission (see note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
Note: Preauthorization is not required to receive Emergency Care. For Emergency Care admissions, you, your authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible.		

CASE MANAGEMENT (INCLUDES DISCHARGE PLANNING)

Case Management is a health care management feature designed to promote the most appropriate and cost effective care setting. This feature allows us to customize your Benefits by approving otherwise Non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting.

PROCEDURES FOR UTILIZATION REVIEW DECISIONS, MAKING, NOTIFICATION:

1. The Plan will maintain written procedures for making Utilization Review decisions and for notifying Members and Providers acting on behalf of Members of its decisions. For purposes of this section, "Member" includes the representative of a Member.
2. For determinations, the Plan will make the determination within 36 hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or Second Opinion that may be required.
    (1) In the case of a determination to certify (authorize) an admission, procedure or service, the Plan will notify the Provider rendering the service by telephone or electronically within 24 hours of making the Certification, and provide written or electronic confirmation of the telephone or electronic notification to the Member and the Provider within two working days of making the initial Certification;
    (2) In the case of an Adverse Determination, the Plan will notify the Provider rendering the service by telephone or electronically within 24 hours of making the Adverse Determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the Member and the Provider within one working day of making the Adverse Determination.
3. For Concurrent Review determinations, the Plan will make the determination within one working day of obtaining all necessary information.
    (1) In the case of determination to certify (authorize) an extended stay or additional services, the Plan will notify by telephone or electronically the Provider rendering the service within one working day of making the Certification, and provide written or electronic confirmation to the Member and the Provider within one working day after the telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;
    (2) In the case of Adverse Determination, the Plan will notify by telephone or electronically the Provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Member and the Provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the Member until the Member has been notified of the determination.
4. For Retrospective Review determinations, the Plan will make the determination within 30 working days of receiving all necessary information. The Plan will provide notice in writing of our determination to a Member within 10 working days of making the determination.
5. A written notification of an Adverse Determination shall include the principal reason or reasons for the determination, including the clinical rationale, the instructions for initiating a Grievance or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination to the health care Provider. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination to any party who received notice of the Adverse Determination and who requests such information.
6. The Plan has written procedures to address the failure or inability of a Provider or a Member to provide all necessary information for review. These procedures shall be made available to health care providers on

the health carrier's website or provider portal. In cases where the Provider or Member will not release necessary information, the Plan may deny Certification of an admission, procedure, or service.

7. Provided the patient is an enrollee of the Plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of the date the health care Provider receives the Prior Authorization.

8. Provided the patient is an enrollee of the Plan at the time the service is provided, Cox HealthPlans, or any utilization review entity, or health care provider shall not bill an enrollee for any health care service for which a Prior Authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any In-Network Deductible or Out-of-Pocket Maximum applicable to the enrollee's health benefit plan.

SECTION 5. COVERED SERVICES

BASIS OF COVERED BENEFITS & SERVICES:

Services performed by an Out-of-Network Provider are not covered under this Plan except for Emergency Services including Urgent Care, Emergency ambulance services, two office sessions per year for the purpose of diagnosis or assessment of mental health, or care that we approved as an authorized service.

No benefits are payable unless the Covered Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Plan.

- The Benefits and services described below are provided by this Certificate of Coverage only if, and to the extent that they are:
  - Medically Necessary unless specified otherwise in this Certificate of Coverage;
  - Subject to the exclusions, limitations and penalties described elsewhere in this Certificate of Coverage,
  - Subject to Deductible/ Co-insurance/ Co-payments designated under the terms and conditions contained within this Certificate of Coverage and as defined in the Schedule of Benefits.
- Services are deemed to be received on the date a Covered Service is performed or furnished.
- A service that is provided as a Covered Service under a particular section of this Certificate of Coverage will not be considered a Covered Service under any other section of this Certificate of Coverage.
- If an authorized representative of the Plan authorizes the provision of a health care service, the health carrier shall not subsequently retract its authorization after the health care service has been provided, or reduce payment for an item or service furnished in reliance on approval, unless:
  - Such authorization is based on an act or practice that constitutes fraud, or intentional misrepresentation of material fact about the treated person's health condition or the cause of the health condition; or
  - The health benefit Certificate of Coverage terminates before the health care services are provided; or
  - The Covered Person's coverage under the health benefit Certificate of Coverage terminates before the health care services are provided.
- The Plan may specifically disclaim any insurance producer's authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the company's other rights or requirements.

PREVENTIVE SERVICES

PREVENTIVE SERVICES WILL BE COVERED PER THE FOLLOWING:

Preventive Care services include Inpatient services, Outpatient services, and Office Services. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition, but instead Benefits will be considered under the diagnostic services benefit. Preventive Care Covered Services include:

- All services recommended by the U.S. Preventive Services Task Force without cost-sharing for In-Network Providers.
- If a preventive service is billed separately from an office visit, the Plan may impose cost sharing on the office visit. Office visits together with the preventive service will require no additional cost-sharing on the visit if it the primary purpose of the visit is to receive the preventive item or service.
- Additional preventive services or treatments not described in the regulations, which includes any treatment resulting from an item or service which is listed, may require cost-sharing by the Member.

The Plan may use reasonable medical management techniques for coverage of preventive items and services to determine the frequency, timing method, treatment or setting of services as permitted by state and federal guidelines.

Preventive Services and items delivered by Out-of-Network Providers are not covered.

PREVENTIVE SERVICES FOR CHILDREN & ADOLESCENTS

- Physician office visits and laboratory tests associated with preventive checkups.
- Immunizations currently recommended by the Advisory Committee on Immunization Practices of the CDC are provided without cost sharing. Immunizations that exceed minimum requirements of the Advisory Committee on Immunization Practices of the CDC require applicable Deductible / Co-insurance / Co-payment and apply to the maximum preventive services benefit listed on the Schedule of Benefits.
- Immunizations of a child from birth to five years of age as provided by department of health and senior services regulations.
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration.

PREVENTIVE SERVICES FOR ADULT

- All preventive care and screenings for women supported by the Health Resources and Services Administration are provided without cost-sharing.
- Immunizations currently recommended by the Advisory Committee on Immunization Practices of the CDC are provided without cost-sharing. Immunizations that exceed minimum requirements of the Advisory Committee on Immunization Practices of the CDC require applicable cost-sharing (Deductible/ Co-insurance/ Co-payments) and apply to the maximum preventive services benefit listed on the Schedule of Benefits.

PHYSICIAN SERVICES

The Covered Person will be responsible for the appropriate Deductible/ Co-insurance/ Co-payments for any covered Physician office visit charge. Any other covered charge that occurs during or as a consequence of an office visit such as lab, radiology, treatment, facility fee, and or diagnostic procedures may be subject to the applicable Deductible/ Co-insurance in addition to the Co-payment for the office visit. Please refer to your Schedule of Benefits for specific coverage.

This plan does not require designation of a Primary Care Physician or require referrals for obstetrical or gynecological care provided by In-Network providers who specialize in obstetrics or gynecology.

PHYSICIAN SERVICES INCLUDING BUT NOT LIMITED TO:

- Consultations for diagnostic, treatment, and follow up medical care.
- Blood pressure checks, injections, and other services without a direct attendant Physician.
- Physician fees associated with covered Surgery and appropriate level of anesthesia.
- Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- Hospital consultations and other Physician-rendered Hospital services.
- Voluntary sterilization, including tubal ligations and vasectomies.
- Casts, splints, and dressings that are part of treatment in a Provider’s office or in a Hospital Outpatient Treatment Facility.
- Home visits when Medically Necessary.

Some services may require plan approval.

INPATIENT AND OUTPATIENT SERVICES

INPATIENT HOSPITAL SERVICES

All Inpatient admissions require Plan approval. Preauthorization and Concurrent Review of an admission is required as described within the terms and conditions of the Certificate of Coverage. Inpatient Hospital Services include but are not limited to the following:

- Semi-private room and board accommodations.
- Private room accommodations up to the Hospital's semi-private rate when the Plan deems the private room Medically Necessary.
- Intensive Care Units and services (including specialty care units).
- Operating room and related facilities.
- General nursing services.
- Laboratory, radiologic, imaging and other diagnostic testing, drugs, medications, biologicals, anesthesia, oxygen service, and supplies.
- Respiratory therapy, radiation and chemotherapy, physical, speech, and occupational therapy.
- Administration and processing, but not the storage, of whole blood and blood derivatives.

For an Inpatient admission following Emergency Care, including emergent childbirth/delivery services, Preauthorization is not required.

AMBULANCE SERVICE

MEDICALLY NECESSARY AMBULANCE TRANSPORTATION IS COVERED UNDER THE FOLLOWING CIRCUMSTANCES:

- Transportation by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, and air transportation. Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

GROUND TRANSPORTATION:

- From your home, the scene of an accident or medical Emergency to the nearest Hospital where Emergency care and treatment can be rendered;
- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

AIR OR WATER AMBULANCE:

- Air and water ambulance transportation is covered for acute trauma cases. Scheduled air and water ambulance transportation for other than acute trauma must be Preauthorized by the Plan based upon Medical Necessity as determined by Plan. For example;
  - from the scene of an accident or medical Emergency to a Hospital;
  - between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - between a Hospital and an approved Facility.
- We will negotiate allowed amounts for Out-of-Network air or water ambulance transport or set the amount at no greater than 300% of the published rate allowed by the Centers for Medicare and Medicaid Services (CMS) for Missouri for the same services (or a similar service).

Important ambulance services benefit specifications are listed below and are subject to review for Medical Necessity as determined by the Plan:

- Ambulance transportation may be covered when ordered by an Employer, school, fire, or public safety official and the Member is not in a position to refuse.
- Water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan may cover the air ambulance. Air ambulance may also be covered if you are in an area that a ground or water ambulance cannot reach.
- Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home. You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.
- Non-Emergency surface ambulance transportation will be covered when certified as Medically Necessary by Covered Person's Physician and agreed upon and approved in advance by the Plan.
- Coverage is not available for air, ground, or water ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.
- Any ambulance usage for transportation home or another place of residence such as a nursing/retirement home, or for the convenience of the Member, family, or Physician is not a Covered Service.
- Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in Emergency situations.
- Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider.
- The Covered Person must pay the appropriate Deductible/ Co-insurance/ Co-payments amounts as identified in the Schedule of Benefits.
- Any ambulance service charges in excess of the Maximum Allowable Amount will not be covered by the Plan. If you use an Out-of-Network Provider, you may be billed for any charges that exceed the Maximum Allowable Amount.
- Out-of-Network Providers may bill you for any emergency medical charges that exceed the Plan's Maximum Allowable Amount.

AMBULATORY SURGICAL CENTER

Ambulatory Surgical Center services and supplies furnished in connection with a surgical procedure performed in the center. Some services may require plan approval.

AUTISM SPECTRUM DISORDERS

Treatment for Autism Spectrum Disorders is care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder or Developmental or Physical disabilities by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to:

- Psychiatric care;
- Psychological care;
- Habilitative or rehabilitative care, including Applied Behavior Analysis (ABA) therapy;
- Therapeutic care;
- Pharmacy care.

Coverage provided for Autism Spectrum Disorder or Developmental or Physical disabilities is limited to Medically Necessary treatment that is ordered by the insured's treating licensed Physician or licensed psychologist, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, in accordance with a treatment plan.

The treatment plan, upon request by the health benefit plan, shall include the elements necessary for the health benefit plan or health carrier to pay Claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

Except for Inpatient services, if an individual is receiving treatment for an Autism Spectrum Disorder, or developmental or physical disability we have the right to review the treatment plan not more than once every 6 months unless we establish an agreement between the individual's treating Physician or psychologist and find that a more frequent review is necessary.

Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual receiving Applied Behavior Analysis and shall not apply to all individuals receiving applied behavior analysis from that autism service provider, physician, or psychologist. The cost of obtaining any review or treatment plan shall be borne by us, as applicable.

Autism Spectrum Disorder services or Applied Behavior Analysis shall not be subject to any limits on the number of visits an individual may make to an Autism Service Provider, except the maximum total benefit for coverage provided under this section for Applied Behavior Analysis (ABA) that shall be subject to a maximum benefit per Calendar Year not less than what is required by Missouri state law. Such maximum Benefit limit may be exceeded, upon prior approval by the Plan, if the provision of Applied Behavior Analysis (ABA) services beyond the maximum limit is Medically Necessary for such individual.

The maximum benefit limit per Calendar Year described above for Applied Behavior Analysis (ABA) services does not apply to other covered Autism benefits that may be provided under this Plan. Payments made on behalf of a covered individual for any care, treatment, intervention, service or item; the provision of which was for the treatment of a health condition unrelated to the covered individual's Autism Spectrum Disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required by state mandates shall not be subject to the age and dollar limitations described in this subsection. Please call the Member Services telephone number printed on your Identification (ID) Card for information on any applicable benefit maximum.

DISPOSABLE MEDICAL SUPPLIES

Disposable medical equipment and specialty supplies required to support ongoing treatment of chronic medical conditions that are not for custodial purposes as determined by the Plan.

Glucometer supplies, blood glucose monitors, insulin syringes, and other testing supplies are covered under the Pharmacy Services benefit.

Equipment must be prescribed by the attending Physician for a medically appropriate use that is not for custodial purposes as determined by the Plan.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment that is required to complete home recuperation is a covered benefit upon order by your Physician and Preauthorization by the Plan.

Benefits for rental are limited up to the purchase price only. Equipment will be at a level of functionality deemed by the Plan to be appropriate to provide basic assistance to the Covered Person. Examples of covered Durable Medical Equipment include, but are not limited to: Wheelchairs and mobility assistive equipment (MAE); Hospital style beds; walkers; crutches; canes; braces (not orthodontic) which are required for post-operative or post-Injury/Illness care (over-the-counter braces and supports and braces and supports used to enhance competitive athletic endeavors are not covered); etc.

We will pay for Durable Medical Equipment in accordance with your Schedule of Benefits.

Electric wheelchairs and mobility assistive equipment (MAE) shall be covered when Medically Necessary and authorized by the Covered Person's Physician and the Plan, and are covered by rental cost only, the cost not to exceed the purchase price.

Electric Wheelchairs are covered by rental cost only, unless deemed appropriate for purchase by the plan. Purchase price not to exceed the 12 month rental price.

Your applicable Deductible/ Co-insurance/ Co-payments requirement will be determined as indicated in the Schedule of Benefits.

EDUCATION SERVICES

The following are education services covered by this Certificate of Coverage as ordered by the Covered Person's Physician.

- Educational services are covered for diabetes including:
  - Initial diabetic education classes up to 4 days for persons diagnosed with diabetes within the past 12 months from diagnosis.
  - Education class regarding the use of a newly prescribed insulin pump initiated within the 6 months of pump Prescription.
  - Education class for diabetics who have had no education in the past 5 years.
  - Additional diabetic education classes may be covered with Plan approval for changes in diabetic management (diet controlled to medication controlled, oral medication to insulin, etc.), uncontrolled diabetes, or a new diabetic complication (diabetic neuropathy/ nephropathy, etc.).
    - Diabetic Education Classes must be provided by a Hospital-based or a certified diabetic educator affiliated with a Provider.
- Nutritional counseling as adjunctive treatment for a properly diagnosed and otherwise covered metabolic disorder, excluding obesity diagnoses.
- Parent Education, assistance and training in breast or bottle-feeding, and education and services for complete childhood immunizations.
  - These services are covered only during the two minimum post discharge visits required for early maternal discharge patients.
- Asthma Education classes must be certified by the American Lung Association and taught by a Certified Asthma Education (AE-C) or be a Hospital-based program approved by the Plan.

EMERGENCY SERVICES

Emergency Services are provided without prior authorization, regardless of whether the Provider is an In-Network provided by Out-of-Network Providers will be provided without regard to any other restriction other than an exclusion or coordination of Benefits, an affiliation or Waiting Period, and cost-sharing.

Should a Covered Person receive covered Emergency Services, the Covered Person will be responsible for In-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits. Deductible/ Co-insurance/ Co-payments will include appropriate payments to the emergency room facility and a Deductible/ Co-insurance/ Co-payments for the emergency room Physician. Follow-up care is not considered Emergency Care.

Should a Covered Person be admitted to an Out-of-Network facility as a result of an Emergency Service, the Covered Person will be responsible for In-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits. Deductible/ Co-insurance/ Co-payments will include appropriate payments to Physicians and ancillary services related to the episode of care. Our Health Care Management staff will monitor an Out-of-Network admission/episode of care.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be available unless we agree to cover them as an Authorized Service. At such time as the Covered Person's condition no longer meets the definition of Emergency Services as stated above and the Covered Person continues to receive treatment Out-of-Network, the Covered Person will be responsible for Out-of-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits.

Should a Covered Person be admitted to an Out-of-Network facility as a result of an Emergency Service, the Plan must be contacted by the Covered Person, or a Covered Person's representative, within 48 hours or as soon as possible.

Failure to contact the Plan will result in penalties for failure to obtain Preauthorization as required by Certificate of Coverage and may result in benefit reimbursement / Covered Person responsibility being applied at the Out-of-Network level as specified in the Schedule of Benefits.

Out-of-Network Emergency Services/admissions/episodes of care will be reimbursed at the In-Network level by the Plan only in instances when the Covered Person's condition meets the definition for Emergency Services. When an Out-of-Network facility is used the Plan will review the condition treated to determine whether or not In-Network Benefits apply.

Out-of-Network Emergency Services Providers may bill you for any emergency medical charges that exceed the Plan's Maximum Allowed Amount.

Should a member receive "Unanticipated Out-of-Network care", defined as: health care services received by a patient in an In-Network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged; the Plan will coordinate reimbursement with the provider in compliance with Missouri statute §376.690.

HOME HEALTH CARE BENEFITS

Home Health Care services, as identified below, are covered with the approval of the Plan; and if such services are provided in lieu of Hospitalization or Skilled Nursing Facility. Covered Persons must be considered Homebound as determined by the Plan to receive Home Health Care services. Limited to a Calendar Year maximum benefit as shown in the Schedule of Benefits.

- Part-time or intermittent care by an RN or by an LPN;
- Physical, occupational, speech therapy by a licensed Provider;
- All to the extent they would have been covered if the person had been confined in a Hospital. Medical Supplies, drugs and medicines prescribed by a licensed Provider and lab services provided by or for a Home Health Care Provider.
- Physician home visits.
- Medical/Social Services by an MSW.

HOSPICE BENEFITS

Hospice services are covered by the Certificate of Coverage when authorized by the Covered Person's Physician and pre-approved by the Plan. Covered Persons may participate in home health Hospice care for such Illness. We will pay for Hospice service in accordance with your Schedule of Benefits. Determination of individual visits versus a per diem rate will be at the Plan's discretion and based on medical needs of the Covered Person. Hospice may be terminated if the Member's condition improves, if the Member decides to seek curative/ aggressive measures, as determined by the plan, or if the Member decides to revoke Hospice Benefits.

Individual Hospice visits include: Skilled Nursing service (by RN or LPN), home health aide, and medical social services by an MSW. All individual visits are for intermittent use only and do not cover continuous care. The following services will be included for Covered Persons covered under the per diem rate: Physicians visits, services of home health aides, nursing care (part time or intermittent), Durable Medical Equipment rental, medical social worker, Prescription Drugs (oral and rectal only and must pertain to terminal diagnosis), physical or occupational therapy, Disposable supplies, psychological and dietary counseling.

Intravenous medications and supplies are not covered under the Hospice benefit but are a covered benefit under the home health benefit and must be Preauthorized.

HUMAN ORGAN TRANSPLANTS

Plan approved human organ transplants where the recipient is a Covered Person of this Certificate of Coverage and which are determined by this Plan to be Medically Necessary and are not Experimental, Investigational or for Research Purposes are covered Benefits. Coverage includes prescribed post-surgical immunosuppressive Outpatient drugs required as a result of a covered transplant.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID Card for information about these guidelines.

We will assist you in maximizing your Benefits by providing coverage information, including details regarding what is covered; and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or Exclusions are applicable.

Important note: Even if a Hospital is an In-Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact us to determine which Hospitals are Network Transplant Providers.

- Network Transplant Provider – A Provider that has been designated as a "Center of Excellence" by us and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant Network. A Provider may be a Network Transplant Provider with respect to certain Covered Transplant Procedures or Covered Transplant Procedures.
- The Network Transplant Provider is not required to be in the same geographical area in which you reside.
- Non-Network Transplant Provider – Any Provider that has NOT been designated as a "center of excellence" by us or has not been selected to participate as a Network Transplant Provider by a designee.

LABORATORY, IMAGING, RADIOLOGICAL SERVICES

These services are covered when the services are Medically Necessary and ordered by the Covered Person's Physician.

MENTAL HEALTH BENEFITS

Benefits for Outpatient Mental Health/Substance Use Disorder include diagnosis and sessions with a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license and under the following standards:

- Coverage and Benefits shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and
- Coverage and Benefits shall not be subject to any conditions of pre-approval, and shall be deemed reimbursable as long as the provisions of this benefit are satisfied.

OUTPATIENT TREATMENT (NON-RESIDENTIAL)

- Benefits for Outpatient Mental Health include diagnosis and sessions with a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license. Benefits are provided for Outpatient treatment, including treatment through partial or full-Day Program services for mental health services for a recognized Mental Illness rendered by a Licensed Professional to the same extent as any other Illness based on utilization management guidelines.

HOSPITAL INPATIENT TREATMENT (NON-RESIDENTIAL)

- Benefit payments are provided for Hospital Inpatient treatment at the appropriate level of care based on utilization management guidelines, to the same extent as for any other Illness.

RESIDENTIAL TREATMENT

- Benefit payments are provided for Residential Treatment Programs for the therapeutic care and treatment when prescribed by a Licensed Professional and rendered in a psychiatric Residential Treatment Center licensed by the Missouri Department of Mental Health, at the appropriate level of care based on utilization management guidelines to the same extent as any other Illness.

Note: Out-of-Network benefits include two office sessions per year with an Out-of-Network licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license.

NON-EMERGENCY OUTPATIENT HOSPITAL SERVICES

The following services provided on an Outpatient basis are covered by the Certificate of Coverage when ordered by the Covered Person's Physician.

- Outpatient Surgery
- Outpatient diagnostic laboratory, radiologic, imaging services, medications and other medical services appropriate for Outpatient Hospital services
- Outpatient endoscopic procedures
- Outpatient therapies such as physical, occupational, speech, etc.
- Voluntary sterilization, including tubal ligations and vasectomies.

Certain Outpatient procedures and/or therapies may require Preauthorization or be subject to limitations. Please refer to the Preauthorization requirements or Limitations specified in this plan, or refer to your Schedule of Benefits.

ORTHOTICS

Orthotic devices are covered when prescribed and provided by a licensed Provider and approved by the Plan. Preauthorization by the Plan is required.

Covered Orthotic devices include, but are not limited to the following:

- Cervical Orthoses
- Spinal Orthotics
- Upper limb Orthotics
- Lower limb Orthotics
- Cranioplasty banding treatment
- Cranial molding helmets

Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics.

Therapeutic shoes (depth or custom-molded) along with inserts are a Covered Service when the following criteria are met:

- Prescription by a licensed Provider, podiatrist, or other qualified Provider;
- Preauthorized by the Plan; and
- Diagnosis of diabetes with documentation that the Covered Person has one or more of the following conditions:
- Peripheral neuropathy with evidence of callus formation.
- History of pre-ulcerative calluses.
- History of previous ulceration.
- Foot deformity.
- Previous amputation of the foot or part of the foot.
- Poor circulation.
- Coverage is limited to one of the following:
  - One pair of custom molded shoes (including inserts) and two additional pairs of inserts per year, or
  - One pair of extra-depth shoes (including inserts provided with such shoes) and two pairs of inserts per year.

See your Schedule of Benefits for applicable Deductible/ Co-insurance/ Co-payments.

PROSTHETIC DEVICES

Prosthetics are covered upon plan approval.

- All Prosthetics require the Covered Person's Physician's authorization and advance Plan approval.
- Permanently implanted Prosthetic devices that are not Experimental and are generally and customarily available are covered except dental.
- Prosthetics that are primarily for cosmetic purposes, but serve to replace a body part removed due to Injury or Illness are covered.
- Internal breast prosthesis as a result of a mastectomy shall be covered as specified in Special Provisions subsection. External breast prostheses shall be covered upon initial placement and replacement due to ordinary wear and tear.
- External Prosthetic devices required to assist in the activities of daily living (artificial hands, arms, feet, legs, and eyes) include the fitting and necessary adjustments. These Prosthetics must be recommended by a multidisciplinary rehabilitation team and require advance Plan approval.
- Upon approval, 1 set of air conduction hearing aids will be covered every 5 years. Replacement of lost or broken hearing aids is not a covered benefit unless it has been greater than 5 years since the hearing aids were last purchased.
- Additional revisions or adjustments may be made based on Medical Necessity and are subject to advance Plan approval. Revisions or adjustments are Non-Covered if damage results from negligence or abuse of the Prosthetic device by Covered Person or Covered Dependents.
- If a Covered Person does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance his quality of life or mobility, he does not meet the criteria for coverage of an external Prosthetic device.
- Covered Prosthetic devices are not defined as Durable Medical Equipment.

REHABILITATION/HABILITATION & THERAPY BENEFITS

The categories of Rehabilitation Services listed below must be Medically Necessary and the treatment(s) must result in measurable, consistent, and significant improvement in the Covered Person's condition during the period of coverage described below. Associated fees shall be limited to the Maximum Allowable Amount and the Calendar Year maximum benefit as shown in the Schedule of Benefits.

- Physical therapy services including pool therapy, aquatic therapy, or hydrotherapy by a Physician or physical therapist for physical therapy modalities that require direct one-on-one patient contact.
- Occupational therapy services.
- Speech therapy services. (Preauthorization is required for Coverage).
- Cardiac Rehabilitation Therapy.
- Pulmonary Rehabilitation Therapy.
- Other Therapy Services: Medically Necessary chemotherapy, dialysis treatments, inhalation therapy, and radiation therapy (including the professional fee for each of these therapies) are covered Benefits.

SKILLED NURSING SERVICES

Skilled Nursing Services are limited to those that are Medically Necessary and are not for Custodial Care. The services must be authorized by the Covered Person's Physician and approved in advance by the Plan. The care must be provided in a licensed Skilled Nursing Facility, by a licensed Home Health Agency, or by another licensed Provider for transitional care of an Injury or Illness or for care which otherwise would require confinement in a Hospital. Skilled Nursing Services may also upon approval of Plan be utilized if the care is Medically Necessary

and can be used in lieu of Hospital admission. Services limited to a Calendar Year maximum benefit as shown in the Schedule of Benefits.

SKILLED NURSING BENEFITS:

- Semi-private room and board accommodations (private accommodations will be covered when deemed Medically Necessary by the Plan).
- General nursing care provided by or under the supervision of a Registered Nurse.
- Drugs, biologicals, supplies, equipment, and services that are Medically Necessary to provide Skilled Nursing Care services and which are ordered by the attending Physician and authorized by the Covered Person's Physician.

DURATION OF BENEFITS:

A Covered Person is eligible for Skilled Nursing Care services only for the time period for which these services are Medically Necessary and appropriate, and for services that do not constitute Custodial Care. Covered Person will be financially responsible for any continued Skilled Nursing Care expenses after the Plan has determined that the services are no longer a covered Benefit.

SUBSTANCE USE DISORDERS

OUTPATIENT TREATMENT (NON-RESIDENTIAL)

- Benefits provided through a Nonresidential Treatment Program or through partial or full-Day Program Services based on utilization management guidelines, to the same extent as for any other Illness.

HOSPITAL INPATIENT TREATMENT (NON-RESIDENTIAL)

- Benefits provided for Hospital Inpatient treatment for chemical dependency at the appropriate level of care based on utilization management guidelines to the same extent as for any other Illness.

RESIDENTIAL TREATMENT PROGRAM

- Benefits based on utilization management guidelines, to the same extent as for any other Illness.

MEDICAL OR SOCIAL SETTING DETOXIFICATION

- Benefits provided based on utilization management guidelines, to the same extent as for any other Illness.

URGENT CARE

Urgently needed services that are required in order to prevent serious deterioration of your health are covered Benefits. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Deductible/ Co-insurance/ Co-payments may apply.

Out-of-Network Emergency / Urgent care services will be reimbursed at the In-Network level by the Plan only in instances when the Covered Person's condition meets the definition for Emergency Services. When an Out-of-Network facility is used the Plan will review the condition treated to determine whether or not In-Network Benefits apply.

Out-of-Network Emergency Services Providers may bill you for any emergency medical charges that exceed the Plan's Maximum Allowed Amount.

SPECIAL PROVISIONS REQUIRED BY LAW

ADOPTED CHILDREN

Adopted children are provided health care coverage on the same basis as other dependents as described within the "Eligible Dependents" portion of the "Eligibility, Enrollment, Effective Date" Section.

APPLIED BEHAVIOR ANALYSIS (ABA)

Coverage is provided as outlined in the “Autism Spectrum Disorders” portion of the “Covered Services” Section.

BREAST CANCER TREATMENT BY DOSE-INTENSIVE CHEMOTHERAPY/AUTOLOGOUS BONE MARROW TRANSPLANTS

Certificate of Coverage shall offer coverage for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols. Service shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than any other health care service provided by the Certificate of Coverage.

CANCER SCREENINGS

Benefits related to cancer screening including examinations and tests are covered and subject to the same dollar limits, Deductible, Co-insurance and Co-payments as other covered Benefits or services.

- A pelvic examination and Pap smear for any non-symptomatic woman in accordance with the current American Cancer Society guidelines;
- A prostate examination and laboratory tests for cancer for any non-symptomatic man in accordance with the current American Cancer Society guidelines; and
- A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic person in accordance with the current American Cancer Society guidelines.

CHILD COVERAGE, DISCRIMINATION PROHIBITED

A child will not be denied coverage because of marital status of parents, residence or income tax dependency claim including the following:

- The child was born out of wedlock; or
- The child is not claimed as a Dependent on the parent’s federal income tax return; or
- The child does not reside with the parent or in the insurer’s Service Area.

CHILDHOOD IMMUNIZATIONS

Coverage is provided for immunizations of a child from birth to 5 years of age in accordance with Missouri Department of Health and Senior Services regulations without a Deductible or Co-pay limit as outlined in the Preventive Services Section.

CHILD HEALTH SUPERVISION

- The “Child Health Insurance Reform Plan” provides Child Health Supervision as follows: The term "Child health supervision services" means the periodic review of a child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards;
- Services shall include coverage from the moment of birth through the age of 12 years.
- Benefits are provided for child health supervision services at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, and 12 years.
- Child health supervision services which are rendered during a periodic review shall only be covered to the extent that services are provided by or under the supervision of a single Physician during the course of one visit.
- Benefits shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than any other health care service provided by the Certificate of Coverage.

CHIROPRACTIC SERVICES

The plan provides coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice to include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the Plan. A Covered Person may access chiropractic care for a total of 26 chiropractic Physician office visits per policy period, before needing to provide the Plan with notice prior to any additional visit as a condition of coverage. The Plan requires prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six in any policy period.

If a Covered Person receives Chiropractic Services, coverage will be subject to the Deductible/ Co-insurance/ Co-payments and preauthorization limits as indicated in the Schedule of Benefits. Co-payments will not exceed 50% of the total cost of any single Chiropractic Service when utilizing a licensed, In-Network Provider.

CLINICAL TRIALS

Coverage will be provided for Phase I, Phase II, Phase III, or Phase IV Clinical Trials for the purposes of the prevention, early detection, or treatment of cancer or other life threatening disease or condition.

Coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and Medically Necessary services needed to administer the drug or use the device under evaluation in the Clinical Trial, the study or investigation is conducted under an investigational new drug application reviewed by the FDA, or the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the Clinical Trial.

Coverage for routine patient care costs shall apply to Phase I, Phase II, Phase III, and Phase IV Clinical Trials federally funded by one or more entities cited in 42 U.S.C. § 300gg-8(d)(1)(A) ,(B),(C)., and also as identified below in compliance with Missouri statute §379.429:

One of the National Institutes of Health (NIH);

- An NIH cooperative group or center, defined as a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans' Affairs or Defense;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or
- A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Routine patient care costs shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the Clinical Trial except:

- The investigational item or service itself;

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

CONTRACEPTIVES

Coverage is provided for Contraceptives administered by the services of a participating Physician, of the Member's choice within the Provider Network; and includes Prescription Drugs and devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall exclude drugs and devices that are intended to induce an abortion. Benefits shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than any other pharmacy benefit provided by the Certificate of Coverage.

DIRECT ACCESS TO OB/GYN

- Direct access is provided to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of the Member's choice within the Provider Network for Covered Services.
- The services are limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services.
- Service shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than any other health care service provided by the Certificate of Coverage.

FIRST STEPS EDUCATIONAL PROGRAM

The program is a system of early intervention for infants and toddlers with disabilities and their families designed to enhance their development and to minimize their potential for developmental delay.

ELIGIBILITY FOR FIRST STEPS BENEFITS

- Children between the ages of birth and 36 months who have been evaluated and assessed as meeting the criteria for early intervention services under Part C of the Individual with Disabilities Education Act, 20 U.S. C. Section 1431, et seq. It is the Member's responsibility to provide proof of eligibility for First Steps to the Plan from the appropriate agency or institution as designated by the state.

COVERAGE DESCRIPTIONS

- First Steps shall provide coverage for the services provided by the First Steps Program as required in Missouri Statutes and Regulations.
- Coverage for early intervention services that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.
- "Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services. Early intervention services shall include services under an active individualized family service plan that enhances functional ability without affecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.
- Benefits shall be limited to $3,000 per Member per Benefit Period, with a lifetime maximum of $9,000 per child. Payments made during a Benefit Period to the Part C early intervention system for services provided to children covered by the Part C early intervention system shall not exceed one-half of one percent of the

direct written premium for health benefit plans as reported to the Department of Commerce & Insurance, financial institutions and professional registration on the health carrier's most recently filed annual financial statement. Any dollar or visit limits listed elsewhere in the Plan will not apply to Early Intervention Services.

- Payment for coverage, as required in Missouri Statutes and Regulations, shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than other coverage within this Plan, if applicable.
- No Preauthorization for eligible services will be required once proof of eligibility for the program is provided.
- The same benefit schedule shall apply as defined in the Plan for In-Network and Out-of-Network Providers.

GENERAL ANESTHESIA AND FACILITY CHARGES

Benefits are provided only for the administration of general anesthesia and for both facility and professional charges occurring in connection with dental services, regardless of age when Preauthorization for Inpatient dental care procedure is approved by us.

General anesthesia is a drug, gas or other modality, that when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

Administration of general anesthesia and Hospital charges for dental care shall be covered for the following Covered Persons:

- A child under the age of 5.
- A person who is severely Disabled; or
- A person who has a medical or behavioral condition that requires Hospitalization or general anesthesia when dental care is provided.

Coverage is provided for administration of general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of whether the services are provided in a participating hospital or surgical center or office. Preauthorization for these dental services is required in the same manner that Preauthorization is required for Hospitalization of other covered diseases or conditions.

In addition, dental services required to relieve pain and stop bleeding as a result of Accidental Dental Injury to sound natural teeth are covered. No other dental services are covered unless otherwise specified as a Covered Service in this Plan.

HEARING AND SCREENING BENEFITS

Hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification are Covered Services. Purchase of initial amplification shall apply to Covered Person's Durable Medical Equipment limits. If a Covered Person joins and he has received initial amplification from a prior carrier, replacement amplification is not a covered benefit.

Benefits also include hearing aids provided to a newborn for initial amplification following a newborn hearing screening. A hearing aid is an electronic device worn or implanted for the purpose of amplifying sound and assisting the physiological process of hearing.

HIV INFECTION

Human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC) shall be covered the same as any other serious medical condition.

HUMAN LEUKOCYTE ANTIGEN TESTING

Coverage is provided for Covered Persons for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

- The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College

of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists.

- At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.
- Certificate of Coverage limits each Member to one such testing per lifetime. Health care service shall not be subject to any greater Deductible/ Co-insurance/ Co-payments than any other health care service provided by the Certificate of Coverage.

LEAD POISONING

Coverage is provided for testing Covered Persons who are pregnant and/or children less than 6 years old for lead poisoning.

MAMMOGRAPHY

Benefits are provided for low-dose mammography screening for any non-symptomatic woman and shall include:

- A baseline mammogram for women age 35 to 39, inclusive;
- A mammogram every year for women age 40 and over;
- A mammogram for any woman, deemed by the treating Physician to have an above-average risk of breast cancer in accordance with ACR guidelines for breast cancer screening.

Coverage of any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed medically necessary by a treating Physician for proper breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and ultrasound or magnetic resonance imaging services, if determined by a treating Physician to be medically necessary for the screening or evaluation of breast cancer for any woman deemed by the treating Physician to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening. Certificate of Coverage shall apply to such services the same Deductible/ Co-insurance/ Co-payments, and limitations as apply to other Covered Services.

MASTECTOMY AND BREAST CANCER RECONSTRUCTION

Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis; and for prosthetic devices or reconstructive Surgery necessary to restore symmetry as recommended by the oncologist or primary care Physician for patient incident to the mastectomy, or alleviate functional impairment, including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Initial and subsequent Prosthetic devices to replace the removed breast or portions thereof are Covered Benefits due to Physical complications of all stages of mastectomy, including lymphedemas. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same Deductible and Co-insurance conditions applied to the mastectomy and other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of prosthetic devices or reconstructive surgery.

MENTAL HEALTH / CHEMICAL DEPENDENCY

Coverage is provided as outlined in the “Mental Health Benefits” and “Substance Use Disorders” portions of the “Covered Services” Section.

NEWBORN COVERAGE

Coverage is provided for a newborn child, the “Special Enrollment Provisions” portion of the “Eligibility, Enrollment, Effective Date Section” outlines the Effective Dates and extent of coverage.

ORAL CHEMOTHERAPY

Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, Co-payment, Deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected anticancer medication, regardless of formulation or benefit category determination.

The total amounts paid by a covered person through all Cost-share requirements will not exceed the dollar amount specified by Missouri state law for the current year.

OSTEOPOROSIS

Services related to diagnosis, treatment, and appropriate management of osteoporosis are covered. Certificate of Coverage shall apply to such services the same Deductible/ Co-insurance/ Co-payments, and limitations as apply to other Covered Services.

PKU TESTING AND FORMULA

Treatment for phenylketonuria including dietary formula product to achieve and maintain normalized blood levels of phyenylalanine and adequate nutritional status when prescribed and supervised by an appropriate Provider is a Covered Service. Formula and low protein modified food products recommended by a Physician for the treatment of a Covered Person with phenylketonuria, or any inherited disease of amino and organic acids who is covered under the Certificate of Coverage is covered.

"Low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Services will be subject to Deductible/ Co-insurance/ Co-payments as other similar health services, which shall not be greater than fifty percent of the cost of the formula and food products, and may be subject to an annual benefit maximum no less than the dollar amount per Calendar Year required by Missouri state law per covered child. (Please call the Member Services telephone number printed on your Identification (ID) Card for information on any applicable benefit maximum). Services may require individual Case Management and include contracting with vendors of the formula and food products.

PREGNANCY BENEFITS

Pregnancy Benefits are provided to the same extent as any other Illness under the policy, and include coverage for a minimum of 48 hours of Inpatient care following a vaginal delivery and a minimum of 96 hours of Inpatient care following a cesarean section for a mother and her newly born child in a licensed Hospital or any other health care facility licensed to provide obstetrical care.

Notwithstanding the above, the Plan may authorize a shorter length of Hospital stay for services related to maternity and newborn care if:

- A shorter Hospital stay meets with the approval of the attending Physician after consulting with the mother. The Physician’s approval to discharge shall be made in accordance with the most current version of the “Guidelines for Prenatal Care” prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and
- We provide coverage for post-discharge care to the mother and her newborn. Such post-discharge care shall consist of a minimum of two visits (at least one of which shall be in the home) in accordance with accepted maternal and neonatal physical assessments, by a registered professional Nurse with experience in maternal and child health nursing or a Physician. The attending Physician shall determine the location and schedule of the post-discharge visits. Services provided by the registered professional Nurse or Physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the

medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the Nurse shall be reported to the attending Physician as medically appropriate.

For the purpose of this provision, the term "attending Physician" shall include the attending obstetrician, pediatrician, or other Physician attending the mother or newly born child. This benefit shall be subject to the same Deductible/ Co-insurance/ Co-payments as other similar health care services provided by the Certificate of Coverage. Any applicable Deductible/ Co-insurance/ Co-payments will apply to newborns at the date of birth.

PRESCRIPTION EYE DROP REFILLS

Coverage is provided for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill and the Plan is notified.

PROSTHETICS

Coverage is provided for Prosthetics, the "Covered Services" Section outlines the extent of coverage.

SECOND OPINION

A Covered Person may seek a Second Opinion or Consultation from the Plan's Network of Physicians at no additional cost to the Covered Person beyond what the Covered Person would otherwise pay for an initial medical opinion or consultation. When/if the Plan is made aware we will notify the member or representative that is contacting the plan. In the case of a second opinion for cancer diagnosis, if no specialist in that specific cancer diagnosis area is available In-Network, a referral shall be made to an Out-of-Network specialist in accordance with Missouri statute §376.1253.

TELEHEALTH/TELEMEDICINE SERVICES

Telehealth/telemedicine Services are defined as an "Electronic visit", or "e-visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit.

COVERED EXPENSES FOR THIS BENEFIT:

- Health care services provided through telehealth/telemedicine will receive benefits in the same manner as if provided through face-to-face diagnosis, consultation, or treatment.
- The plan will not require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth/telemedicine determines that the presence of a health care provider is necessary.

LIMITATIONS ARE AS FOLLOWS:

- No reimbursement will be provided to a telehealth/telemedicine provider or a consulting provider for site origination fees or costs for the provision of telehealth/telemedicine services; however, subject to correct coding, reimbursement will be provided to a health care provider for the diagnosis, consultation, or treatment of an insured or enrollee when the health care service is delivered through telehealth/telemedicine on the same basis that health plan covers the service when it is delivered in person.
- Coverage may be limited to health care services that are provided through telehealth/telemedicine to health care providers that are in a network approved by the plan.

- The plan may undertake Utilization Review to determine the appropriateness of telehealth/telemedicine as a means of delivering a health care service in the same manner as those regarding the same service when it is delivered in person.

COSTSHARES:

- A health care service provided through telehealth/telemedicine shall not be subject to any greater Deductible, Co-payment, or Co-insurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.
- The plan shall not impose upon any person receiving benefits under this section any Co-payment, Co-insurance, or Deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan.
- Benefit levels and Deductible/ Co-insurance/ Co-payments shall apply as defined in the Schedule of Benefits.

PRESCRIPTION DRUG BENEFITS

SEE THE SCHEDULE OF BENEFITS FOR ANY APPLICABLE DEDUCTIBLE/ CO-INSURANCE/ CO-PAYMENTS AND BENEFIT LIMITATION INFORMATION.

If drugs and medicines are prescribed to treat you or one of your dependents, the Plan will pay Prescription Drug Benefits for covered charges as stated in the In-Network Pharmacy and Out-of-Network Pharmacy section of the Schedule of Benefits. Prescription Drugs may be subject to a separate Deductible (see Schedule of Benefits for Prescription Deductible/ Co-insurance/ Co-payments) per person.

Prescription Drugs may be subject to a separate Deductible (see Schedule of Benefits for Prescription Deductible/ Co-insurance/ Co-payments) per person. 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 amounts applicable to the Plan.

A list of Participating Pharmacies accompanies the Covered Person's Enrollment material and can be updated by calling the Member Services number or the Pharmacy Benefit Management Company at the number indicated on your ID Card.

If a Covered Person is out of the area, there are participating pharmacies available that should be used. If there are no participating pharmacies available, the Covered Person should purchase the required medications and manually file a Claim following the appropriate billing procedure.

Members currently taking a Prescription Drug shall be notified at least 30 days prior to any deletions, other than Generic substitutions, in the Plan's Prescription Drug Formulary that may affect such Members regarding changes. This notification will be made electronically; or upon request of the Member, notifications will be issued in writing.

PHARMACY BENEFITS MANAGER

The pharmacy Benefits available to you under this Certificate of Coverage are managed by our Pharmacy Benefits Manager (PBM). The PBM is a Pharmacy Benefits Management company with which we contract to manage your pharmacy Benefits. The PBM has a nationwide Network of retail pharmacies, a Mail Service Pharmacy, and provides clinical management services.

The management and other services the PBM provides include among others; making recommendations to and updating the covered Prescription Drug list (also known as a Formulary), and managing a Network of retail pharmacies, operating a Mail Service Pharmacy and a Specialty Drug Pharmacy Network. The PBM, in consultation with us, also provides services to promote and enforce the appropriate use of pharmacy Benefits such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the PBM at the telephone number on the back of your ID Card. The covered Prescription Drug list is subject to periodic review and Amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/ Investigative in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

The PBM shall not require a Covered Person to make a payment for a Prescription drug at the point of sale in an amount that exceeds the lesser of:

- The Co-payment/ Co-insurance amount as required under the health benefit plan; or
- The amount an individual would pay for a Prescription if that individual paid with cash.

A pharmacy or pharmacist shall have the right to provide to a Covered Person, information regarding the amount of the Covered Person's Cost-share for a Prescription drug, the Covered Person's cost of an alternative drug, and the Covered Person's cost of the drug without adjudicating the claim through the PBM. Neither a pharmacy nor a pharmacist shall be proscribed by a PBM from discussing any such information or from selling a more affordable alternative to the Covered Person.

No PBM shall, directly or indirectly, charge or hold a pharmacist or pharmacy responsible for any fee amount related to a claim that is not known at the time of the claim's adjudication, unless the amount is a result of improperly paid claims or charges for administering a health benefit plan.

PREAUTHORIZATION:

Preauthorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Preauthorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a Prescription, the Network pharmacist is informed of the Preauthorization requirement through the Pharmacy's computer system and the pharmacist is instructed to contact us or the PBM. We, or the PBM, use pre-approved criteria and communicate the results of the decision to the pharmacist. We, or the PBM, may contact your prescribing Physician if additional information is required to determine whether Preauthorization should be granted.

If Preauthorization is denied, you have the right to file a Grievance through the Grievance process outlined in the "Grievances" Section of this Certificate of Coverage.

For a list of the current Drugs requiring Preauthorization, please contact the PBM at the telephone number on the back of your ID Card. The covered Prescription Drug list is subject to periodic review and Amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Certificate of Coverage. Please refer to the Plan's formulary for Benefits and restrictions.

Exclusions apply to Experimental or Investigational drugs or supplies as determined by the Plan.

STEP THERAPY

Step therapy protocol means that a Member may need to use one type of medication before qualifying for another medication. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Physician will need to submit a letter to the PBM for review by the PBM and/or us including the following details:

- Member name and ID number
- Diagnosis
- Drug name
- Reason for Grievance

- Physician name, specialty, address and telephone number.

SPECIALTY PHARMACY NETWORK

Our Specialty Pharmacy Network is available to Members who use Specialty Drugs. "Specialty Drugs" are Prescription Drugs that:

- Are only approved to treat limited patient populations, indications or conditions.
- Are normally injected, infused or require close monitoring by a Physician or clinically trained individual.
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any of which make the Drug difficult to obtain through traditional pharmacies.
- Most of these drugs are only available through a Participating specialty vendor. Limited distribution drugs are available through select specialty Providers as determined by the drug manufacturer. Access to limited distribution drugs is available through other specialty Providers in the PBM's Specialty Drug Management Program.

The Specialty Pharmacy Network may fill Specialty Drug Prescription Orders, up to a 30-day supply, and subject to the applicable Deductible/ Co-insurance/ Co-payments shown in the Schedule of Benefits. 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 amounts applicable to the Plan.

The Specialty Pharmacy Network has dedicated patient care coordinators to help you manage your condition and offer toll-free access to Nurses and registered Pharmacists to answer questions regarding your medications.

You may obtain a list of the Specialty Pharmacy Network and covered Specialty Drugs by calling the Member Services telephone number on the back of your ID Card.

THERAPEUTIC SUBSTITUTION OF DRUGS

Therapeutic Substitution of Drugs is a program approved by us and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options.

Therapeutic substitution may also be initiated at the time the Prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact the PBM by calling the telephone number on the back of your ID Card. The therapeutic Drug substitutes list is subject to periodic review and Amendment.

COVERED PRESCRIPTION DRUG BENEFITS

- Prescription Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin, and blood glucose monitoring supplies are Covered Expenses (excludes alcohol wipes). Blood glucose monitors can be obtained by calling the toll-free Prescription Plan telephone number on the back of your ID Card.
- Contraceptive Drugs, including injectable contraceptive Drugs and patches, are covered when obtained through an eligible Pharmacy.

All injectable medications (except insulin) require Plan Approval.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS AND LIMITATIONS

Please also see the "Non-Covered Services / Exclusions" Section of this Certificate of Coverage for other Non-Covered Services.

- Prescription Drugs dispensed by any Mail Service program other than our Mail Service, unless prohibited by law.
- Over the counter medications (except insulin) or medication for which a Generic equivalent can be obtained without a Prescription (unless otherwise specified).
- The Prescription Drug Benefits of this plan include coverage for a limited list of over the counter (OTC) medications. A list of the OTC medications that are covered by this benefit is available by calling the Member Services Department or the Pharmacy Benefit Manager for Cox Health Systems Insurance Company.
  - To obtain the Benefits for covered OTC medications, a valid Prescription by a qualified Provider must be presented to the Participating pharmacy. The qualified OTC medication shall be subject to the same durational limits, dollar limits, and Deductible/ Co-insurance/ Co-payments factors as other Prescription Drug Benefits services in the Plan. The applicable Deductible/ Co-insurance/ Co-payments are detailed in the Schedule of Benefits.
- Off label use, unless approved by us or the PBM.
- Drugs that exceed the limits established by the Plan.
- Drugs not approved by the FDA for their proposed use.
- Prescription Drugs which have not been proven to have superior efficacy or safety through peer-reviewed, objective, evidence-based clinical studies including, require plan approval prior to payment, including but not limited to:
  - Isomeric products
  - Active metabolites
  - Compounded hormone replacement therapy.
- Charges for the administration of any Drug under your pharmacy benefit.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a diagnostic service, with chemotherapy performed in the office, or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug that is used primarily in the treatment of obesity or for weight loss.
- Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin.
- Drugs for treatment of sexual or erectile dysfunctions except as approved with Preauthorization.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as Medical Supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Human Growth Hormone except as approved with Preauthorization.
- Compound Drugs unless there is at least one ingredient that requires a Prescription.
- Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, except as indicated on the Schedule of Benefits.
- Drugs for the treatment of Respiratory Syncytial Virus (RSV) except as approved by Preauthorization.
- Drugs used for cosmetic purposes.
- Vitamins, except pre-natal vitamins.
- Treatment of Onchomycosis (toenail fungus) except as approved with Preauthorization.

- Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. “Clinically equivalent” means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please contact the PBM at the telephone number on the back of your ID Card.
- Prescription Drugs dispensed by any specialty medication pharmacy other than our specialty medication pharmacy except as allowed by the Plan.

Other drugs may be subject to plan limitations or exclusions in addition to those listed above, please refer to the PBM telephone number listed on the back of your ID Card.

DEDUCTIBLE/ CO-INSURANCE/ CO-PAYMENTS

If covered drugs and medicines are prescribed, the Plan will pay Prescription Drug Benefits for charges subject to a separate Deductible/ Co-insurance/ Co-payments if applicable as stated in the Schedule of Benefits.

If a covered drug is prescribed in a single dosage amount but not manufactured in such single dosage amount and dispensing requires a combination of different manufactured dosage amounts, only one Co-insurance/ Co-payment shall apply for the dispensing of the combination of manufactured dosages that equal the prescribed dosage, not to exceed a one month supply. Please contact the Member Services Department at the number indicated on your ID Card for Preauthorization before purchase; or if unable at the time, to request reimbursement after purchase.

Each Prescription Order may be subject to a Deductible and Co-insurance/ Co-payment. If the Prescription Order includes more than one covered Drug, a separate Co-insurance/ Co-payment will apply to each covered Drug.

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 amounts applicable to the Plan.

Your Prescription Drug Deductible/ Co-insurance/ Co-payments will be the lesser of your scheduled Deductible/ Co-insurance/ Co-payments amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible/ Co-insurance/ Co-payments.

GENERIC DRUG ENCOURAGEMENT

- The Prescription Drug benefit is a “Mandatory Generic” program. Each Prescription will be filled as a Generic when available. If the Physician or the Covered Person requests a Brand Name Medication when there is an FDA “AB” rated Generic available, the Covered Person will be charged the applicable Deductible/ Co-insurance/ Co-payments plus the difference in the price of the Brand Name Medication and the available Generic. Exceptions may apply, please refer to your Formulary.
- If a Generic drug is not available, other drugs will be classified as either preferred brand drugs or non-preferred brand drugs. Preferred brand drugs will be determined by the Plan and updated periodically. Preferred brand drugs will have a lower Deductible/ Co-insurance/ Co-payments than non-preferred brand drugs. Your Physician has the flexibility of ordering covered drugs in accordance with his medical judgment; however, the amount of Deductible/ Co-insurance/ Co-payments will depend upon the placement of the drugs on the Formulary.
- We may offer incentives to encourage the use of Generic Drugs. This may involve waiving a Deductible/ Co-insurance/ Co-payment for certain Generic Drugs for a period of time, or other incentives.
- After any applicable Prescription Deductible has been met a Co-payment may be assessed for each 30 day supply. Some drugs based upon Plan’s determination, manufacturer’s recommendation, and/or advice of the Plan’s Pharmacy & Therapeutics Committee may have a maximum limit less than a 30 day supply per Co-payment.

If you are going on vacation and you need more than the days' supply allowed under this Certificate of Coverage, you should ask your Pharmacist to call the PBM and request an override for any additional refills. This will allow you to fill your next Prescription early.

TIERS

Your Deductible/ Co-insurance/ Co-payments amount may vary depending on which of the tiers of the Plan's Prescription Drug Formulary the Prescription Drug or Specialty Drug is listed. The determination of Tiers is made by us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. 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 amounts applicable to the Plan.

PAYMENT OF BENEFITS

The amount of Benefits paid is based upon whether you receive the Covered Services from an In-Network Pharmacy, Participating Pharmacy, Specialty Pharmacy, or our Mail Service Program. It is also based upon which Tier we have classified the Prescription Drug or Specialty Drug. Please see the Schedule of Benefits for the applicable amounts, and the Formulary for applicable limitations on number of days' supply.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by us for any Covered Service unless the negotiated rate exceeds any applicable Deductible/ Co-insurance/ Co-payments for which you are responsible.

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.

For Covered Services provided by a Network Pharmacy or Specialty Drug Network Pharmacy or through our Mail Service, you are responsible for Deductible/ Co-insurance/ Co-payments amounts. Benefits are not provided for drugs obtained from an Out-of-Network Pharmacy.

NETWORK PHARMACY

A list of Participating Pharmacies may be obtained by contacting the PBM as listed on your ID Card. If a Covered Person is out of area, there are Participating Pharmacies available that should be used.

SPECIALTY DRUGS

You or your Physician can order your Specialty Drugs directly from the Specialty Network Pharmacy. Please contact the PBM listed on the ID Card for the telephone number or website of the Specialty Network Pharmacy.

OUR MAIL SERVICE

Registration through the PBM, at the telephone number listed on the back of your ID Card, is required to use Mail Service prior to submission of your first Prescription. Written Prescriptions from your Physician may be mailed, or your Physician may phone or fax the Prescription to the Mail Service. You will need to submit the applicable Deductible/ Co-insurance/ Co-payments amounts to the Mail Service when you request a Prescription or refill.

DRUG EXCEPTIONS PROCESS

An enrollee, the enrollee's designee, or the enrollee's prescribing Physician (or other prescriber, as appropriate) may request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception). In the event that an exception request is granted, the Plan will treat the excepted drug(s) as an essential health benefit.

STANDARD EXCEPTION REQUEST

An enrollee, the enrollee's designee, or the enrollee's prescribing Physician (or other prescriber) may request a standard review of a decision that a drug is not covered by the Plan.

CHP will make a determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing Physician (or other prescriber, as appropriate) of the coverage determination no later than 72 hours following receipt of the request.

For any standard exception request that is granted, the Plan will provide coverage of the non-Formulary drug for the duration of the Prescription, including refills.

EXPEDITED EXCEPTION REQUEST

An enrollee, the enrollee's designee, or the enrollee's prescribing Physician (or other prescriber) may request an expedited review based on exigent circumstances.

Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-Formulary drug.

CHP will make a coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing Physician (or other prescriber, as appropriate) of the coverage determination no later than 24 hours following receipt of the request.

For any exception based on exigent circumstances that is granted, the Plan will provide coverage of the non-Formulary drug for the duration of the exigency.

EXTERNAL EXCEPTION REQUEST REVIEW

If a request for a standard exception or for an expedited exception as outlined above is denied; the enrollee, the enrollee's designee, or the enrollee's prescribing Physician (or other prescriber) may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

The Plan will make a determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing Physician (or other prescriber, as appropriate) of the coverage determination within these timelines:

- For an external exception review request, no later than 72 hours following receipt of the request, if the original request was a standard exception request as defined above,
- For an expedited exception request, no later than 24 hours following its receipt of the request, if the original request was an expedited exception request as defined above.

For any external exception review granted of either a standard exception request or an expedited exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the Prescription.

SECTION 6. NON-COVERED SERVICES / EXCLUSIONS

In addition to any other exclusions and limitations described in this Plan, there are no benefits provided for Services obtained from an Out-of-Network (Non-Participating) Provider, except for Emergency Services (including those provided by an Urgent Care facility) and two sessions per year for the purpose of diagnosis or assessment of mental health.

ALTERNATIVE TREATMENTS

- Services or supplies including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bio-energetic synchronization technique (BEST), iridology (study of the iris), auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy and neurofeedback.

DENTAL

- Diagnosis and treatment to repair accidental injuries to natural teeth or dental prostheses and dental x-rays except as otherwise specified; operation on the mandible or maxillae for cosmetic purposes, correction of malocclusion.

DEVICES, APPLIANCES, PROSTHETICS AND SUPPLIES

- Over the counter Disposable supplies and medicines that are self-administered for care of minor problems, not requiring a Prescription by State or Federal regulation (unless otherwise specified in the Pharmacy Benefit Provision).
- All artificial aids, corrective appliances, and other Prosthetic devices not specifically listed as a Covered Service in this Certificate of Coverage.
- Fabric compression garments available for over the counter purchase including but not limited to leotards, pressure leotards, elastic bandages, support hose, fabric supports and surgical leggings. This exclusion does not apply to custom fitted fabric compression garments, not available for purchase over the counter.
- Prosthetic devices or additions/components not required for participation in normal activities of daily living, including those that are chiefly for convenience, for participation in recreational activities, or that otherwise exceed the medical needs of the individual.

DRUGS

- Please refer to the Prescription Drug Benefits subsection of Covered Services for Prescription Drug Benefit Exclusions and Limitations.

EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

- Experimental, Investigational or Research Services:
  - Procedures, equipment, treatment, services, drug, or drug usage, facility or facility usage, or supplies and all services related to Experimental, Investigational or Unproven services that the Plan determines and defines to be Experimental, Investigational or Unproven. The fact that a service is the only available treatment for a particular condition will not make it eligible for coverage if it is considered to be Experimental Investigational or Unproven in the treatment of that particular condition.
  - Procedures, services, or supplies that have not been determined through objective evidenced-based, peer-reviewed, medical literature to be safe and/or effective for the proposed use.
    - This exclusion does not apply to Clinical Trials for which benefits are provided as described in under Clinical Trials in Section 5, Covered Services.

FOOT CARE

- Treatment of weak, strained, or flat feet, including orthopedic shoes, and other supportive devices, including arch supports, corrective shoes and inserts.
- Routine foot care, which includes the cutting or removal of corns, or calluses, the trimming of nails and other hygienic and preventive maintenance care, except for treatment associated with diabetes, peripheral neuropathies, or peripheral vascular disease.

NUTRITION

- Orthomolecular therapy and/or nutrients, vitamins, and food supplements except for supplements intended for specific deficiencies (i.e. B-12 deficiency anemia or other specified anemias).
- Over the counter baby formulas.

PERSONAL CARE, COMFORT OR CONVENIENCE

- Lifestyle improvements, personal hygiene, environmental control, or convenience items including but not limited to:
  - Air conditioners, humidifiers, air purifiers.
  - Physical fitness or exercise equipment such as a treadmill or exercise cycles.
  - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program.
  - Charges from a physical fitness program, health spa, gym or similar facility.
  - Massage therapy, aquatic exercise programs, and any associated membership fee or fees for the use of facility, pool, or equipment.
  - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots, or visitor's meals.
  - Charges for non-medical self-care except as otherwise stated.
  - Purchase or rental of supplies for common household use, such as water purifiers.
  - Hypoallergenic pillows, cervical neck pillows, special mattresses, or waterbeds.
  - Safety helmets for Members with neuromuscular diseases; or sports helmets.
  - Car seats.
- Any equipment or supplies including but not limited to: equipment that conditions the air, heating and cooling pads, hot water bottles, personal care items, wigs, hairpieces and their care; items for comfort or convenience, such as, whirlpools, Jacuzzis and any other primarily non-medical equipment; warning devices for non-life-threatening conditions; stethoscopes, blood pressure cuffs or other types of apparatus used for diagnosis.
- Services and supplies that are not immediately nor clinically appropriate.

PHYSICAL APPEARANCE

- Service, Surgery, and supplies for cosmetic purposes or to improve appearance, including restoration of hair and appearance of skin. This provision does not apply to newborns as stipulated under the Covered Services.
- Surgical treatment of scarring secondary to acne or chicken pox to include, but not limited to dermabrasion, chemical peel, salabrasion and collagen injections.
- Rhinoplasty whether an independent procedure or done in conjunction with any other surgical procedure.

PROCEDURES AND TREATMENTS

- Growth hormones, with the exception of approval by Preauthorization and clinical review.
- Complications as the result of Non-Covered Service/Surgery are not covered by the Certificate of Coverage. This exclusion does not apply to emergency complications.

- Complications directly related but not limited to cosmetic or obesity services, treatment or Surgery, as determined by us are not covered. This exclusion applies even if the original services treatment or Surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate of Coverage. Directly related means that the treatment or Surgery occurred as a direct result of the services treatment or Surgery and would not have taken place in the absence of the services treatment or Surgery.
  - This exclusion does not apply to emergency complications.
  - This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.
- Services, Surgery and supplies for diagnosis and treatment of temporomandibular joint (TMJ) pain-dysfunction syndrome, craniomandibular dysfunction or related diagnoses.
- Services, supplies, medication, or treatment for any type of obesity, including but not limited to Surgery, diet instruction, exercise programs, or other regimens for reducing caloric absorption or controlling weight.
- Marriage counseling.

PROVIDERS

- Services prescribed, ordered or referred by, or received from a Member of your Immediate Family; including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, grandparent/step-grandparent in-law, or self.
- Services rendered or billed by a school or halfway house.
- Christian Science Practitioners.
- Mailing and/or shipping and handling expenses, unless otherwise required by law.
- Services received from an individual or entity that is not a Provider, as defined in this Certificate of Coverage, or recognized by us.

REPRODUCTION AND SEXUAL PROCEDURES

- Services, supplies, and medications for the treatment of sexual dysfunction that is not related to organic disease. This exclusion also includes penile prostheses or implants, vascular or artificial reconstruction, and other procedures and equipment developed for or used in the treatment of impotency.
- For services and supplies related to sex transformation and/or the reversal thereof, including penile prosthesis, penile implant or other equipment, vascular or artificial reconstruction, and related diagnostic testing as related to sex transformation. This exclusion does not apply to mental health or pharmacy benefits.
- Services, drugs, supplies related to the evaluation, diagnosis, and treatment of Infertility are not covered.
- Services, Surgery, drugs and supplies for aiding conception. This includes but is not limited to drug regimens, artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures. It also includes surgeries whose main purpose is to improve the opportunity for conception.
- Services, supplies and equipment for home uterine activity monitoring.
- Services and supplies to reverse an elective sterilization procedure.
- Elective abortion. For purposes of this section, an elective abortion means an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed.

SERVICES PROVIDED UNDER ANOTHER PLAN

- Services or supplies to the extent they have been covered under any other health care program issued by Cox Health Systems Insurance Company.

- Services and supplies to the extent they are covered by any governmental unit, except as required by federal law for veterans in Veteran's Administration or armed forces facilities for non-service related medical conditions. This Certificate of Coverage will provide coverage on a primary or secondary basis as required by state or federal law. Any free service or supply that you receive from any governmental body or subdivision thereof (unless the insured is legally required to pay in the absence of insurance) and any public or private educational institution is not covered.

TRANSPLANTS

- Treatment related to human organ transplants which have not been determined by this Plan to be Medically Necessary or are Experimental, Investigational, or for Research Purposes including expenses related to transplantation of animal, human and/or artificial organs.
- All health services for or related to the removal of an organ/tissue from a Covered Person for purposes of transplantation into another person unless the transplant recipient is also covered under this Certificate of Coverage and such services are not payable by any other group plan.

TRAVEL

- Travel, whether or not recommended or prescribed by a Physician, except transportation by local professional ambulance to nearest health care facility qualified to treat Injury or disease. Travel exclusions include, but are not limited to, oxygen supplies and other Medical Supplies.
- Health services provided in a foreign country unless required as Emergency health services.
- Air Ambulance Services outside the Continental United States except in Emergency situations as approved by the Plan
- Non-medical expenses, including but not limited to, out-of-hospital living expenses such as hotel or motel, meals, transportation and entertainment.
- Immunizations for travel related to work or pleasure are Non-Covered Services.

TYPES OF CARE

- Home Health Services for the following:
  - Services and supplies not part of the Home Health Care plan.
  - Services of a Covered Person’s Immediate Family or a person residing with the Covered Person receiving care.
  - Transportation.
  - Disposable supplies self-administered for care of minor problems.
- Private Duty Nursing.
- Confinement in a Skilled Nursing Care home, convalescent Hospital, a facility or that part of a facility which is primarily for:
  - Rest care, convalescent, Custodial Care.
  - Rehabilitation training, schooling, or occupational therapy unless part of an approved treatment plan for Autism Spectrum Disorders.
  - Care provided or billed by a hotel, wilderness camp, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Respite care is not a covered benefit.
- Services and/or supplies for custodial, convalescent or intermediate level care, domiciliary care, rest cures, or care designed primarily to assist in activities of daily living.
- Treatment for any conditions for Inpatient confinement for the purpose of environmental change.

- Any service or supply that is not Medically Necessary whether or not recommended, provided or prescribed by a Physician.
- Services or supplies that are considered obsolete and no longer meet accepted standards of medical practice as determined by established medical review mechanisms.
- Private room accommodations to extent charges are in excess of the institution's most common semi-private room charge, unless the Plan approves the Medical Necessity of the accommodations.

VISION AND HEARING

- The purchase, examination, and supplies for Prescription and Prosthetic devices, eye glasses, contact lenses, or, except for soft lenses or sclera shells intended for use in the treatment of a disease or Injury.
  - Exception: Coverage will be available for the first pair of eyeglass lenses and/or contact lenses after cataract Surgery while covered by this Certificate of Coverage subject to any applicable Deductible/ Co-insurance/ Co-payment.
- Vision therapy.
- Surgery that is intended to provide better vision without glasses or other vision correction including radial keratotomy, laser, and other refractive eye Surgery.
- Any examination, procedure, or supplies associated with a cochlear implant.

TERMS OF COVERAGE

- Medical Services for any person not covered by the Plan.
- Services incurred prior to the Effective Date of coverage for a Covered Person.
- Services incurred after a Covered Person's Termination of coverage, after any extension of Benefits or continuation of coverage as specified in this Certificate of Coverage.
- Out-of-Pocket costs, including Deductible/ Co-insurance/ Co-payments.
- The Plan will not pay for any amounts in excess of the Maximum Allowable Amount for Covered Services.
- Charges by a Hospital, or ancillary Provider (including but not limited to pathologist, radiologist, anesthesiologist, etc.) when the procedure being performed is not covered by the Certificate of Coverage.
- Care or treatment for which no charge has been made.
- Charges for missed appointments, administrative fees, including but not limited to medical records not requested by the Plan, or other administrative sanctions.

SERVICES / TESTING WHICH ARE PERFORMED, REQUESTED, OR PROVIDED BY THIRD PARTIES

- Any services, supplies or examinations furnished for the protection or convenience of, or to meet a requirement of third parties. This includes medical, physical, mental health, and Substance Use Disorders. Third parties include, but are not limited to, attorneys, school systems, Employers, and insurers or court ordered commitments except as otherwise stated under Preventive Services.
- Services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.
- Services for injuries or diseases related to a Covered Person's job to the extent he is covered or required to be covered by a worker's compensation law. If the Covered Person enters into a settlement giving up rights to recover past or future medical Benefits under a worker's compensation law, this Certificate of Coverage will not cover past or future medical services that are the subject of or related to that settlement. In addition, if the Covered Person is covered by a worker's compensation program that limits Benefits if other than specified Providers are used, and the Covered Person receives care or services from a Provider not specified by the program, this Certificate of Coverage will not cover the balance of any costs remaining after the program has paid.
- Vocational Rehabilitation Services.

    - This exclusion does not apply to treatment of “Autism Spectrum Disorders” as outlined in the “Covered Services” section.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified, such as treatment for Autism or ABA services.
- Screening examinations, examinations for or in connection with insurance, employment, extracurricular school activities, or any recreational activities; exercise programs and equipment such as, but not limited to, bicycles and treadmills.
- Care for conditions that the state or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
- For court ordered testing or care unless the service is Medically Necessary.
- Non Routine Immunizations, screening tests, vaccinations, exams or treatments, such as but not limited to services that:
    - Are related to judicial or administrative proceedings or orders.
    - Are conducted for purposes of medical research.
    - Are to obtain or maintain a license or official document of any type.

ALL OTHER EXCLUSIONS

- Services received for any Illness or Injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
- Injury or Illness resulting from any act or incident of war, whether declared or undeclared, insurrection or any atomic explosion or other release of nuclear energy (except when being used solely for medical treatment of an Injury or Illness), whether in peacetime or in wartime and whether intended or accidental.
- Injury or Illness to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation.
- Care and treatment for a condition resulting from direct participation in a riot or civil disobedience.

No payment will be excluded due to suicide or attempted suicide while insane; unintentional or involuntary inhalation of gas or taking of poisons; pyogenic infections which result from an accidental bodily injury; bacterial infections which result from the accidental ingestion of a contaminated substance; or the insured's being under the influence of drugs if these drugs were taken as prescribed by a Physician.

SECTION 7. CLAIMS PAYMENT

DEDUCTIBLE

The Deductible is the amount you are required to pay toward covered charges each year before the Plan begins paying toward your Claims. The specific maximum amount of your Deductible is specified in the Schedule of Benefits attached to your Certificate of Coverage.

Each Dependent who is a Covered Person is subject to the same Deductible as the Employee. No further Deductible is necessary for the Benefit Year once family Members have accumulated Deductible Amounts that satisfy the family Deductible maximum stated on the Schedule of Benefits. No one individual shall contribute more than his individual Deductible amount for the specific Certificate of Coverage toward the family Deductible (with the exception of plans with non-Embedded Deductibles). Pharmacy Benefits do not have a family Deductible maximum unless specifically outlined on your Schedule of Benefits.

Deductibles are applied in the order received by the Plan. The Benefits in the Certificate of Coverage are subject to a Deductible, unless otherwise noted. In calculating Benefits payable, the Deductible first shall be applied to the allowable expenses covered by the policy or certificate prior to applying any applicable Co-insurance factor.

Your Certificate of Coverage may require one Deductible amount to be applied for covered medical services received and a separate Deductible to be applied for covered pharmaceutical services. The Schedule of Benefits identifies the Deductible amounts applicable to your Certificate of Coverage. If separate Deductibles do apply, each Deductible amount shall remain separate and distinct from one another.

DEDUCTIBLES WILL APPLY IN ACCORDANCE WITH THE FOLLOWING SCHEDULE:

- Existing Covered Persons of the Plan: January 1 through December 31.
- New Covered Persons of existing Certificate of Coverage: Effective Date through December 31.
- When a Policyholder's entire group changes coverage to our Plan during a Calendar Year, amounts paid under the prior plan for that Calendar Year will be credited toward the Deductible required within your Certificate of Coverage. Any employees or dependents added to the Plan after the initial Enrollment will be considered a new Covered Person of an existing Certificate of Coverage, upon plan-approved documentation.
- We will not credit accrued Out-of-Network Deductible amounts if a Covered Person moves from one Employer plan to another plan.
- When a Covered Person exercises the Continuance of Coverage provision that Covered Person's Deductible accumulated during the Calendar Year will apply to the continuance.
- Amounts paid toward Non-Covered Services are not part of your Deductible and do not apply toward your Deductible.
- Pharmacy Deductible does not carry over from previous plan unless your plan has a combined medical/ pharmacy Deductible.
- 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 and/or Out-of-Pocket Maximum applicable to the Plan.

CO-INSURANCE/ CO-PAYMENTS

Co-insurance is the percentage of covered charges you will be responsible to pay if you have met your Deductible when you receive a Covered Service. In most cases, the Provider may request you pay the Co-insurance/ Co-payment due from you at the time of service.

Co-payment is a fixed amount you will pay when you receive a covered medical service or covered pharmacy service.

- A Co-payment will be required for medical services received whether or not you have met your Deductible.

- The Deductible for pharmacy services must be met before a Co-payment will be required for pharmacy services.
- 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 Out-of-Pocket applicable to the Plan.

The amounts you pay towards your Deductible are not considered a Co-insurance or Co-payment.

OUT-OF-POCKET MAXIMUM

An important feature of your Certificate of Coverage that provides additional protection to Covered Employees and their covered family Members is a maximum annual Out-of-Pocket Limit. Each Calendar Year, the total amount of Deductibles/Co-insurance/Co-payments you pay for medical services shall not exceed the Out-of-Pocket Maximum Limits for medical services established by your Certificate of Coverage. Amounts you pay for Non-Covered Services do not apply toward the maximum annual Out-of-Pocket Limit.

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 Out-Of-Pocket Maximum applicable to the Plan.

Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on your Plan's Out-of-Pocket Maximum for the Covered Service that you receive. The Out-of-Pocket Maximum for this Plan is the maximum amount of reimbursement we will allow for services and supplies that:

- Meet our definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- Are Medically Necessary; and
- Are provided in accordance with all applicable Pre-authorization, utilization management, or other requirements set forth in your Plan.

You will be required to pay a portion of the Out-of-Pocket Maximum to the extent you have not met your Deductible, or have a Co-payment or Co-insurance.

Generally, services received from an Out-of-Network Provider under this Plan are not covered except for Emergency care, two office sessions per year for the purpose of diagnosis or assessment of mental health, or when services have been previously authorized by us. When you receive Covered Services from an Out-of-Network Provider either in an Emergency or when services have been previously authorized, you may be responsible for paying any difference between the Out-of-Pocket Maximum and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Out-of-Pocket Maximum. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary.

DEDUCTIBLES/CO-INSURANCE/CO-PAYMENT AMOUNTS APPLY AS FOLLOWS:

Co-insurance/Co-payments amounts you pay for Covered Services to In-Network Providers will be applied to the In-Network Maximum Annual Out-of-Pocket Limit only.

The specific maximum annual Out-of-Pocket Limits are identified in the Schedule of Benefits attached to your Certificate of Coverage.

Amounts paid as penalties for failing to obtain Preauthorization when required are not applied toward your Out-of-Pocket Maximum Limit.

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 Out-of-Pocket Maximum applicable to the Plan.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or an Out-of-Network Provider.

For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for Your Plan is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met Your Deductible or have a Co-payment or Co-insurance.

If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency care, two office sessions per year for the purpose of diagnosis or assessment of mental health, or unless the services were previously authorized by us.

Out-of-Network claims may be priced using the Plan's pricing arrangements required by applicable State or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained In-Network, or a special negotiated price.

Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will result in lower Out-of-Pocket costs to you.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

CLAIMS REVIEW FOR FRAUD, WASTE AND ABUSE

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency services, Urgent Care services received in an Urgent Care Center or other services authorized by us in accordance with this Certificate from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

RIGHTS TO RECOVERY

If the amount of the payments made by Cox Health Systems Insurance Company is more than it should have paid it may recover the excess from the person it has paid or for whom it has paid.

The amount of the payments made includes the reasonable cash value of any Benefits provided in the form of services. This right to recovery is limited to within 12 months from the date the claim was paid, except in cases of fraud or misrepresentation by the health care Provider.

SECTION 8. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE

ELIGIBILITY

ELIGIBLE EMPLOYEE:

- A lawful permanent resident as defined by the United States Citizenship and Immigration Services (USCIS), with a current U.S. Street address, and
- Meets the Policyholder's prescribed Waiting Period for eligibility for health Benefits, and
- Submits a completed appropriate Plan-provided Enrollment form to Plan within the prescribed time limits, and
- Actively at Work, and
- Working the minimum number of hours as specified in the Employer Agreement and Group Application and verifiable by Policyholder's quarterly Missouri State Wage and Contribution reports, or
- Owner of company and/or similarly situated individuals as agreed upon by the Plan, or
- Independent contractors of Policyholder as agreed upon by the Plan.

Note: An employee who meets the eligibility criteria may decline coverage if a waiver of coverage is signed.

ELIGIBLE DEPENDENTS:

An eligible "Dependent" shall mean:

- A lawful permanent resident as defined by the United States Citizenship and Immigration Services (USCIS), with a current U.S. Street address and;
- a Covered Employee's lawful spouse who is a lawful permanent resident of the U.S. with a current U.S. street address; or the child of a Covered Employee or their Dependent spouse to include the natural child, step child, foster child, any child for whom the Covered Employee or their Dependent spouse has been granted legal custody, or a child in the process of being adopted, from the date of placement in the home who; is under 26 years of age, and / or;
- has a Disability which occurred prior to age 26 which renders the dependent to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance.
  - Proof of such incapacity and dependency must be furnished to the Plan by the certificate holder at least thirty-one days after the child's attainment of the limiting age. The Plan may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, the Plan may require subsequent proof not more than once each year.

Coverage of a Dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance.

A person may not be covered as both a Covered Employee and a Dependent within the same Employer sponsored group under this Certificate of Coverage. Coverage as a Dependent terminates when coverage as a Covered Employee begins.

A person may not be covered under this Certificate of Coverage as a Dependent of more than one Covered Employee within the same Employer sponsored group.

ENROLLMENT

INITIAL ENROLLMENT FOR NEWLY ELIGIBLE EMPLOYEES

- An employee who newly attains eligibility by meeting the terms and conditions as set forth in the Certificate of Coverage and Employer Agreement and Group Application may Enroll by submitting to Plan a completed Plan Enrollment form.
- Eligible Dependents of a newly eligible employee must be Enrolled at the same time as the employee or provide written waiver of coverage.
- The completed Enrollment form must be received by Plan within 31 days of the employee and dependents becoming eligible.
- Failure to submit the completed application form within the required 31 days shall constitute waiver of the right to Enroll until the next Annual Open Enrollment Period.
- An Employee may choose to waive the right to Enroll by submission of a completed Plan Enrollment form with the waive option selected.

ANNUAL OPEN ENROLLMENT PERIOD

- The Annual Open Enrollment Period shall be held the first 31 days after the anniversary date of the Policyholder's Effective Date of coverage, (or other such date as agreed by Policyholder and Plan) and the Policyholder and Plan enter into agreement to continue coverage.
- An employee who had previously declined employee-only and/or dependent coverage and meets eligibility as set forth in the terms and conditions as set forth in the Certificate of Coverage and Employer Agreement and Group Application may Enroll by submitting to Plan a completed Plan Enrollment form during the Annual Open Enrollment Period and any Premiums due.
- The completed Enrollment form must be received by Plan no later than 5 business days after the end of the Annual Open Enrollment Period.
- Failure to submit the completed application form within the Annual Open Enrollment Period shall constitute waiver of the right to Enroll until the next Annual Open Enrollment Period unless there is a qualifying event.

SPECIAL ENROLLMENT PROVISIONS

The following describes Special Enrollment provisions that allow for an eligible Covered Employee or Dependent who did not elect coverage under this Certificate of Coverage at the Initial Enrollment Period or subsequent Open Enrollment Periods to Enroll with the Plan by means of a qualifying event.

LOSS OF COVERAGE WITH ANOTHER HEALTH PLAN EXCEPT:

- For failure to pay Premiums, or
- Termination for cause.

LOSS OF COVERAGE AS A RESULT OF:

- Exhaustion of COBRA continuation coverage;
- Termination of employment,
- Loss of Eligibility for coverage,
- Death of a Covered Employee's spouse,
- The Covered Employee's legal separation or divorce from spouse,
- Termination of Policyholder contributions towards coverage,

- Employee's or Dependent's loss of coverage under Medicaid or the State's Children's Health Insurance Program (SCHIP),
- In the event a person covered as a dependent under another Employer sponsored group plan is deemed ineligible for Enrollment due to their own access to another group plan.
- Change of Coverage under another Employer's Plan during that Plan's Open Enrollment Period.

NEWLY ACQUIRED DEPENDENTS

- A court or administrative order stating the Covered Employee shall provide insurance for the Dependent child, or a Dependent child who would otherwise meet eligibility requirements for coverage at Open Enrollment.
- A court or administrative order granting Legal Custody/Guardianship for the Dependent child, or a Dependent child who would otherwise meet eligibility requirements for coverage at Open Enrollment.
- A person becomes your eligible Dependent through marriage, birth, or adoption or placement for adoption; (in the case of the birth, adoption of a child, or placement for adoption, your spouse may also be Enrolled as your Dependent if s/he is otherwise eligible for coverage. Other dependents who are not currently Enrolled cannot be added at this time).
- Members with existing dependent (employee/ spouse, employee/ child, employee/ family) coverage: Newborns are covered under your Membership for the first 31 days. This includes an adopted newborn or a newborn placed in your physical custody so long as we receive the court-approved adoption petition or placement documents within 31 days of birth. For continued coverage beyond the 31 day period, we must receive a completed Special Enrollment application within 31 days of birth, or within 10 days from the date the forms and instruction are issued, whichever is later (provided the Enrollee has contacted CHP within the 31 days grace period). An increase in Premium may apply from the date of birth.
- Policyholders with employee-only coverage: Special Enrollment Options are available for newborn coverage. The coverage will be effective at the date of birth, upon timely receipt of the Special Enrollment application. This includes an adopted newborn or a newborn placed in your physical custody, as long as we receive the court-approved adoption petition or placement documents within 31 days of birth, or within 10 days from the date the forms and instruction are issued, whichever is later (provided the Enrollee has contacted CHP within the 31 days grace period).

For those Covered Persons whose Employer Agreement and Group Application require no additional Premium to add a newborn to the Plan, we will allow Special Enrollment to take place within 90 days of the event.

The eligible Covered Employee or Dependent will have a Special Enrollment Period of 31 days (unless otherwise stated above) that begins on the date of the Special Enrollment Provision, as long as the Waiting Period provisions are met as required within this Certificate of Coverage.

EFFECTIVE DATE OF COVERAGE

ANNUAL OPEN ENROLLMENT PERIOD

If the employee's request is received by the Plan during the Annual Open Enrollment Period, coverage will begin on the anniversary of the Policyholder's Effective Date of coverage or as otherwise determined by the Plan.

Coverage for eligible dependents will begin at the same time as the eligible Employee if:

- the Employee has requested dependent coverage during Annual Open Enrollment Period,
- submitted a completed application form, and
- paid the required Premium.

NEWLY ELIGIBLE EMPLOYEES

After an eligible Employee meets Enrollment requirements, the Effective Date of coverage will begin the first Service Date following date of completion of Waiting Period, or as agreed to in Employer Agreement and Group Application and Certificate of Coverage.

SPECIAL ENROLLMENT

If the employee's request is received by the Plan during the 31 day Special Enrollment period, the coverage shall become effective:

- in the case of marriage, on the first day of the first calendar month following the date of marriage; or on an earlier date as agreed to by the Plan;
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption,
- in the case of a court or administrative order granting Legal Custody/ Guardianship, on the first day of the first calendar month following the order; or on an earlier date as agreed to by the Plan,
- in the event of Loss of coverage, on the first day of the first calendar month following the Loss of coverage; or on an earlier date as agreed to by the Plan.
- In the event of Employee's or Dependent's loss of coverage under Medicaid or the State's Children's Health Insurance Program (SCHIP), the Special Enrollment Period is a length of 60 days.

SECTION 9. TERMINATION

TERMINATION OF COVERED PERSON'S COVERAGE

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual Effective Date of Termination may vary based on your Group's agreement with us and your specific circumstances, such as whether Premium has been paid in full:

- If you voluntarily elect to terminate coverage for yourself or dependents while still eligible, Termination will generally be effective on the last day of the billing period in which we received your notice of Termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements, or are no longer Actively at Work as outlined in this Certificate of Coverage, your coverage will terminate on the last day of the billing period or as agreed to in the Employer Agreement and Group Application. The Group and/or you must notify us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act or practice that constitutes fraud or an intentional misrepresentation of material fact relating to Claims or application for coverage, then we may terminate your coverage upon a 30 day written notice to the Policyholder as permitted by current state and federal guidelines. You are responsible to pay us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Co-payments made or Premium paid for such services. On the date your coverage is terminated, we will also terminate your Dependent's coverage. We will notify the Group in the event we terminate you and your Dependent's coverage.
- If payment and/or satisfactory arrangements to pay have not been made in accordance with the terms of the Group Contract, we may terminate your coverage and may also terminate the coverage of your Dependents, generally effective immediately upon our written notice to the Group.
- If you permit the use of your or any other Member's Plan ID Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan ID Card will be liable to and must reimburse us for the Maximum Allowable Amount for services received through such misuse.

EMPLOYEE COVERAGE TERMINATION

A Covered Employee's insurance will terminate, except as provided in the Continuance of Coverage provision, upon the occurrence of the first of the following events:

- this Certificate of Coverage terminates;
- the Employee's employment terminates;
- the Employee is no longer Actively at Work;
- the Employee's Employer ceases to be a participating Employer under this Certificate of Coverage;
- an active Employee voluntarily terminates his coverage under this Certificate of Coverage;
- the Employee ceases to be employed in an eligible employment status;
- the Employee is on unpaid medical or personal leave, unless coverage is continued pursuant to the Family Medical Leave Act if applicable; or
- the Premium for the Employee's insurance has not been paid within the grace period.

Coverage for terminating employees will end the last day of the service period following termination or date of termination indicated on the Employer Agreement and Group Application, provided notification is received by CHP within 31 days of the coverage of Termination Date, or as agreed upon by the Plan.

Employment Termination, for purposes of this Certificate of Coverage, occurs when a Covered Employee is not Actively at Work; however, an Employee who is in one of the following special classes:

- Disabled, after having been Actively at Work for at least one year prior to commencement of the Disability.
- Family Medical Leave Act (FMLA) after having been Actively at Work for at least one year;
- on a leave of absence; or
- temporarily laid-off.

Will be deemed Actively at Work, until the first of the following occurrences:

- the Policyholder terminates insurance for Employees in one or more of the special classes, by giving the Plan written notice of such Termination;
- the Policyholder stops paying Premium for one or more of the special classes;
- the Employee has been continuously Disabled for 90 consecutive days;
- the Employee commences work for remuneration or profit with any Employer other than the Policyholder; or
- the Employee is on a leave of absence or temporary layoff, for a period exceeding the end of the policy month following the policy month during which the leave of absence or layoff commences.

DEPENDENT COVERAGE TERMINATION

The insurance of a Covered Employee's Covered Dependent will terminate, except as provided in the Continuation of Coverage provision, upon the occurrence of the first of the following events:

- this Certificate of Coverage terminates;
- the Employee's coverage terminates for any reason, except due to the Employee's attainment of the maximum amount payable under this Certificate of Coverage;
- the Employee's Employer ceases to be a subsidiary of or affiliated with the Policyholder;
- the required Premium is not paid within the grace period;
- the Dependent no longer meets the eligibility requirements unless the Dependent is incapable of self-support due to mental or physical handicap; or
- an active Employee voluntarily terminates Dependent coverage under this Certificate of Coverage.

Coverage will terminate end of the month following the Plan’s receipt of request, or on an earlier date as agreed to by the Plan.

RESTRICTIONS ON TERMINATION

Should a Covered Employee and/or Covered Dependent terminate coverage, eligibility for future coverage shall be at Open Enrollment Period unless Special Enrollment/eligibility conditions are met.

CONTINUANCE OF BENEFITS

FEDERAL CONTINUATION OF COVERAGE (COBRA)

The following applies if you are covered under a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group’s health plan. It can also become available to your dependents who are covered under the Group’s health plan when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Group’s health plan you should contact the Employer.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health coverage under the Group's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, the Group must offer COBRA continuation coverage to each person who is a "qualified beneficiary". You, your spouse and Dependent children could become qualified beneficiaries if coverage under the Group's health plan is lost because of the qualifying event. Contact the Employer for Premium payment requirements or questions regarding continuation rights. We are not the Employer's designated Plan Administrator as that term is used in Federal law, and we do not assume any responsibilities of a Plan Administrator according to Federal law.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment terminates for any reason other than for gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment terminates for any reason other than for gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's health plan because any of the following qualifying events happens:

- The Subscriber dies;
- The Subscriber's hours of employment are reduced;
- The Subscriber's employment terminates for any reason other than for gross misconduct;
- The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The Subscriber becomes divorced or legally separated; or
- The child stops being eligible for coverage under the Group's health plan as a "Dependent child".

STATE MANDATED CONTINUATION OF COVERAGE

Continuation coverage under the Missouri statutes is applicable only for Covered Persons Enrolled through a Group whose policy has been issued in the State of Missouri. The manner in which the Missouri mandates apply effective June 26, 2009 is in the same manner as continuation of coverage required under the continuation of coverage provisions set forth in the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Please refer to the Subsection titled, "Federal Continuation of Coverage (COBRA)" immediately preceding this Subsection for coverage details.

If a participant has questions about rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll-free at (866) 444-3272 or visit the EBSA website at www.dol.gov/ebsa.

UNIFORMED SERVICE EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Service Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that Employers provide a cumulative total of 5 years and in certain instances more than 5 years, of military leave during an employee's employment with the Employer.

CONTINUATION OF COVERAGE DURING A MILITARY LEAVE

The law requires that an Employer continue to provide coverage during a military leave that is covered by the Act for you or your dependents. The coverage provided must be identical to the coverage provided under the Employer's health plan to similarly situated, active employees and dependents. This means that if the coverage for similarly situated active employees and dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

- For military leaves of 30 days or less, the same as the employee contribution required for active employees.
- For military leaves of 31 days or more, up to 102% of the full cost of the coverage, e.g., the employee and Employer share.

Continuation coverage rights apply to medical, dental, Prescription Drugs and other health coverage. Short- and long-term Disability and life benefits are not subject to continuation rights. Continued coverage provided under USERRA will reduce any continuation provided under COBRA.

MAXIMUM PERIOD OF COVERAGE DURING MILITARY LEAVE

Continued coverage under this provision will terminate on the earlier of the following events:

- The date you fail to return to Employment with the Company following completion of your military leave. Employees must return to employment within:
  - The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
  - 14 days after completing military service for leaves of 31 to 180 days.
  - 90 days after completing military service, for leave of more than 180 days; or
- 18 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law also requires, regardless of whether continuation coverage as stated above was elected, that your coverage and your dependent coverage be reinstated immediately upon your honorable discharge from military service and return to employment.

If due to Illness or Injury caused or aggravated by your military service, you cannot return to work within the times stated above, you may take up to a period of 2 years, or as soon as reasonably possible if for reasons beyond your control you cannot return within 2 years, to recover from such Illness or Injury and return to employment.

If your coverage under the Plan is reinstated, provisions and limitations of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continual under the Plan.

This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by your military services, as determined by the Secretary of Veterans Affairs.

EXTENSION OF BENEFITS IN THE EVENT OF TOTAL DISABILITY

Benefits do not include any care rendered after termination of coverage here under, regardless of when the treated condition(s) arose, and whether or not the care is a continuation of care received prior to the termination, except as follows:

- If an employee is Totally Disabled on the day his or her coverage terminates and that termination is the result of the termination of the Employer Agreement and Group Application the Policyholder's entire contract, Cox Health Systems Insurance Company will continue to provide Benefits only for care for the condition creating the Total Disability, as if the care were a benefit, subject to limitations and exclusions specified in this Certificate of Coverage, until the earliest of the following event occurs:
- The employee no longer is Totally Disabled; or

- One year passes following the date coverage here under terminates.

If the Covered Person is Totally Disabled when the policy terminates, the Covered Person will be eligible for Extension of Benefits no matter how long the Covered Person has been Totally Disabled. The 12 month period as noted in the definition of Disability does not apply to the Extension of Benefit Provision.

CONVERSION COVERAGE

If a Covered Person's Enrollment under the Employer's group plan terminates, he shall be entitled to have a Conversion Policy issued to him without evidence of insurability subject to the following terms and conditions:

- The Member was continuously covered under this Certificate of Coverage for at least 3 consecutive months.
- A completed application for conversion and the first Premium payment for the converted policy are made to the Plan within 31 days after the date of Termination. Premiums for the converted policy will be based on the Covered Person's:
  - class of risk; and
  - attained age; at the time the coverage is to become effective.

A Covered Person will be notified of his conversion rights, no later than 15 days after his Termination of coverage under this Certificate of Coverage. If the Plan fails to give such notice, then the Covered Person's right to conversion will be extended to the earlier of:

- 15 days after the Plan provides notice; or
- 91 days after the Covered Person's Termination of coverage under this Policy.

THE PLAN IS NOT REQUIRED TO PROVIDE A CONVERSION PRIVILEGE TO A COVERED PERSON:

- Who is eligible for coverage under Medicare;
- Who is eligible for coverage that duplicates the coverage provided by Medicare; or
- Who is eligible for coverage for similar Benefits by another individual policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured; or similar Benefits are provided for or available to such person, by reason of any state or federal law; or
- Whose Termination occurred because he failed to make timely payment of any required contribution; or
- Whose Termination occurred because the group policy terminated or an Employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within 31 days of the date of Termination.

The Effective Date of the converted policy will be the day following the date of the Termination of coverage under this Certificate of Coverage, provided all terms and conditions have been met.

The coverage provided under the conversion policy may differ from the Benefits under this policy, subject to applicable state laws and regulations in effect at the time of conversion. In no event will the Benefits of the Conversion Policy exceed those which are available under this Certificate of Coverage.

SECTION 10. GRIEVANCES AND GRIEVANCE PROCEDURE

GRIEVANCE PROCEDURE

DEFINITIONS

Complaint: A complaint is any expression of concern or inquiry about a condition in the Plan's operation.

Grievance: A Grievance is a written complaint submitted by or on behalf of a Grievance Party regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and a health carrier.

Grievance Party: A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person pursuant to an authorized assignment who submits a Grievance.

A Complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to Cox Health Systems Insurance Company.

PROCEDURES FOR COMPLAINTS:

Covered Persons with complaints regarding any aspect of services rendered by a Cox Health Systems Insurance Company Provider, or relationships with that Provider should contact the Provider with whom the problem occurred. If the matter is not satisfactorily resolved, the Covered Person may contact Cox Health Systems Insurance Company Member Services Department for assistance.

If the Complaint is not with a particular Provider but is with the administrative operations of Cox Health Systems Insurance Company itself, the Member Services Department should be contacted directly. The Covered Person has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time for assistance by mail at P.O. Box 690, Jefferson City, MO 65101; or by phone at (800) 726-7390 or (573) 751-2640.

The Grievance Party may file a Grievance with the director of the Missouri Department of Commerce & Insurance without exhausting all remedies available under Cox Health Systems Insurance Company's Grievance process. The Plan or plan sponsor also may file a Grievance with the director concerning an Adverse Determination. A Grievance will be processed by the division as any other consumer complaint. The Missouri Department of Commerce & Insurance will attempt to resolve the issue with the health carrier (or party).

If the director determines a Grievance is unresolved after completion of the division's consumer complaint process, the director shall refer the unresolved Grievance to an independent review organization (IRO). The director will provide the IRO and the Grievance Party, or the Plan copies of all medical records and any other relevant documents which the division has received from any party. The Grievance Party and the Plan may review all the information submitted to the IRO for consideration. The Plan and the Missouri Department of Commerce & Insurance and the IRO will comply with all processes and timelines as established in Missouri Code of State Regulations 20 CSR 100-5.020.

The Grievance Party or the Plan may also submit additional information to the Missouri Department of Commerce & Insurance which the division shall forward to the IRO. All additional information must be received by the division. If Grievance Party or the Plan has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the division within 15 working days from the date the division mailed that party copies of the information provided the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the division by means other than mail if it is in writing, typeset, or easily transferred into typeset by the division's technology and a date of transmission is easily determined by the division. Any additional information submitted by the Grievance Party shall be reviewed by the IRO when conducting the external review. At the

director's discretion, additional information which is received past the 15 working-day deadline may be submitted to the IRO.

The IRO shall request from the division any additional information it wants. The division shall gather the requested information from the Grievance Party or the Plan or other appropriate entity and provide it to the IRO. If the division is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

Within 20 calendar days of the receipt of the request for external review, the IRO shall submit to the director its opinion of the issues reviewed. Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed 5 calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the Grievance Party and the Plan. The director's decision shall be in writing and must be provided to the Grievance Party and the Plan within 25 calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the Grievance Party and the Plan are notified of the director's decision be longer than 45 days.

PROCEDURES FOR FORMAL GRIEVANCES:

Cox Health Systems Insurance Company has a first-level and second-level Grievance review. A Grievance Party may submit a Grievance. Any Grievance of any nature or kind relating to or involving the Plan must be made by a Grievance Party, the Covered Person, authorized representative or any other party claiming a right or benefit under the Plan, within the time frames and in the manner set forth in these Grievance Procedures. No such grievance procedure shall act as a bar to any suit in a court of competent jurisdiction instituted by any such enrollee, or as a bar to any defense thereto by the Plan.

FIRST LEVEL GRIEVANCE

First-level Grievance reviews must be submitted in writing within 180 days from the date of written notice from the Plan to the Grievance Party of a processed or denied Claim (whether in whole or part), Adverse Determination, or response to a Preauthorization request.

Upon receipt of a request for first-level Grievance review, the Plan will:

- Acknowledge receipt in writing of the Grievance within 10 working days;
- Conduct a complete investigation of the Grievance within 20 working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, the Covered Person shall be notified in writing on or before the 20th working day and the investigation shall be completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;
- Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance and notify you in writing of the Plan's decision regarding the Grievance and of the right to file for a second-level review. The notice shall explain the resolution of the Grievance and the right to file for a second-level review in terms which are clear and specific;
- Within 15 working days after the investigation is completed the Grievance Party will be notified in writing of the Plan's decision regarding the Grievance. The notice shall explain the resolution of the Grievance and, if applicable, the right to file for a second-level Grievance review in terms which are clear and specific. The notice of the Plan's decision also will include the Grievance Party's rights to file a request for review with the Missouri Department of Commerce & Insurance.
- The Grievance Party has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or

(573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce & Insurance, then it shall be resolved by referral to an independent review organization.

SECOND LEVEL GRIEVANCE

Second-level Grievance reviews must be submitted in writing within 180 days from the date of written notice from the Plan to the Grievance Party who submitted the First-level Grievance.

Upon receipt of a request for second-level Grievance review, the Plan will submit the Grievance to a Grievance advisory panel consisting of:

- Other Members and the Representatives of Cox Health Systems Insurance Company who were not involved in the First-Level Grievance review.
- If the Second-level Grievance review involves an Adverse Determination, and the Grievance advisory panel makes a preliminary decision that the Adverse Determination should be upheld, the Plan shall submit the Grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance.

  In the event that both independent reviews concur with the Grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both independent reviewers disagree with the Grievance advisory panel's preliminary decision, the initial Adverse Determination shall be overturned. In the event that one of the two independent reviewers disagrees with the Grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion.
- Review by the Grievance advisory panel shall follow the same time frames as a First-level Grievance review, except as provided for in section 376.1389 if applicable.

The Grievance Party has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640.

EXPEDITED REVIEW OF GRIEVANCES

The Plan has written procedures for the expedited review of a Grievance involving a situation where the time frame of the standard Grievance procedures would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person’s ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, for purposes of the Grievance register requirements, the request shall not be considered a Grievance unless the request is submitted in writing. Expedited review procedures shall be available to a Grievance Party. Please call the phone number on the back of your ID card to submit an oral request for an expedited review and for instruction on how to submit the request in writing.

The Plan will notify the Grievance Party orally within 72 hours after receiving a request for an expedited review of the Plan’s determination, and shall provide written confirmation of its decision covering an expedited review within 3 working days of providing the notification of the determination.

SECTION 11. GENERAL PROVISIONS

POLICYHOLDER PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate of Coverage (COC), the Group Insurance Policy, the Employer Agreement and Group Application, the Premium Schedule, and attached papers shall constitute the “Contract” between the Plan and the Policyholder.

No change in this Contract shall be effective until approved by one of the Plan’s Company Officers. This approval must be noted on or attached to the Employer Agreement and Group Application. No agent may change this Policy or waive any of its provisions. A copy of the Contract shall be supplied to the Policyholder when issued. Statements made by the Policyholder or by the persons insured shall be deemed representations and not warranties. No statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person, or in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

PREMIUMS

The initial Premium rates in effect on the Effective Date of Coverage are illustrated on the Final Rate illustration approved and accepted by the Policyholder during the initial Enrollment process and are included with the Policyholder’s copy of the Employer Agreement and Group Application supplied to the Policyholder upon acceptance/issuance of this Contract. The initial Premium must be paid in advance of the Effective Date of Coverage.

Premiums as approved and accepted by the Policyholder during the initial Enrollment process are initially guaranteed for 12 months from the Effective Date of Coverage, unless:

- Otherwise agreed upon by the Plan and the Policyholder within the Employer Agreement and Group Application for a shortened or extended time period,
- The demographics of the group changes substantially, at which time the Plan reserves the right to adjust the Premium rates. The Policyholder will be notified of the adjusted Premium rates at least 31 days prior to the change becoming effective.
- The terms of the contract change.

Thereafter, the Plan shall have the right to change the Premiums as of the anniversary date of the Policyholder’s Effective Date of Coverage, in which case the Policyholder will be notified at least 31 days prior to the anniversary date. The adjusted renewal rates are illustrated on the Renewal Authorization supplied within the above notification. Adjusted renewal rates will take effect upon the first month of the renewal period and will be deemed accepted upon payment of the first Premium due upon renewal.

MISSTATEMENT OF AGE

If the age of the Covered Person has been misstated, amounts payable under this Certificate of Coverage shall be such as the Premium paid would have been if purchased at the correct age.

PAYMENT

Premium payments are due the first business day of the effective coverage month. The Policyholder agrees to remit on or before the Premium due date the full monthly Premium payment set forth in the Premium schedule for each eligible Covered Employee and Dependent(s) Enrolled here under, in accordance with the Plan’s records.

If payment in full is not received within 31 days after the Premium due date, coverage will be terminated unless otherwise agreed upon by the Plan, at its option.

TERMINATION

The Contract will become effective at 12:01 AM Central Time on the Effective Date of Coverage as specified in the Employer Agreement and Group Application, and will remain in force for 12 months, or as agreed upon by the Plan and Policyholder, subject to the right of either the Plan or the Policyholder to terminate the Contract.

The Contract will be terminated without notice as of 12:00 midnight on the last day of the 31 day grace period, except for the first, following the Premium due date if Premiums are not paid on or before the due date or during that grace period, unless otherwise agreed upon by the Plan. The plan may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period. If the Contract is terminated due to non-payment of Premiums; the Plan may, at its discretion, require reapplication by the Policyholder and Covered Employees, including underwriting and Premium rate adjustment in order to re-instate the coverage for the remainder of the 12-month period. The Plan reserves the right to require an advance payment of up to 3 months estimated Premium as an advance deposit in such cases and/or the completion of an Authorization Agreement for Direct Debit. The advance deposit at the Plan's discretion would be:

- Applied to the last 3 months of the Policyholder's current annual Contract; or
- Returned at the Termination of the Contract less any unpaid Premiums or Claims paid after Termination Date.

The Contract may be terminated upon a 31 day written notice to the Policyholder for an act or practice that constitutes fraud or an intentional misrepresentation material fact by the Policyholder, or with respect to the coverage of individual Covered Employees, by the Covered Employee or his representative as permitted by current state and federal guidelines. This contract Termination provision is subject to the "Time Limit on Certain Defenses" provision as stated in this section.

The Insured's right to examination of coverage allows 10 days following the date of delivery in which to examine the insurance coverage and to return that coverage for a full refund of Premiums paid. Any coverage returned for a refund of premium will be null and void from its inception.

If the Contract is terminated by the Policyholder without 31 days prior written notice to the Plan, and Claims are paid for services received after the date of the Termination, the Policyholder will be liable for Premiums and service charges for the billing period or periods in which Claims were paid.

TERM OF AGREEMENT

This Agreement shall remain in effect for the first year and thereafter for successive years unless terminated as provided herein. The term of the Agreement may differ, if specified in the Employer Agreement and Group Application.

If after the commencement of this Agreement the percentage of Covered Employees fails to maintain the participation requirements as outlined in the Employer Agreement and Group Application, the Plan may, at its sole option, terminate this Agreement upon 31 days' notice.

The Covered Employees retain all member rights to file a Grievance following the process outlined in Section 10, Grievances and Grievance Procedure.

CONSIDERATION

The Plan has issued this Certificate of Coverage to the Policyholder in consideration of the payment of the initial Premium and the statements in the application. This Certificate of Coverage takes effect on the Effective Date in the Employer Agreement and Group Application.

FURNISHING INFORMATION

The Policyholder and Covered Employees shall promptly give the Plan information that has a bearing on the insurance under this Certificate of Coverage. This information shall include but not be limited to the persons eligible for insurance and the essential particulars of such coverage for such persons. The Policyholder's records that have a bearing on the insurance shall be open for inspection by the Plan at any reasonable time.

AMENDMENTS TO CERTIFICATE OF COVERAGE

This Certificate of Coverage may be amended at any time by agreement between the Policyholder and the Plan without the consent or notice to any Covered Person or beneficiary. To be effective, such Amendment will be evidenced by an endorsement signed by the Plan's President or Secretary. If an Amendment affects the rights described in the Certificate of Coverage, the Plan will issue Amendments or a revised Certificate of Coverage if applicable to the Policyholder for delivery to each Covered Employee via the Employer Plan Administrator.

Any Amendment shall be without prejudice to any Claim arising prior to the date of the change.

TIME LIMIT ON CERTAIN DEFENSES

No misstatement in the application can be used to deny a Claim or void this Certificate of Coverage unless the misstatement constituted fraud or intentional misrepresentation of material fact; or

Validity of the contract shall not be contested, except for nonpayment of Premiums, after it has been in force for 2 years from its date of issue, and that no statement made by any person covered under the contract relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the contract or upon other provisions in the contract.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision of this Certificate of Coverage which, on its Effective Date, is in conflict with the federal law or the laws of the state in which the Policyholder resides on that date is amended to conform to the minimum requirements of such laws.

TIME PERIODS

All periods of insurance begin and end at 12:01 AM, Central Time.

CHANGES TO WAITING PERIOD

Changes to the Waiting Period as designated on the Employer Agreement and Group Application may only occur as follows:

- A change that decreases the length of the Waiting Period may occur only at the time of the contract renewal upon receipt and approval by the Plan of a new completed Employer Agreement and Group Application.
- A change that increases the length of the Waiting Period will be honored anytime during the contract year upon receipt and approval by the Plan of a new completed Employer Agreement and Group Application prior to the requested Effective Date of the change.
- Or, as agreed upon by the Plan and the Policyholder.

FILING OF CLAIMS

The Plan shall furnish to the Claimant, or to the Policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of Loss. If such forms are not furnished before the expiration of 15 days after the Plan receives notice of any Claim under the Certificate of Coverage, the Claimant making such Claim shall be deemed to have complied with the requirements of the Certificate of Coverage as to proof of Loss upon submission, within the time fixed by the Certificate of Coverage for filing proof of Loss, written proof covering the occurrence, character, and extent of the Loss for which Claim is made.

All Benefits payable under the Certificate of Coverage shall be payable not more than 30 days after receipt of a clean Claim and required proof of Loss.

NOTICE OF CLAIMS

Written notice of Claims must be given to us within 20 days after the occurrence or commencement of any Loss covered by the Certificate of Coverage, unless we determine it was not possible to file the Claim within the time frame due to extenuating facts and circumstances. Under no circumstances, however, will any proof of charges be accepted more than 90 days after the end of any Benefit Year. Notice given by or on behalf of the Covered Person to any authorized agent of Cox Health Systems Insurance Company, which information sufficient to identify the Covered Person shall be deemed notice to Cox Health Systems Insurance Company. Failure to give notice within such time shall not invalidate nor reduce any claim if we determine it was not possible to file the Claim within the timeframe due to extenuating facts and circumstances.

CERTIFICATE OF COVERAGE

The Plan will issue to the Policyholder, for delivery to each person insured, a Certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance Benefits are payable, and a statement as to any family Member's or dependents' coverage.

PROOF OF CLAIM

Written proof of charges upon which a Claim could be based must be furnished to the Plan within 90 days after the period for which the Plan is liable. If it was not reasonably possible to give written proof in the time required, the Plan will not reduce the Claim for this reason if proof is provided to the Plan as soon as reasonably possible. In any event, the proof required must be given no later than one year from the 90-day time period referenced above unless the Claimant was legally incapacitated. Failure to furnish such proof within such time shall not invalidate or reduce any Claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required by CHP.

Written proof must be given to us at our operating office, P.O. Box 5750, Springfield, Missouri 65801-5750.

PHYSICAL EXAMINATIONS

The Plan shall have the right and opportunity, at the Plan's own expense, to examine the person of the individual for whom Claim is made when and so often as it may reasonably require during the pendency of the Claim under the Certificate of Coverage, and also the right and opportunity, at the Plan's own expense, to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Certificate of Coverage prior to the expiration of 60 days after proof of Loss has been filed in accordance with the requirements of this Certificate of Coverage and no such action shall be brought at all unless brought within 3 years from the expiration of the time within which proof of Loss is required by this Certificate of Coverage.

PROCESSING OF THE FILED CLAIM

Eligible reimbursements payable under this Certificate of Coverage will be paid upon receipt of due written proof of claim by paper or electronic submission.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower Out-of-Pocket costs to you.

The Plan will send a Covered Person an Explanation of Benefits form or letter to show what services were paid, how much was paid, who was paid, when payment was made or why payment for some services was not made or was made in part.

If the Plan denies all or any part of a Covered Person's Claim, the Plan will send the Covered Person an Explanation of Benefits form or a letter telling why the Claim was denied. The form or letter may also tell the Covered Person what other information, if any, the Plan would need to reconsider its decision.

Cox Health Systems Insurance Company reserves the right to audit any Claim filed for reimbursement. If a Covered Person does not agree with the Plan's decision, he has the right to file a Grievance.

ASSIGNMENT AND PAYMENT OF BENEFITS

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or Grievances, or to file lawsuits. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cox Health Systems Insurance Company to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cox Health Systems Insurance Company, it is the provider's responsibility to reimburse the overpayment to you. Cox Health Systems Insurance Company may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-participating Provider has been authorized by you, Cox Health Systems Insurance Company may, at its option, make payment of benefits to you. When benefits are paid to you, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cox Health Systems Insurance Company is not able to give a valid receipt for any payment due, such payment will be made to their legal guardian. If no request for payment has been made by their legal guardian, Cox Health Systems Insurance Company may, at its option, make payment to the person or institution appearing to have assumed their custody and support.

COORDINATION OF BENEFITS

1. Applicability

A. This Coordination of Benefits (COB) provision applies to this Plan when a Covered Employee or a Covered Employee's Covered Dependent has health care coverage under more than one plan. A plan and this Plan are defined here.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the Benefits of this Plan are determined before or after those of another plan. The Benefits of this Plan:

1. Shall not be reduced when, under the order of benefit determination rules, this Plan determines its Benefits before another plan; but
2. May be reduced when, under the order of Benefits determination rules, another plan determines its Benefits first. This reduction is described in subsection 4 below, "Effect on the Benefits of this Plan".

2. Definitions

A. A plan is any of the following that provide Benefits or services for, or because of, medical or dental care or treatment;

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. This Plan is the part of the Employer Agreement and Group Application that provides Benefits for health care expenses.

C. Primary plan/secondary plan. The order of benefit determination rules state whether this Plan is a primary plan or secondary plan to another plan covering the person. When this Plan is a primary plan, its Benefits are determined before those of the other plan and without considering the other Plan's Benefits. When this Plan is a secondary plan, its Benefits are determined after those of the other plan and may be reduced because of the other Plan's Benefits. When there are more than two plans covering the person, this Plan may be a primary plan as to one or more other plans and may be a secondary plan to a different plan(s).

D. Allowable expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the Claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an allowable expense under this definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan. When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When Benefits are reduced under a primary plan because a Covered Person does not comply with the Plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, Preauthorization of admissions or services, and Exclusive Provider arrangements.

E. Claim determination period means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this Plan or any part of a year before the date this COB provision or similar provision takes effect.

3. Order of Benefit Determination Rules

A. General. When there is a basis for a Claim under this Plan and another plan, this Plan is a secondary plan which has its Benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its Benefits with those of this Plan; and
2. Both those rules and this Plan's rules in subsection 3.B. require that this Plan's Benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of Benefits using the first of the following rules which applies:

1. Nondependent/Dependent. The Benefits of the plan which cover the person as an employee or retiree are determined before those of the plan which covers the person as a Dependent; except that; if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a. Secondary to the plan covering the person as a Dependent; and
   b. Primary to the plan covering the person as other than a Dependent (for example, a retired employee), then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
2. Dependent child/parents not separated or divorced. Except as stated in paragraph 3.B.(3), when this Plan and another plan cover the same child as a Dependent of different persons, called parents:

a. The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the Benefits of the plan that covered one parent longer are determined before those of the Plans that covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously in 3.B(2)(a) or (b) and if, as a result, the plans do not agree on the order of Benefits, the rule in the other plan will determine the order of Benefits.

3. Dependent child/separated or divorced. If two or more plans cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan of the spouse of the parent with custody of the child; and

   c. Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the Benefits of the Plan of that parent or spouse of the other parent has actual knowledge of those terms, the Benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any Claim determination period or plan year during which any Benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph 3.B.(2).

5. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan,

a. The plan which was in effect first becomes the primary plan,

b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's spouse.

6. Active/inactive employee. The Benefits of a plan which cover a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (5) is ignored.

7. Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination.

   a. First, the Benefits of a plan covering the person as a Covered Employee or Covered Person (or as that person's Dependent); and

   b. Second, the Benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.

8. Longer/shorter length of coverage. If none of the previous rules determine the order of Benefits, the Benefits of the plan which covered a Covered Employee or Covered Person longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of This Plan

A. This subsection 4 applies when, in accordance with subsection 3, Order of Benefit Determination Rules, this Plan is a secondary plan as to one or more other plans. In that event, the Benefits of this Plan may be reduced under this section. Other plan(s) are referred to as the other plans in 4.B. immediately following.

B. Reduction in this Plan's Benefits. The Benefits of this Plan will be reduced when the sum of:

1. The Benefits that would be payable for the allowable expense under this Plan in the absence of this COB provision; and
2. The Benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not Claim is made, exceeds those allowable expenses in a Claim determination period. In that case, the Benefits of this Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those allowable expenses. When the Benefits of this Plan are reduced as described previously, each benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of this Plan.

5. Right to Receive and Release Needed Information

Certain facts are needed to apply those COB rules. Cox Health Systems Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Cox Health Systems Insurance Company need not tell or get the consent of any person to do this. Each person claiming Benefits under this Plan must give Cox Health Systems Insurance Company any facts it needs to pay the Claim.

6. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Cox Health Systems Insurance Company may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Cox Health Systems Insurance Company will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by Cox Health Systems Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of:

a. The person it has paid or for whom it has paid;

b. Insurance companies; or

c. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

8. Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

RENEWABILITY OF INSURANCE

This Certificate of Coverage is renewable on a year-to-year basis, for Covered Employees and Dependents, except for the following reasons:

1. Nonpayment of required Premiums or failure to make timely payment;

2. Fraud or intentional misrepresentation of material fact by the Policyholder, or for coverage of a Covered Person, fraud or intentional misrepresentation of material fact by the Covered Person or that person's representative, this exception is subject to the "Time Limit on Certain Defenses" as stated in the General Provisions of this COC;

3. Noncompliance with the Certificate of Coverage provisions, including failure to provide proof, when requested by the Plan that the Policyholder is complying with the minimum Employee and Dependent participation requirements or Policyholder contribution requirements;

4. With respect to Employer groups, if the type of coverage under this Certificate of Coverage is no longer offered by the Plan in which event the Plan will provide 90 days prior written notice of the discontinuance and the Plan will offer the option to purchase any other Health Insurance coverage currently being offered by the Plan to Employers; or

5. The Plan decides to discontinue offering Health Insurance in the small or large group market in the state in which the Policyholder's Certificate of Coverage was originally delivered, in which event the Plan will provide the applicable State authority and the Policyholder written notice 180 days prior to the discontinuance and the Plan will discontinue Health Insurance issued or issued for delivery in the small or large group market in that state and will not renew coverage.

All insurance under the Certificate of Coverage for the Policyholder and its Employees shall terminate under provisions of:

- Number 1., at 12:01 AM, Central Time, on the Premium due date following the end of the month for which the last Premium payment is made for the Policyholder's insurance; and
- Numbers 2. through 3., at 12:01 AM, Central Time, on the Premium due date coinciding with or next following the date the event took place.
- Numbers 4. through 5., at 12:01 AM, Central Time, on the date set forth in the notice.

SECTION 12. DEFINITIONS

TERMS USED HEREIN, WHETHER OR NOT CAPITALIZED IN THIS DOCUMENT SHALL BE DEEMED TO DEFINE WORDS THAT ARE USED IN THIS CERTIFICATE OF COVERAGE.

These Definitions shall not be construed to provide coverage under any benefit unless specifically provided by that benefit. Pronouns used in this Certificate of Coverage shall apply to both sexes.

Actively at Work (Active Employment): You are considered to be Actively at Work when performing in the customary manner all of the regular duties of your occupation with the Policyholder, either at one of the Policyholder's regular places of business or at some location to which the Policyholder's business requires you to travel to perform your regular duties or other duties assigned by your Policyholder for the number of hours as defined in the Employer Agreement and Group Application. With regard to employees, an employee will be deemed to be Actively at Work on each day of regular paid vacation or each day on which he is on sick leave, Disability leave, or FMLA (the Family and Medical Leave Act of 1993), provided he was Actively at Work on the last preceding regular working day.

Adverse Determination: A determination by a health carrier or a Utilization Review entity that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the Utilization Review entity or health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced or terminated.

Alcoholism Treatment Facility: A residential or nonresidential facility certified by the Department of Mental Health for treatment of alcoholism / Substance Use Disorder.

Allowed Amount: The maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate."

Ambulatory Review: Utilization Review of health care services performed or provided in an Outpatient setting.

Ambulatory Surgical Center: A facility, with an organized staff of Physicians, that:

- Is licensed as such, where required.
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility.
- Does not provide Inpatient accommodations; and is not, other than incidentally, used as an office or clinic for the private practice of a Physician.

Amendment (Amend): A formal document signed by an officer of Cox Health Systems Insurance Company. The Amendment changes the provisions of the Certificate of Coverage and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Autism Treatment Definitions include the following which apply specifically to the treatment of Autism Spectrum Disorders, or a Developmental or Physical disability as the Benefits are described in the Covered Services Section of this document:

- **Autism Spectrum Disorders** means a neurobiological disorder, an Illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Applied Behavior Analysis (ABA)** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in

human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

- **Autism service Provider** includes**:**
  - Any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the state of Missouri; or
  - Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst Certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Developmental or Physical** disability includes a severe chronic disability that:
  - Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or Autism Spectrum Disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;
  - Manifests before the individual reaches age nineteen;
  - Is likely to continue indefinitely; and
  - Results in substantial functional limitations in three or more of the following areas of major life activities:
    - Self-care;
    - Understanding and use of language;
    - Learning;
    - Mobility;
    - Self-direction; or
    - Capacity for independent living;
- **Diagnosis** includes Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an Autism Spectrum Disorder, or a Developmental or Physical disability.
- **Habilitative or Rehabilitative care** includes professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis (ABA) for those diagnosed with Autism Spectrum Disorder, that are necessary to develop the functioning of an individual.
- **Line therapist** means anyone who provides supervision of an individual diagnosed with an Autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** includes medications used to address symptoms of an Autism Spectrum Disorder, or a Developmental or Physical disability prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.
- **Psychiatric care** includes direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** includes direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- **Therapeutic care** includes services provided by licensed speech therapists, occupational therapists, or physical therapists.
- **Treatment** means care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder, or for an individual diagnosed with a Developmental or physical disability by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to:
  - Psychiatric care;

- Psychological care;
- Habilitative or rehabilitative care, including Applied Behavior Analysis (ABA) therapy;
- Therapeutic care;
- Pharmacy care.

Balance Billing: Occurs when a Provider bills you for the difference between the Provider's charge and the Allowed Amount.

Benefit Year: The period starting on January 1 of any Calendar Year and ending on December 31 of such Calendar Year.

Brand Name Medication: A prescription medication that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer.

Calendar Year: The period starting on January 1 of any year and ending on December 31 of such year.

Case Management: A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:

- Assessment of your individual benefit needs.
- Formulation and modification of a comprehensive benefit plan of action.
- Coordination of Benefits.
- Evaluation of the effectiveness of the plan of action.
- Negotiation of extra-contractual services, if necessary.

Certificate of Coverage (COC): This document including all Riders, Amendments and Schedule of Benefits.

Certification: a determination by a health carrier or a Utilization Review Entity that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care and effectiveness, and that payment will be made for that health care service provided the patient is an enrollee of the health benefit plan at the time the service is provided.

Chemical Dependence, or Substance Use Disorder: The psychological or physiological dependence upon or abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and the impairment of social or occupational role functioning or both.

Chiropractic Services: Shall be defined as diagnosis, clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder when delivered by a licensed chiropractor acting within the scope of his or her practice/license.

Claim: A written request or demand by a Claimant for the payment of health care services provided, whether made in electronic format by a Provider or in an electronic or non-electronic format by a Claimant.

Claimant: A Covered Person, authorized representative or any other party claiming a right or benefit under the Plan who makes a Claim.

Clinical peer: A Physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Clinical review criteria: The written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, decision abstracts, clinical protocols, medical protocols, practice guidelines, and any other criteria or rationale used by the health carrier or Utilization Review Entity to determine the necessity and appropriateness of health care services.

Co-insurance: A specific percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits that you must pay. Co-insurance normally applies after the Deductible, if applicable, that you are required to pay. See the Schedule of Benefits for any exceptions.

Co-payment: A specific dollar amount of the Maximum Allowable Amount for Covered Services that is indicated in the Schedule of Benefits which you must pay. The Co-payment does not apply to any Deductible or Co-insurance that you are required to pay.

Company: Refers to Cox Health Systems Insurance Company.

Complications of Pregnancy: Conditions experienced during pregnancy that may seriously jeopardize the health of either the mother or her unborn infant. The condition may be related to the pregnancy itself or be non-pregnancy related occurring coincidentally and adversely influencing the course of the pregnancy.

Concurrent review: Utilization Review conducted during a patient's hospital stay or course of treatment.

Contributing Cause: The action or event which is responsible for the injury for which treatment or benefits are sought.

Cost-share: The portion covered by your Plan that you pay out of your own pocket. This term generally includes Deductibles, Co-insurance, and Co-payments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Covered benefit or "Benefit": A health care service that an enrollee is entitled under the terms of a health benefit plan.

Covered Dependent: Each person who is eligible as provided herein, and Enrolled by a Covered Employee.

Covered Employee: An Employee of the Employer/Association (as defined in this Certificate of Coverage) who is eligible here under. To be considered as a Covered Employee, the Employee must satisfy the requirements as stipulated in the "Eligibility Provisions."

Covered Expense: A legitimate Injury or Illness expense from a Provider, resulting from the rendered to the Covered Person.

Covered Person: A Covered Employee or a Covered Dependent.

Covered Service: Any service listed in the COC under the section titled "Covered Services".

Custodial Care: Treatment or services,

- Primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs.
- Activities of daily living may include, but is not limited to, assistance with walking, bathing, or dressing; transfer or positioning in bed; normally self-administered medicine; meal preparation; feeding by utensil, tube, or gastrostomy, oral hygiene, ordinary skin and nail care, catheter care, suctioning, using the toilet, and enemas.
- Not specifically for an illness or injury.
- Which cannot be expected to substantially improve a medical condition and has minimal therapeutic value.
- Which does not require administration by trained medical personnel in order to be delivered safely & effectively, such as preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible, if applicable: The amount you must pay for Covered Health Services in a Calendar year before we will begin paying for Benefits in that Calendar year. Deductible amounts are separate from and not reduced by Co-payments. Deductibles, Co-payments and Co-insurance are included in any Out-of-Pocket Maximum you pay.

- **Embedded**: The plan Deductible is the amount that you pay during a Calendar Year before the health plan begins to share in any medical expenses. Some plans may pay certain Benefits before the Deductible is satisfied, for example office visits may be covered with a Co-payment. Some plans may have additional Deductible for certain expenses; a common example is an additional Deductible for Prescription Drugs. In

general, the Subscriber must pay the Deductible amount before the Plan reimburses for covered medical expenses.

Below are various family Deductible arrangements:

- Embedded Deductible - If any family Member reaches the individual Deductible then the Deductible is satisfied for that family Member. If any combination of family Members reach the family Deductible, then the Deductible is satisfied for the entire family.
- Non-Embedded Deductible - For persons who do not cover dependents, the single Deductible applies. For persons who cover dependents, there is no single Deductible involved. Expenses for all family Members accrue toward the family Deductible. The family as a whole must satisfy the Deductible before medical expenses are reimbursed.

Disability, Total Disability: The Covered Person's inability, because of Illness or Injury, to perform the material and substantial duties of the Covered Person's occupation for a period of at least 12 months, unless the total benefit period is less than 12 months. After the initial benefit period, Total Disability shall mean the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is qualified by education, training, or experience.

Discharge Planning: The formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

Disposable: Medical equipment and supplies that have a very limited life expectancy, are consumable, expendable, Disposable, or non-durable, which are required to support ongoing treatment of chronic medical conditions such as diabetes, asthma, or bowel/bladder resection patients.

Drug: Any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication.

Durable Medical Equipment (DME): Equipment that can withstand repeated use, is primarily and/or customarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury, and is appropriate for use in the home.

Effective Date: Coverage beginning on the first Service Date following the date of completion of Waiting Period, or as agreed to in the Employer Agreement and Group Application, and Certificate of Coverage.

Emergency Medical Condition: The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the person's health in significant jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.
- Inadequately controlled pain.
- With respect to a pregnant woman who is having contractions; that there is inadequate time to effect a safe transfer to another Hospital before delivery; or transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Medical Transportation: Ambulance services for an Emergency Medical Condition.

Emergency room care: Emergency Services received in an emergency room.

Emergency Services: A health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

Employer/ Association: The Policyholder.

Enroll: To make electronic/written application for coverage on the prescribed forms. Enrollment is not completed until the Plan receives and approves such forms.

Enrollee: a policyholder, subscriber, covered person, or other individual participating in a health benefit plan.

Enrollment Date: The earlier of the first day that a Covered Person is covered under the Certificate of Coverage or the first day of the Waiting Period for that Enrollment.

Excluded Services: Health care services that the Plan doesn't pay for or cover.

Experimental, Investigational, or for Research means Cox Health Systems Insurance Company will determine one or more of the following after consultation with a medical professional:

- The procedure, service, or supply has not been determined through objective, evidenced based, peer-reviewed medical literature to be safe and effective for the proposed use.
- Cox Health Systems Insurance Company will make its determination based on:
  - Published reports in authoritative medical literature; and
  - Regulations, reports, publications and evaluations issued by government agencies such as the agency for health care policy and research, the national institutes of health, the USFDA.
  - In the case of a drug, a device, or other supply that is subject to USFDA approval:
  - It does not have USFDA approval;
  - It has USFDA approval only under its treatment investigational new drug regulation or a similar regulation; or
  - It has USDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.
  - An accepted off-label use of an USFDA-approved drug is a use which is determined by cox health systems insurance company to be:
    - Included in one or more of the following medical compendia: the American Medical Association drug evaluations, the American Hospital Formulary Service drug information, the United States Pharmacopoeia information and other authoritative compendia as identified from time to time by the secretary of health and human services; or
    - The procedure, service, or supply has not been determined through peer-reviewed, objective, evidence-based, medical literature to be safe and effective for the proposed use.
  - The provider's research protocols indicate that the procedure, service, or supply is investigational or experimental.

Phase I, II, III, and IV Clinical Trials determined as Experimental, Investigational, or for Research may meet criteria for benefits as described under Clinical Trials in Section 5, Covered Services.

Facility: An institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical, or treatment centers, skills nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

FDA: the Federal Food and Drug Administration.

Formulary: A list of drug products that are available for use by Covered Persons. The Formulary is periodically updated, maintained, and approved by the Plan, Pharmacy and Therapeutics Committee, or delegate.

Generic Medication: A medication that is identified by the chemical name, and is a pharmaceutical equivalent of one or more Brand Name Medications. A Generic Medication is approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Medication.

Genetic Testing: A process which involves examining an individual's genetic material for the presence of a change that indicates why they may have developed a disease or disorder. Genetic Testing may also tell if someone is at increased risk for developing a disease in the future and/or provide information to Providers that would affect the outcome of treatment.

Grievance: A written complaint submitted by or on behalf of an enrollee regarding the:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between an enrollee and a health carrier.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Health Benefit Plan: A policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy.

Health Carrier: An entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy.

Homebound: Covered Persons who are confined to the home. The Covered Person does not have to be bedridden to be considered as confined to the home; however, the condition should be such that there exists an expected inability to leave the home, and leaving the home would require a considerable and taxing effort. If the Covered Person does in fact leave the home, he may nevertheless be considered Homebound if the absences from the home are infrequent or of relatively short duration.

Home Care: Medical care ordinarily administered on an Outpatient basis in a facility, licensed in the state in which it is located, which provides Skilled Nursing and other services on a visiting basis in the Member's home.

Home Health Care: Health care services a person receives at home.

Hospice: Outpatient supportive and palliative (prevent and ease suffering & improve quality of life) care for persons in the last phase of an incurable disease or who are considered terminally ill. Hospice must be ordered by a Physician, who certifies the patient is terminally ill and is expected to have 12 months or less to live, if the disease runs its normal course. Hospice care is not curative (aggressive work-up, regimes, surgeries and/or Hospitalizations with the expectation of possibility curing the disease) treatment.

Hospital: A provider who is licensed and

- Operates pursuant to law; and
- Has organized facilities for the care and treatment of sick and injured persons on a resident or Inpatient basis,
- Including facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of one or more licensed Physicians; and
- Provides 24 hour a day nursing service by or under the supervision of a registered nurse on duty or call.
- A hospital also includes tuberculosis facilities, mental health treatment facilities, and Substance Use Disorder treatment facilities that are licensed and operated according to the law.

Hospital does not mean any institution that is primarily used as:

- A nursing home or convalescent home;
- A place for rest, custodial care, rehabilitation, extended care facilities or facilities operated exclusively for treatment of the aged, Substance Use Disorder, even though the facilities are operated as a separate institution by a hospital; or
- An institution or agency operated by the United States or its agencies, unless the covered person is legally required to pay in the absence of insurance.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Hospitalization: Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay.

Illness means**:**

- Bodily Illness or disease;
- Psychiatric or Substance Use Disorders; and
- Congenital abnormalities of a newborn child which cause Loss while this Certificate of Coverage is in force. An Illness, which is the same or is related to another existing or previously existing Illness or disease process, will be considered the same Illness.

Immediate Family: Refers to services prescribed, ordered or referred by or received from a Member of your Immediate Family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, grandparent/step-grandparent in-law, or self.

In-Network Co-insurance: The percent you pay of the Allowed Amount for covered health care services to Providers who contract with the Cox Health Systems Insurance Company Exclusive Provider Organization. In-Network Co-insurance usually costs you less than Out-of-Network Co-insurance.

In-Network Co-payment: A fixed amount you pay for covered health care services to Providers who contract with the Cox Health Systems Insurance Company Exclusive Provider Organization. In-Network Co-payments usually are less than Out-of-Network Co-payments.

In-Network Provider: A Physician or medical facility contracted with the Cox Health Systems Insurance Company Exclusive Provider Organization.

Infertility: The medically documented inability to conceive after one year of unprotected sexual intercourse between a male and female partner. The inability to conceive may be due to either the male or female partner.

Initial Enrollment Period: The period of time during which you are first eligible to Enroll for coverage under the Certificate of Coverage. It starts on the date of your, or your Dependent's, initial date of eligibility and ends 31 days later.

Injury: A condition that results from an accident independently of Illness and all other causes.

Inpatient: A Covered Person shall be considered an "Inpatient" if treatment requires Hospital confinement including room and board charges.

Intensive Care Unit: That part of a Hospital service specifically designed as an Intensive Care Unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

Loss means:

- The receipt of Covered Services; and
- The incurring of expenses or services which may be eligible for payment under this Certificate of Coverage.

Maximum Allowable Amount: The Maximum Allowable Amount for Covered Services is the lesser of:

- The fee charged by the Provider for the services;
- The fee that has been negotiated with the Provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
- The fee based on a percentage determined by us of the fee Medicare allows for the same or similar services provided in the same geographic area.

Medical Supplies: Items which, due to their therapeutic or diagnostic characteristics, are essential in treating or diagnosing a Covered Person's Illness or Injury, or is required as part of the treatment of a Covered Person's existing Illness or Injury.

Medically Necessary (Medical Necessity): Any service or supply required for the diagnosis or treatment of an active Illness or Injury that is rendered by or under the direct supervision of the attending Physician, and is considered Medically Necessary in objective, evidence-based, peer-reviewed, medical literature, and is non-Experimental. Services and supplies will not automatically be considered Medically Necessary because your Physician prescribes them. Not all Medically Necessary treatments and procedures are covered Benefits. We will determine whether services or supplies are covered Benefits and meet the above criteria for Medical Necessity. We may consult with Peer Review committees, Utilization Review committees, or other appropriate sources for recommendations. Cox Health System Insurance Company's determination of Medical Necessity will be final and conclusive for all purposes. The Covered Employees retain all member rights to file a Grievance following the process outlined in Section 10, Grievances and Grievance Procedure.

Medicare: The programs of health care for the aged and Disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member: A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Premium payment; Members are sometimes called "you" or "your" in this Certificate of Coverage.

Mental Illness / Mental Health Condition: Any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Network: The facilities, Providers, and suppliers the Plan has contracted with to provide health care services.

Network (Participating) Provider / Exclusive Provider: A Physician or medical facility that contracted with the Cox Health Systems Insurance Company Exclusive Provider Organization to provide services to you at a discount.

Network Specialty Pharmacy: A Pharmacy that has entered into a contractual agreement or is otherwise engaged by us to render Specialty Drug Services, or with another organization that has an agreement with us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Covered Service: Any service listed in the COC under the section titled "Non-Covered Services / Exclusions".

Nonresidential Treatment Program or Facility: A program certified by the Department of Mental Health involving structured, intensive treatment or those who do not have acute physical and mental complications that require Inpatient care.

Nurse: A Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

Occupation: A person's usual or principal work or business, especially as a means of earning a living; vocation.

Open Enrollment Period: The period of Enrollment designated by the Plan in which Eligible Persons or their dependents can Enroll without penalty after the initial Enrollment.

Orthotics: Orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve function of movable parts of the body.

Out-of-Network (Non-Participating) Provider: means a Physician or medical facility not contracted with the Cox Health Systems Insurance Company Exclusive Provider Organization. Services you obtain from any Provider other than a In-Network Provider are considered an Out-of-Network Service except for Emergency Care, ambulance services, or as an Authorized service. This Plan does not provide benefits for any services you receive from an Out-of-Network Provider except:

- Emergency Care, Urgent Care, Emergency ambulance services.
- Two sessions per year for the purpose of diagnosis or assessment of mental health.
- Care that we approve as an Authorized Service.

Out-of-Pocket Limit / Maximum: Each Benefit Year, the total amount of Deductible/ Co-insurance you pay for medical services shall not exceed the maximum Out-of-Pocket Limits for medical services established by your

Certificate of Coverage. Amounts you pay for Non-Covered Services do not apply toward the maximum annual Out-of-Pocket Limit.

Participating Provider: A Provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to Enrollees with an expectation of receiving payment, other than Deductible/ Co-insurance/ Co-payments, directly or indirectly from the health carrier.

Peer Reviewed Medical Literature: A published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act (42 U.S.C. Section 1395x), as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

Phase I Clinical Trials: These first studies in people evaluate how a new drug should be given (by mouth, injected into the blood, or injected into the muscle), how often, and what dose is safe. A Phase I Trial usually enrolls only a small number of patients, sometimes as few as a dozen.

Phase II Clinical Trials: A Phase II Trial continues to test the safety of the drug, and begins to evaluate how well the new drug works. Phase II studies usually focus on a particular type of disease process or other condition.

Phase III Clinical Trials: These studies test a new drug, a new combination of drugs, or a new surgical procedure in comparison to the current standard for treatment. A participant will usually be assigned to the standard treatment group or the new treatment group at random (called randomization). Phase III Trials often Enroll large numbers of people and may be conducted at many Physicians' offices, clinics, and medical centers nationwide.

Phase IV Clinical Trials: These trials are conducted to further evaluate the long-term safety and effectiveness of a treatment. They usually take place after the treatment has been approved for standard use. Several hundred to several thousand people may take part in a Phase IV study.

Physician: A licensed medical practitioner acting within the scope of his/her license.

Physician Services: Health care services a licensed medical professional provides or coordinates.

Plan (the Plan): A benefit your group sponsor provides to you to pay for your health care services. This Certificate of Coverage is the legal document between Cox Health Systems Insurance Company and the Employer to provide Benefits to Covered Persons ("you", your"), subject to the terms, conditions, exclusions and limitations of the Policy.

Plan Administrator: Cox Health Systems Insurance Company and/or its designee, who is the sole fiduciary of the Plan, has discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. The term Plan Administrator has no reference to COBRA/ERISA Administrator. The Plan is not the Employer's/Association's COBRA Administrator or Employer's/Association's ERISA Administrator. Cox Health Systems Insurance Company, or designee, may choose to hire a consultant and/or contract with an administrator to perform specified duties in relation to the Plan.

Plan Approval: A process of review by the Cox HealthPlans Medical Management Department for services and/or treatment rendered. The process is applied to in-patient admissions, and certain services and radiological procedures, treatments, Non-Emergency Services, and drugs to define and/or limit the conditions under which they will be covered.

Policyholder: The entity purchasing the group policy from the Plan**.**

Preauthorization: A process of review by the Cox HealthPlans Medical Management Department before services and/or treatment are rendered. The process is applied to in-patient admissions, and certain services and radiological procedures, treatments, Non-Emergency Services, and drugs to define and/or limit the

conditions under which they will be covered. Preauthorization does not guarantee that all services will be considered Medically Necessary and all charges will remain subject to the terms and conditions of the Plan.

Premium: The amount that must be paid to purchase your health insurance or plan.

Prescription means a lawful order for:

- Medications - Issued by an authorized prescriber within the scope of his professional practice, which is to be dispensed by a pharmacist for the Covered Person. A Prescription may be transferred to the pharmacist verbally, electronically, or in writing.
- Treatment or device - Any written instructions for a service or a device ordered by the Physician, even though a Prescription may or may not be required by law for the service/device to be provided or dispensed.

Prescription Drug Coverage: Insurance that helps pay for Prescription Drugs / medications.

Prescription Drugs: Drugs / medications that by law require a Prescription.

Primary Care Physician/Provider: A Physician who directly provides or coordinates a range of health care services for a patient.

Prior Authorization Review: Utilization Review conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pretreatment review, Utilization Review, and Case Management.

Prosthetics: Replacement of an absent part by an artificial substitute. Artificial substitute for a missing part such as an eye, leg, tooth, used for functional or cosmetic reasons or both.

Provider: Any professional or entity licensed, certified, or accredited as required by state law, who provides health care services, supplies, care, or treatment to a Covered Person.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and / or Outpatient settings.

Residential Treatment Program or Facility: A program certified by the Department of Mental Health involving 24 hour a day residential care and structured, intensive treatment in a non-acute treatment facility.

Retrospective Review: Utilization Review of Medical Necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Rider: Includes any attached written description of additional Covered Health Services not described in this Certificate of Coverage. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to the conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Schedule of Benefits: A brief description of Covered Services. Your Employer can provide the specific Schedule of Benefits for your Plan.

Second Opinion: An opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

Service Area: The geographical area, designated by us, in which the program described in this Certificate of Coverage is marketed and sold.

Service Date: The monthly anniversary of the Effective Date of the policy. For example: if the policy is effective on January 1st, then the Service Date each month will be the 1st ; February 1st, March 1st, etc.

Skilled Nursing Care: A level of care that must be given or supervised by a Registered Nurse; for example intravenous injections, tube feeding, and changing sterile wound dressings. Any service that could be safely

done by an average non-medical person (or one's self) without the supervision of a Registered Nurse is not considered skilled care**.**

Skilled Nursing Facility: A Provider constituted, licensed, and operated as set forth in applicable state law, which:

- Mainly provides Inpatient care and treatment for persons who are recovering from an Illness or Injury.
- Provides care supervised by a Physician.
- Provides 24 hour per day nursing care supervised by a full-time Registered Nurse.
- Is not a place primarily for care of the aged, Custodial or domiciliary care, or treatment of Mental Illness or Substance Use Disorder.
- Is not a rest, educational, or custodial Provider or similar place.

Social Setting Detoxification: A program in a supportive non-Hospital setting designed to achieve detoxification without the use of drugs or other medical intervention, to establish a plan of treatment and to provide for medical referral when necessary.

Special Enrollment: Any additional period of Enrollment required by state and Federal law which begins on the date of the event, in addition to the Open Enrollment Period.

Standard Reference Compendia: The American Hospital Formulary Service-Drug Information; or The United States Pharmacopoeia-Drug Information.

Substance Use Disorder: The psychological or physiological dependence upon or abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and the impairment of social or occupational role functioning or both.

Subscriber: An Eligible Person who is properly Enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Surgery: Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Termination Date: means for the Member, the last date on which the Member is eligible for coverage; or for the Group, the last date on which this Policy is in force.

Urgent Care: Care for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgent Care Center: A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Utilization Review: A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include Ambulatory Review, Prior Authorization Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning, or Retrospective Review. Utilization Review shall not include elective requests for clarification of coverage.

Utilization Review Entity: a Utilization Review agent as defined in section 374.500, or an individual or entity that performs Prior Authorization Reviews for a health carrier or health care provider. A health carrier or health care provider is a Utilization Review Entity if it performs prior authorization review.

Waiting Period: The period designated by the Policyholder on the Employer Agreement and Group Application that must pass before the Employee is eligible to be covered for Benefits under the Certificate of Coverage.

Cox Health Systems Insurance Company

Amendments

When necessary, Cox HealthPlans files amendments to the plan to add or clarify benefits for members; or as required by regulatory mandates. Amendments shall amend or replace any references within the policy as stated. The provisions within the amendments will control in the event that the benefits described within the Policy as originally stated differ.

- Covered Services Clarification Amendment, Form# CHSIC EPO GROUP 2021 CSC, effective 1/1/2022.
- Emergency Services Clarification Amendment, Form# CHSIC EPO GROUP 2021 EMG, effective 1/1/2022.

Electronic (Adobe PDF) document versions of your Certificate of Coverage, the main plan document, include all current Amendments listed above within the file. Plan booklets or previously printed versions of the main plan document may need these amendments printed in addition to complete a current full description of benefits.

Cox Health Systems Insurance Company • Cox Health Systems HMO, Inc.

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Cox Health Systems Insurance Company
Large Employer EPO Group Health Plan

COVERED SERVICES CLARIFICATION AMENDMENT

This amendment is attached to and made a part of the Certificate of Coverage effective January 1, 2022.

"THIS IS A NETWORK – ONLY PLAN" as appears in Section 3, "HOW TO OBTAIN SERVICES" is replaced to read as follows:

THIS IS A NETWORK – ONLY PLAN

Services that are not obtained from an In-Network Provider or that are not Authorized Services will be considered an Out-of-Network Service. This Plan does not provide benefits for any services you receive from an Out-of-Network Provider except:

- Emergency Care, Urgent Care, Emergency ambulance services
- Two sessions per year for the purpose of diagnosis or assessment of mental health
- Care that we approve as an Authorized Service.

In-Network Providers include Physicians, Hospitals, and other health care facilities. Check the provider directory, available at www.coxhealthplans.com, or call the number on your ID Card to determine if a Provider is In-Network.

No benefits are payable unless the Covered Person receives services from an In-Network Provider, except in the case of initial treatment and stabilization of a Medical Emergency, as indicated below under "Special Circumstances".

Benefits are provided only for those services that are Medically Necessary as defined within this Plan and for which the Covered Person has benefits. The fact that a Physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Plan document or contact us if you have any questions regarding whether services are covered.

Out-of-Network Providers shall not balance bill a member for services provided at an In-Network facility unless the provider has provided notice to and obtained consent from the member. Notice and consent requirements shall not apply to ancillary services.

Ancillary services are:

- items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services (including radiology and laboratory services) (except as the Secretary specifies as excluded through rulemaking;
- items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

“*SPECIAL CIRCUMSTANCES*” appearing under “PROVIDER NETWORK” of Section 3, “HOW TO OBTAIN SERVICES” is replaced to read as follows:

SPECIAL CIRCUMSTANCES

Covered Expenses for the services of an Out-of-Network Provider will be paid according to the In-Network Provider benefit schedule in certain circumstances as provided below:

- Hospital Emergency Services: Emergency Services for an Emergency Medical Condition will be paid at the In-Network Provider benefit schedule. This includes Emergency Services for an Emergency Medical Condition obtained at an independent freestanding emergency department. Once the patient is stabilized and his/her condition permits transfer to an In-Network Hospital, services of an Out-of-Network Hospital will no longer be covered.
- Physician or other Provider Emergency Services: Covered Expenses will be paid at the In-Network Provider benefit schedule for the initial care of an Emergency Medical Condition.

“CONTINUITY OF CARE” appearing under “PROVIDER NETWORK” of Section 3, “HOW TO OBTAIN SERVICES” is replaced to read as follows:

CONTINUITY OF CARE

There may be instances in which your PCP or In-Network specialist ceases to be an In-Network Physician. In such cases, you may select a new PCP or In-Network specialist to continue receiving Covered Services. However, in special circumstances you may be able to continue seeing your PCP or In-Network specialist, even though he or she is no longer affiliated with CHP.

Continuity of Care allows you to receive services at In-Network coverage levels if your PCP is leaving the Network and you are receiving “Active treatment” for a condition which includes:

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your doctor should contact Member Services for details. Such continuity of care must be approved in advance by CHP; and your doctor must agree to accept our reimbursement rate, and to abide by CHP’s policies and procedures and quality assurance requirements. Any decision by us regarding a request for Continuity of Care is subject to the Grievance Process. There may be additional circumstances where continued care by a Provider who ceases to be a Network Provider will not be available, such as when the Provider loses his/her license to practice or retires.

***AMBULANCE SERVICE*” appearing under “INPATIENT AND OUTPATIENT SERVICES” of Section 5, “COVERED SERVICES” is replaced to read as follows:**

AMBULANCE SERVICE

MEDICALLY NECESSARY AMBULANCE TRANSPORTATION IS COVERED UNDER THE FOLLOWING CIRCUMSTANCES:

- Transportation by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, and air transportation. Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

GROUND TRANSPORTATION:

- From your home, the scene of an accident or medical Emergency to the nearest Hospital where Emergency care and treatment can be rendered;
- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

AIR OR WATER AMBULANCE:

- Air and water ambulance transportation is covered for acute trauma cases. Scheduled air and water ambulance transportation for other than acute trauma must be Preauthorized by the Plan based upon Medical Necessity as determined by Plan. For example;
  - from the scene of an accident or medical Emergency to a Hospital;
  - between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - between a Hospital and an approved Facility.
- Emergency and medically necessary air or water ambulance transport will apply to In-Network Deductible, In-Network Co-insurance and In-Network Maximum Out-of-pocket.

Important ambulance services benefit specifications are listed below and are subject to review for Medical Necessity as determined by the Plan:

- Ambulance transportation may be covered when ordered by an Employer, school, fire, or public safety official and the Member is not in a position to refuse.
- Water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan may cover the air ambulance. Air ambulance may also be covered if you are in an area that a ground or water ambulance cannot reach.
- Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home. You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.
- Non-Emergency surface ambulance transportation will be covered when certified as Medically Necessary by Covered Person's Physician and agreed upon and approved in advance by the Plan.
- Coverage is not available for air, ground, or water ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.
- Any ambulance usage for transportation home or another place of residence such as a nursing/retirement home, or for the convenience of the Member, family, or Physician is not a Covered Service.
- Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in Emergency situations.
- Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider.
- The Covered Person must pay the appropriate Deductible/ Co-insurance/ Co-payments amounts as identified in the Schedule of Benefits.

“*CLINICAL TRIALS*” appearing under “SPECIAL PROVISIONS REQUIRED BY LAW” of Section 5, “COVERED SERVICES” is replaced to read as follows:

CLINICAL TRIALS

Coverage will be provided for Phase I, Phase II, Phase III, or Phase IV Clinical Trials for the purposes of the prevention, early detection, or treatment of cancer or other life threatening disease or condition.

In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the Clinical Trial.

Coverage for routine patient care costs shall apply to Phase I, Phase II, Phase III, and Phase IV Clinical Trials federally funded by one or more entities cited in 42 U.S.C. § 300gg-8(d)(1)(A) ,(B),(C)., and also as identified below in compliance with Missouri statute §379.429:

One of the National Institutes of Health (NIH);

- An NIH cooperative group or center, defined as a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans' Affairs or Defense;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or
- A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Routine patient care costs shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the Clinical Trial except:

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

***"DEFINITIONS"* appearing under "GRIEVANCE PROCEDURE" of Section 10, "GRIEVANCES AND GRIEVANCE PROCEDURE" is replaced to read as follows:**

GRIEVANCE PROCEDURE

DEFINITIONS

Complaint: A complaint is any expression of concern or inquiry about a condition in the Plan's operation.

Grievance: A Grievance is a written complaint submitted by or on behalf of a Grievance Party regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and a health carrier; or
- A request for a standard or expedited internal review of an adverse benefit determination involving a rescission of coverage.

Grievance Party: A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person pursuant to an authorized assignment who submits a Grievance.

A Complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to Cox Health Systems Insurance Company.

***"FIRST LEVEL GRIEVANCE"* appearing under "GRIEVANCE PROCEDURE" of Section 10, "GRIEVANCES AND GRIEVANCE PROCEDURE" is replaced to read as follows:**

FIRST LEVEL GRIEVANCE

First-level Grievance reviews must be submitted within 180 days from receipt of a notification of an adverse benefit determination.

Upon receipt of a request for first-level Grievance review, the Plan will:

- Acknowledge receipt in writing of the Grievance within 10 working days;
- Conduct a complete investigation of the Grievance within 20 working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, the Covered Person shall be notified in writing on or before the 20th working day and the investigation shall be completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;
- Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance and notify you in writing of the Plan's decision regarding the Grievance and of the right to file for a second-level review. The notice shall explain the resolution of the Grievance and the right to file for a second-level review in terms which are clear and specific;
- Within 15 working days after the investigation is completed the Grievance Party will be notified in writing of the Plan's decision regarding the Grievance. The notice shall explain the resolution of the Grievance and, if applicable, the right to file for a second-level Grievance review in terms which are clear and specific. The notice of the Plan's decision also will include the Grievance Party's rights to file a request for review with the Missouri Department of Commerce & Insurance.
- The Grievance Party has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce & Insurance, then it shall be resolved by referral to an independent review organization.

***"CHANGES TO WAITING PERIOD"* appearing under "POLICYHOLDER PROVISIONS" of Section 11, "GENERAL PROVISIONS" is replaced to read as follows:**

CHANGES TO WAITING PERIOD

Changes to the Waiting Period as designated on the Employer Agreement and Group Application may only occur as follows:

- A change that decreases the length of the Waiting Period may occur only at the time of the contract renewal upon receipt and approval by the Plan of a new completed Employer Agreement and Group Application.
- A change that increases the length of the Waiting Period will be honored anytime during the contract year upon receipt and approval by the Plan of a new completed Employer Agreement and Group Application prior to the requested Effective Date of the change.
- Or, as agreed upon by the Plan and the Policyholder.
- No waiting period shall exceed 90 days.

***"Section 12* "DEFINITIONS" is updated to replace or add the following definitions:**

The definition for "Emergency Services" is replaced to read:

Emergency Services: A health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider, including services within an Independent Freestanding Emergency Department.

A new definition for "Independent Freestanding Emergency Department" is added to read:

Independent Freestanding Emergency Department: means a health care facility that-is geographically separate and distinct and licensed separately from a hospital and provides emergency services.

These updates replace the referenced portions of the Certificate of Coverage as indicated above. In all other respects, the Certificate shall remain unchanged, and the provisions thereof shall apply to this Amendment.

Signed for Cox Health Systems Insurance Company by:

Matthew Aug, President

COX HEALTHPLANS
CoxHealth

Website: CoxHealthPlans.com
Phone: (417) 269-4679 ▪ (800) 205-7665
Mailing Address: PO Box 5750 ▪ Springfield, MO 65801-5750
Street Address: 3200 S. National Ave., # B ▪ Springfield, MO 65807-7303

Cox Health Systems Insurance Company Large Employer EPO Group Health Plan

EMERGENCY SERVICES AMENDMENT

This amendment is attached to and made a part of the Certificate of Coverage effective January 1, 2022.

"EMERGENCY SERVICES" as appears under "INPATIENT AND OUTPATIENT SERVICES" in Section 5, "COVERED SERVICES" is replaced to read as follows:

EMERGENCY SERVICES

Emergency Services are provided without prior authorization, regardless of whether the Provider is an In-Network provider or a participating emergency facility with respect to the services (regardless of the department of the hospital in which such items and services are furnished). Services by Out-of-Network Providers will be provided with cost-sharing that is no greater than that which would apply for an In-Network Provider and without regard to any other restriction other than an exclusion or coordination of Benefits, an affiliation or Waiting Period, and cost-sharing.

Emergency services include any additional items and services that are covered under a plan or coverage after a participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished (referred to as post-stabilization services) unless certain notice and consent requirements are met.

Should a Covered Person receive covered Emergency Services, the Covered Person will be responsible for In-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits. Deductible/ Co-insurance/ Co-payments will include appropriate payments to the emergency room facility and a Deductible/ Co-insurance/ Co-payments for the emergency room Physician. Follow-up care is not considered Emergency Care.

Should a Covered Person be admitted to an Out-of-Network facility as a result of an Emergency Service, the Covered Person will be responsible for In-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits. Deductible/ Co-insurance/ Co-payments will include appropriate payments to Physicians and ancillary services related to the episode of care. Our Health Care Management staff will monitor an Out-of-Network admission/episode of care.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services may not be available. At such time as the Covered Person's condition no longer meets the definition of Emergency Services as stated above and the Covered Person continues to receive treatment Out-of-Network, the Covered Person will be responsible for Out-of-Network Deductible/ Co-insurance/ Co-payments as specified in the Schedule of Benefits.

Should a Covered Person be admitted to an Out-of-Network facility as a result of an Emergency Service, the Plan must be contacted by the Covered Person, or a Covered Person's representative, within 48 hours or as soon as possible.

Should a Covered Person receive "Unanticipated Out-of-Network care", the Plan will coordinate reimbursement with the Provider in compliance with Missouri statutes.

"Unanticipated Out-of-Network Care", is defined as: health care services received by a patient in an In-Network facility from an Out-of-Network Provider from the time the patient presents with an Emergency Medical Condition until the time the patient is discharged.

When Unanticipated Out-Of-Network Care is provided, the Provider who sends a claim to the Plan may bill a patient for no more than the Cost-sharing requirements as established in your Schedule of Benefits.

Within 45 processing days of receiving the health care professional's claim, the Plan shall offer to pay the Provider a reasonable reimbursement for Unanticipated Out-Of-Network Care based on the Provider's services. If the Provider participates in one or more of the Plan's networks, the offer of reimbursement for unanticipated Out-of-Network care shall be the amount from the network which has the highest reimbursement.

If Provider declines the Plan's initial offer of reimbursement, the Plan and Provider shall have 60 days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the Unanticipated Out-Of-Network Care.

If the Plan and Provider do not agree to a reimbursement amount by the end of the 60-day negotiation period, the dispute shall be resolved through an arbitration process

The Plan shall inform the Provider of its Member's Cost-sharing requirements within 45 processing days of receiving a claim from the Provider for services provided.

The In-Network Deductible and Out-of-Pocket Maximum Cost-sharing requirements shall apply to the claim for the unanticipated Out-of-Network care.

"Section 12 "DEFINITIONS" is updated to add the following definition:

Post-stabilization Services: means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or to improve or resolve the enrollee's condition with respect to the visit in which the other emergency services are furnished.

These updates replace the referenced portions of the Certificate of Coverage as indicated above. In all other respects, the Certificate shall remain unchanged, and the provisions thereof shall apply to this Amendment.

Signed for Cox Health Systems Insurance Company by:

Matthew Aug, President

COX HEALTHPLANS
CoxHealth

Website: CoxHealthPlans.com
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Street Address: 3200 S. National Ave., # B ▪ Springfield, MO 65807-7303

Cox Health Systems Insurance Company

Disclosures

As a regulated managed care organization we are required to make certain disclosures to our members. The following pages contain required disclosures related to your health plan.

This includes:

1. Additional Materials Available
   - Summary of Benefits and Coverage (SBC)
   - Grandfather Status
2. Company Address and Telephone Disclosure
3. Cox HealthPlans Notice of Privacy Practices
4. Cox HealthPlans Patient Protection Disclosure
5. Grievances Notification
6. Guaranty Fund Notice
7. Health & Wellness Notification
8. Notice of Health Screenings, Contraceptive Options
9. Notice of Newborn Benefits
10. Notice of Nondiscrimination
11. Statement of Members' Rights and Responsibilities
12. Surprise Medical Bills
13. Utilization Management Affirmation Statement
14. Women's Health and Cancer Rights

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

ADDITIONAL MATERIALS AVAILABLE

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Your SBC provides important information about health coverage option in a standard format. For your convenience, your SBC is available on the web at: www.coxhealthplans.com. A printed copy is also available upon request, free of charge by contacting our Member Services Department at 417-269-2900 or 1-800-205-7665.

GRANDFATHER STATUS

Cox HealthPlans provides notice to members if your health plan has Grandfather Status as defined under Healthcare Reform. If your plan has Grandfather Status you will receive a postcard regarding this within the month following your health plan's renewal each year. For detailed information about this provision, please visit www.dol.gov/ebsa/healthreform.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

COMPANY ADDRESS AND TELEPHONE DISCLOSURE

This notice is pursuant to Chapter 375, Provisions Applicable to All Insurance Companies, Section 375.924.

Cox HealthPlans is your local health insurer, here to offer personal service and can be reached by your preference of any of the following options:

- In person at our Street Address: 3200 S. National Ave., # B Springfield, MO 65807-7303
- By Mail at our Post Office Box: P.O. Box 5750, Springfield, MO 65801-5750
- At our Web Address: www.CoxHealthPlans.com
- By Phone at (417) 269-4679 / (800) 205-7665 or by FAX at (417) 269-4667.

Non-English-speaking Members can contact the same telephone number to connect to a language services interpreter. Our Member Service representatives are trained to make the connection to provide clear access to Benefits information.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

COX HEALTHPLANS NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.

Cox Health Systems Insurance Company, Inc., Cox Health Systems HMO, Inc., and Cox HealthPlans, LLC shall be referred to hereafter as Cox HealthPlans. Cox HealthPlans is part of the CoxHealth family of companies. Cox HealthPlans is a provider of insurance services, which requires compiling personal and sometimes sensitive information. Cox HealthPlans takes seriously a commitment to protecting the confidentiality and security of information collected about individuals. We respect the confidentiality of your health information and will protect your information in a responsible and professional matter. We are required by law to maintain the privacy of your health information, to send you this notice, and abide by the terms of the Notice currently in effect, and to notify you if there is a breach in the privacy or security of your health information.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

Personally identifiable information (PII), defined by the Office of Management and Budget (OMB), refers to information that can be used to distinguish or trace an individual's identity, like their name, Member ID Number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, like date and place of birth, mother's maiden name, etc. Medicare Fee-for-Service eligibility and enrollment information and claims data are considered protected health information (PHI) under the Health Insurance Portability and Accountability Act (1996) (HIPAA) regulations.

If you have any questions about this notice or about how we use or share information, please contact the HIPAA Official of Cox HealthPlans at (800) 205-7665 or 417-269-2900. Business hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. or our Regulatory Compliance Department at Cox HealthPlans, PO Box 5750, Springfield, MO 65801-5750.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Regulatory Compliance Department at Cox HealthPlans, PO Box 5750, Springfield, MO 65801-5750. You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.

We will not take any action against you for filing a complaint.

Any additional questions regarding this policy may be addressed to us at: Privacy Policy, Cox HealthPlans, PO Box 5750 Springfield, MO 65801-5750.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information

- Ask us to restrict how we use or disclose your information for treatment, payment, or health care operations
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.
- You do not have to provide us with personal information if you do not want to; however, that may limit your ability to use certain functions of the website or to request certain services or information.

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- To assist in fundraising activities within our health care operations.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Recent claims information is also available on our website. By visiting and using our Site, you consent to our processing of your information as set forth in this Privacy Policy. If you do not agree with this policy, please do not use our Site.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share PII for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For PII, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We may report information to state agencies that regulate us such as the Missouri Department of Commerce & Insurance.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Assist in fundraising activities

We can use or share health information for purposes of fundraising activities within these guidelines:

- The information used or disclosed must be limited to demographic information related to you and the dates of health care provided to you.
- If we are not preparing the fundraising within our organization, the information can only be disclosed to a business associate or an institutionally related foundation.
- Any fundraising materials must include a description of how you can opt-out of future fundraising communications.
- Your PHI will not be used for fundraising activities unless you provide an authorization for the fundraising activity.
- Upon authorization of your use of PHI in a fundraising activity, we will provide instructions on how you may opt out of future fundraising communications or revoke the authorization relating to these activities.
- We will maintain a log of all individuals who have revoked fundraising authorizations or opted out of receiving future communications.
- We must make reasonable efforts to ensure that you do not receive further fundraising materials if you have revoked your authorization or exercised your opt-out rights.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice is effective: June 2021

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

PATIENT PROTECTION DISCLOSURE

This notice is required by Section 2719A of the Affordable Care Act.

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable.

Cox HealthPlans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact our Member Services Department at 417-269-2900 or 1-800-205-7665, or access this information at our website, www.coxhealthplans.com.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact our Member Services Department at 417-269-2900 or 1-800-205-7665, or access this information at our website, www.coxhealthplans.com.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

GRIEVANCES NOTIFICATION

Cox HealthPlans members have the right to file a Grievance and submit a request for a Second-level Review through a formal process. This notice addresses the identification, review and resolution of member Grievances and Second-level Reviews.

If you have any questions about your coverage, or are unhappy with the service from Cox HealthPlans or providers contracted with us, please call our Member Services Department at 1 (800) 205-7665, or access information by visiting www.coxhealthplans.com. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language line services interpreter. Our Member Service representatives are trained to make the connection to provide clear access to Benefits information.

GRIEVANCE PROCEDURE

DEFINITIONS

Complaint: A complaint is any expression of concern or inquiry about a condition in the Plan's operation.

Grievance: A Grievance is a written complaint submitted by or on behalf of a Grievance Party regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and a health carrier.
- A request for a standard or expedited internal review of an adverse benefit determination involving a rescission of coverage.

Grievance Party: A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person pursuant to an authorized assignment who submits a Grievance.

A Complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to Cox Health Systems Insurance Company.

PROCEDURES FOR COMPLAINTS:

Covered Persons with complaints regarding any aspect of services rendered by a Cox Health Systems Insurance Company Provider, or relationships with that Provider should contact the Provider with whom the problem occurred. If the matter is not satisfactorily resolved, the Covered Person may contact Cox Health Systems Insurance Company Member Services Department for assistance.

If the Complaint is not with a particular Provider but is with the administrative operations of Cox Health Systems Insurance Company itself, the Member Services Department should be contacted directly. The Covered Person has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time for assistance by mail at P.O. Box 690, Jefferson City, MO 65101; or by phone at (800) 726-7390 or (573) 751-2640.

The Grievance Party may file a Grievance with the director of the Missouri Department of Commerce & Insurance without exhausting all remedies available under Cox Health Systems Insurance Company's Grievance process. The Plan or plan sponsor also may file a Grievance with the director concerning an Adverse Determination. A

Grievance will be processed by the division as any other consumer complaint. The Missouri Department of Commerce & Insurance will attempt to resolve the issue with the health carrier (or party).

If the director determines a Grievance is unresolved after completion of the division's consumer complaint process, the director shall refer the unresolved Grievance to an independent review organization (IRO). The director will provide the IRO and the Grievance Party, or the Plan copies of all medical records and any other relevant documents which the division has received from any party. The Grievance Party and the Plan may review all the information submitted to the IRO for consideration. The Plan and the Missouri Department of Commerce & Insurance and the IRO will comply with all processes and timelines as established in Missouri Code of State Regulations 20 CSR 100-5.020.

The Grievance Party or the Plan may also submit additional information to the Missouri Department of Commerce & Insurance which the division shall forward to the IRO. All additional information must be received by the division. If Grievance Party or the Plan has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the division within 15 working days from the date the division mailed that party copies of the information provided the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the division by means other than mail if it is in writing, typeset, or easily transferred into typeset by the division's technology and a date of transmission is easily determined by the division. Any additional information submitted by the Grievance Party shall be reviewed by the IRO when conducting the external review. At the director's discretion, additional information which is received past the 15 working-day deadline may be submitted to the IRO.

The IRO shall request from the division any additional information it wants. The division shall gather the requested information from the Grievance Party or the Plan or other appropriate entity and provide it to the IRO. If the division is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

Within 20 calendar days of the receipt of the request for external review, the IRO shall submit to the director its opinion of the issues reviewed. Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed 5 calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the Grievance Party and the Plan. The director's decision shall be in writing and must be provided to the Grievance Party and the Plan within 25 calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the Grievance Party and the Plan are notified of the director's decision be longer than 45 days.

PROCEDURES FOR FORMAL GRIEVANCES:

Cox Health Systems Insurance Company has a first-level and second-level Grievance review. A Grievance Party may submit a Grievance. Any Grievance of any nature or kind relating to or involving the Plan must be made by a Grievance Party, the Covered Person, authorized representative or any other party claiming a right or benefit under the Plan, within the time frames and in the manner set forth in these Grievance Procedures. No such grievance procedure shall act as a bar to any suit in a court of competent jurisdiction instituted by any such enrollee, or as a bar to any defense thereto by the Plan.

FIRST LEVEL GRIEVANCE

First-level Grievance reviews must be submitted within 180 days from receipt of a notification of an adverse benefit determination.

Upon receipt of a request for first-level Grievance review, the Plan will:

- Acknowledge receipt in writing of the Grievance within 10 working days;

- Conduct a complete investigation of the Grievance within 20 working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, the Covered Person shall be notified in writing on or before the 20th working day and the investigation shall be completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;
- Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance and notify you in writing of the Plan's decision regarding the Grievance and of the right to file for a second-level review. The notice shall explain the resolution of the Grievance and the right to file for a second-level review in terms which are clear and specific;
- Within 15 working days after the investigation is completed the Grievance Party will be notified in writing of the Plan's decision regarding the Grievance. The notice shall explain the resolution of the Grievance and, if applicable, the right to file for a second-level Grievance review in terms which are clear and specific. The notice of the Plan's decision also will include the Grievance Party's rights to file a request for review with the Missouri Department of Commerce & Insurance.
- The Grievance Party has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce & Insurance, then it shall be resolved by referral to an independent review organization.

SECOND LEVEL GRIEVANCE

Second-level Grievance reviews must be submitted in writing within 180 days from the date of written notice from the Plan to the Grievance Party who submitted the First-level Grievance.

Upon receipt of a request for second-level Grievance review, the Plan will submit the Grievance to a Grievance advisory panel consisting of:

- Other Members and the Representatives of Cox Health Systems Insurance Company who were not involved in the First-Level Grievance review.
- If the Second-level Grievance review involves an Adverse Determination, and the Grievance advisory panel makes a preliminary decision that the Adverse Determination should be upheld, the Plan shall submit the Grievance for review to two independent clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance.

  In the event that both independent reviews concur with the Grievance advisory panel's preliminary decision, the panel's decision shall stand. In the event that both independent reviewers disagree with the Grievance advisory panel's preliminary decision, the initial Adverse Determination shall be overturned. In the event that one of the two independent reviewers disagrees with the Grievance advisory panel's preliminary decision, the panel shall reconvene and make a final decision in its discretion.
- Review by the Grievance advisory panel shall follow the same time frames as a First-level Grievance review, except as provided for in section 376.1389 if applicable.

The Grievance Party has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640.

EXPEDITED REVIEW OF GRIEVANCES

The Plan has written procedures for the expedited review of a Grievance involving a situation where the time frame of the standard Grievance procedures would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, for purposes of the Grievance register requirements, the request shall not be considered a Grievance unless the request is submitted in writing. Expedited review procedures shall be available

to a Grievance Party. Please call the phone number on the back of your ID card to submit an oral request for an expedited review and for instruction on how to submit the request in writing.

The Plan will notify the Grievance Party orally within 72 hours after receiving a request for an expedited review of the Plan's determination, and shall provide written confirmation of its decision covering an expedited review within 3 working days of providing the notification of the determination.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

GUARANTY FUND NOTICE

Notice Concerning Coverage Limitations and Exclusions under the Life and Health Insurance Guaranty Association Act.

Residents of this state who purchase life insurance, annuities, or health Insurance should know that the insurance companies licensed the this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that Policyholders will be protected, within limits, in the unlikely event that a member insured becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection, provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this Policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance Policy.

Coverage is not provided for your Policy or any portion of it that is not guaranteed by the insurer or for which you have assumed that risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance Policy. You may contact either the Association or the Missouri Department of Insurance at the following addresses should you have any questions regarding this notice.

The Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, MO 65109

Phone: 573-634-8455

Missouri Department of Commerce & Insurance
P.O. Box 690
Jefferson City, MO 65102-0690

Phone: 573-522-6115

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. On the next page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it, in any way, change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group Policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state.
2. The person purchased the insurance from a company that was not authorized to do business in this state;
3. The Policy is issued by an organization which is not a member insurer of the association; or
4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the Policy. The Association does not provide coverage for any portion of the Policy where the person has

assumed the risk, for any Policy or reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with administration of Policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees).

The Act also limits the amount the Association is obligated to pay persons on various policies. The basic protections provided by the Association are as follows:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender and withdrawal values

Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

The Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, MO 65109

Phone: 573-634-8455

Missouri Department of Commerce & Insurance
P.O. Box 690
Jefferson City, MO 65102-0690

Phone: 573-522-6115

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

HEALTH & WELLNESS NOTIFICATION

Get the Most out of Your Health plan This Year!

Cox HealthPlans (CHP) strives to promote wellness for its members. Please use this notice to access information about the wellness activities and classes available to you.

Step 1: Schedule your annual physical with your Primary Care Provider. To find in-network providers, use the Provider Directory on CHP's website.

- You can find this by visiting www.coxhealthplans.com. The Provider Directory link appears within the tab labeled "For Members".

Step 2: Get set up for your Preventive Services. You can find a detailed list of Preventive Services included in your plan by going to your Member Portal.

- To get started, visit our website and click on "For Members", to access the Member Portal to find this listed under the "Coverage & Benefits" tab.

Step 3: Visit the Health Education page on CHP's website for information about classes and community resources focused on your wellness; and complete an annual Health Risk Assessment (HRA) Questionnaire, if applicable to your health plan, which can be found in your Member Portal.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

NOTICE OF HEALTH SCREENINGS, CONTRACEPTIVE OPTIONS

This notice is required by Missouri Statute § 376.1199.

Members are entitled to the following benefits under this plan:

- Cancer Screenings as currently recommended by American Cancer Society guidelines.
- Coverage for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual.
  - In determining whether testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical literature. A policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services.
- This plan shall not impose additional co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care services pursuant to this regulation, unless similar additional co-payments, coinsurance or deductibles are imposed for other types of health care services received within the provider network.
- As a part of the plan's Covered Services, benefits for contraceptives will be provided either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug, device or service.
  - No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall exclude all drugs and devices that are intended to induce an abortion, as defined in Missouri statutes section 188.015, which shall be subject to section 376.805.
  - Nothing in this regulation shall be construed to exclude coverage for prescription contraceptives, devices, or services ordered by a health care provider with prescriptive authority for reasons other than contraceptive or abortion purposes.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

NOTICE OF NEWBORN BENEFITS

This notice is required by the Newborns' and Mothers' Health Protection Act of 1996.

Pregnancy Benefits are provided to the same extent as any other Illness under the policy, and include coverage for a minimum of 48 hours of Inpatient care following a vaginal delivery and a minimum of 96 hours of Inpatient care following a cesarean section for a mother and her newly born child in a licensed Hospital or any other health care facility licensed to provide obstetrical care.

Notwithstanding the above, the Plan may authorize a shorter length of Hospital stay for services related to maternity and newborn care if:

- A shorter Hospital stay meets with the approval of the attending Physician after consulting with the mother. The Physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization; and
- We provide coverage for post-discharge care to the mother and her newborn. Such post-discharge care shall consist of a minimum of two visits (at least one of which shall be in the home) in accordance with accepted maternal and neonatal physical assessments, by a registered professional Nurse with experience in maternal and child health nursing or a Physician. The attending Physician shall determine the location and schedule of the post-discharge visits. Services provided by the registered professional Nurse or Physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the Nurse shall be reported to the attending Physician as medically appropriate.

For the purpose of this provision, the term "attending Physician" shall include the attending obstetrician, pediatrician, or other Physician attending the mother or newly born child. This benefit shall be subject to the same Deductible/ Co-insurance/ Co-payments as other similar health care services provided by the Certificate of Coverage. Any applicable Deductible/ Co-insurance/ Co-payments will apply to newborns at the date of birth.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan and other plan provisions.

Cox Health Systems Insurance Company
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NOTICE OF NONDISCRIMINATION

Cox HealthPlans is committed to administering fair practices and does not apply discriminatory enrollment processes, benefit designs, or benefit determinations.

WE WILL NOT DISCRIMINATE AGAINST ANY PERSON ON THE BASIS OF:

- race, color, national origin, or
- age, sex, religion, marital status, gender identity, sexual orientation, or
- present or predicted disability, or
- health status or conditions including expected length of life, degree of medical dependency, quality of life or other health conditions, health care needs, previous medical information, genetic information, or
- other status such as a victim of violence, or receipt of public assistance.

Cox HealthPlans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages.

If you need these services, please contact our Member Services Department at 1(800) 205-7665, or access information by visiting www.coxhealthplans.com. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language line services interpreter. Our Member Service representatives are trained to make the connection to provide clear access to Benefits information.

If you believe that Cox HealthPlans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with us by writing to Cox HealthPlans-Member Services, P.O. Box 5750, Springfield, MO 65801-5750, or by fax at 417-269-2949. You can file a grievance in person or by mail or fax. If you need help filing a grievance, our Member Services Department is available to help you. Please call 1-800-205-7665.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 1-800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

STATEMENT OF MEMBERS' RIGHTS AND RESPONSIBILITIES

As a valued Cox HealthPlans member, you are entitled to certain rights and services. As a member, there are also responsibilities in your health care. If you acquaint yourself with and follow these steps when you receive medical services, our performance as your health insurance company will be enhanced.

AS A MEMBER, YOU HAVE THE RIGHT TO:

- Receive information about the organization and its services, practitioners and Providers, and Member rights and responsibilities.
- Be treated with respect, consideration, recognition of your dignity, and right to privacy.
- Participate with practitioners in making decisions about your health care.
- Discuss appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be informed about, and refuse to participate in any experimental treatment.
- Be informed about applicable fees and payment policies.
- Change your Primary Care Provider (PCP). Your plan does not require the designation of a PCP; however we encourage you to select a PCP to assist in coordinating your care.
- Get information about Cox HealthPlans, our services, network providers, and the credentials of health care professionals.
- Receive complete information concerning a medical evaluation, diagnosis, treatment, and prognosis from your provider.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive the Benefits to which you are entitled under your Health Plan and Schedule of Benefits.
- Access wellness information to help you maintain a healthy lifestyle.
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.
- Interpretive Services as necessary. Non-English-speaking Members can contact the same Member Services telephone number printed on the back of the ID Card to connect to a language services interpreter.
- Privacy and confidential handling of your disclosures and records. You may approve or refuse their release, except when the release is required by law.
- Cox HealthPlans is committed to protecting the confidentiality and security of health information. A complete privacy statement is provided on an annual basis. It is also accessible at any time on our website at www.coxhealthplans.com.

AS A MEMBER, YOU HAVE THE RESPONSIBILITY TO:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Provide an accurate health history, including information about medications and over-the-counter products, dietary supplements, and allergies or sensitivities.
- Follow plans and instructions for care that you have agreed to with your practitioners.
- Take part in understanding your health problems and participate in mutually agreed-upon treatment goals, to the degree possible.
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship.
- Present your current ID Card each time you receive a medical/pharmaceutical service.
- Inform providers about living wills, medical power of attorney, or other directives affecting care.
- Treat healthcare providers, staff, and others, with respect.
- Know your Provider Network and verify the Provider’s status at your time of service.
- Follow up with your Provider to verify Preauthorization is obtained as required by your Health Plan.
- Read and understand your Health Plan and Schedule of Benefits and other materials from us concerning your health Benefits.
- Understand how to access care in routine, Emergency, and Urgent situations; and to know your health care Benefits as they relate to out-of-area coverage, Deductible/ Co-insurance/ Co-payments, etc.
- Know the limitations and exclusions of your Health Plan.
- Provide timely, accurate, and complete information to us about other health care coverage and/or insurance Benefits you may carry as it pertains to your plan.
- Accept personal fiscal responsibility for costs not covered by insurance if applicable.
- Inform us of changes affecting your coverage including but not limited to your name, address, telephone number, and family status.
- Contact our Member Services Department when you have a question concerning your coverage or experience a problem.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

This notice informs you of your protections under the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Claims for **unanticipated out-of-network care** arising out of a situation involving **emergency care** are eligible for the negotiation and arbitration process outlined in section 376.690. **Unanticipated out-of-network care** is health care services a patient receives at a facility that is in-network, from a health care professional who is out of network. This definition applies to all services performed from the time the patient presents with an emergency medical condition until the time the patient is discharged.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

YOU'RE NEVER REQUIRED TO GIVE UP YOUR PROTECTIONS FROM BALANCE BILLING. YOU ALSO AREN'T REQUIRED TO GET CARE OUT-OF-NETWORK. YOU CAN CHOOSE A PROVIDER OR FACILITY IN YOUR PLAN'S NETWORK.

Claims for **unanticipated out-of-network care** arising out of a situation involving **emergency care** are eligible for the negotiation and arbitration process outlined in section 376.690. **Unanticipated out-of-network care** is health care services a patient receives at a facility that is in-network, from a health care professional who is out of network. This definition applies to all services performed from the time the patient presents with an emergency medical condition until the time the patient is discharged.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.
- **If you believe you've been wrongly billed**, you may contact the Missouri Department of Commerce & Insurance at the following address and telephone number: P.O. Box 690, Jefferson City, MO 65102-0690, 1-800-726-7390 or (573) 751-2640.

Visit https://www.hhs.gov/ for more information about your rights under federal law.

Visit https://health.mo.gov/ for more information about your rights under Missouri state laws.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

UTILIZATION AFFIRMATION STATEMENT

This Utilization Management Affirmation Statement is provided to all members; and to all practitioners, providers and employees who make UM decisions regarding incentives to encourage appropriate utilization and discourage underutilization.

DEFINITIONS:

- Utilization Management (UM) is the evaluation and determination of coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.
- Utilization review is a formal evaluation (pre-service, concurrent, or post-service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.
- Underutilization is the failure to provide appropriate or indicated services, or provision of an inadequate quantity or lower level of services than required.

AFFIRMATION:

Cox HealthPlans does not use incentives to encourage barriers to care and service. Cox HealthPlans is also prohibited from making decisions regarding hiring, promoting or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

Cox HealthPlans affirms to all members and to all practitioners, providers and employees who make UM decisions of the following:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

PROCEDURES FOR UTILIZATION REVIEW DECISIONS, MAKING, NOTIFICATION:

1. The Plan will maintain written procedures for making Utilization Review decisions and for notifying Members and Providers acting on behalf of Members of its decisions. For purposes of this section, “Member” includes the representative of a Member.
2. For determinations, the Plan will make the determination within 36 hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination. For purposes of this section, “necessary information” includes the results of any face-to-face clinical evaluation or Second Opinion that may be required.
   (1) In the case of a determination to certify (authorize) an admission, procedure or service, the Plan will notify the Provider rendering the service by telephone or electronically within 24 hours of making the Certification, and provide written or electronic confirmation of the telephone or electronic notification to the Member and the Provider within two working days of making the initial Certification;

(2) In the case of an Adverse Determination, the Plan will notify the Provider rendering the service by telephone or electronically within 24 hours of making the Adverse Determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the Member and the Provider within one working day of making the Adverse Determination.

3. For Concurrent Review determinations, the Plan will make the determination within one working day of obtaining all necessary information.

(1) In the case of determination to certify (authorize) an extended stay or additional services, the Plan will notify by telephone or electronically the Provider rendering the service within one working day of making the Certification, and provide written or electronic confirmation to the Member and the Provider within one working day after the telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of Adverse Determination, the Plan will notify by telephone or electronically the Provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Member and the Provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the Member until the Member has been notified of the determination.

4. For Retrospective Review determinations, the Plan will make the determination within 30 working days of receiving all necessary information. The Plan will provide notice in writing of our determination to a Member within 10 working days of making the determination.

5. A written notification of an Adverse Determination shall include the principal reason or reasons for the determination, including the clinical rationale, the instructions for initiating a Grievance or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination to the health care Provider. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination to any party who received notice of the Adverse Determination and who requests such information.

6. The Plan has written procedures to address the failure or inability of a Provider or a Member to provide all necessary information for review. These procedures shall be made available to health care providers on the health carrier's website or provider portal. In cases where the Provider or Member will not release necessary information, the Plan may deny Certification of an admission, procedure, or service.

7. Provided the patient is an enrollee of the Plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of the date the health care Provider receives the Prior Authorization.

8. Provided the patient is an enrollee of the Plan at the time the service is provided, Cox HealthPlans, or any utilization review entity, or health care provider shall not bill an enrollee for any health care service for which a Prior Authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any In-Network Deductible or Out-of-Pocket Maximum applicable to the enrollee's health benefit plan.

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, MO 65801-5750

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS

This notice is required by the Women's Health and Cancer Rights Act of 1998.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan and other plan provisions.