COX HEALTHPLANS
CoxHealth
THINKING HEALTH FORWARD

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 policy.

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. Notice of Health Screenings, Contraceptive Options
8. Notice of Newborn Benefits
9. Notice of Nondiscrimination
10. Statement of Members' Rights and Responsibilities
11. Utilization Management Affirmation Statement
12. Women's Health and Cancer Rights
13. Health & Wellness Notice

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
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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.ThinkingHealthForward.com
- By Phone at (417) 269-2959 / (800) 869-1093 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.

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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

A complaint is any expression of concern about a condition in the Plan's operation. A complaint may be initiated in person, in writing, or by telephone to the Member Services Department.

A Grievance is a written complaint submitted by or on behalf of a Member 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 a Member and a health carrier.

A complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to Cox HealthPlans.

A Covered Person may file a Grievance when he feels Cox HealthPlans has not adequately responded to his needs.

PROCEDURES FOR COMPLAINTS:

Covered Persons with complaints, suggestions, or problems 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 make an informal complaint by contacting Cox Health Systems Insurance Company Member Services Department.

If the informal 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.

PROCEDURES FOR FORMAL GRIEVANCES:

Cox HealthPlans has a first-level and second-level Grievance review process. A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person, may submit a Grievance.

A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person, has the right to contact the Director of the Missouri Department of Commerce & Insurance at any time regarding an external review of a Grievance. Neither a first-level or second-level Grievance is required prior to a Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person contacting the Missouri Department of Commerce & Insurance.

First Level Grievance

First-level Grievance reviews must be submitted within 180 days from the date of written notice from the Plan to the enrollee of a processed claim or response to Preauthorization request.

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

1. Acknowledge receipt in writing of the Grievance within 10 working days;
2. 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;
3. 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;
4. Within 15 working days after the investigation is completed the Covered Person and/or the person who submitted the Grievance will be notified in writing of the Plan's decision regarding the Grievance. The notice of the Plan's decision will include the Covered Person's or the Plan's rights to file a request for review with the Missouri Department of Commerce & Insurance.
5. The Covered Person 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 within 180 days from the date of written notice from the Plan to the person who submitted the First-level Grievance.

- Upon receipt of a request for second-level review, the Plan will submit the Grievance to a Grievance advisory panel consisting of:
  - Other Members and the Representatives of Cox HealthPlans who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance.
- Where the second level review involves an Adverse Determination, and the grievance advisory panel makes a preliminary decision that the 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 review, except as provided for in section 376.1389 if applicable.
- The Covered Person 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.

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 Covered Person, the representative of a Covered Person and to the Provider acting on behalf of a Covered Person. 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 Covered Person 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.

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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

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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.

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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
P.O. Box 5750, Springfield, MO 65801-5750

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.

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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.

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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.

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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.

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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.