Short-Term *Plus* Medical Insurance

Plans Benefit Guide and Application

COX HEALTHPLANS
CoxHealth

THINKING HEALTH FORWARD

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

This policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Short-Term Plus Coverage has a Lot to Offer

Advantages of Short-Term Plus Medical Insurance plans include:

- *Provide you with a package of health care benefits to cover hospital, physician and emergency services, as well as many specialized services.*
- *The Cox HealthPlans EPO network offers care within the preferred CoxHealth network. When you or your family need medical care, you can choose from doctors, health professionals, and facilities operating in our network of participating health professionals. These plans pay no benefits for out-of-network expenses except for Emergency and/or Urgent Care service situations, as well as certain mental health services.*
- *Offers an alternative to traditional insurance for individuals and families looking for coverage. Short-term plans are a great affordable option for healthy applicants with no preexisting conditions, ages 1-64.*
- *Reissue Riders - by purchase of a reissue rider, a policy is guaranteed to reissue for one consecutive term of up to 6 months without regard to underwriting.*

Disclaimers:

- *Quoted rates are not effective further than 60 days from the effective date.*
- *Applications must be printed and submitted to Cox HealthPlans, along with payment and non-refundable application fee for review prior to the requested effective date.*
- *The effective date will be moved to the first of the following month if a completed application with payment is not received prior to the requested effective date.*
- *Commission is paid per member per month (PMPM) based on cumulative active members by agency. Agencies with 1-99 total active members are paid $15 PMPM, 100-299 total active members are paid $25 PMPM, 300-499 total active members are paid $27 PMPM and 500+ total active members are paid $30 PMPM.*

Let's Get Started

Whether you need individual or family coverage, our representatives are ready to help you select the best plan for your unique situation. Simply call (800) 664-1244 or (417) 269-4679 for assistance. If you have already selected a plan, use this guide to complete your application.

Submit the completed application, first month's premium, and $25 non-refundable application fee to Cox HealthPlans using:

Mail: Cox HealthPlans, Attn: Individual Dept, PO Box 5750, Springfield, MO 65801-5750

Fax: (417) 269-4667, Attn: Individual Dept

Office: 3200 S National Suite B, Springfield, MO 65807 (Monday-Friday, 8:00am-5:00pm)

Email: IndividualMarketing@CoxHealthPlans.com
(please encrypt all attachments that include Personal Health Information)

Cox HealthPlans
CoxHealth
THINKING HEALTH FORWARD

(417) 269-4679 • (800) 664-1244
CoxHealthPlans.com

Covered Expense Highlights

Plan Features	In-Network Member is responsible for:	
Lifetime Maximum Benefit	$1,000,000	
Deductible		
Per Covered Person	$1,000, $2,500 or $5,000	
Per Family	3x Individual Deductible	
Co-insurance Out-of-Pocket Maximum *(not including Deductible)*		
Per Covered Person	$3,000	
Per Family	$6,000	
Accident Benefit Services	$1,500 paid at 100% for eligible accident expenses up to the maximum benefit within the first 30 days following an accidental injury	
Inpatient Hospitalization & Outpatient Hospital Services	20%	
Physician Services		
Primary Care Physician (PCP) *Specialty Care Physician (SCP)*	$30 Co-pay (First 3 visits, then deductible/coinsurance applies)	
Physician Telehealth Visits	$10 Co-pay	
Physician Services not received in an office setting	20%	
Select Preventive Health Services	$0	
Outpatient Services		
Emergency Ambulance Services	20%	
Emergency Services	20%	
Urgent Care Services	20%	
Chiropractic Services	20%	
Diagnostic Laboratory, Imaging and Radiology	20%	
Outpatient Prescription Drugs	**Retail (30 day supply)**	**Mail Order**
Deductible		*$1,000 (Tier 2-4)*
Tier 1 - Preferred Generics	$10 Co-pay	2.5x Retail Co-pay
Tier 2 - Preferred Brand	$35 Co-pay	2.5x Retail Co-pay
Tier 3 - Non-Preferred Brand	$75 Co-pay	2.5x Retail Co-pay
Tier 4 - Specialty Formulary Brand	$100 Co-pay	Not Available
Tier 5 - Preventive	$0 Co-pay	$0 Co-pay

This is only a brief summary of benefits, which is not intended to be comprehensive. Your Individual EPO Short-Term Medical Expense Policy is the governing document for benefit information.

Application Instructions

Section A: Applicant Information

Complete this section for everyone who needs coverage. For Child-Only coverage, please indicate the child's information in the Applicant Information section. Child-Only coverage is for ages 1-17. Parent signature is required.

Section B: Product and Coverage Selection

Requested Effective Date – Select when you would like your coverage to begin. Mark *1st of the Month following application date* or if other, mark *Other date* and write in the preferred date. Dates other than first of the month will be charged a pro-rated partial month premium.

Length of Coverage – Mark the box that corresponds to the length of time you will need coverage. The *6 months* option can only be selected if the effective date of coverage is the first of the month.

Deductible Amount – Mark the deductible amount you wish to have on your plan.

Optional Benefits Selection – If applicable, select the rider(s) you would like to add to your plan. An additional premium is required for each rider selected.

Section C: Application Questions

Complete all questions for all applicants. Only complete for those applying for coverage.

Section D: Referral Information

Please indicate how you became familiar with Cox HeathPlans.

Section E: Agent Certification

Completion is required by your insurance agent. If you are not represented by an insurance agent, please leave this section blank.

Section F: Electronic Consent

Complete this section if you would like to have plan documents or notices regarding your policy delivered to you by electronic means. Electronic delivery will require an active e-mail address and internet capability.

Section G: Authorization

All adults applying for coverage must sign and date the application, including the primary applicant, spouse and each dependent age 18 or older.

For Child-Only policies, a parent or legal guardian must sign and date the application as the Personal Representative of the minor child(ren).

Section H: Payment

Please select one of the two options for payment.

Single Payment Option (Full Payment) - Mark *Single Payment Option* to pay the entire premium in full. This option requires the entire premium including applicable partial month premium, applicable rider premium(s) and the nonrefundable application fee for the entire policy period selected.

Monthly Payment Option – Mark *Monthly Payment Optio*n to make an initial payment and subsequent payments each month for the term of the policy. This option requires a minimum of one month's premium including one month's premium for all riders, plus partial month premium (if the effective date is other than the first of the month) and non-refundable application fee.

Total Remitted - Complete the *Total Remitted* section which is the minimum amount due for the payment option selected.

Payment Type – Select the payment type that corresponds with how you will be paying for your policy.

Individual EPO
Short Term Medical Expense Policy
Application for Health Insurance

COX HEALTHPLANS
CoxHealth
THINKING HEALTH FORWARD

Section A: Applicant(s) Information

Legal Name: (Last, First, MI)	Social Security #	Gender	Birth Date (mm/dd/yyyy)	Height:	Weight:	Use Tobacco
		◉ M ○ F				○ Y ◉ N

Residential Address: (where you live and pay taxes)	City:	County:	State:	Zip:

☐ Billing or ☐ Mailing Address: (if different than above)	City:	County:	State:	Zip:

Primary Phone:	Secondary Phone:	Marital Status:	Occupation:
		◉ Single ○ Divorced ○ Married ○ Widowed	

Dependents: (Last, First, MI)	Relationship	Social Security #	Gender	Birth Date (mm/dd/yyyy)	Height:	Weight:	Use Tobacco
			○ M ○ F				○ Y ○ N
			○ M ○ F				○ Y ○ N
			○ M ○ F				○ Y ○ N
			○ M ○ F				○ Y ○ N
			○ M ○ F				○ Y ○ N
			○ M ○ F				○ Y ○ N

Section B: Product and Coverage Selection:

Requested Effective Date: (See Authorization Section)	Length of Coverage:	Deductible Amount: Choose one
◉ 1st of Month following application date, or ○ Other date: _____ (mm/dd/yyyy)	○ 1 Month ○ 2 Months ○ 3 Months ○ 4 Months ○ 5 Months ◉ 6 Months (6 Months – this option is only available for policies starting on the 1st of the month and not to exceed 6 months total)	○ $1,000 ◉ $2,500 ○ $5,000

Optional Benefits Selection (Additional Premium Required).

☐ Reissue Rider
Can only be selected if initial term is 6 months.
Choose Reissue Term in full months:
◉ 1 Month ○ 2 Months ○ 3 Months
○ 4 Months ○ 5 Months ○ 6 Months

☐ Autism Benefit Rider
Initial Term must be 6 months.
Autism Rider must be selected.
Reissue term must be 6 months.

Section C: Application Questions

Medical History Information

1	Are you or is any applicant an expectant mother or father, in the process of adopting a child, or undergoing infertility treatment? **If yes, coverage cannot be issued.**	○ Y ◉ N
2	Has any applicant within the last 10 years received medical or surgical consultation, lab, radiology, or genetic testing, advice, or treatment, including medication, for any of the following: immune system disorders, blood disorders, congenital conditions, rare diseases (e.g. hereditary angioedema-HAE, spinal muscular atrophy-SMA, Wilson's, etc.), liver disorders, kidney disorders, chronic obstructive pulmonary disease (COPD), emphysema or asthma, diabetes, cancer, multiple sclerosis, heart or circulatory system disorders, conditions of the nervous, digestive, muscular/skeletal, respiratory, or reproductive system, Crohn's/ulcerative colitis, or alcohol/drug abuse, mental or behavioral illness (e.g. schizophrenia, bi-polar disorder, manic depressive disorder, autism spectrum disorder, etc.), or any other condition requiring management from a health care professional? **If yes, select each person: ☐ Primary, ☐ Spouse, ☐ Dependent 1, ☐ Dependent 2, ☐ Dependent 3, ☐ Dependent 4, ☐ Dependent 5.** **Diagnosis / Condition:** _____ **The person(s) indicated may not be covered under the policy.**	○ Y ◉ N

3	Has any applicant had testing performed and has not received results, or been advised by a medical professional to have treatment, testing, or surgery that has not been performed? **If yes, select each person: ☐Primary, ☐Spouse, ☐Dependent 1, ☐Dependent 2, ☐Dependent 3, ☐Dependent 4, ☐Dependent 5.** **Diagnosis / Condition:** _____ **The person(s) indicated may not be covered under the policy.**	◯ Y ◉ N
4	Within the last 5 years, has any applicant received treatment, advice, medication, or surgical consultation for HIV infection from a doctor or other licensed clinical professional, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional? **If yes, select each person: ☐Primary, ☐Spouse, ☐Dependent 1, ☐Dependent 2, ☐Dependent 3, ☐Dependent 4, ☐Dependent 5.** **The person(s) indicated may not be covered under the policy.**	◯ Y ◉ N
5	Are you or any applicant taking a prescribed medication? If yes, please select each person and list medication name(s), dosage(s), and frequency. ☐ **Primary** _____ ☐ **Spouse** _____ ☐ **Dependent 1** _____ ☐ **Dependent 2** _____ ☐ **Dependent 3** _____ ☐ **Dependent 4** _____ ☐ **Dependent 5**	◯ Y ◉ N

Other Coverage Information

6	Does any applicant now have hospital or medical expense insurance that will not terminate prior to the requested effective date? **If yes, select each person: ☐Primary, ☐Spouse, ☐Dependent 1, ☐Dependent 2, ☐Dependent 3, ☐Dependent 4, ☐Dependent 5.** **The person(s) indicated may not be covered under the policy.**	◯ Y ◉ N

Section D: Referral Information

How did you hear about Cox HealthPlans Short Term Individual Health Plans?		☐ **Television – Station:** _____
☐ **Brochure**	☐ **Direct Mailing** ☐ **Internet**	☐ **Radio – Station:** _____
☑ **Insurance Agent**	☐ **Word of Mouth/Referral** ☐ **Other:** _____	☐ **Advertisement – Publication:** _____

Section E: Agent Certification (To be completed by Agent representing applicant(s).

Agent Use Only

I hereby certify that I hold a valid health insurance license issued by the state of Missouri and that all of the information contained herein is correct to the best of my knowledge, and that I know nothing unfavorable about any individual applying for coverage unless fully described herein.

I understand that this application and any other required parts shall not be binding until approved by Cox Health Systems Insurance Company (CHSIC).

Producer agrees that any agent of record change is subject to approval by CHSIC and that any commissions payable are subject to change at the discretion of the company. Commissions are paid to agent or agency as directed in agent/broker agreement.

Signature of Writing Producer:	Jamey Bunch	**Printed Name:**	Jamey Bunch	**Date Signed:**	08/17/2026

Section F: Electronic Consent (Optional)

I understand and consent to receiving plan documents or notices delivered by electronic means. I understand I have the right to delivery of these documents or notices in paper form at no additional cost upon request. I understand I have the right to withdraw consent to have these documents or notices delivered by electronic means upon verbal request to Cox Health Systems Insurance Company (CHSIC) by contacting the Member Service Department.

These documents are always available on the Member Portal located on our website at www.coxhealthplans.com or by calling 800-205-7665 and requesting the information to be mailed. Electronic delivery will require e-mail and internet capability.

Please initial and clearly print your e-mail address:		**Initial Here:**	

Section G: Authorization

I have read this application and represent that the information on it is true and complete. I understand that:

1	Payment is required with my application, including non-refundable application fee and my initial premium; and receipt of my payment by CHSIC does not mean that coverage has been approved. I understand that, to the extent permitted by law, CHSIC reserves the right to accept or decline this application, and that no right whatsoever is created by this application. No insurance will become effective unless my application is approved and the application fee and appropriate premium are received by CHSIC prior to the effective date of coverage.
2	No benefits will be paid for a health condition that exists prior to the date insurance takes effect.
3	If coverage is issued, the coverage will not be a continuation of any prior coverage.

4	Incorrect or incomplete information in this application may result in voidance of coverage and claim denial.
5	I am responsible to timely notify CHSIC of any change that would make me or any dependent ineligible for coverage. I acknowledge that termination of this contract is subject to the right of either CHSIC or the Policy Holder to terminate the contract based on the terms outlined in the Termination Section of the Individual Health Plan Policy. The contract will be terminated on the last day of the thirty-one (31) day grace period following the premium due date if premiums are not paid on or before the premium due date or during the grace period, unless otherwise agreed upon by CHSIC.
6	I acknowledge that I have read the terms and conditions of this application, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand that they are being relied on by CHSIC in acceptance of this application.
7	By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medically-related facility, records custodian, or insurance company, that has any records of me or any members of my family named in this application, of our health, to give Cox Health Systems Insurance Company, its reinsurers, affiliates, or business associates, any such information. I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies or other persons or organizations performing business or legal service in connection with my application, claim, or as may otherwise lawfully require or as I may further authorize.
8	The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued.
9	Applications, if approved will be effective the later of; the requested effective date, or the first of the month following receipt by or the date approved by CHSIC.
10	I acknowledge that I have personally completed this application. I represent the information to be complete and accurate to the best of my knowledge and understand that this application and other required parts shall not be binding until approved by CHSIC. The undersigned Applicant(s) certify that each person proposed for insurance has read the completed application.
11	The producer is only authorized to submit the application and initial payment and may not change or waive any right or requirement.

Signatures(s). Must be signed and dated by each applicant 18 years and older:

	Printed Name	**Signature**	**Date**
Applicant or Personal Representative*:			
Spouse Applying for Coverage (required):			
Dependent Age 18 or Older Applying for Coverage:			
Dependent Age 18 or Older Applying for Coverage:			
Dependent Age 18 or Older Applying for Coverage:			
Dependent Age 18 or Older Applying for Coverage:			
Dependent Age 18 or Older Applying for Coverage:			

***A parent or legal guardian must submit this document. If you are a personal representative or legal guardian of the applicant, you must attach documentary evidence of your authorization to act in this capacity for this application to be valid.**

Important Notes:

- "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.
- No application will be accepted if received by CHSIC more than 15 days after the date signed.
- Altered applications will not be accepted.

You will be notified within 60 days as to whether this application has been accepted, or you will be given the reason for any further delay.

Section H: Payment

Choose one Payment Option and Indicate Payment Type

◯ **Single Payment Option (Full Payment)**	**Total Remitted:**		**(Includes $25 Non-refundable Application fee)**
◯ **Monthly Payment Option**	**Total Remitted:**		**(Includes $25 Non-refundable Application fee)**

Payment Type:	◯ **Check**	◯ **Cash**	◯ **ACH**	**Credit Card**	**Payment Confirmation #:**	

Short-Term Automatic Direct Debit

Cox HealthPlans is offering Short-Term applicants the option of paying their initial binder payment, including the $25 non-refundable application fee, and monthly premium payments through automatic checking withdrawals.

This option is convenient, secure, and available at no cost! Bank account information is safeguarded and there is no service charge for using this payment method. Payment information will NOT be disclosed for any reason other than for processing this transaction with your bank.

Participating in Automatic Direct Debit is Easy!

- Complete the "Authorization Agreement for Short-Term Direct Debit" form (see reverse side).
- Attach to the Authorization Agreement a voided check, a printed account card or a letter from your bank with the account holder's name, account number and bank routing number. Please note: Deposit slips will not be accepted.
- Once your application is received, your initial premium payment including a $25 non-refundable application fee will be debited from your checking account. The non-refundable application fee is due regardless of approval and enrollment in the plan.
- If your application is approved, subsequent premium payments will be debited on the 1st of each month.
- The Authorization Agreement will remain in effect until we receive written notification stating your desire to cancel the agreement or the policy terms.
- A monthly statement disclosing your account debit amount will be forwarded to your address.

All debits will be made on the 1st of each month. If your account has insufficient funds, another attempt will be made to withdraw money from the account. Please note: If there are insufficient funds after two attempts, your policy will be terminated. Any account changes must be made as soon as possible as it may take up to 10 business days to update account information.

The completed Authorization Agreement for Short-Term Direct Debit form may be faxed to (417) 269-4667, mailed or delivered.

Mailing Address:
Cox HealthPlans
P.O. Box 5750
Springfield, MO 65801-5750

Physical Address:
Cox HealthPlans
3200 South National, Building B
Springfield, MO 65807

If you have additional questions, please feel free to contact our office at ***(417) 269-4679 or (800) 664-1244.***

THINKING HEALTH FORWARD

Authorization Agreement For Short-Term Direct Debit

Applicant's Name:
(Legal Name shown on application)

I (we) hereby authorize Cox Health Systems Insurance Company ("Cox") to initiate a debit entry, and the Financial Institution named below to debit, my/our Checking/Savings account in the amount of my/our initial premium payment plus a $25 non-refundable application fee.

I (we) hereby authorize Cox Health Systems Insurance Company ("Cox") to initiate debit entries, and the Financial Institution named below to debit, my/our Checking/Savings account in the amount of my/our monthly premium on the 1st of each month, which shall be applied by Cox for the payment of my/our health insurance premium. I/We acknowledge and agree that the timely payment of premiums is my/our sole responsibility and that Cox is not responsible for a policy cancellation due to nonpayment if the direct debit request is presented but not honored, or for any other reason the premium is not timely paid.

Financial Institution:

City:	State:	Zip:

Routing No.:	Account No.:

This authorization to debit my/our account will remain in full force and effect until Cox and the above-named Financial Institution receive written notice of termination from me (or either of us), which is effective ten (10) days after receipt or first date on which Cox and the Financial Institution have a reasonable opportunity to act on it, whichever is later.

Name(s):

Signature	Date Signed:

Signature	Date Signed:

Attach Voided Check or Other Acceptable Documentation Here

For Office Use Only

Member No. _____

Cox Health Systems Insurance Company
P.O. Box 5750, Springfield, Missouri 65801-5750 • (417) 269-4679 • (800) 664-1244 • Fax: (417) 269-4667 • coxhealthplans.com