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

CLAIMS PAYMENT POLICIES & OTHER INFORMATION

This Notice Provides Important Information for your Individual Health plan Policy.

This includes:

This notice contains only select claims payment information for your health plan Policy and you should read your Policy carefully, and refer to it when you require medical services. The Policy 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 Policy.

Please refer to Individual Health plan EPO Policy for complete benefit information. This is only a brief description of benefits, which is not intended to be comprehensive. Your Individual Health plan EPO Policy is the governing document for benefit information.

1. OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

Your Policy is an EPO "Exclusive Provider Organization" health plan. As a member of an EPO, you can use the Providers and hospitals within the EPO network, but cannot go outside the network for care.

Services you obtain from any Provider other than an In-Network Provider are 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, or Care that we approve as an Authorized Service.

DEFINITIONS

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." If your Provider charges more than the Allowed Amount, you may have to pay the difference.

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

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

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 an In-Network Provider are 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.

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.

Usual and Customary (U&C): The usual fee paid to Providers of comparable skills and qualifications in the Providers' general geographic area as determined by Cox Health System Insurance Company.

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.thinkinghealthforward.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 your Policy 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.

Services obtained from an Out-of-Network Provider are not Covered Services, except for Emergency Services, (including those provided by an Urgent Care facility), ambulance services, and mental health including two sessions per year for the purpose of diagnosis or assessment of mental health; or as an Authorized Service. 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 Network Providers. 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 Network Provider(s) for any Non-Covered Services you receive or when you have not acted in accordance with your Policy.
- 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.

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.
- Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your Plan does not cover. Balance billing may be waived for emergency services received at an Out-of-Network facility.

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 the Usual and Customary rate or 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.

Please refer to Individual Health plan EPO Policy for complete Network and Benefit information. This is only a brief description of benefits, which is not intended to be comprehensive. Your Individual Health plan EPO Policy is the governing document for benefit information.

2. MEMBER CLAIM SUBMISSION

A Member, instead of the provider, submits a claim to Cox HealthPlans, requesting payment for services that have been received.

FILING CLAIMS:

Whenever you or your dependents enrolled under this plan receive care from a physician, hospital, or care from another provider of healthcare services; identify yourself as a Cox HealthPlans member by presenting your identification card. In most situations the providers of service will file the claims for you. If your provider does not file the claim, you may file the claim yourself using a claim form as provided on our website: https://www.coxhealthplans.com/files/medicalclaimform.pdf

You may access a Medical Claim Form on our website or request a form from our Member Services Department, and then follow the instructions.

1. Each patient must complete a separate claim form.
2. Each course of treatment or medical case will require an individual claim form.
3. Itemized bills must be included with each completed claim form. Information required on each bill:
   - Patient's name
   - Provider's name and address
   - Date(s) of service
   - CPT codes or descriptions of services
   - The charge for each service rendered
   - Patient's medical diagnosis

   Claims submitted on HCFA forms, Superbills and UB92 forms are all customary and acceptable.
4. There is no limitation to the number of bills attached to each claim form.
5. "Balance due" bills or "professional services rendered" bills are not acceptable.
6. Claims should be submitted by the end of the year in which the services are incurred, if possible. Claims older than one year will not be accepted.
7. When submitting bills for reimbursement, they must be marked paid by the provider's office.
8. If other health coverage exists that is primary to this plan, you should submit claims to that carrier first. After you have received the primary carrier's Explanation of Benefits (EOB), send a copy of the EOB with this claim form to Cox HealthPlans for claim consideration.
9. Pharmacy bills for reimbursement must have the pharmacy letterhead or pharmacist's signature, prescription number and drug name. The National Drug Code number is acceptable in lieu of the drug name with the pharmacist's signature. Register receipts or paid receipts are not acceptable.

10. The claim form must be signed and dated by the contractholder.

11. Submit claims to: Cox HealthPlans, P.O. Box 5750, Springfield, MO 65801-5750.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

3. GRACE PERIODS AND CLAIMS SUBMISSION

A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90-day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Grace Period: A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended.

Pended Claim: When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full.

GRACE PERIOD

When a member is receiving a premium subsidy:

After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period, and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advance premium tax credits on behalf of the member from the Department of the Treasury, and will return the advance premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above.

When a Member is not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 31 day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for covered services rendered to the member during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the grace period.

Third Party Payment of Premiums:

Cox HealthPlans requires each Policyholder to pay his or her premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay premiums on your behalf:

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

2. Indian tribes, tribal organizations or urban Indian organizations;

3. State and Federal Government programs; or

4. Family members.

Upon discovery that premiums were paid by a person or entity other than those listed above, we will reject the payment.

COVERAGE TERMINATION

A Policyholder's insurance will terminate upon the occurrence of the first of the following events:

- your Policy terminates;
- the Policyholder voluntarily terminates his coverage under their Policy;
- the date of your death, if you are the only member on your Policy;
- the Premium has not been paid within the grace period.

Coverage for terminating individuals will end on the day prior to the first Service Date following date of Termination notification to Plan. However we may, at our option, allow an earlier Termination Date if you present evidence to us of other existing coverage within the first ten days of a billing period, and no claims have been presented to and paid by us within that billing period.

If the Policy is other than an individual coverage only plan (includes family coverage), it may be continued after your death by:

- Your spouse if, a member, otherwise by
- the youngest child who is a member.

This contract will be changed to a plan appropriate, as determined by us, to the member(s) who continue to be covered under it.

DEPENDENT COVERAGE TERMINATION

The insurance of a Policyholder's Covered Dependent will terminate upon the occurrence of the first of the following events:

- the Policy terminates;
- the Policyholder's coverage terminates for any reason, except due to the Policyholder's attainment of the maximum amount payable under the Policy;
- 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 Policyholder voluntarily terminates Dependent coverage under the Policy.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

Please refer to Individual Health plan EPO Policy for complete Benefit information. This is only a brief description of benefits, which is not intended to be comprehensive. Your Individual Health plan EPO Policy is the governing document for benefit information.

4. RETROACTIVE DENIALS

A retroactive denial is the reversal of a previously paid claim, through which the Member then becomes responsible for payment.

A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already

paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.

You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service performed is a covered benefit.

You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

RIGHTS TO RECOVERY

If the amount of the payments made by Cox HealthPlans 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 Member, such as inaccurate or false information provided at enrollment, or misuse of a Member ID Card. A Member may reduce the chance of retroactive denials due to unpaid premiums by submitting their premium payments on time.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

5. RECOUPMENT OF OVERPAYMENTS

Member recoupment of overpayments is the refund of a premium overpayment by the Member due to over-billing by Cox HealthPlans.

If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.

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. 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 will be in effect from the Effective Date of Coverage through the end of the Calendar Year, unless:

- Otherwise agreed upon by the Plan and the Policyholder within the Individual Application for a shortened or extended time period,
- If a Covered Person's birthday moves them into the next age classification, your Premium will change. Your Premium is based upon the ages at the first of each month of all Covered Persons covered by the Policy,
- 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.

A Member's overpayment of Premium will be applied as a credit to the next month's Premium due.

If the Premium has been overbilled by Cox HealthPlans, the overpayment will be applied as a credit to the next month's Premium due, unless the Member requests a refund. Refunds will be issued either by check or automatic

deposit, as determined by the Member's original method of payment. A Member who has questions about how to obtain a refund should contact Cox HealthPlans directly at (417) 269-2959 or toll free at 1 (800) 869-1093. The refund request will be processed by Cox HealthPlans after speaking to the Member.

REFUND UPON CANCELLATION

We will refund any premium paid and not earned due to contract termination. You may cancel the contract at any time by written notice, delivered or mailed to the Marketplace, or if an off-exchange member by written notice, delivered or mailed to us. Such cancellation shall become effective the last day of the month in which notification is received, or on such later date specified in the notice ending on the last day of the specified month. If you cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days of the termination effective date. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

For coverage purchased within the Marketplace, the Health Insurance Marketplace should be contacted for cancellation effective dates at www.healthcare.gov or 1-800-318-2596.

6. MEDICAL NECESSITY AND PRIOR AUTHORIZATION TIME FRAMES AND MEMBER RESPONSIBILITIES

Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.

Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

DEFINITIONS

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.

Plan Approval: A process of review by the Cox HealthPlans Medical Management Department for services and/or treatment rendered. The process is applied to Inpatient 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: A process of review by the Cox HealthPlans Medical Management Department before services and/or treatment are rendered. The process is applied to Inpatient 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.

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, prospective review, Second Opinion, Preauthorization, concurrent review, Case Management, discharge planning, or retrospective review. Utilization Review shall not include elective requests for clarification of coverage.

We must approve some services before you obtain them. This is called prior authorization or pre-service review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get prior

authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll.

We typically decide on requests for prior authorization for medical services within 36 hours which includes one working day of obtaining all necessary information regarding the proposed service.

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, 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 your Policy.

- The Benefits and services described below are provided by your Policy only if, and to the extent that they are:
  - Medically Necessary unless specified otherwise in your Policy;
  - Subject to the exclusions, limitations and penalties described elsewhere in your Policy,
  - Subject to Deductible/ Co-insurance/ Co-payments designated under the terms and conditions contained within your Policy 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 the Policy will not be considered a Covered Service under any other section of your Policy.
- If an authorized representative of the Plan authorizes the provision of a health care service, the health carrier shall not subsequently retract its certification after the health care service has been provided, or reduce payment for an item or service furnished in reliance on Plan Approval, unless:
  - Such certification 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 Policy terminates before the health care services are provided; or
  - The Covered Person's coverage under the health Benefit Policy 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.

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 Policy 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 a Plan Approval be obtained from us before incurring expenses for certain Covered Services.

- For initial 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.

- 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 initial certification, and provide written or electronic confirmation of the telephone notification to the Member and the Provider within two working days of making the initial certification.
- 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 the telephone notification to the Member and the Provider within one working day of making the Adverse Determination.
- For concurrent review determinations, the Plan will make the determination within one working day of obtaining all necessary information.
- In the case of determination to certify (authorize) an extended stay or additional services, the Plan will notify by telephone 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 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.
- 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 the telephone notification. The service shall be continued without liability to the Member until the Member has been notified of the determination.
- For retrospective review determinations, the Plan will make the determination within 301 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.
- A written notification of an Adverse Determination shall include the principal reason or reasons for the determination, 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. 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.
- The Plan has written procedures to address the failure or inability of a Provider or a Member to provide all necessary information for review. In cases where the Provider or Member will not release necessary information, the Plan may deny certification of an admission, procedure, or service.

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 In-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.		

If a Member fails to obtain Prior Authorization when required to do so by the health plan Policy, Cox HealthPlans may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please contact the Cox HealthPlans Member Services Department to verify that all Prior Authorization requirements are met.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

Please refer to Individual Health plan EPO Policy for complete Benefit information. This is only a brief description of benefits, which is not intended to be comprehensive. Your Individual Health plan EPO Policy is the governing document for benefit information.

7. DRUG EXCEPTION TIME FRAMES AND MEMBER RESPONSIBILITIES

Exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by Cox HealthPlans through the formulary exception review process as provided below under the heading, "DRUGS EXCEPTION PROCESS". The member or provider can submit the request by submitting an Exception Request form accessible on our website under the "Resources & Forms" tab, or by clicking here:
https://www.thinkinghealthforward.com/files/2020-ENVADM-EnvisionRx%20Non%20Formulary%20Exception%20(NFE)%20Request%20-%2042681.pdf

If the drug is denied, you have the right to an external review. If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision.

An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request. This process is provided below under the heading, "EXTERNAL EXCEPTION REQUEST REVIEW". A member or provider can submit a Prescription Appeal form accessible on our website under the "Resources & Forms" tab, or by clicking here:
https://www.thinkinghealthforward.com/files/Prescription%20Appeal%20Form.pdf

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 Plan (a request for exception). In the event that an exception request is granted, the Plan will treat the excepted drug(s) as a standard Formulary drug.

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.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

Please refer to Individual Health plan EPO Policy for complete Benefit information. This is only a brief description of benefits, which is not intended to be comprehensive. Your Individual Health plan EPO Policy is the governing document for benefit information.

8. EXPLANATION OF BENEFITS (EOB)

An EOB is a statement Cox HealthPlans sends the Member to explain what medical treatments or services it paid for on a Member's behalf, Payments by Cox HealthPlans, and the Member's financial responsibility pursuant to the terms of the Policy.

Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form.

The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.

PROCESSING OF THE FILED CLAIM:

Eligible reimbursements payable under your Policy will be paid immediately upon receipt of due written proof of Claim.

All eligible reimbursement will be payable to In-Network Providers. Reimbursement for services received from an Out-of-Network Provider will be paid to the Covered Person unless there was an assignment of Benefits signed by the Covered Person allowing payment directly to the Out-of-Network Provider.

The Plan will send a Covered Person an Explanation of Benefits (EOB) 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.

UNDERSTANDING YOUR EOB

An EOB is provided to assist you in understanding your health plan benefits. This is a summary of the health care services and benefits you received on the dates listed. It explains the services, the cost of those services, and the benefits from your Policy that may be applied to the care you received. The EOB is not a bill. You can use this notice to:

- Contact us immediately if you think Cox HealthPlans has paid for a service you did not receive;
- Show your provider how much of your deductible you have met;
- Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.
- Track payments for services received.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.

9. COORDINATION OF BENEFITS

Coordination of benefits exists when a Member is covered by more than one plan and determines which plan pays first.

Coordination of benefits, or COB, is when you are covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about coordination of benefits can be found in your Plan document.

Benefits will be coordinated for any person covered under either Part A or Part B of Medicare, not only for persons covered under both Medicare Part A and Part B.

When any Covered Person is eligible for Medicare, any Medicare Benefits will reduce all Policy Benefits otherwise payable with respect to the Covered Person. For the purposes of this provision, Benefits will be paid on the basis that the Covered Person is covered by either Part A or Part B of Medicare. If the Covered Person should not receive Benefits under either Part A or Part B because of:

- Failure to Enroll when required; or
- Failure to pay any Premiums that may be required for full coverage of the person under Medicare; or
- Failure to file any written request or Claim required for payment of Medicare Benefits, the Plan will make determination of the total Benefits that would have been payable under Medicare in the absence of this failure.

If you have any questions about this information, please contact the Cox HealthPlans Member Services Department by phone at (417) 269-2959 or toll free at 1 (800) 869-1093, or visit online at www.thinkinghealthforward.com.