friday health plans

Georgia Health Insurance

GEORGIA HEALTH BENEFIT EXCHANGE INDIVIDUAL MARKET MEDICAL AND HOSPITAL POLICY

POLICY

FHPGA-0126-051622

2023_FHP_GA_IND_EOC_ONEX

SECTION 1: TITLE PAGE (COVER PAGE)

FRIDAY HEALTH PLANS OF GEORGIA, INC.

GEORGIA HEALTH BENEFIT EXCHANGE INDIVIDUAL MARKET MEDICAL AND HOSPITAL PLAN

POLICY

SECTION 2: CONTACT US

GEORGIA HEALTH BENEFIT EXCHANGE

Healthcare.gov provides a marketplace where insurance companies may sell their insurance products. The marketplace allows purchasers, like You, to compare and chose from different insurance options. After comparing the plans offered through Healthcare.gov You have selected a plan insured by Friday Health Plans of Georgia, Inc. (the "Carrier" or "the Plan").

PURPOSE OF THIS DOCUMENT

This Policy describes the health care benefits available to You under the Plan. It also describes the rules that apply to individuals who participate in the Plan. To understand the benefits and the rules that apply, You should know the meanings of terms used in this Policy. Generally, if a capitalized term is used in this Policy, it will have the meaning set forth in the DEFINITIONS section. However, some capitalized terms may be defined in the sections of the Policy where they are used.

If You have any questions about the Plan or the information set forth in this Policy, You may contact the carrier in writing at:

Friday Health Plans of Georgia, Inc.
700 Main Street.
Alamosa, Colorado 81101
questions@fridayhealthplans.com

Or contact us by telephone at:1-844-521-7999

Together with the Enrollment Application, Summary of Benefits and Coverage, Schedule of Benefits, and the Member ID Card, this document is the entire contract between You and Us. Not agent may change this contract, waive any of the provisions of this contract, extend the time for payment of premium, or waive any of the Plan's rights or requirements.

All riders or endorsements added after date of issue, except those by which the insurer effectuates a request made in writing be the Policyholder or exercises a specifically right under this document or those which increase benefits, shall require signed acceptance by the Policyholder.

NOTICE OF NONDISCRIMINATION

Friday Health Plans of Georgia, Inc. complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Friday Health Plans of Georgia does not exclude people or treat them differently because of race, color, nationality origin age disability, or sex.

Friday Health Plans of Georgia:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreter
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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, contact Member Services at 1-844-521-7999.

If You believe that Friday Health Plans of Georgia has failed to provide these services or discriminated is another way on the basis of race, color, national origin, age disability, or sex, You can file a grievance with: the Chief Compliance Office, 700 Main Street, Suite 100, Alamosa, Colorado 81101; 1-800-475-8644 (TTY: 1-800-659-2656); compliance@fridayhealthplans.com. You can file a grievance in person, or by mail, or email. If You need help filling a grievance, our Chief Compliance Officer is available to help You.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically though the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscree./main.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, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al l 844-512-7999.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-512-7999.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-512-7999.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오.844-512-7999

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-512-7999.

Arabic: 844-512-7999 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

ا ديك لحق 844-512-7999 Friday Health Plans كا إن ل ن ل أو ديك شخ دى تساء ص أ ده بخصـ سئلة وص

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-512-7999 .

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-512-7999.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-512-7999

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer: 844-512-7999

Portuguese: I cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. HHS não exclui ou trata de forma diferente devido à raça, cor, nacionalidade, idade, deficiência ou sexo.844-512-7999.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-512-7999.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-512-7999 まで、お電話にてご連絡ください。

SECTION 3: TABLE OF CONTENTS

SECTION 4: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

ELIGIBILITY OF APPLICANTS

Healthcare.gov will determine whether You are eligible for coverage under the Plan based on Your Application. If You are eligible, and You elect to enroll in the Plan, Healthcare.gov will assist with Your enrollment. If Healthcare.gov determines that You are not eligible, Healthcare.gov will notify You. Healthcare.gov will give You a chance to appeal the determination.

For an individual to be eligible to enroll as a subscriber, the must meet the following criteria:

- Live in Friday Health Plans Service Area.
- Complete and submit to **Healthcare.gov** such Enrollment Applications or forms that the Exchange may reasonably request.
- Be a United States citizen or national.

ELIGIBILITY OF DEPENDENTS

Healthcare.gov will also determine whether Your Dependents are eligible coverage under the Plan. If one or more of Your Dependents are eligible, and You elect to enroll them in the Plan, Healthcare.gov will assist with the enrollment. If Healthcare.gov determines that one or more of Your Dependents are not eligible, Healthcare.gov will notify You. Healthcare.gov will give You a chance to appeal the determination. The following are the acceptable Dependents:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage (Spouse includes a partner in a valid civil union under state law)
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or in the Subscriber's spouse the legal guardian.
    - The child must be under the age of twenty-six (26).

INDIVIDUALS THAT ARE NOT ELIGIBLE

The Plan may consider You and You Dependents to be ineligible if You have done one of these in the past.

- You failed to make payments owed to the Plan.
- You performed an act or practice that is considered fraud, in regard to Plan coverage.
- You made a false representation of fact, in connection with Plan coverage.

In addition, a subscribing individual or their Dependent is not eligible if they meet any of the below:

- An individual who is eligible and/or enrolled for coverage under Medicare Part A and/or B at the time of Application.
- A foster child of the applicant or Subscriber.
- A child placed in the applicant or Subscriber's home other that for adoption.

- A grandchild of the applicant or Subscriber.
- A person in prison (in prison; does not apply if You are waiting for disposition of charges).
- An individual who is eligible and/or enrolled in Medicaid either at the time of Application or after they enroll.

ELIGIBILITY FOR PREMIUM ADVANCES AND COST-SHARING SUBSIDES

PREMIUM ADVANCES

Certain Enrollees may be eligible for help to pay their Plan Premium. Healthcare.gov will decide if an Enrollee should get Premium Advances when he/she applies. In general, to be eligible for Premium Advances, the Enrollee must have certain household income levels. The Enrollee also must not be eligible for Minimum Essential Coverage (other than through the individual market or through an employer- sponsored plan that is unaffordable or does not provide minimum value). If an Enrollee is eligible for Premium Advances, the Federal government will send a payment each month to the Plan. This payment may pay for all or part of the Enrollee's Premium.

COST-SHARING SUBSIDES

Certain Enrollees who get Premium Advances will be eligible for financial help paying their Deductibles, Copayment and/or Coinsurance cots when they receive Covered Services. Healthcare.gov or HHS will decide if an Enrollee is eligible for Cost-Sharing Subsidies. To be eligible for Cost-Sharing Subsidies, the Enrollee must be eligible for Premium Advances. The Enrollee must also enroll in a plan that Healthcare.gov deems to be a "silver-level" plan. Alternatively, the Enrollee must be an Indian in a Healthcare.gov plan. The term "Indian" is defined by the Indian Health Care Improvement Act.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

Healthcare.gov will have an open enrollment period. If You are eligible, then You apply, and You select a plan during this time period. Then You will be enrolled for coverage. Likewise, if any Dependent is eligible, You should include such Dependent on Your Application, and You select coverage for such Dependent. You will do this during the initial open enrollment period. If done, then such Dependent will be enrolled for coverage.

You must be enrolled in the Plan in order to enroll any Dependent in the Plan. In order for You and any Dependent to enroll in the Plan, You must also agree to pay any required Premium.

If You do not enroll Yourself (and Your eligible Dependents) in the Plan during the Open Enrollment Period, You (and Your eligible Dependents) must wait until the next annual Open Enrollment Period to do so. In certain cases, You may be able to enroll Yourself and/or Your eligible Dependents in the Plan before the next Open Enrollment Period. Please review the Special Enrollment section for more details.

EFFECTIVE DATE OF COVERAGE

If You enroll Yourself and/or Your eligible Dependents during the Open Enrollment Period, Healthcare.gov will inform You of the date such coverage becomes effective.

ANNUAL OPEN ENROLLMENT

Each year (during September), Healthcare.gov will provide a written notice to each Enrollee. The notice will inform the Enrollee of the upcoming Open Enrollment Period. During this period, You can decide whether to elect Plan coverage for Yourself and Your eligible Dependents. You can also make any changes to Your prior enrollment election. If You want to participate in the Plan, You must complete and submit the Application required by Healthcare.gov during the Open Enrollment Period.

You must be enrolled in the Plan in order to enroll any Dependent in the Plan. In order for You and any Dependent to enroll in the Plan, You must also agree to pay any required contributions.

If You do not enroll Yourself (and Your eligible Dependents) must generally wait until the next annual Open Enrollment Period to do so. However, in certain cases, You may be able to enroll Yourself and/or Your eligible Dependents in the Plan before the next Open Enrollment Period, Please review the Special Enrollment section for more information.

DOCUMENTION OF DISABLED CHILD

If You enroll a Child who is over the age of twenty-six (26), You must provide proof of the Covered Child's incapacity and dependency on You. You will be required to submit such information to the Plan within thirty-one (31) days if the date of the Covered Child's enrollment. The Plan may also require proof periodically during the Covered Child's coverage.

IMPROPER ENROLLMENT

If You or any Dependent is not eligible to participate in the Plan, You or such Dependent will not be covered by the Plan. This is true if You or Your Dependent has been enrolled in the Plan. If such an enrollment occurs, the Plan will have the right to seek repayment directly from You. The Plan may recover the cost of any benefits provided to You or Your Dependent during the Refund Period, if those costs are greater than the Premium received by the Plan for You or Your Dependent for the Refund Period. The Plan will refund Your Premium (or Your Dependent's Premium) for the Refund Period only if You (or Your Dependent) received no benefits from Plan.

IDENTIFICATION CARD

You and Your Covered Dependents will receive Plan identification cards when You enroll in the Plan. You should notify the carrier if You do not receive Your identification card after Your enrollment, You and Your Covered Dependents will be responsible for presenting the identification card to each health care Provider. You should present the identification card at the time health care services are rendered. If You fail to do so, You may be obligated to pay for the cost of those services.

Identification cards are issued by the Plan for identification purposes only. Having a Plan identification card will not give You or any other person a right to receive Plan benefits. The holder of a Plan identification card must be an Enrollee in order to receive Plan benefits. If a person who is not allowed to receive Plan benefits uses an Enrollee's card to receive benefits, that person will be required to pay for any health care services he/she receives.

MISUSE OF IDENTIFICATION CARD

If You allow another person to use Your Plan identification card, the Plan may reclaim Your identification card. The Plan may also terminate Your right (and the rights of Your Covered Dependents) to receive Plan benefits. If this occurs, the Plan will provide You with thirty (30) days' advance written notice of termination. The Plan may also require You to pay for any costs paid by the Plan as a result of Your conduct.

CONSUMER ADVISORY BOARD

You are a critical part of our organization. We value Your feedback about our services and Health Plan operations. We have started a Consumer Advisory Board that meets every quarter to discuss general operation from our Members' perspectives and how we might better serve You. As a Member of this Plan, You are eligible to participate on this Board. If You are interested , call us at 1-844-521-7999.

CHANGE OF BENEFICIARY

The right to change a beneficiary is reserved for the Policyholder, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other change in the Policy.

SPECIAL ENROLLMENT SECTION

SPECIAL ENROLLMENT RIGHTS

In certain cases, You will have the right to enroll Yourself and/or Your eligible Dependents in the Plan during the Plan Year. This means that You will not have to wait until the next Open Enrollment Period to receive Plan coverage. Following a triggering event, You will have a special enrollment period of no less than sixty (60) days. In order to qualify for a special enrollment period, You may be required to provide proof of prior credible coverage and payment of prior Premiums, based on federal regulations.

When You are notified or become aware of a triggering event that will occur in the future, You may apply for enrollment on a new health benefit plan during the sixty (60) calendar days prior to the effective date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. You must be able to provide written documentation to support the effective date of the triggering event at the time of Application. The effective date of this enrollment must comply with the coverage effective dates found in this section.

TRIGGERING EVENTS

- The loss of Your creditable coverage for any cause other than fraud, misrepresentation, or failure to pay a premium.
- Gaining a Dependent or becoming a Dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, or by entering into a designated beneficiary agreement if coverage if offered to designated beneficiaries.
- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent. Or erroneous and is the result of an error, misrepresentation, or inaction of the Plan, producer or Healthcare.gov
- Showing to the Insurance Commissioner that the health benefit plan in which You are enrolled has violated a material provision of its contract in relation to You.
- A Healthcare.gov enrollee becomes eligible or no longer eligible for the federal advance payment tax credit or cost-sharing reductions through Healthcare.gov.
- If an income change makes a consumer eligible for premium tax credits or cost-sharing reduction during the plan year and the person bought an off-exchange plan, then they will experience a triggering event allowing them to purchase an on-exchange plan and can take advantage of those benefits. As in all cases of special enrollment, the newly purchased benefit plan will have a deductible and max out-of-pocket that is reset.
- If You gain access to other coverage due to a permanent change in residence.
- A parent or legal guardian dis-enrolls a Dependent or a Dependent is no longer eligible for the Children's Basic Health Plan.
- As an individual, who was not a citizen, a national, or a lawfully present individual, gains sub status.
- Or an Indian, as defined by section 4 if the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

COVERAGE EFFECTIVE DATES

- In the case of marriage, civil union, or in case one loses creditable coverage, coverage must be effective no later than the first day of the following month.
- In the case of birth, adoption, placement for adoption, placement in foster care, coverage must be effective on the date of the event.
- In the case of all triggering events, where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.
- In case of all triggering events, where individual coverage is purchased between the sixteenth and the last day of the month, coverage shall become effective no later than the first day of the second following month.

SECTION 5: THE HMO NETWORK

As a member, You may receive Covered Services from Network Providers including medical, surgical, diagnostic, therapeutic and preventative services provided in the Plan Service Area. Covered Services must also be Medically Necessary. As a Member of an HMO, You and Your Primary Care Provider (PCP) must work together to manage Your healthcare services. When a Covered Service requires Prior Authorization, You and Your Network Provider will work with the Plan to get Prior Authorizations.

Each member is encouraged to select a (PCP). If You select a PCP, You must choose Your PCP by referring to the current Friday Health Plan's Provider Directory or by calling the Plan's Friday Care Crew.

It is the responsibility of each Friday Health Plan's Member to provide FHP with a change of Your mailing address within thirty-one (31) days of such address change. Changes can be made by contacting Friday Care Crew at 1-844-521-7999.

Except for Emergency Services only services which are coordinated by a Network Provider, and/or Prior Authorization by the Plan and obtained from a Network Practitioner/Provider are considered Covered Services. There must be a Prior Authorization for all care from Non-Network Providers to be a Covered Service.

THE HMO NETWORK OF PARTICIPATING PROVIDERS

The Plan has contracted with health care Providers to give affordable health care to its member. This is also done to manage Your healthcare needs. You must choose Your PCP from the current Friday Health Plan's Network Providers. You must receive Your own care from Network Providers. Except for rare cases where a Non-Network Provider is Prior Authorized by the Plan or in emergency situations, You MUST receive care from a Network provider for it to be considered a Covered Service. If You receive healthcare services from a Non-Network Providers, then it will result in a significant increase in cost to You. It is vital that You confirm that the Provider that You intend to see is a Network Provider. You should confirm that a Provider is a Network Provider by checking the Provider Directory or by calling Friday Care Crew at 1-844-512-7999. You can also find the directory at www.fridayhealthpalns.com.

ACCESSING NON-NETWORK PROVIDERS

If a Provider is not contracted with the Plan, then they are a Non-Network Provider. Unless the Member has Prior Authorization, the Plan will not cover Non-Network Provider expenses, and the Member must pay for any expenses related to Non-Network services or supplies. Prior Authorization for a Non-Network provider will be granted when FHP concludes that it is not possible to get the necessary medical services In-Network. Please check that the Provider You intend to receive care through is a Network Provider. You can check that a Provider is a Network Provider by checking the Provider Directory. The Provider Directory can be found at www.fridayhealthplans.com or call Friday Care Crew at 1-844-512-7999.

In rare cases, a Member may receive services from a Non-Network Provider in a Network Facility. If a Member receives care from a Non-Network Provider at a Network facility and the Member had not specifically requested the Non-Network Provider, then the member will be held harmless and will have no greater share of cost than if an In-Network Provider treated them. The Plan will pay the Allowable Amount which is the amount established under Georgia state law for reimbursement for health care services to covered persons at a Network facility provided by an Non-Network Provider or for emergency services that are provided by Non-Network providers or facilities. If an Enrollee receives emergency services from a Non-Network Facility, then the payment from the Plan will be limited to the Allowable Amount. The Plan will pay the Allowable Amount which is the amount established under Georgia state law for reimbursement for health care services to covered persons at a Network facility provided by an Non-Network provider of for emergency services that are provided by Non-Network Providers or facilities.

IMPORTANT NOTICE ABOUT SURPRISE BILLING – KNOW YOUR RIGHTS

Georgia state law and federal law protects You from "surprise billing." This is sometimes called "balance billing" and it may happen when You receive covered services, other than ambulance services, from a Non-Network Provider in Georgia. This law does not apply to all health plans and may not apply to Non-Network Providers located outside of Georgia. Check to see if You have a "GA-OCI" on Your ID card; if not, this law may not apply to Your health plan. What is surprise/balance billing and when does it happen? You are responsible for the cost-sharing amounts required by Your health plan, including Copayments, Deductibles and/or Coinsurance. If You are seen by a provider or use services in a hospital or other type of facility that are not in Your health plan's Network, You may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network." Non-Network hospitals, facilities or Providers often bill You the difference between what The Plan decides is the eligible charge and what the Non-Network provider bills as the total charge. This is called 'surprise' or 'balance' billing.

When You CANNOT be balance-billed

- **Emergency Services:** When You receive services for emergency medical care, usually the most You can be billed for emergency services is Your plan's Network Cost-Sharing amounts, which are Copayments, Deductibles, and/or Coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any Providers You may see for emergency care.

- **Non-emergency services at a Network or Non-Network Facility:** The hospital or facility must tell You if You are at a Non-Network location or at a Network location that is using Non-Network providers. It must also tell You what types of services may be provided by any Non-Network provider. When they notify you of these services, Providers may ask that you sign a balance billing waiver. This waiver allows

Providers to balance bill you for amounts greater than your Cost Sharing amounts from the health plan

You have the right to request that Network providers perform all covered medical services. However, You may have to receive medical services from a Non-Network Provider if a Network provider is not available. When this happens, the most You can be billed for Covered Services is Your Network Cost-Sharing amount (Copayments, Deductibles, and/or Coinsurance). These Providers cannot balance bill You.

Additional Protections

- Friday Health Plans will pay Non-Network Providers and facilities directly. Again, You are only responsible for paying Network Cost Sharing for Covered Services.

- Friday Health Plans will count any amount You pay for emergency services or certain Non- Network services as (described above) toward Your Network Deductible and out-of-pocket limit.

- Your Provider, hospital, or facility must refund any amount You overpay within 60 days of reporting the overpayment to them.

- A Provider, hospital, or other type of facility cannot ask You limit or give up these rights.

If You receive services from a Non-network, hospital, or facility in any OTHER situation, You may still be Balance Billed, or You may be responsible for the entire bill. If You intentionally receive non-emergency services from a Non- Network provider or facility, You may also be Balance Billed.

If You do receive a bill for amounts other than Your copayments, deductible, and/or coinsurance, please contact Friday Care Crew at 719-589-3696 or 800-475-8466.

Ambulance Information You may be Balance Billed for emergency ambulance services You receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does not apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if You receive such services and they are not service and they are not a service covered by Friday Health Plans, You may receive a balance bill.

SECTION 6: HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

PRIMARY CARE PROVIDER (PCP)

A PCP is a Network Provider who You choose and who guides, tracks, and manages Your health care services. They work to assure continuity of care for the Member. The PCP also works with the Plan to get a Prior Authorization for specialized care the Member may need. You have the right to designate any Primary Care Provider who participates in the Plan's Network and who is available to accept You or Your Covered Dependents. The Plan does not guarantee that the Primary Care Provider You select will be able to add You or Your Covered Dependents as patients. However, the Plan will make an adequate panel of Primary Care Providers available for Your selection. By selecting a PCP, You will have access to a Provider that will work with You to manage Your health care needs.

You may contact the Plan for a list of Primary Care Providers in writing at:

Friday Health Plans of Georgia, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call Friday Care Crew at 1-844-712-7999

You may contact Healthcare.gov to see if a provider is accepting new patients at healthcare.gov or if You prefer You may call at 1-800-706-7893 or TTY line at 1-888-201-6445.

PEDIATRICIAN AS PRIMARY CARE PROVIDER

For any Covered Child, You may select a pediatrician as the Child's Primary Care Provider. You may contact the Plan for a list of the Primary Care Providers who are pediatricians. You may contact the Plan in writing at:

Friday Health Plans
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call Friday Care Crew at 1-844-512-7999.

SIGNIFICANCE OF PRIMARY CARE PROVIDER

As a general rule. You and Your Covered Dependents are required to receive all Covered Services within the Service Area from Your Primary Care Provider.

EXCEPTION FOR GYNECOLOGICAL CARE

You do not need Prior Authorization for obstetrical or gynecological care from a Network Provider who is an OB GYN or reproductive health specialist. You also do not need a referral from Your PCP to get such care. For a list of Network Providers who specialize in OB GYN or reproductive health, You may contact the Plan at this address.

Friday Health Plans
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call Friday Care Crew at 1-844-512-7999.

EXCEPTION FOR EMERGENCY SITUATIONS

In unusual cases where You have an urgent need for health care services, You must attempt to access Your Primary Care Provider. If accessing Your Primary Care Provider is not an option, You may obtain care without obtaining Prior Authorization from the Plan. If Your Primary Care Provider is unavailable or does not provide the particular health care services that You need, You may obtain care without obtaining Prior Authorization from the Plan. However, the health care Provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services. This paragraph applies when the situation does not qualify as a Medical Emergency, as described below.

EXCEPTION FOR EMERGENCY SITUATIONS

You are not required to obtain Prior Authorization from the Plan when You receive health care services in a Medical Emergency. However, the health care Provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services that could be considered non-emergent. If You are hospitalized without Prior Authorization due to a Medical Emergency, You must notify the Plan by telephone of the hospitalization at 1-844-512-7999. Alternatively, You must instruct the hospital or a family member to notify the Plan. This notice must occur on the first business day following the hospital admission, or as soon as medically possible. If You are unable to contact the Plan or to instruct another person to do so, the notice may be delayed until You are able to notify the Plan or to instruct another person to notify the Plan. If You can communicate with others, You will be considered capable of notifying the Plan. The Plan may refuse to reimburse You for the cost of any non-emergent treatment if proper notice is not provided to the Plan.

OTHER EXCEPTIONS TO PRIOR AUTHORIZATON REQUREMENTS

You are not required to obtain Prior Authorization from the Plan when You visit a Participating Provider who is covering in the absence of Your Primary Care Provider. You are also not required to obtain Prior Authorization from the Plan when You have routine tests performed by a Network Provider.

Prior Authorization is not required for therapy visits to a Psychiatrist, Behavioral Health Practitioner and/or Other Professional Provider.

FAILURE TO USE A PARTICIPATING PROVIDER

As a general rule, if You receive health care services from a Non-Network Provider, the Plan will not pay for such services. However, if the reason You are receiving care from a Non-network Provider is due to a Medical Emergency or an urgent medical situation, the Plan will

pay for the Covered Services You receive. This is true only if You follow the other terms and conditions explained in this Policy, if You access a Non-Network provider for emergency and non-emergency services the Plan will provide disclosures concerning a covered person's financial responsibility for those services. This information is also available on our website titled "Appendix A." This document outlines Your rights as a member in regard to surprise billing.

MEMBER PORTAL

As a Member of FHP, You can use the online Member Portal to review claims, print Your ID card, check the status of Prior Authorizations, and perform many other functions that will help You as a Member. To enter the Member Portal, go to www.fridayhealthplans.com website, Members link (found in the ribbon at the top of the home page), then click on Member Hub in the drop down. Then click on the member portal login (located at the bottom then the Member Hub page. You will be prompted to set up Your account, and You will need Your member ID number.

UTILIZATION REVIEW AND UTILIZATION MANAGEMENT

To make sure You have access to high quality, cost-effective health care, the Plan has a Utilization Management (UM) program. The UM program requires that certain health care services be reviewed and approved by the Plan in order to receive benefits. As a part of this process, the Plan looks at whether heath care services are Medically Necessary, provided in the proper setting and provided for a reasonable length of time. The Plan will honor a Certification to cover medical services or supplies under Your health benefit plan unless Certification was based on a material misrepresentation about Your health condition, or You were not eligible for these services under Your health plan due to termination of coverage (including Your voluntary termination of coverage) or nonpayment of Premiums.

RIGHTS AND REPSPONSIBILITES UNDER THE UM PROGRAM

You have the right to:

- A UM decision that is timely, meeting applicable state and federal timeframes.
- The reasons for and Adverse Determination of a requested treatment or healthcare service, including an explanation of the UM criteria and treatment protocol used to reach the decision.
- Have a Medical Director from the Plan make a final determination of all Adverse Determinations that were based upon Medical Necessity.
- Request a review of an Adverse Determination through our Appeals process.
- Have an authorized representative pursue payment of a claim or make an Appeal on Your behalf.
- An authorized representative may act on the Member's behalf with the Member's written consent.

THE PLAN'S RESPONSIBILITIES

As part of all UM decisions, the Plan will:

- Provide You and Your Provider with a toll-free telephone number to call UM review staff when Certification of a health care service is needed.
- Limit what we request from You and Your Provider to only the information that is needed to review the service in question.
- Request all necessary information necessary to make the UM decision, including pertinent clinical information.
- Provide You and Your Provider prompt notification of the UM decision consistent with applicable state and federal law and Your health benefit plan.

In the event that the Plan does not receive sufficient information to approve coverage for a health care service within the specified time frames, the Plan will notify You of an Adverse Determination in writing. The notice will explain how You may Appeal the Adverse Determination.

PRIOR AUTHORIZATION

The Plan reviews certain health services to determine whether the services are or were Medically Necessary, or Experimental/Investigational. This process is called Utilization Review includes all review activities, whether they take place prior to the service being performed (Prior Authorization); while the services are being performed (Concurrent); or after the service is performed (Retrospective). This review process results in a service being Prior- Authorized or denied as a Plan benefit.

SERVICES SUBJECT TO PRIOR AUTHORIZATION

In some cases, You must obtain Prior Authorization from the Plan before You receive health care services from anyone other than Your Primary Care Provider. Visits to a network Specialist does not require Prior Authorization. Generally, Your Primary Care Provider will begin the process of obtaining Prior Authorization on Your behalf. This is done by making a request for Prior Authorization to the Plan. Your Primary Care Provider will ask that You be permitted to receive services from another Network Provider. The Plan will respond to each request with either an approval or an Adverse Determination. The Plan will send a copy of its response to You. The Plan will also send a copy to Your Primary Care Provider, and the Network Provider who is the subject of the request. When a request is approved, the Plan will issue a Prior Authorization. The Prior Authorization request will identify the name of the Network Provider, and the date range when the services can be performed. The Prior Authorization from the Plan guarantees payment by the Plan of all Covered Services approved in the Prior Authorization. This guaranty does not apply if You lose Plan eligibility before the date of the services.

Please note that this Policy may contain some, but not all, of the exclusions.

The Plan will pay for Covered Services that require Prior-Authorization only if You get a Prior Authorization from the Plan <u>before</u> You get the Services. If You require the Services without Prior Authorization when Prior Authorization is required by the Plan, the Plan will deny Your claims for such services.

To make sure You are receiving the maximum benefit from the Plan, You should obtain all health care services from Network Providers. You should also comply with the Prior Authorization requirements. This is the case even if You are expecting another plan or third party to pay for Your health care services.

You should contact the Plan at 1-844-512-7999 You are unsure if a service needs Prior Authorization before services are rendered.

PRIOR AUTHORIZATION TIMELINE

All timelines for Prior-authorization requirements are provided in keeping with applicable state and federal regulations.

On receipt of a request from a Participating Provider for Prior-Authorization, the Plan shall review and issue a determination indicating whether the health care services are authorized. The determination will be issued and transmitted no later than the 5th Business day.

Concurrent Prior-Authorization – For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than twenty-four (24) hours after receipt of Your claim for benefits.

Urgent/Expedited Prior Authorization Review with respect to urgent Prior-Authorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow the determination within two (2) business days or three (3) calendar days of receipt of the request, whichever is earlier.

If additional information is required, we will request it from Your provider as soon as possible but not later than the timelines listed above. You or Your Provider will then have forty-eight (48) hours to submit the information. We will continue the review of the requested services as soon as possible but not later than 15 Calendar days.

LIST OF PRIOR AUTHORIZATION REQUIREMENTS

Service	Authorization Required	Service	Authorization Required
Acupuncture	Not covered	Allergy Testing	No
Artificial insemination	Not covered	Amniocentesis	No
Bariatric Surgery	Yes	Blood products	No
Biopsy – Bone Marrow	Yes	Bereavement Counseling	No
Bone Scan – 3 phase	Yes	Biopsy – Breast	No
BRCA	No	Bone Density – DEXA only	No
Breast Pump	No member gets $250	Cardiac Rehab	Plan year limit 36 visits, No auth req
Breast Reconstruction	Yes	Carotid Ultrasound	No
Chemotherapy	Yes	Cataract Surgery	No
Cleft lip/palate services/surgery	Yes	Chiropractic	Plan year limit 40 visits, No auth req
Cochlear implants	Not Covered	Continuous Glucose Monitor Supplies	No
Continuous Glucose Monitor	Yes	Colonoscopy	No
CPAP	Yes	CPAP Supplies	No
CT/CTA Scan	Yes	Depo Provera Injection	No
Dialysis	Yes	Diabetes Education	No
DME	Yes, items over $500	Diabetes Testing Supplies	No
EEG- Inpatient only	Yes	Echocardiogram	No
Elective Abortion	Not covered	EGD/Endoscopy	No
Genetic Testing	Yes	Epidural Injection	No
Hearing Aid-Adult	Not covered	Essure	No
Hida Scan	Yes	Flu Vaccination	No
Home Health	Yes after first 30 visits	Hearing Aid- ≤ 18yo	No auth req, max $3000 per Hearing aid
Hospice-Inpatient	Yes	Holter/Event Monitor	No
Hospice Outpatient	Required after first 6 months	Hospital- OBS <48hrs	No
Infertility Testing	Yes	HPV Vaccination	No

Service	Authorization Required	Service	Authorization Required
Injectables	Yes, for meds over $1000	Implanon/Nexplanon	No
Inpatient Admission-Preplanned	Yes	Insulin pump supplies	No
Inpatient Surgery	Yes	IUD/Diaphragm	No
Insulin Pump	Yes	Mammograms	No
Invitro fertilization	Not covered	Maternity-Global	No
IV infusion Home or Outpatient	Yes	Medication port	No
Mastectomy	Yes	Mental Health- Outpatient	No
Maternity-Dependents	Baby not covered	Neuropsychic Testing	No
Maternity-Vaginal-delivery only	Yes	O_2 & O_2 concentrator	No
Maternity- C-section-delivery only	Yes	PICC line (all procedures)	No
Maternity- Surrogate	Not Covered	Pneumococcal Vaccine	No
Mental Health- Inpatient	Yes	Pulmonary Function Test-PFT	No
MRI	Yes	Radiology/Diagnostic/x-ray	No
Newborn Stay – Beyond Mom's	Yes	Shingles <60yo	No
Nuclear Medicine	Yes	SPECT/Lexiscan	No
Nutrition Counseling	No	Stress Test	No
Nuclear Stress	Yes	Tubal Ligation	No
Orthotics/diabetic shoes	Yes	Ultrasounds	No
Orthotics	Yes	Vasectomy	No
OP Surgery	Yes	Wound care- In office	No
In-office procedures	Yes >$1000	PT/OT/ST-rehabilitative	Plan year limit 40 visits combined therapies
PET Scan	Yes	PT/OT/ST-habilitative	Plan year limit 40 visits combined therapies
Pulmonary Perfusion Test	Yes	Vaccinations	No
VQ Scan	Yes		

SECTION 7: BENEFITS OF COVERAGE (WHAT IS COVERED)

GENERAL RULES

The Plan will pay for the Covered Services provided to You or Your Covered Dependents, as long as the below is true.

- The services are Medically Necessary and are received when Plan coverage is in effect;
- The services are received from a Network Provider (unless there is a Medical Emergency)
- You have obtained Prior Authorization for the services when required.

Even if the Plan pays for Covered Services, You must meet Your Copayment, Coinsurance and/or Deductible obligations. The Covered Services are subject to other limitations found in this Policy.

A. COVERAGE FOR NEWLY BORN AND ADPOTED CHILDREN

1. **Automatic Coverage** - Your newborn child will automatically be covered by the Plan for the first thirty-one (31) days of his/her life. His/her coverage will then end unless You enroll Your Child in the Plan. Please refer to the Special Enrollment section.
   - **Whether the newborn child is covered for only 31 days or is enrolled beyond the 31 days, the family Deductible and out-of-pocket maximum is applicable to the newborn child as it would be for any other Dependent of the Subscriber.**
2. **Initial Hospital Stay** - The Plan will cover the hospital stay for Your newborn Child; The hospital stay after a normal vaginal delivery will not be less that forty-eight (48) hours. If the forty-eight (48) hours ends after 8 p.m., Your stay will continue until 8 a.m. the next day. The hospital stay after a caesarean section will not be less that ninety-six (96) hours. If the ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the next day. The Plan will also cover circumcision for newborn males.

3. **Illness and Injury During First Month of Life** - Generally, the Plan will cover the treatment of Your newborn Child for illness and injury. This includes the care and treatment of medically diagnosed congenital defect and birth abnormalities for the first thirty-one (31) days of Yours Child's life. However, for Your Child's Plan coverage to continue beyond the thirty-first (31st) day of life, You must enroll Your Child in the Plan. Please refer to the Special Enrollment section. The Plan also covers Medically Necessary Air Transport to the nearest available tertiary care facility for newborn infants.

4. **Cleft Lip and/or Cleft Palate** - The Plan will cover the care and treatment of a newborn Child born with a cleft lip or cleft palate or both. If Medically Necessary, the care and treatment will include oral and facial surgery; surgical management; and follow-up care by plastic surgeon and oral surgeons; prosthetic treatment such as obturators; speech appliances and feeding appliances; orthodontic treatment prosthodontic treatment; habilitative speech therapy; otolaryngology treatment and audiological assessments and treatments. The Plan will also cover any conditions or illness related to or developed as a result of the cleft lip or cleft palate. In order for Your Child's Plan coverage to continue beyond the thirty-first (31st) day of life, You must enroll Your Child in the Plan. Please refer to the Special Enrollment section.

   There are no age limits on the benefits described in this subsection (4). Therefore, these benefits are available to all Enrollees.

5. **Reconstructive Surgery for Craniofacial Abnormalities-** The Plan will provide Medically Necessary surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

6. **Genetic Inborn Errors of Metabolism** - The Plan will provide coverage for the inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids as we as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and non-immunoglobulin E- mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidence by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and mobility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent Medically Necessary, medical foods for home use for which a Provider who is a Network Provider has issued a written, oral, or electronic prescription. In order for Your Child's Plan coverage to continue beyond the thirsty-first (31st) day of life, You must enroll Your Child in the Plan. Please refer to the Special Enrollment section.
   - There are no age limits on the benefits described in this subsection (5), except for benefits relating to phenylketonuria. Women of child-bearing age may receive benefits for phenylketonuria until age thirty-five (35). Otherwise, benefits are provided only until age twenty-one (21).

7. **Food Supplements** - The care covered by the Plan will include medical food for home use, if Medically Necessary. "Medical foods" means metabolic formulas and their modular counterparts, obtained through a pharmacy. These foods are specifically designated and made for the treatment of inherited enzymatic disorders

for which medically standard methods of diagnosis, treatment and monitoring exist. Such formulas are specifically processed to be deficient in one or more nutrients. These foods are to be consumed or administered enterally either via tube or oral route under direction of a Network Provider. You must have a prescription from a Network Provider and receive the medical foods through a pharmacy. This shall not be construed to apply to cystic fibrosis, lactose-intolerant, or soy-intolerant Enrollees.

Coverage of medical foods, as contained on this Policy shall only apply to benefit plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers

Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition and parenteral nutrition are provided under Your hospital inpatient care benefit.

B. EARLY INTERVENTION SERVICES

1. **Standard** - Your covered Child may receive certain early intervention services that are covered by the Plan. These benefits are available for birth until Your Covered Child reaches age three (3). The Georgia Department of Human Services must determine that Your Covered Child has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or had a developmental disability. These services are subject to Deductibles but are not subject to Copayments or Coinsurance.

2. **General Coverage** - Generally, the Plan will cover those early intervention services specified in Your Covered Child's Individualized Family Service Plan (IFSP). However, the services must be delivered by a Participating Provider who/which is a qualified early intervention provider. These services may not duplicate or replace treatment for autism spectrum disorders. Services for the treatment of autism spectrum disorders shall be considered the primary service. The early intervention services will supplement, but not replace, services for autism spectrum disorders.

3. **Exclusions** - The Plan does not cover the following services: respite care; non-emergency medical transportation; service coordination (as defined by State or Federal law); or assistive technology.

4. **Annual Limitation** - Each Plan Year, the Plan will pay for up to forty-five (45) therapeutic visits for early intervention services for Your Covered Child.

5. **Exceptions** - The annual limitations on early intervention services do not apply to: rehabilitation or therapeutic services that are necessary as a result of an acute medical conditions or post-surgical rehabilitation; services provided to a Covered Child who is not participating in the early intervention program for infants and toddlers under the "Individuals with Disabilities Act" or services that are not provided based on an Individualized Family Service Plan (IFSP). However, such services will be subject to a limit of twenty (20) visits for each of the following therapies each Plan Year: physical therapy, occupational therapy, and speech therapy.

C. AUTISM SPECTRUM DISORDERS

1. **Standard** - The Plan provides coverage for the assessment, diagnosis, and treatment of autism spectrum disorders or Members under the age of twenty (20) or if enrolled in high school, until the Member reaches the age of twenty-two (22). This includes treatment for the following neurobiological disorders: Autistic disorder. Asperger's disorder, and atypical autism as a diagnosis within pervasive development disorder not otherwise specified as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, at the time of the diagnosis.

2. **General Coverage** - Generally, the Plan will cover the following:
    - Evaluation and assessment services;
    - Behavior training and behavior management and applied behavior analysis; this includes but is not limited to consultations, direct care, supervision, or treatment, or any combination of these. Such services must be provided by a Participating Provider who/which is an autism services provider.
    - Habilitative or rehabilitative care; This includes, but is not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of these therapies.
    - For a Covered Child who is covered under the section below relating to Congenital Defect and Birth Abnormalities, the Plan will cover more than twenty (20) visits for each therapy occupational, physical, and speech. Such therapy must be Medically Necessary to treat autism spectrum disorders.
    - Pharmacy care and medication if the Enrollee has pharmacy benefits under the Plan.
    - Psychiatric care;
    - Psychological care, including family counseling;
    - Therapeutic care.

3. **Limitations-** Applied Behavioral analysis treatment and coverage are subject to a maximum benefit of $35,000 per plan year. Covered services for the treatment of Autism Spectrum Disorder do not include services provided through school services.

D. CONGENITAL DEFECTS AND BIRTH ABNORMALITIES

1. **General Coverage** - The Plan will cover Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities of a Covered Child. This coverage only applies from the Covered Child's third (3rd) birthday to the Covered Child's sixth (6th) birthday.

2. **Annual Limitation** - Each Year, the Plan will pay for up to forty (40) visits for each type of therapy (physical, occupational and speech) for the Covered Child. The therapy visits must be spread out throughout the Plan Year without regard to the reason of the therapy is to maintain or to improve functional capacity.

E. CHILD SPEECH AND HEARING BENEFITS

1. **Speech Therapy** - If a Covered Child under the age of six (6) experiences speech delay, the Plan will cover up to forty (40) speech therapy visits. The plan may cover additional speech therapy visits. However, the Covered Child's Participating Provider must apply for additional visits. If additional therapy visits are expected to result in significant improvement, the Plan will cover more visits.
2. **Hearing Services** - The Plan will cover hearing aids and hearing services for a Covered Child who is under the age of eighteen (18) and has a hearing loss. The Plan will cover hearing tests in support of a diagnosis and medically covered condition. The Plan does not include audiometry and tympanograms not in support of a diagnosis. Coverage is provided for purchase, rental, and replacement of (1) Medically Necessary hearing aid, once every three years. The Plan does not cover hearing aids that have functionality that is not Medically Necessary such as Bluetooth and GPS technology. Hearing aids are only covered if obtained from approved Providers.
    - **Exclusions:** Bone anchored hearing aids are excluded except when either of the following applies:
        - Members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable Hearing aid; or
        - Member's hearing loss of sufficient severity that is would not be adequately remedied be a wearable hearing aid.

3. **Routine Hearing Exams** - The Plan will cover routine hearing exams for a Covered Child who is under the age of nineteen (19).

F. CHILD DENTAL AND VISION BENEFITS

1. **Hospitalization/Anesthesia for Dental Procedures** - The Plan cover general anesthesia. The Plan will also cover associated hospital or facility charges, when anesthesia is provided in a hospital, outpatient surgical facility or other licensed facility to a Covered Child. However, in order for coverage to apply, the Covered Child must be:
   - Under the age of twenty-six (26); or
   - Unmarried and medically certified as disabled and a Dependent of You or Your spouse

   In addition, the Covered Child must have one or more of the following:

   - Must have a physical, mental, or medically compromising condition
   - Must have dental needs for which local anesthesia is not effective because of acute infection, anatomic variation, or allergy
   - Must be extremely uncooperative, unmanageable uncommunicative or anxious and have dental needs that cannot be postponed
   - Must have experienced extensive orofacial and dental trauma.
2. **Pediatric Dental Care** – A pediatric dental benefit is not included in the Plan's benefit design. That benefit is available to purchase through Healthcare.gov.
3. **Pediatric Vision Care** – The Plan will cover one vision exam each Plan Year for a Covered Child who is under the age of nineteen (19). Eyeglasses for a Covered Child will be covered for 1 pair every 12 months and includes either eyeglasses frames and lenses or contact lenses.

G. SPECIAL PREVENTITIVE SERVICES WITH NO COST-SHARING

1. **How No Cost-Sharing Applies** – When You or Your Covered Dependents receive certain preventative services from a Participating Provider, You do not have to pay a Copayment, Deductible, or Coinsurance for the preventive services. However, if You or Your Covered Dependent receives services at a Network Provider for more than one reason, the Network Provider may bill for each purpose separately. In that case, if the primary billed reason of the service is not the delivery of the preventative service or item, then the Copayment or Cost-Sharing requirement can be imposed on the service. In addition, if a "no cost-sharing" screening turns into a diagnostic procedure, then the appropriate Deductible and Coinsurance will apply.
2. **Preventative Services** – The Plan will pay for the preventative services, based on the A or B recommendations of the United States Preventive Task Force (USPSTF). The Plan reviews the A or B recommendations throughout the plan year. If the USPSTF makes a change to the A and B recommendations, then those changes will be reflected in the benefits of the following plan year.

Office Screenings

- Alcohol misuse screening and behavioral counseling interventions for adults. Including pregnant women and providing persons engaged in risky or hazardous drinking with behavioral counseling interventions to reduce unhealthy alcohol use.
- Smoking Screening and Cessation Program- The Plan will cover smoking cessation programs including, intervention services, behavioral interventions, and prescription drugs. The Plan will cover two quit attempts per plan year. The Plan will cover at least four (4) sessions of individual, group, or telephone cessation counseling. The smoking cessation program includes all FDA approved tobaccos cessation medications (Nicotine patch, gum, lozenge, nasal spray, and inhaler; bupropion and varenicline). The smoking cessation services must be provided by a Network provider or be an approved Plan program. There is no cost sharing or Prior Authorization requirements for these programs. You can access the Quitline by calling 1-800-QUIT-NOW/1-800-784-8669.
- Low Dose Aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults 50-59 years old who have a 10 % or greater 10-year CVD risk, are not at risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin for at least 10 years.
    - Low-dose aspirin as preventative medication after 12 weeks of gestation in women who are at risk for pre-eclampsia.
- Screening for high blood pressure in adults aged 18 years or older.
- Screening for intimate partner violence (IVP) in women of reproductive age and provider or refer women who screen positive to ongoing support services.
- Screening for latent tuberculosis infectio0n (LTBI) in populations at increased risk.
- Screening for depression in adolescent and adult populations.
    - Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
    - Screening for depression in pregnant and post-partum women
- Screening for pre-eclampsia in pregnant women with blood pressure measurements throughout pregnancy.
- Interventions during pregnancy and after birth to support breastfeeding.

Imaging or Procedures

- Preventative care and screenings established be the Patient Protections and Affordable Care Act (PPACA) One Breast cancer screening with mammography per Plan Year, covering the actual charge of the screening with mammography.

- Benefits for preventative mammography screening are determined on a Policy Year basis. These preventative and diagnostic benefits do not reduce, or limit diagnostic benefits otherwise allowed under the Policy. If a Covered Person receives more than one screening in a Policy Year, the other benefit provisions in the Policy apply with respect to the additional screenings.
- Regardless of the A or B recommendations of the United States Preventative Services Task Force (USPSTF), FHP follows the recommendations of the American College of Obstetricians and Gynecologist (ACOG) guidelines for breast cancer screening which recommend screening earlier and more frequent that USPSTF. One mammogram and clinical screening breast exam once a year for female. Enrollees who are at least forty (40) years of age but up to seventy-five (75) years of age – Start mammogram ages between 35 and 4- for BRACA ½ carriers or 10 years Younger for female Enrollees with family members with breast cancer or female Enrollees with at least one risk factor for breast cancer.

- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps starting at age 45 and continuing until age 85.
  - If a colorectal cancer screening turns into a diagnostic procedure, that the procedure is then considered a diagnostic procedure and the member will be responsible for any fees such as Deductible and Coinsurance.
  - In addition to Enrollees who are eligible for colorectal cancer screening coverage on the A or B recommendations of the United States Preventative Task Force (USPSTF), the Plan will cover the colorectal cancer screening for Enrollees who are at high risk for colorectal cancer, including Enrollees who have a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the Participating Provider. If a Colorectal cancer screening turn into a diagnostic procedure, then the plan's deductible and coinsurance will apply.
  - This also included Cologuard testing and processing
- The USPSTF recommends screening for cervical cancer in women in age 21 to 29 years with cervical cytology (Pap smear) alone every 3 years or, for women aged 30 to 65 years to receive screening for cervical cytology alone every three (3) years, and for a combination of cervical cytology and human papillomavirus (HPV) testing every 5 years.
  - Cervical Cancer Screening for immunosuppressed Enrollees may be as frequent as once a year.

- One- time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged sixty-five (65) years to seventy-five (75) years who have ever smoked.
- Scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis. This service does not require Prior Authorization.
- Screening for lung cancer with low-dose computed tomography (LDCT) in adults aged fifty-five (55) to eighty (80) years who have a thirty (30) pack-year smoking history and currently smoke or have quit within the last fifteen (15) years.
- Ovarian Cancer Screening for female Members ages twenty-five (25) and older at risk for ovarian cancer. Coverage includes and annual screening, transvaginal ultrasound, and a rectovaginal pelvic examination.
    - A female Member is “at risk” is she:
        - Has a family history with at least one first-degree relative with ovarian cancer, and a second relative, either first-degree or second-degree with breast, ovarian or nonpolyposis colorectal cancer; or
        - Tested positive for a hereditary ovarian cancer syndrome.

Laboratory Testing

- Cholesterol screening for lipid disorders. Cholesterol or lipid panel
- Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged forty (40) to seventy (70) who are overweight or obese.
- Screening for gonorrhea, chlamydia or syphilis in sexually active women aged twenty-four (24) or younger and in older women who are at risk
    - This also applies to all pregnant women.
- Screening for Hepatitis B virus (HBV) infection in person at high risk for infection.
    - This includes all pregnant women at their first prenatal visit.
- Screening for hepatitis C virus (HCV) infection in adults aged eighteen (18) to seventy-nine (79).
- Screening for HIV infections in adolescents and adults aged fifteen (15) to sixty-five (65) years. Younger adolescents and older adults who are at increased risk of infection should also be screened.
    - This also includes all pregnant women, including those who present for delivery whose HIV status is unknown.
- Screening for gestational diabetes mellitus (GDM) in asymptomatic women after 24 weeks of gestation.

- Rh(D) antibody testing for all unsensitized Rh(D) negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(d) negative as well.
- The USPSTF recommends screening younger women and men aged 20 or older for lipid disorders if they are at increased risk for coronary heart disease.

Vaccinations

- All immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as required by Federal law
    - Influenza (yearly)
    - Pneumococcal vaccinations
    - COVID-19 vaccination (as recommended)
    - Hepatitis A
    - Hepatitis B
    - MMR
    - TDAP
    - Varicella
    - HPV

Medications

- Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.
- Coverage for daily supplement containing 0.4 to 0.8 mg of folic acid for women who are planning or capable of pregnancy.

PrEP

- HIV testing: Persons must be tested and confirmed to be HIV uninfected before starting PrEP and tested again for HIV every three months while taking PrEP so that, if they have become infected, the medication can be stopped promptly before it could cause a harmful drug resistance to develop.

- Hepatitis B and C testing: Persons should be screened for hepatitis B virus (HBV) at baseline for the initiation of PrEP consistent with CDC guidelines, so that when the PrEP medications, which suppress HBV replication in the liver, are stopped, persons can be monitored to ensure safety and to rapidly identify any potential injury. Additionally, persons should be screened for hepatitis C virus (HCV) infection at baseline and periodically consistent with CDC guidelines. Screening for HCV infection is indicated for all people with ongoing risk of contracting HCV.

- Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular

filtration rate (eGFR): For persons taking PrEP, their estimated eCrCl or eGFR must be measured and calculated at the beginning of treatment to assess if kidney function is in the range for safe prescribing of PrEP medication. Creatinine and eCrCL or eGFR should be checked periodically consistent with CDC guidelines while on PrEP medication to assess for potential kidney injury and to ensure that it is safe to continue PrEP medication.

- Pregnancy testing: Persons with childbearing potential taking PrEP must be tested for pregnancy at baseline and should be tested again periodically thereafter consistent with CDC guidelines until PrEP is stopped so that pregnant patients, together with their health care providers, can make a fully informed and individualized decision about taking PrEP.

- Sexually transmitted infection (STI) screening and counseling: Persons taking PrEP must be screened for STIs at baseline and should be screened periodically thereafter consistent with CDC guidelines, which may require multiple anatomic site testing (i.e., genital, oropharyngeal, and rectal) for gonorrhea and chlamydia, and testing for syphilis, together with behavioral counseling, which are recommended to reduce the risk of STIs, the presence of which may increase the likelihood of acquiring HIV sexually.

- Adherence counseling: Persons taking PrEP must be offered regular counseling for assessment of behavior and adherence consistent with CDC guidelines to ensure that PrEP is used as prescribed and to maximize PrEP's effectiveness.

Any other preventative services that are included in the A or B recommendations of the United States Preventative Services Task Force (USPSTF) or are required by Federal law

For a detailed list of the preventive services covered by the Plan, You may contact the Carrier in writing at:

Friday Health Plans
700 Main Street, Suite #100
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call Friday Care Crew at 1-844-512-7999.

H. WELLNESS VISITS

1. **Well Child Visits** - The Plan will cover Your Covered Child's visits to his/her Primary Care Provider from birth to age eighteen (18). This cover includes age-appropriate physical exams; routine immunizations; history; guidance and education (such as examining family functioning and dynamics; injury prevention counseling; discussing dietary issues; reviewing age appropriate, etc.), and growth and development assessment. Services covered herein may not be all inclusive and may change from time to time to comply with Federal and State Statutes and Regulations.

2. **Health Maintenance Visits** - The Plan will cover visits to the Enrollee's Primary Care Provider. This coverage includes age-appropriate physical exams, guidance, and education (such as examining family functioning and dynamics; discussing dietary issues; reviewing health promotion activities; exercise and nutrition counseling; including folate counseling for women of childbearing age); blood work; history and physical; urinary analysis; chemical profile; fasting lipid panel; and stool hemoccult. The Plan will also cover cervical cancer vaccines (HPV) for Enrollees. However, these Enrollees must meet the standards identified by HHS Services covered herein may not be all inclusive and may change from the time to time to comply with Federal and State Statutes and Regulations.

3. **Well Child Visits and Health Maintenance** - Visits are covered according to the following schedule:

Age of Enrollee	Number/Type of Visits
0-12 Months	Six (6) Well Child Visits
0-12 Months	One (1) PKU Test
0-12 Months	One (1) hone visit (for newborns released less than 48 hours after birth)
13-35 Months	Three (3) Well Child Visits
Age 3-6	Four (4) Well Child Visits
Age 7-12	Four (4) Well Child Visits
Age 13+	One (1) Health Maintenance Visit Per Plan Year

Services covered herein may not be all inclusive and may change from time to time to comply with Federal and State Statutes and Regulations.

4. **For Adult Men-** When provided by a Network Provider, the Plan will cover screening for the early detection of prostate cancer as follows
   - One screening per year for any male Enrollee who is fifty (50) years or older
   - One screening per year for any male Enrollee between forty (40) and fifty (50) years and has an increased risk of developing prostate cancer.
   - The prostate screening may include:
     - A prostate-specific antigen test (PSA) blood test;
     - A digital rectal exam
5. **For Adult Women** - When providing by a Participating Provider, the Plan will cover a yearly breast and pelvic exam and PAP test. The Plan will also cover screening

mammography when recommended by a Participating Provider. The following schedule will apply:

- One Mammogram and clinical breast exam is covered annually for a female Enrollee who is at least forty (40) years of age and up to seventy-five (75) years of age.
- One mammogram and clinical breast exam annually between 35 and 40 for BRACA ½ carriers or 10 years younger for a female Enrollee with family members with breast cancer or with at least one risk factor for breast cancer. (This includes a family history of breast cancer or a genetic predisposition to breast cancer or a calculated lifetime risk of developing breast cancer greater than 2-%. This determination must be made by the Enrollee's Primary Care Provider).

6. Limitations on Services and Examinations. Some services completed within your office visit such as EKGs, chest X-rays, in office labs or sigmoidoscopies may not be included in the fee for the office visit. These may have a separate Cost -Sharing amount. . In addition, the Plan will generally not cover wellness or preventative examinations that are more frequent than those identified on the schedule above.

7. Services covered herein may not be all inclusive and may change from time to time to comply with Federal and State Statutes and Regulations.

I. OUT-PATIENT SERVICES

1. **Routine Office Visits with Primary Care Provider** - The Plan will cover a Member's routine office visits to a Primary Care Provider. Covered Services, not otherwise listed in Your schedule of Benefits, which are provided during an office visit, a scheduled procedure visit, or provided by a Specialty Provider require Deductible and Coinsurance.
2. **Telehealth** The Plan will cover Telehealth services. The Plan will include a reasonable compensation to the originating site for the transmission cost incurred through telehealth delivered by a Network Provider, except when the originating site does not include a private residence at which the Member is located when he or she receives health care services through Telehealth.
3. **Home Visits** – The Plan will cover a Medically Necessary visits by the Member's Primary Care Provider to the Member's home within the Service Area.
4. **Specialty Provider Services** – The Plan will cover services of any specialty Network Provider with no Prior Authorization required. Covered Services, not otherwise listed in Your Schedule of Benefits, which are provided during an office visit, a scheduled procedure visit, or provided by a Specialty Provider require Deductible and Coinsurance.
5. **Diagnostic Services** – The Plan will cover diagnostic services. Certain diagnostic services require Prior Authorization. This is the case for Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, and Transcranial Magnetic Stimulation (TMS), among others. Please see Prior Authorization list above.

6. **Outpatient Surgery** – Your Plan covers outpatient hospital and/or ambulatory surgical procedures, including operating, recovery and other treatment rooms, Physician and surgeon services, laboratory and pathology services, pre-surgical testing, anesthesia, and medical supplies. Services may be provided at a hospital, Provider's office, or any other appropriately licensed facility. The Provider delivering services must be licensed to practice and must be practicing under authority of the Health Care Insurer, the medical group, and independent practice association, or other authority as applicable be state law. Prior Authorization is required for these services.
7. **Special Right to Reconstructive Breast Surgery**- If and Enrollee has had a mastectomy and elects breast reconstruction, the Plan will cover her care and treatment as required under the Women's Health and Caner Rights Act. Coverage will include:
   - Reconstruction of the breast on which the mastectomy was performed**;**
   - Surgery and reconstruction of the other breast to produce symmetrical appearance;
   - Prosthesis and physical complication for all states of the mastectomy, including lymphedemas

   These benefits are subject to any Copayments, Deductibles, and Coinsurance obligations applicable to other Plan coverage. These services require Prior Authorization.
8. **Radiation Therapy and Chemotherapy** – The Plan will cover Medically necessary radiation therapy and chemotherapy, for treatment of cancer the Member must obtain Prior Authorization.
9. **Urgent Care** – Urgent Care Services are Medically Necessary Health Care Services provided in urgent situations for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention. The Plan will cover Urgent Care provided in a Network Urgent Care center within the Service Area. The Plan also covers Urgent Care Services outside the service area if Medically Necessary and are of an urgent nature. If a Non-Network Urgent Care center is utilized, the need for services must meet the definition of Emergency and Urgent Care Services- see Definitions section for more details.
10. **Testing and treatment of COVID-19**, as required by applicable Federal or Georgia bulletins, laws or regulations.
11. **Sickle Cell Disease and its Variants**. Your Plan includes benefits for treatment if Sickle Cell Disease and its Variants, including Medically Necessary Prescription Drugs and necessary care management services to assist patients in identifying and facilitating additional resources and treatments, to the extent required by law.

J. GENETIC COUNSELING AND TESTING

1. **Covered services** include Medically Necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene

products to determining the presence of disease related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests for research, or for the benefit of individuals not covered under the Policy.

2. Covered Services also include the explanation by a genetic counselor or medical and scientific information about an inherited condition, birth defect, or other genome related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.
3. Genetic testing may only be done after consultation with a certified genetic counselor and/or, in our discretion, as approved by a Provider that we may designate to review the utilization, Medical Necessity, clinical appropriateness and quality of such genetic testing
4. Medically Necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals: Parents of a Child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality; Parents of a Child with mental retardation, autism, Down Syndrome, trisomy conditions, or fragile X syndrome;
5. Pregnant women who, based on prenatal ultrasounds or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects; or Parent affected with an autosomal dominant disorder who are contemplating pregnancy; or Women who are known to be, or who are likely to be carriers of an x-linked recessive disorder.
6. Covered Services include genetic testing of inheritable disorders as Medically Necessary when the following condition are met:
   - The results will directly impact clinical decision making and/or clinical outcome for the individual;
   - The testing method is considered scientifically valid for identification of a genetically linked inheritable disease; and
   - One of the following conditions is met:
     - The Member demonstrates signs or symptoms of a genetically linked inheritable disease
     - The Member or fetus has a direct risk factor (e.g., based on your family history or pedigree analysis) for the development of a genetically linked inheritable disease. This includes BRCA 1&2 testing
7. Additional genetic testing will be covered as required by Federal or state mandates.
8. In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that

genetic tests for inherited disease need only be conducted once per lifetime of the Member.

9. Limitations: Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, testing for sex of the fetus and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology, or mandated by federal law.

K. HOSPITAL INPATIENT SERVICES

1. **Standard** - Generally, the Plan will cover Medically Necessary hospital inpatient services. However, the Enrollee must obtain Prior Authorization form the Plan before his/her hospital stay. The Plan will also cover a hospital stay resulting from a Medical Emergency. However, the Enrollee must comply with the requirements described in the section below relating to Emergency Services.
2. **General Coverage** - The Plan will cover the following items and services when an Enrollee is hospitalized: a semi-private room accommodations; general nursing care; meals and special diets or parental nutrition when Medically Necessary; Physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be Medically Necessary by the person's Primary Care Provider or the treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary; intensive care unit and services; X-ray, laboratory, and other diagnostic tests; drugs; medications, biologicals, radiation therapy; chemotherapy; physical therapy; inhalation therapy; prosthetic devices approved by the Food and Drug Administration and implanted during a surgery performed pursuant to Prior Authorization (such as pacemakers and hip joints); and the administration of whole blood, blood plasma and other blood products. The Plan will cover a private room only when Medically Necessary.
3. **Providers and Medical Personnel** - The Plan covers the services of Participating Providers who care for the Enrollee when he/she is hospitalized. This includes the Enrollee's Primary Care Provider. It also includes specialist surgeons, assistant surgeons, anesthesiologists, and other appropriate medical personnel. The Plan will cover private duty nurses, as Medically Necessary.

L. MENTAL HEALTH AND CHEMICAL DEPENDNCY TREATMENT

1. **General Coverage** – Outpatient treatment for diagnostic and therapeutic behavioral/mental health services are covered without Prior Authorization UNLESS You are seeking services from a Non-Network Provider. Some procedures do require Prior Authorization by the Plan see Your Summary of Benefits and Coverage for level of Covered Services. Services on an outpatient basis are covered for treatment, outpatient testing, and assessment.

   Inpatient and partial hospitalization for psychiatric care is covered when Medically Necessary for the acute stabilization of a mental illness. Clinically appropriate facilities and programs include those offering a clearly defined course of mental

health services and special programming provided by licensed clinicians in a controlled environment offering a degree of security, supervision, and structure as deemed medically appropriate, These facilities and programs must be licensed and accredited by the appropriate federal, state and local authorities to provide such services effectively and safely and be recognized by national by national accrediting bodies in accordance with the Plan credentialing policy.

Care in an Inpatient setting for Members with mental illness or chemical dependency must include medical monitoring with 24-hour medical availability and 24-hour on-site nursing service. Such facilities and programs exclude half-way houses, supervised living arrangements, group home, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs.

2. **Outpatient Mental Care** – The Plan will cover outpatient mental health visits in the same manner that it covers other outpatient visits.
3. **Inpatient Mental Health Care** – Like other inpatient care, the Plan will cover Medically Necessary inpatient mental health care services. Coverage is provided for inpatient treatment if the member has a mental or behavioral disorder or requires crisis intervention. Inpatient care is covered only if You have obtained Prior Authorization before Your hospital stay. The Plan will also cover a hospital stay resulting from a Medical Emergency. However, You must comply with the requirements described in the Section below relating to Emergency Services.
4. **Outpatient Chemical Dependency/Substance Abuse Treatment** – The Plan will cover outpatient chemical dependency/substance abuse visits in the same manner that it covers other outpatient visits.
5. **Inpatient and Residential Chemical Dependency/Substance Abuse Treatment** - Like other inpatient care, the Plan will cover Medically Necessary inpatient or 30-day short term residential chemical dependency/substance abuse treatment. Inpatient or residential care is covered only if You have obtained Prior Authorization before Your stay. The Plan will also cover a hospital stay resulting from a Medical Emergency. However, You must comply with the requirements described in the Section below relating to Emergency Services.

M. DURABLE MEDCIAL EQUIPMENT

1. **General coverage**- With respect to durable medical equipment, the Plan will cover an Enrollee's rental, purchase, maintenance or repair, when necessary sir to accidental damage, or due to changes in the condition or size of the Enrollee; home administered oxygen, corrective appliances and artificial aids and braces, prosthetic and orthotic appliances, and/or fittings for such devices; and prescription lenses following a cataract operation or to replace organic lenses missing because of congenital absence; and diabetic equipment(i.e. glucometer). Such durable medical equipment must be provided of distributed through a Network hospital or other Network supplier. Prior Authorization may also be required for some items. Durable

Medical Equipment is authorized following applicable Medicare statutory and regulatory requirements, unless otherwise established in this document.

- Limitations: Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.
- Exclusions: Items not covered under this benefit include but are not limited to: dressings, and equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort care, convenience or beautification items, deluxe equipment, hearing aids, exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended be a Professional to treat a medical condition).

2. **Prosthetic Arms and/or Legs**- The Plan will cover and Enrollee's prosthetic arms and/or legs at the rate applied by Medicare for such Benefits. Coverage will be at 80% of the Plan's allowable rates minus an amount equivalent to the Medicare Part B Deductible as of January 1 of each Plan Year. Qualified High Deductible Health Plans (HSA qualified Plans) and Catastrophic Plans will have the medical Deductible applied, as required under federal law. If a Non-Network Provider is used the Benefits Plan's standard Coinsurance and Deductible will apply instead of the 80%. Covered prosthetics are limited to the most appropriate model that adequately meets the medical needs of the Enrollee. Prosthetic arms and/or legs and related service must be provided by a Network Provider vendor. The Plan will cover repairs and replacements of prosthetic arms and/or legs. However, the Plan will not cover repairs and replacements that are necessary because of misuse or loss.
   - One (1) Medically Necessary prosthetic device, approved by the centers for Medicare & Medicaid (CMS), is covered for each missing or non-functioning body part or organ ever three (3) years.
   - Limitations:
     - Devices that are required to substitute for the missing or non-functioning body part or organ;
     - Devices provided in connection to an Illness or Injury that occurred subsequent to Your effective date of coverage;
     - Adjustment of initial prosthetic device; and
     - The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
   - Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.
3. **Orthotics**: Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective for or function of a body part that is not functioning correctly or is diseased or injured. Orthotic devices are covered when Medically Necessary and require Prior Authorization. Corrective shoes and orthotic

devices for podiatric us and arch supports, except for diabetic shoes are not covered. Orthotics are limited to one item every three (3) years.

4. **Breast pumps**: Breast pump rentals are covered up to Plan year max of $250. Purchase of Plan approved breast pumps are covered.
5. **Enteral Nutrition**: The Plan covers enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a Provider; administered via tube feeding; and must be the primary source of nutrition for the Member. The Plan does not cover oral nutrition products even when prescribed or administered by a Provider. Food obtained from a grocery store or internet Provider will not be covered as Special Medical Foods.

N. EMERGENCY SERVICES

1. **Standard** – An Emergency Medical Condition that qualifies of Emergency Services is one in which a prudent layperson with an average knowledge of health and medicine would believe that symptoms require immediate medical attention to help prevent the loss of life, limb, or the loss of function of a limb. Symptoms may be due to an illness, injury, severe pain, or a medical condition that is quickly getting worse. For the service to be covered as an Emergency Service, the Service must meet the standard set forth in the definition of Emergency and Urgent care Services.
   - For a Medical Emergency, the Plan will cover the Emergency Services listed below. These services are covered without Prior Authorization. In addition, Emergency Services linked to Mental Health or Substance Abuse issues are covered at the same level as Emergency Services for Medical conditions. Emergency Services are covered even if the Provider is a Non-Network Provider. Please see definition of Emergency and Urgent Care Services.
   - Emergency and Urgent care services shall include:
     - Acute medical care that is available twenty-four (24) hours per day, seven (7) days per week, so as not to jeopardize a covered person's health status if such services were not received immediately; such medical care shall include ambulance or other emergency transportation; in addition, acute medical care shall include, where appropriate, transportation and indemnity payments or service agreements for out-of-service are or out-of-network coverage in cases where covered person cannot reasonably access in-network services or facilities.
     - Coverage for trauma services at any designated level I, level II or other appropriately designated trauma center according to established emergency medical services triage and transportation protocols; coverage for trauma services and all other emergency services shall continue at least until the covered person is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgement of the attending physician or health care professional in consultation with the Plan;

- Reimbursement for emergency medical care and emergency transportation shall not be denied be the health care insurer or Plan when the covered person, who in good faith and who possesses average knowledge of health and medicine, seeks medical care for what reasonably appears to the covered person to be an acute condition that requires immediate medical attention, even if the patient's condition is subsequently determined to be non-emergent.

2. **Emergency Transportation** – For a Medical Emergency, the Plan will pay for the Enrollee's transportation to the hospital by ambulance. As noted, section above, a Medical Emergency is limited to certain situations. There must be sudden and severe medical condition (including severe pain). The condition must be reasonably be expected to result in one or more of the following, if the Enrollee does not seek medical attention:
   - Placing the health of the Enrollee (or, with respect to a pregnant woman, the health of the Enrollee or her unborn child) in serious danger;
   - Serious impairment to bodily functions; or
   - Serious dysfunctions of any bodily organ or part.
3. **Enrollee Costs** - In an Enrollee receives emergency care from a Non-Network Provider, the Enrollee's Copayment amount and Coinsurance amount will be the same as if a Network Provider had treated the Enrollee.
4. **Plan Notification Required** - The Enrollee must notify the Plan of any Medical Emergency. The Enrollee must do so on the first business day after the treatment is received. If that is not possible, the Enrollee must notify the Plan as soon as medically possible. This notification must include the identity of the Enrollee and the hospital where he/she is receiving care. If an Enrollee is hospitalized, the Enrollee must notify the Plan by telephone of the hospitalization. Alternatively, the Enrollee must instruct the hospital or a family member to notify the Plan. The notification must include the identity of the Enrollee and the hospital where he/she was admitted. This notice must occur in the Enrollee is unable to contact the Plan personally or ask another person to do so, the notification may be delayed. A delay is only allowed until the Enrollee is conscious and able to communicate with others, the Enrollee will be treated as able to notify the Plan.
5. **Transfer** - If an Enrollee is hospitalized in a non-Participating Provider hospital, the Plan will have the Enrollee transferred to a Participating Provider hospital as soon as medically feasible. The Plan will not cover any services provided by a non-Participating Provider to an Enrollee who has refused a medically feasible transfer. The Plan must approve in advance any expenses for care provided after the Enrollee is stabilized, and transfer to a Participating Provider is medically feasible.

O. MATERNITY BENEFITS

1. **Prenatal and Postnatal Office Visits** – Prenatal and postnatal care visits are covered in the same manner as routine office visits with Your Primary Care Provider.
2. **Prenatal Diagnosis** – The Plan will cover prenatal will cover the prenatal diagnosis of congenital disorders of the fetus. This coverage applies to screening and diagnostic procedures during the pregnancy of the Enrollee when Medically Necessary. This includes an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen (16) and twenty (20) weeks of pregnancy, to screen for certain genetic abnormalities in the fetus.
3. **Complications of Pregnancy** – The Plan will cover a sickness or disease which is a complication of pregnancy.
4. **Hospitalization for Delivery** – The Plan will cover the Enrollee's hospitalization for deliver. The hospital stay following a normal vaginal delivery will not be less than forty-eight (48) hours. The hospital stay following a caesarean section will not be less than ninety-six (96) hours These timeframes could be less at the discretion of the attending physician and the Member. If the mother of the child are discharges prior to 48 hours following delivery, the one newborn visit within the first week of life will be covered. Breast pump rentals are covered. Purchase or Plan approved breast pumps are covered.

P. FAMILY PLANNING AND INFERTILITY SERVICES

1. **Family Planning** – The Plan will cover family planning counseling and the provision of information about birth control. Coverage also includes the insertion of contraceptive devices and the fitting of diaphragms. The Plan also covers the provision of vasectomies and tubal ligation procedures performed by a Network Provider. Oral contraceptives, including emergency contraceptives, are covered under the Enrollee's pharmacy benefit.
2. **Infertility Services** – The Plan will cover the following services, including X-ray and laboratory procedures: services for diagnosis of involuntary infertility. See additional information under Limitations and Exclusions.
3. **Contraceptive Coverage** – Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception have options available that are covered under this policy without cost sharing as required by federal and state law.
4. **Abortion Services:** The Plan will cover therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life of the mother, or as a result of incest or rape. The Plan will cover elective abortions in the instance of rape and/or incest.

Q. HOME HEALTH CARE SERVICES

1. **General Coverage** - The Plan will cover home health care provided to an Enrollee who is under the direct care of a Network Provider. Services will include visits to the Enrollee by Network Providers. Visits will be limited to the usual and customary time required to perform the particular services.

2. Coverage is Provided for**:**
    - Part- time or intermittent home nursing care for:
        - Skilled nursing care under the supervision of a Registered Nurse (RN);
        - Certified Home health aide services under the supervision of an RN or therapist;
        - Medical social services by a licensed social worker.
    - Infusion services;
    - Physical, occupational, pulmonary, respiratory and speech therapies;
    - Nutritional counseling by a nutritionist or dietician;
    - Audiology services
    - Medical supplies and lab services that would be covered if the Enrollee were an inpatient at a hospital;
    - Prosthesis and orthopedic appliances;
    - Rental or purchase of DME.
3. **Limitations** – Coverage of home health care by the Plan is subject to the following conditions and limitations:
    - The care provided must follow an Authorized Home Health Treatment Plan.
    - Services will be covered only if hospitalization would be required if such home health services and benefits were not provided.

The services provided will be limited to the professional services ad listed in 2.a. above and will not cover non-skilled personal care or services or supplies for personal comfort or convenience, including homemaker services.

- Visits are limited to no more than 28 hours a week with a maximum 120 visits per Plan Year
- Home Health Services require Prior Authorization after the first 30 visits per therapy.

R. ORGAN and TISSUE TRANSPLANTS

1. **General Coverage** – The Plan will cover the following transplants when provided in a Specialty Care Center: heart; lung; heart/lung; kidney; pancreas; cornea; bone marrow for treatment of neuroblastoma and Hodgkin's or non-Hodgkin's lymphoma; autologous or allogeneic bone marrow transplants and stem cell rescue or hematopoietic support only for malignant tumors when necessary to support high dose chemotherapy, and autologous or allogeneic bone marrow transplants and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and high risk stage II and III breast cancer.
2. **Related Items** – The Plan will also cover services, supplies and pharmaceuticals required in connection with a covered transplant procedure. This includes valuation of an Enrollee as a transplant candidate; tissue typing; covered transplant procedure; scheduled follow up care and anti-rejection medication.

3. **Donors** – When the recipient of a covered transplant is an Enrollee, the Plan will pay for certain donor costs. This includes the costs directly relating to the acceptability of an organ. It also includes the costs of services directly related to surgical removal of the organ for the donor. It also includes the costs of treating complications directly resulting from the surgery. All of these costs are subject to the other limits of the Plan. Coverage applies only if the donor is not eligible for coverage under any other health care plan or government funding program.
4. **Conditions** – All transplant services require Prior Authorization. However, the Enrollee must first be accepted into the transplant program at one of the Plan's Specialty Care Centers. Coverage may also be subject to approval by an appropriate evaluation committee designated by the Plan. The committee will consider factors such as the treatment's effectiveness in improving the length and quality of life; the mortality and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and the Enrollee's physical and mental condition.
5. **Exclusions** – The Plan does not cover organ or bone marrow search, selection, transportation, or storage costs.

S. HOSPICE

1. **General Coverage** – The Plan covers physical, psychological, spiritual and bereavement care for terminally ill Enrollees and their families. The services cover a range of inpatient and twenty-four (24) hour on-call home care. The care may be provided in the home. It could also be provided in a Participating Provider hospice facility; and/or other Participating Provider facility. Services include, but are not limited to, the following: nursing services; physician services; certified nurse aide services; nursing services of other assistants; homemaker services; physical therapy services; pastoral care; counseling; trained volunteer services; and social services. Other benefits available through hospice are covered by the Plan. Such Benefits are subject to the other limitations in the Evidence of Coverage and include:
    - Medical Supplies
    - Drugs and biologicals;
    - Prosthesis and orthopedic appliances;
    - Oxygen and respiratory supplies;
    - Diagnostic testing;
    - Renting or purchase of durable medical equipment;
    - Transportation;
    - Physician services;
    - Therapies including physical, occupational and speech;
    - Nutritional counseling by a nutritionist or dietitian.
2. **Limitations** – Hospice care is subject to the following conditions and limitations:

- All hospice services must be provided under active management through a hospice. The hospice is responsible for coordinating all hospice care services. This is true regardless of the location or facility providing services.
- Hospice services are allowed only for only Enrollees who are terminally ill and have a life expectancy of six (6) months or less. An Enrollee may live beyond the prognosis for life expectancy. In this case benefits will continue at the same rate for up to three (3) benefit periods. If additional benefit periods are needed the Plan's case managements staff shall work with the member's attending physician and the hospice's medical director to determine the appropriateness of continued hospice care.
- Hospice requires Prior Authorization after the first benefit period.
- Bereavement support services for the family of the deceased Enrollee will be covered for up to twelve (12) months after the Enrollee's death.
- Prior Authorization is required by the hospice interdisciplinary team for short term acute patient care or continuous home care, which may be required during a period of crisis, for pain control or symptom management. Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

T. OTHER IMPORTANT SERVICES

1. **Diabetes** - The Plan's coverage of an Enrollee's diabetes includes new improved treatment for monitoring equipment; supplies; and outpatient self-management training and education. All supplies, including medications and equipment for the control of diabetes must be dispensed as written, including brand name products, unless a substitution approved by the Provider who issues the written order for the supplies or equipment. Such items, when obtained for a Qualified Participant shall include but not be limited to the following:
    - Diabetes Equipment
        - Blood glucose monitors (including noninvasive glucose monitors, monitor for the blind and continuous glucose monitors);
        - Insulin pumps (both external and implantable) and associated appurtenances, which include insulin devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges and durable and disposable devices to assist in the injection of insulin; and
        - Podiatric appliances, including up to two pairs of therapeutic footwear per Plan year, for the prevention of complications associated with diabetes.
    - Diabetic Supplies
        - Test strips specified for use with a corresponding blood glucose monitor, lancets and lancet devices, visual reading strips and urine testing strips and tablets;
        - Insulin and insulin analog preparations; injection aids. Including devices used to assist with insulin injection and needleless systems, insulin syringes

- Biohazard disposable containers;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits.

- Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.
- Qualified Participant means an individual eligible for coverage under this Policy who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

2. **Morbid Obesity**- Diagnosis, treatment and rehabilitation services for obesity which is defined as a weight which is at least one hundred (100) pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables. Morbid obesity also means a body mass index (BMI) equal to or greater than thirty-five (35) kilograms per meter squared (kg/m2) with comorbid or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of fort (40) kg/m2 without such comorbidity. BMI equals weight in kilograms divided by height in meter squared. The treatment modality of morbid obesity shall be based on a clinical decision made by the Provider based on set guidelines.
3. **Bariatric Surgery**- Medically Necessary surgery is covered. You must meet the Plans criteria to be eligible for this service and it is only covered through programs meeting Plan criteria and centers of excellence.

   Covered Services include Medically Necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese with associated Illnesses. These services will not be covered unless You receive Prior Authorization.

   Benefits for gastric restrictive services are limited to one (1) surgery per lifetime.

   Medically Necessary treatment for complications resulting from Gastric Restrictive Surgical Services will be covered the same as any other Illness.

   - Plan criteria: Bariatric Restrictive Services are covered when all of the following have been determined and are limited to one procedure every three years:
     - The Member must have either:
       - BMI $\geq$ 40 kg/m2 without co-morbidities
       - BMI $\geq$ 35 kg/m2 and a high-risk obesity related condition or a combination of three (3) other obesity related diseases or cardiovascular risk factors (documented evidence of risk factors required)

- High risk diseases are chronic coronary disease, atherosclerosis, Type 2 diabetes, or sleep apnea.
- Other obesity-associated diseases include osteoarthritis, gallstones, stress incontinence and gynecological abnormalities.
- Must be 18 years or older.
- Cardiovascular risk factors included, but not limited to, history of cigarette smoking, hypertension, high LDL cholesterol serum levels, low HDL-cholesterol serum levels, impaired fasting glucose, family history of premature CHD.

o There is adequate documentation that the Member has failed less invasive methods of weight loss and is at high risk for obesity associated morbidity or mortality. Less invasive therapies include low calorie dieting, increased physical activity, behavioral therapy, and pharmacotherapy, where appropriate.
  - The less invasive therapy must have been in place for more than a continuous six (6) month period.
  - Failure of less invasive methods is determined be the Plan Medical Director and his/her designee.

o Member has been obese for at least five years;
o If Member is diabetic, disease is controlled;
o Member must have the capacity to be compliant with post-surgical treatment or follow-up requirements, which may include a psychiatric or behavioral evaluation;
o Procedures must be performed at a Network Facility unless pre-approved by the Plan to be performed at a Non-Network Facility/Provider; and
o Tobacco free for eight (8) weeks prior to the surgery.

4. **Skilled Nursing Care** - The Plan will cover an Enrollee's skilled nursing services. Such services must be provided in a Participating Provider skilled nursing facility. These services also require Prior Authorization. Coverage by the Plan is limited to sixty (60) days per Plan Year.
5. **Rehabilitative Services** - The Plan will cover services of licensed therapists providing short term rehabilitative services, including physical, occupational and speech therapies. Coverage by the Plan is limited to two (2) months of inpatient services and forty (40) outpatient visits per therapy (physical, occupational, speech) per Plan Year. The sixty (60) day inpatient period begins with the first therapist visit. Inpatient rehabilitative services require Prior Authorization. The Plan will not cover services for chronic or recurring conditions that do not show sustained significant improvement within the allowed time frame.
   - The Plan will also allow for reimbursement of visits with an athletic trainer for up to 40 visits per Plan Year.
6. **Habilitative Services** - Habilitative services include services that help a person keep, learn, or improve skills and functioning for daily living. Examples include

therapy for a Covered Child who is not walking or talking at the expected age. These services include physical therapy; occupational therapy; speech-therapy; speech-language pathology; and other services for Enrollees with disabilities.

- Limitations:
  - The Plan will not cover services for chronic or recurring conditions that do not show sustained significant improvement with the allowed time frame.
  - Services are limited to forty (40) visits per Plan Year.
  - Excludes maintenance care for habilitative services: "When the Member reaches his maximum level of improvement or does not demonstrate continued progress under a treatment Plan, a service that was previously habilitative is no longer habilitative. "

7. **Cardiac Rehabilitation** – Treatment in a program is provided, if prescribed or recommended by a Network Provider and provided by Network therapists at Network facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of an initial evaluation, no more that eighteen (18) cardia rehabilitation exercise and counseling sessions and a final evaluation to be completed with is a six-month period.
8. **Pulmonary Rehabilitation** – Treatment in a program is provided if prescribed or recommended by a Network Provider and provided by Network therapist at Network facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of an initial evaluation, six (6) educational sessions and up to twelve (12) exercise sessions and a final evaluation to be completed within a two-to-three-month period.
9. **Continuing Care** – If an Enrollee is hospitalized within a Non-Network Provider or hospital, the Enrollee may return to such hospital for follow-up care. However, the Plan will cover such follow-up care only if the Non-Network Provider or hospital is willing to accept payment from the Plan at the rates payable to Network Providers. All other limitations and conditions of the Plan would apply.
10. **Health Education Services** – The Plan will cover instruction in the appropriate use of health services. This includes information on the ways each Enrollee can maintain of his/her own health. Such instruction must be provided by a Primary Care Provider. Another Network Provider with Prior Authorization could also provide it. Health education services include instruction in personal health care measures and information about services. For example, instruction may include recommendations on generally accepted medical standards and the frequency of services.
11. **Oral Surgery/Dental Anesthesia Services** – The Plan will cover the following oral surgery services for an enrollee who obtains Prior Authorization:
    - Care for the Treatment of acute facial fractures;
    - Treatment of neoplasms (tumors) of the face, facial bones, or mouth;
    - Medically Necessary Treatment of congenital defects;
    - Treatment of disorders related to temporomandibular joint syndrome
    - Treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue).

No other oral surgery services are covered by the Plan unless they are required by Georgia law.

12. **Eye Exams** – The Plan will cover eye examinations provided by an Enrollee's Primary Care Provider to determine the need for vision correction. Eye examinations for the purpose of determining the need for corrective lenses are not covered. Vision hardware and corrective appliances are not covered. This benefit is only for Members and Dependents up to the age of 26 years of age.
13. **Hearing Exams and Hearing Aids** – The Plan will cover hearing tests in support of a diagnosis and medically covered condition. This is in addition to the benefits described in the section above relating to Child Speech and Hearing Benefits. The Plan does not include audiometry and tympanograms not in support of a diagnosis. The Plan does not cover hearing aids and other corrective appliances, except as provided in the Child Speech and Hearing Benefits section. This benefit is only for Members and Dependents up to the age of eighteen (18) years of age.
14. **Prescription Drugs** - Prescription drugs are covered under Your benefit plan as follows:
    - Inpatient prescription drugs approved by the United States Food & Drug Administration (FDA) ae covered when You are in a hospital or skilled nursing facility.
    - Outpatient prescription drugs are covered subject to the Plan's Formulary, and as follows:
        - Outpatient prescription drugs are designated as Tier 1, Tier 2, Tier 3, Tier 4, Tier 5, and Tier 6 in the Plan's Formulary.
        - Drugs not listed in the Plan's Formulary are not covered as Covered Services.
        - New drugs are excluded from formulary for the first six months after approval by the FDA, unless it is an orphan drug.
            - The Orphan Drug Act (ODA) provides for granting special status to a drug or biological product ("drug") to treat a rare disease or condition. For a drug to qualify for orphan designation both the drug and the disease or condition must meet certain specified in the ODA and FDA's implementing regulations at 21 CFR Part 316.
        - Only outpatient prescription drugs related to Emergency Care and Urgent Care may be received from Non-Network pharmacies. The Plan will repay You for the cost of an outpatient prescription drug purchased through a Non-Network pharmacy in an amount not to exceed the Allowed Charge, less the applicable Copay or Coinsurance set forth in the Schedule of Benefits within ninety (90) days of purchase.
        - Outpatient prescription drugs from a Plan Network pharmacy will be provided subject to the Copay or Coinsurance set forth on the Schedule of Benefits.
        - Off-label use of Drugs approved by the FDA will not be excluded or restricted if the drug:

- The Federal Food and Drug Administration (FDA) have approved the drug;
- The drug is prescribed by a contracted licensed health care professional for the treatment of a life-threatening disease or condition;
- The drug is prescribed by a contracted licensed health care professional for the treatment of a chronic and seriously debilitating disease or condition, the drug is Medically Necessary to treat that disease or condition, and the drug is on the insurer's formulary or preferred drug list, if any; or
- A contracted license health care professional prescribes the drug to treat a disease or condition in a Child where the drug has been approved by the FDA for similar conditions or diseases in adults and the drug is Medically Necessary to treat that disease or condition; and
- The drug has been recognized for treatment of that disease or condition or pediatric application by one of the following:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information; or
    - The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"; or

- Two articles form major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The Plan reserves the right to limit the maximum amount of an outpatient prescription drug covered per Copay or Coinsurance. The applicable Copayment or Coinsurance covers the lesser of a 30-day supply or 100-unit supply or standard trade package, per prescription. Exceptions may apply to prescriptions filled through mail-order of generic maintenance medications. Specialty tier medications are always subject to one Copay/Coinsurance payment per 30-day supply. Medications for which a generic equivalent is available will be filled with an approved generic equivalent. If a brand-name medication is requested when an approved generic equivalent is available the Member will pay the cost difference between the generic and brand-name drug (ancillary charge), in addition to the Copayment or Coinsurance amount. The different will not apply to the Deductible or the Out-of-Pocket Maximum. This is waived if the Prescribing Provider designates the prescription to be dispensed as written and there is a medical reason generic drug does not meet the medical needs of the Member.

Coverage for a renewal of prescription eye drops is covered if:

- The renewal is requested by the inured at least twenty-one (21) days for a thirty (30) day supply of eye drops, forty-two (42) days for a sixty (60) day supply of eye-drops, or sixty-three (63) days for a ninety (90) day supply of eye drops, from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; and
- The original prescription states that additional quantities are needed, and the renewal requested by the insured does not exceed the number of additional quantities needed.

One additional bottle pf prescriptions eye drops is covered if:

- A bottle is requested by the insured or the health care Provider at the time the original prescription is filled; and
- The original prescription states that one additional bottle is needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one bottle every three (3) months.

The prescription eye drops benefits covered under this section are subject to the same annual Deductibles, Copayments, or Coinsurance established for all other prescription drug benefits under the heath benefit plan.

The Plan utilizes step therapy in its pharmacy program. Step therapy is a utilization management process much like Prior Authorization, Step therapy ensures that the Plan participants use clinically appropriate drugs in a cost-effective manner.

Step therapy protocols/algorithms are developed based on current medical findings, FDA approved drugs labeling, and medication costs. In general, Step Therapy is applied to therapeutic categories that have multiple agents, comparable therapeutic efficacy, and utilization and those that have generic alternatives. Generic drugs are commonly prescribed as the “first-line” agent due to their established safety and efficacy for treating a given condition and are typically less expensive than branded medications. Select branded medications may not be covered unless a plan participant tries and fails an alternate “first line” agent(s). The Plan will not require a covered person to undergo step therapy, or to receive Prior Authorization before a pharmacist may prescribe and dispense and HIV infection prevention drug. In addition, the Plan will not require a covered person with Stage four (4) metastatic cancer to undergo step therapy for a covered medication that has been approved by the U.S. Food and Drug Administration, or other recognized body for the treatment of Stage four (4) advanced metastatic cancer.

When a Member presents a prescription for a medication that is under a Step Therapy Algorithm, the dispensing pharmacy receives an electronic message informing the [pharmacist that the medication is under a Step Therapy algorithm. The member will then need to contact their Provider so the Provider can either re-write

the prescription or send the required step therapy information to the Members Pharmacy Benefit Management Company. That contact information is on the members Pharmacy ID card.

Drugs and injectables not included in the Plan's Formulary are excluded. We reserve the right to change the Plan's Formulary from time to time.

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by Us through the exception process. If the Plan grants Your request, we will cover the non-formulary drug for the duration of the prescription. If the Plan denies Your request, You, You designee, or Your Provider may request an appeal of the decision. For more information about the appeal process, please see the appeals and grievance section of this Policy or call Friday Care Crew.

When You ask for an exception, Your doctor or other prescriber will need to explain the medical reasons why You need the exception approved. We will then consider Your request. If Your request is approved, we will cover the non-formulary drug for the duration of Your prescription. This may be approved for a specific time frame and may require re-review.

When we give You our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard coverage decision means we will give You an answer within seventy-two (72) hours after we receive Your doctor's statement. An expedited coverage decision means we will answer within twenty-four (24) hours after we receive Your doctor's statement. You can get an expedited coverage decision only if using the standard deadlines could cause serious harm to Your health or hurt Your ability to function or You have been currently undergoing a course of treatment with a drug not in our formulary. You cannot ask for an expedited exception if You are asking us to pay You back for a dug You already bought.

If the exceptions request id denied, You, Your designee, or Your Provider (based on a written request by You to allow Your physician to do this on Your behalf) may request an external review of the decision by an independent review organization. The Plan will provide coverage, without Prior Authorization, for a five-day supply of at least one of the Federal Food and Drug Administration approved drugs for the treatment of an opioid dependence; except that this requirement is limited to a first request within a twelve-month period. For addition information about the prescription drug exceptions processes for drugs not included in the Plan's formulary, please contact the Plan's Friday Care Crew at 1-844-712-7999.

Non-prescription drugs, vitamins, nutrients, and food supplements, even if recommended or given by a Provider, are excluded unless otherwise required by federal or state statute or regulation to be covered by the Plan.

Outpatient retail prescription drugs are covered under the Plan's prescription drug program.

15. **Oral Anticancer Medication** – These drugs must be FDA approved for the cancer being treated. They must also be part of the approved protocol of care. They must also meet all formulary qualifications.
    Orally administered anticancer medication that has been approved by the FDA and is used to kill or slow the growth of cancerous cells are covered. The orally administered medication shall be provided at a cost to the Enrollee not to exceed the Copay or Coinsurance as it is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided pursuant to this section shall be prescribed for the same purpose. A medication provided pursuant to this section shall be prescribed only upon a finding that is Medically Necessary for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of the medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and primarily for the convenience of the patient, physician, or other health care provider. Nothing herein shall prohibit coverage for oral generic medications in a health benefit plan nor prohibit the Plan for applying an appropriate Formulary or clinical management to any decision described in this section.
16. **Routine Care during Clinical Trails** – Covered Services may be eligible for coverage when received in connection with a clinical trial if all of the following conditions are met:
    - The services would have been covered if they were not related to a clinical trial;
    - You are eligible to participate in the clinical trial according to the protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
        - A Network Provider makes the determination and the Plan's Medical Director agrees.
        - You provide us with medical and scientific information establishing this determination and it is approved by the Plan's Medical Director.
        - If any Network Providers participate in the clinical trial and will accept You as a participant in the clinical trial, You must participate in the clinical trial through a Network Provider unless the clinical trial is outside the state where You live.
    - The clinical trial is approved under the September 19, 2000, Medicare National Coverage Decision regarding clinical trials, as amended.
    - The patient has signed a statement of consent and provided the Plan a copy of the signed clinical trial statement.
    - You have a Child in an approved clinical trial program for treatment of children's cancer. This means a Phase II and III prescription drug clinical trial program in the state, as approved by the Federal Food and Drug Administration of the National Cancer Institute for the treatment of cancer that generally first manifests itself in Children under the age of nineteen (19) and that

- Tests new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in Children;
- Introduces a new therapy or regimen to treat recurrent cancer in Children; or
- Seeks to discover new therapies or regimens for the treatment of cancer in Children which are more cost effective than standard therapies or regimens; and
- Has been certified by and utilizes the standards for acceptable protocols established by the:
  - Pediatric Oncology Group;
  - Children's Cancer Group; or
  - Commissioner as he or she may otherwise define such term by rule and regulation after due notice, any required hearing, and compliance with any other requirements of applicable law, but only providing for such definition in a manner at least as restrictive as that established in this code section.

For Covered Services related to a clinical trial, You will pay the applicable cost share as shown on Your Schedule of Benefits that You would pay if the Covered Services were not related to a clinical trial. Clinical Trial exclusions include the following:

- Any part of the Clinical Trial that is paid for by a government or biotechnical, pharmaceutical, or medical industry entity;
- Any drug or device used in a Clinical Trial that is paid for by manufacturer, distributer or provider of the drug or device;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not related to the clinical management of the participant;
- Costs for the management of research relating to the clinical trial or study;
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the participants Covered Services.

Nothing in this section shall:

- Preclude the Plan from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device in the clinical trial study.
- Be interpreted to provide a private cause of action against the Plan for damages arising as a result of compliance with this coverage requirement.

For the purpose of this section the following definitions apply:

- "Clinical Trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.
- "Routine Patient Care Cost" means all items and services that are a benefit under a health coverage plan that would be covered if the covered person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management if the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine cost in research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

17. **Transgender Services** – The Plan assures Member and Providers that any request for treatment for gender dysphoria is reviewed in a consistent manner and in accordance with accreditation agency standards, state and federal regulations and statutes.
    - Coverage for transgender services may include:
        - Pharmacological support: Please see the Plans Pharmacy formulary or contact the Plan for more information.
        - Surgical Procedures:
            - Male to Female transition:
                i. Intersex surgery, Clitoroplasty, Introitus plastic repair, Labiaplasty, Nipple areola reconstruction, Orchiectomy, Penectomy, Prostatectomy, Vagina/ Perineum reconstruction, Urethroplasty, Vaginoplasty, Vulvoplasty, Phalloplasty.
            - Female to Male transition
                i. Intersex surgery, Hysterectomy with or without removal of fallopian tubes and ovaries, Vaginectomy, Mastectomy, Penile prosthesis, Scrotoplasty, Testicular prosthesis, Penis/Perineum reconstruction, Nipple areola reconstruction, Urethroplasty, Vulvectomy.
        - Exclusions:
            - Abdominoplasty, Calf implants, Cheek, Chin, Nose implants, Collagen injections, Genioplasty, Fat grafts, Hair Removal (Laser or electrolysis), Hair grafts or transplants, Lipectomy, Lip reduction or enhancement, Mandible augmentation or reconstruction, Facial osteoplasty, Liposuction, Skin resurfacing, Voice therapy lessons.

U. Medical Care Provided Outside of Service Area

1. **Urgent Care** – The Plan will cover urgent care that is provided to an Enrollee outside of the Service Area (by a Non-Network Provider). This is true only if the care is provided by a facility other than a hospital or emergency room.
2. **Emergency Care** – The Plan will cover care that is provided to an Enrollee outside the Service Area (by a Non-Network Provider) in a Medical Emergency. This coverage will be subject to the terms described in the section above relating to Emergency Services. All follow-up care must be provided within the Service Area by a Network Provider, except as otherwise stated in this Policy.

V. Cancer Drugs

1. **Off Label Use** – The use of Off-label drugs to treat, prevent, or manage the symptoms of Cancer may be covered by the Plan. Off-Label use of FDA approved Drugs, including Cancer drugs, will be covered even the drug is prescribed as a treatment for a particular indication for which the drug has not been FDA approved. The Plan will approve Off-label Prescriptions if the following is true:
   - The drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the health care Provider", or authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Services.
   - Exclusion: If a drug is being prescribed for Off-label use and the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed, then the drug would not be considered a covered benefit.

W. Chiropractic

1. Chiropractic services are covered when provided by contracted chiropractors and are limited to evaluation, lab services and X-rays required for chiropractic services and treatment of musculoskeletal disorders. Visits are limited to forty (40) per Plan Year.
2. Exclusions related to Chiropractic care are as follows:
   - Hypnotherapy
   - Behavior Training
   - Sleep Therapy
   - Weight loss programs
   - Services not related to the treatment of musculoskeletal system
   - Vocational rehabilitation services
   - Thermography
   - Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances
   - Transportation cost which includes local ambulance charges

- Prescription drugs, vitamins, minerals, food supplements or similar products
- Educational programs non-medical self-care or self-help training
- All diagnostic testing related to these excluded services
- MRI and/or other types of diagnostic radiology
- Physical or massage therapy that is not a part of the chiropractic treatment
- Durable medical equipment (DME) and/or supplies for use in the home
- Nutritional counseling or related testing

SECTION 8: LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

All the following services, accommodations, care, equipment, medications, or supplies are expressly excluded from Plan coverage:

1. Any care that is not Medically Necessary, as determined by the Plan.

2. Any care that is not in accordance with accepted medical standards.

3. All services or supplies that exceed any maximum time limitation (day or visits) identified in this document.

4. Medical, surgical, or other health care procedures, treatments, devices, products, or services that are experimental or investigative.

5. Services by a Non-Network Provider, except the case of an Enrollee's Medical Emergency or the Enrollee's need for urgent care outside in the service area.

6. Services or supplies for any illness, condition or injury received while incarcerated in a county, State or Federal penal facility.

7. A private room or services of private or special duty nurses, other than as Medically Necessary, when an Enrollee is an inpatient in a hospital.

8. Services of any provider other that a physician, a provider acting under the supervision of a physician or certified nurse midwife, or a provider whose services must be covered by health maintenance organizations under the law of the State of Georgia. Examples of providers whose services are not covered include but are not limited to physiologists, homeopaths, naturopaths, rolfers, religious practitioners, and hypnotherapists.

9. Acupuncture and acupressure whether or not provided by a physician.

10. Services performed in connection with treatment to teeth or gums; upper or lower jaw augmentation reduction or cosmetic reconstruction; or orthognathic surgery. These services include treatment for disorders, regardless of the cause, except those services specifically covered under this Policy. All dental services not identified in the Evidence of Coverage. General anesthesia for dental procedures except those services specifically covered under this Policy.

11. Nursing homes and custodial care.

12. Eye refractions or examinations, except as specifically covered under this Policy. Eyeglasses and all other types of vision hardware or vision corrective appliances.

This includes contact lenses; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy; and clear lensectomy.

13. Hearing screening exams except as specifically covered under this Evidence of Coverage. Hearing aids, masking devices or other hearing devices or the fitting of such devices, except as specifically covered under this Policy.

14. Deluxe durable medical equipment, prosthetic, or orthotic appliances, unless Medically Necessary as determined by the Plan. The Plan will cover standard equipment to meet the members need.

15. Durable medical equipment, prosthetic and orthotic appliances and cataract lenses ordered prior to the effective date of Plan coverage. This is true even if they are delivered after the effective date of Plan coverage.

16. Repair or replacement of any durable medical equipment, prosthetic or orthotic appliance resulting from misuse.

17. Batteries for use in implantable medical devices. Physician equipment such as sphygmomanometers, stethoscopes, etc.

18. All disposables, non-prescription, or over-the-counter supplies. This includes items such as ace bandages and splints; exercise and hygiene equipment; corrective shoes and arch support; and support garments. It also includes devices not exclusively medical in nature, such as, but not limited to, sauna baths; spas; elevators; air conditioners or filters; humidifiers and dehumidifiers; equipment that can be used after the medical need is over, such as orthopedic chairs and motorized scooters; and modifications to the home or motorized vehicles. Exceptions to this exclusion would be over-the-counter items or drugs required to be covered by federal or state statutes or regulations.

19. Surgery or other health care services or supplies to correct or restore or enhance body parts not likely to result in significant improvement in bodily function. Except and where expressly covered elsewhere in this Evidence Of Coverage. The Plan shall have sole discretion to determine whether the services are likely to result in significant improvement in function.

20. Cosmetic products; health and beauty aids; and services and medications related to the diagnosis and treatment of, or to reserve or retard the effects of, aging of the skin. Cosmetic services that are intended primarily to change or maintain Your appearance and that will not result in major improvement in physical function. This includes cosmetic surgery related to bariatric surgery.

21. Preparation and presentation of medical or psychological reports or physical examinations required primarily for the protection and convenience of the Enrollee or third parties. This includes, but is not limited to, examinations or reports for school events; camp; employment; marriage; trials or hearings; and licensing and insurance. However, examinations may be covered when performed as a scheduled physical examination.

22. Immunizations required for the purpose of travel outside of the continental United States.

23. All military service-connected conditions.

24. Payment for care conditions that State or local law requires be treated in a public facility.

25. Any and all services connected to reversal of voluntary, surgically induced infertility (sterilization).

26. All services and supplies related to conception by artificial means. This means prescription drugs related to such services and donor semen and donor eggs used for such services such as but not limited to artificial insemination, invitro fertilization. Ovum transplants, zygote intra fallopian transfer and gamete intrafallopian transfer procedures are not covered. These exclusions apply to fertile individuals or couples.

27. Complications caused by treatment of infertility.

28. Surrogacy services.

29. Elective abortions.

30. Services for an organ donor or prospective organ donor when the transplant recipient is not an Enrollee.

31. Organ and bone marrow search, selection, transportation, and storage costs.

32. Transplant disapproved by the appropriate evaluation committee.

33. Bone marrow transplantation for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders).

34. Personal comfort items, such as television; telephone; lotions; shampoos; meals in the home; guest meals in inpatient facilities; housekeeping services, etc.

35. Diagnosis and treatment for mental retardation; learning or behavioral disorders, psychological problems, speech delay, conceptual handicap or developmental

disability or delay, or dyslexia. Exceptions to this exclusion would be services required to be covered elsewhere in the benefit plan.

36. Unless specifically identified as being covered, any testing for ability; developmental status; intelligence; aptitude or interest; or sleep therapy for insomnia.

37. Long term rehabilitative services.

38. Surgical treatment or hospitalization for treatment of impotency, prosthetics, or aids.

39. Recreational or educational therapy, non-medical self-help training or therapy; and sleep therapy.

40. Bone and eye bank charges.

41. Orthoptics; pleoptics; visual analysis; visual therapy and/or training.

42. Services that the Enrollee would not have to pay for in the absence of Plan coverage.

43. Services provided by a person who lives in the Enrollee's home. Services provided by an immediate relative of the Enrollee.

44. The treatment of any injury or illness that arises out of, or as the result of, any work for wage or profit. However, this exclusion will not apply when the Enrollee in not required to be covered by a workers' compensation policy, and, in fact does not have such coverage. This would apply in the case of:
    - A sole proprietor if the Employer is a proprietorship;
    - A partner of the employer if the Employer is a partnership; or
    - An executive officer of the Employer if the Employer is a corporation.

45. Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge (take-home medications).

46. Over the counter drugs other than insulin.

47. Certain injectables obtained through a pharmacy (other than insulin).

48. Prescription drugs that have an over-the-counter equivalent (e.g., Monistat 7, Disobrom, etc.).

49. Anorectics and diet formulations used for the purpose of weight loss.

50. Over-the-counter contraceptive drugs or devices that do not requires a prescription are not covered.

51. Abortifacient drugs are not covered.

52. Compounded medications/prescriptions are not covered.

53. Medications with no approved indications.

54. Immunization agents; biological sera; and prescriptions filled by non-Participating Provider pharmacies.

55. Prescriptions that an Enrollee is entitled to receive without charge from any workers' compensation law or automobile accident liability insurance.

56. Drugs that are labeled "Caution – limited by Federal law to investigational use" or experimental drugs even though a charge may be made to the recipient.

57. Refilling a prescription in excess of the number specified. Any refill dispensed after one year from the original order.

58. Psychiatric therapy as a condition of parole, probation, or court order, unless specifically identified as being covered.

59. Hair analysis.

60. Routine foot care (including treatment for corns, calluses, and cutting of nails). Foot care in connection with flat feet; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.

61. Post-partum exercises.

62. Services for conditions arising from or worsening as a result of the Enrollee's refusal to accept treatment recommended by a Network Provider.

63. Services not rendered in accordance with Plan policies and procedures. Services rendered by Non-Network Providers (except for Medical Emergencies or urgent care situations that occur outside the service area).

64. Any ambulance services that are not Medically Necessary. Medically Necessary ambulance service is provided is authorized prior to transport by the Enrollee's Primary Care Provider or approved after transport as Medically Necessary by the Plan. The Plan does not provide ambulance transportation due to the absence of other transportation on the part of the Enrollee. An ambulance ordered by a

neighbor, relative, school officer, employer, etc. may be denied for coverage if the service is not Medically Necessary, as determined by the Plan.

65. Enteral feedings except as mandated by Statute or Regulation.

SECTION 9: MEMBER PAYMENT RESPONSIBILITY

MONTHLY PREMIUMS

In exchange for Plan coverage, You will be required to pay monthly Premiums to the Carrier. However, Your Premiums may be reduced if You are eligible for Premium Advances. Premium Advances will be sent directly to the Carrier from the Federal Government.

The Carrier will send You a monthly bill for the amount of Premiums You owe. Your coverage may be terminated if You fail to pay Your Premiums timely. The Plan's right to terminate Your coverage is described in the Effective Date of Termination of Coverage section.

PAYMENTS OUTINED IN THE SCHEDULE OF BENEFTS

You will be responsible for paying the Copayment, Coinsurance and Deductible amounts described in the Schedule of Benefits. Your Out-of-Pocket Maximum includes all Copayments, Coinsurance and Deductible amounts. However, these amounts may be reduced if You are eligible for Cost-sharing Subsidies.

You will also be responsible for paying any health care services that do not qualify as Covered Services. Finally, in most cases, You will be required to pay or those health care services that You receive from a health care Provider who/which is not a Network Provider, and for those health care services that were provided without Prior Authorization do not count towards Your Deductible, nor towards Your Out-of-Pocket Maximum. In addition, You will be responsible for the cost of services that do not qualify as Covered Services, the cost of services to Non-Network Providers and/or services provided without Prior Authorization even if Your Out-of-Pocket Maximum has been met.

If You access an Non-Network Provider for emergency and non-emergency services, the Plan will provide disclosures concerning a covered person's financial responsibility for those services. This information is also available on our website titled "Appendix A." This document outlines Your rights as a member in regard to surprise billing.

COORDINATION WITH OTHER COVERAGE

OTHER COVERAGE

The amount of any payment by the Plan for Covered Services provided to an Enrollee may be reduced if the Enrollee is covered under another health care plan. This may be the case even if the Enrollee does not submit a claim to the other plan. The Plan will pay the lesser of:

- The full amount payable for the Covered Services under the Plan; or
- An amount that, when added to the amount payable under the other Plan, will be no more than the amount payable by the Plan for the Covered Services.

MEDICARE COB

Medicare will be primary except as required by law.

AUTO INSURANCE BENEFITS COB

- Coordination with Auto Coverage. Your benefits under this Contract will be coordinated with any no fault coverage or other automobile insurance that provides medical payment coverage or medical expense coverage in any forms as allowed by law.
- Payment. If You are eligible for benefits under Auto Coverage, such coverage will be primary and responsible for all benefits payable under Auto Coverage. If You are eligible for coverage under more than one automobile insurance policy, each policy will pay its maximum Auto Coverage to any Cost Sharing payable under this Contract as required by law. We may request proof of Auto Coverage has paid all benefits required. If we request information, You must give is to us before we are obliged to make any payments.
- Settlement of Auto Coverage Claims. You may not release or settle any Auto Coverage claims without our written consent if we paid or may have to pay benefits for services that would be covered by the Auto Coverage. If You release or settle an Auto Coverage claim without consent, We may refuse to provide benefits for services that would be provided to You by the Auto Coverage. If You release or settle an Auto Coverage claims without our consent, We may refuse to provide benefits that would be provided to You by The Auto Coverage. We may also recover amounts You got under the Auto Coverage for any benefits we provided that should have been provided to You by the Auto Coverage. Amounts You get or may get for future health care services that would be provided by the Auto Coverage will be placed in a trust account as directed by us for payment of these services.

PRIOR COVERAGE

Unless not allowed by law, Benefits under this Contract shall be secondary for care provided during the period of extension of benefits or as the result of accrued liabilities of the Enrollee's prior coverage if any.

NO DOUBLE RECOVERY

In no event will You be entitled to obtain double recovery from Policies for healthcare services provided to You.

INSURANCE WITH OTHER INSURERS

This applies if You have double coverage, and no other coordination of benefits provisions apply. This generally occurs where one of the policies that provides double coverage is not a group policy. For this section, "Other Valid Coverage" means coverage provided by:

- Entities subject to the insurance laws or regulations of Georgia or any other state; or
- Hospital or medical service entities; or HMOs.

If You have Other Valid Coverage, not with us that provides benefits for the same Benefits as this Contract on a provision of service basis or on an expense incurred basis and You have not given us written notice of Your Other Valid Coverage prior to the occurrence or start of loss, our only liability will be for:

- The proportion of the loss as the amount that would otherwise have been payable under this Contract, plus the total of like amounts under all such Other Valid Coverage for the same loss of which we had notice bears to the total like amounts under al valid coverage for loss, and
- For the return of such portion of the Premiums paid that exceed the pro-rata portion for the amount so determined.

For the purpose of applying this provision when other coverage is on a provision-of-service basis, the “like amount” of such other coverage will be taken as the amount which the services rendered would have cost in the absence of such coverage.

ORDER OF BENEFITS

Each plan determines its orders of benefits using the first of the following rules.

1. Subscriber or Dependent - The plan that covers the person other than as a Dependent, for example a member, is the primary plan. The plan that covers the person as a Dependent is the secondary plan.

2. Order of Dependent Coverage – Unless there is a court order stating otherwise, plans covering a Dependent child must determine the order of benefits using the following rules that apply:
   - For a Dependent child, whose parents are married or are living together, whether or not they have ever been married the plan of the parent whose birthday falls earlier in the Calendar Year is the primary Plan.
     - If both parents have the same birthday, then the plan that has covered the parent the longest is the primary plan.
   - For a Dependent child, whose parents are divorced, separated, or not living together, whether or not they have ever been married, the following rules apply.
     - If a court order states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge if those terms, then that Plan is primary.
     - If a court order states that both parents are responsible for the Dependent child’s health care expenses, then the Plan of the parent with the earliest birthday in the Calendar Year is Primary.
     - If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, then the Plan of the parent with the earliest birthday in the Calendar Year is Primary.
     - It there is no court order stating responsibility for the Dependent child’s health care expenses or health care coverage then the following order of benefits will apply: the plan covering the custodial parent, the plan covering the spouse of the custodial parent, the plan covering the noncustodial parent; then the plan covering the spouse of the noncustodial parent.

YOUR DISCLOSURE OBLIGATIONS

You must inform the Carrier and Your health care providers of any other coverage You and/or Your Covered Dependents may have. This includes coverage under any other group insurance policy or blanket disability insurance policy, health care services contract, preferred provider organization or health maintenance organization group agreement issued by an insurer, health care service contractors or health maintenance organization, labor-management trustee plan, labor organization plan, employer organization plan or employee benefit organization plan, governmental plan (such as Medicare or Medicaid), or coverage required or provided by law.

You will be required to disclose this information, at the time You apply for coverage, at the time of receipt of Covered Services, and from time to time as requested by the Carrier. You will also be required to identify the other insurance carrier, the other group providing the coverage, and any other details requested by the Carrier.

RECOVERY RIGHTS OF THE PLAN

RIGHT OF SUBROGATION/REIMBURSEMENT

In certain circumstance, You or Your Covered Dependents (or the heirs, executor, or beneficiaries of You or Your Covered Dependents) may have an obligation to reimburse the plan for payments made to or on behalf of You or Your Covered Dependents. This right of reimbursement arises if You or Your Covered Dependents receive any benefits under the plan as a result of an injury or illness, and there is a third party (including an insurance company) that is legally responsible for paying for Your injuries (or Your Cover Dependents' injuries). The plan's rights under this section arise after You or Your Covered Dependents are fully compensated.

In these cases, the Plan will have a legal right (known as a "right of subrogation") to recover any amounts that are payable by the third party (such as an insurance company).

In these cases, if You or Your Covered Dependents receive payments or settlement from the third party (such an insurance company), You and Your Covered Dependents agree to reimburse the Plan for any benefits paid by the Plan after You or Your Covered Dependents are fully compensated. This reimbursement is not limited by the stated purpose of the payment from the third party or how the payment from the third party is characterized in any agreement, or judgment.

You agree to notify the Plan, in writing of any benefits paid by the Plan that arise out of any illness or injury that was caused by a third party. You also agree to provide the Plan with the following information, in writing:

- The name and address of the party that caused injury, the facts of the accident, and any other information reasonably necessary to protect Plans right;
- All information about the other party's liability insurer(s), if known;

- Information relating to any personal injury protection, underinsured or uninsured motorist insurance or any other insurance, as well as a copy of any such insurance policy;
- Notice of any claim or legal action filed or submitted against a third party (within sixty (60) days of submitting or filing such claim); and
- Prior written notice of any intended settlement.

You may not (and Your Covered Dependents may not) settle any claim or waive any right to be compensated by a third party (including an insurance company) without the Plan's prior written approval.

By filing a claim for and/or accepting benefits from the Plan, You and Your Covered Dependents are considered to have consented to the Plan's subrogation and right of reimbursement. You and Your Covered Dependents are considered to have agreed to cooperate with the Plan in any way necessary to make, perfect or prosecute any related claim, right or cause of action. You or Your Covered Dependents agree to enter into a subrogation and reimbursement agreement with the Plan if the Plan requests such an agreement. You and Your Covered Dependents may not do anything that would prejudice or harm the rights of the Plan to pursue its rights of reimbursement and subrogation.

Georgia Statutes will govern Subrogation and Recovery Rights. If anything in this section is not in accordance with Georgia Statutes, then it shall be suspended by Georgia Statutes.

RIGHT TO OFFSET FUTURE PAYMENTS

If the Plan sends You or Your Covered Dependents a payment by mistake, or the Plan overpays an amount owed to You or Your Covered Dependents, the Plan may reduce, by the amount of the error, future amounts payable to You or Your Covered Dependent. This right to offset does not limit the Plan's right to recover an erroneous payment on any other manner.

ASSIGNMENT OF RIGHTS

You may not assign (transfer) any of Your right or benefits under the Plan to another person. You may not assign (transfer) any claim, right of recovery or right to payment You may have against the Plan. However, You are permitted to assign (transfer), in writing, any amount payable to You by the Plan, for Covered Services provided to You (or Your Covered Dependents).

SECTION 10: CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

HEALTH CARE PROVIDER MAY SUBMIT CLAIM

In most cases, when You or Your Covered Dependents receive health care services, the health care provider will send a claim directly to the Plan for payment. The health care Provider can do this because the Plan's information is set forth on Your identification card.

CLAIMS YOU SUBMIT TO THE PLAN

In other cases (such as when you fail to produce your identification card), You may be required to pay the health care Provider for all services at the time the care is provided. If this happens You may file a written claim with the Plan. If You file your claim in a timely manner, the Plan will reimburse You for the amount You paid for the Covered Services that were provided up to the contracted rate with the provider. However, the Plan will not reimburse You for any Copayment, Coinsurance or Deductible amounts that you were required to pay the health care provider.

In some cases, the health care provider may agree to send you a bill for the health care services provided. If this happens, You may file a written claim with the Plan. If You file your claim in a timely manner, the Plan will pay the health care provider for the Covered Services that were provided at the contracted rate with the provider. However, the Plan will not reimburse You for any Copayment, Coinsurance or Deductible amounts that You were required to pay the health care provider. You are responsible for making sure that You receive the bill from the health care provider on a timely basis. If You do not file your claim in a timely manner, the Plan will not pay the health care provider. Instead, You will be required to pay for all of the health care services that were provided.

TIMING AND CONTENTS OF CLAIM

If You are submitting a claim to the Plan, You must do so within ninety (90) days of the date that the health care services were provided. Your claim must include the diagnosis, the type of treatment rendered, the date of service, the name and address of the health care provider, the charges for the care, the name of the Enrollee, and the Enrollee's identification number. If You have already paid the health care provider, You must also include receipts showing your payment.

All claims should be sent to:

Friday Health Plans of Georgia, Inc.
Attention: Claims Director
700 Main St
Alamosa, CO 81101
Or questions@fridayhealthplans.com

All clean claims shall be paid, denied, or settled within fifteen (15) calendar days after receipt by the Plan if submitted electronically and within thirty (30) calendar days after receipt by the Plan if submitted by any other means.

If a claim requires additional information (the claim is not a clean claim), the Plan shall, within thirty (30) calendar days after receipt of the claim give the provider, policyholder, insured or patient, as appropriate, a full explanation in writing of the additional information needed to resolve the claim. If the requested information is not received within thirty (30) days, the claims could be denied.

REMINDERS

It is important to remember that, in most cases, the Plan will only pay for health care services provided by a Network Provider. It is also important to remember that the Plan will only pay for services that are Covered Services. If You are being reimbursed for a payment You have made to a Network Provider, You will be reimbursed at the Plan's contracted rate with the Participating Provider. If you fail to submit Your claim within the required ninety (90) day period, Your claim will be denied.

CLAIM NOTIFICATIONS

IF A CLAIM IS DENIED

If Your claim, or any part of your claim, is denied, the Plan will notify You in writing. The written notice will contain the following information:

- Specific reasons for the denial;
- An explanation of the medical basis for the decision, if applicable;
- Specific reference to relevant Plan provisions;
- A description of any additional material or information necessary for You to perfect your claim, and an explanation of why such material or information is necessary; and Information as to the steps You can take if you wish to appeal the decision.

The notice may also include any information regarding an internal rule, guideline or protocol that was relied on in making the benefit decision. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the notice may contain an explanation of the scientific or clinical judgement used in making decision. If the notice does not contain this information, the notice will contain a statement that this information will be provided to You upon written request at no charge.

TIMING OF THE NOTICE

After the Plan reviews your claim, the Plan will notify You of any decision to deny Your claim. Notice will be provided within the state laws and regulations timeline. This notification will be in the form of an Explanation of Benefits (EOB). The EOB is not a bill but an explanation of how the cost of Your medical care is applied to Your benefits.

SECTION 11: GENERAL POLICY PROVISIONS

COVERAGE IS LIMITED TO COVERED SERVICES

A participating Provider may provide, prescribe, order, recommend, approve, refer, or direct a service or supply. However, this does not mean that the service or supply is a Covered Service. The Health care services and supplies that are paid for by the Plan are identified in the **BENEFITS/COVERAGE (WHAT IS COVERED).** If a health care service or supply is not identified in the **BENEFITS/COVERAGE (WHAT IS COVERED)** section, it is not a covered service and will not be paid for by the Plan. This is the case even if the health care service or supply is not specifically identified in the **LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)** section.

COVERED SERVICES ARE NOT AUTOMATICALLY PAID BY THE PLAN

It is important to note that the Plan will pay for Covered Services only if other terms and conditions of the Plan are met. For example, for a Covered Service to be paid for by the Plan, The Covered Service must be Medically Necessary. The Medical Director must decide whether a Covered Service is Medically Necessary.

In most cases, the Covered Service must be performed by you Primary Care Provider or by another Network Provider. Generally, if You receive Covered Services from a Participating Provider who/which in not Your Primary Care Provider, You must first receive Prior Authorization.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If You are receiving Premium Advances the Plan will allow a three (3) month grace period for the payment of Premiums. During the first month of this grace period the Plan will continue to pay for Your Covered Services but during the second (2nd) and third (3rd) month of the grace period the Plan will not pay for Your Covered Services and these services would be paid for only after the Premiums for this period have been paid. If You are not receiving Premium Advances, the Plan will allow a thirty-one (31) day grace period for the payment of Premiums, during which Your coverage (and Your Covered Dependents) will remain in effect. The Plan has the right to pursue collection of the Premiums owed for the grace period.

NO LIFETIME LIMITS OR ANNUAL LIMITS

There is no lifetime limit on the essential health benefits You may receive from the Plan. There is also no annual dollar limit on the essential health benefits You may receive from the Plan. However, there are other limits on your benefits. Those limits are described in this Policy.

CASE MANAGEMENT

Our Case Management Program is free and voluntary. Your participation in the Program does not replace the care and services that you receive from your PCP and other Providers. Entry into the Program may happen in many ways. For example:

- Through completing your Health Risk Assessment
- Our review of claims information

- A referral from a hospital care manager or one of your Providers
- Self-referral

Experienced nurses can help You understand and get the care you need if You are overwhelmed with a new diagnosis or if You or Your loved one has and special needs such as limited mobility or intellectual struggles. If You feel You would benefit from our Care Management Program You may call Friday Health Plans at 1-844-512-7999.

SPECIAL RIGHTS OF THE MEMBER

PRIVACY

The Plan will have access to information from Your medical records, including information received from Your health care providers seeking payment from the Plan. The Plan is permitted to use and disclose information only as reasonably necessary in administering your Plan benefits and complying with applicable law. The Plan will protect the confidentiality and privacy of all such information in the manner required by applicable Federal and State law. A copy of FHP's Notice of Privacy is included in the Welcome Kit sent to Subscribers upon enrollment. You can ask for a copy of the Plan's Notice of Privacy at any time.

HEALTH STATUS

An Enrollee may not be cancelled or non-renewed on the basis of the status of his/her health or health care needs.

SECTION 12: TERMINATION/NONRENEWAL/CONTINUATION

TERMINATION OF PLAN COVERAGE

END OF YOUR COVERAGE

Your Plan coverage will end if:

- You fail to satisfy the eligibility conditions for participation in the Plan;
- You terminate Your coverage in the Plan with appropriate notice to Healthcare.gov;
- You change from one Healthcare.gov plan to another during the Open Enrollment Period or through special enrollment;
- You fail to pay Your Premiums, and any applicable grace period has expired;
- Your experience a Rescission of coverage;
- You engage in certain misconduct, as described in the Effective Date of Termination of Coverage section; or
- The Plan is terminated or is "decertified" by Healthcare.gov;
- If the Insured fails to give written notice within thirty-one (31) days of the loss of eligibility, Friday Health Plans will terminate coverage retroactively and refund any corresponding premium.

When information provided to Friday Health Plans in the Application form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage. The Plan shall have the right to retroactively increase past premium payments to the maximum rates allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by the Plan within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to-date.

- For an explanation of eligibility requirements, see Section 4: Eligibility, Enrollment and Effective Date.

END OF YOUR COVERED DEPENDENTS' COVERAGE

Generally, your Covered Dependents' coverage ends when your coverage ends In addition, your Covered Dependents' coverage also ends if:

- He/she no longer meets the definition of a Child or Spouse (for example: if Your non-disabled son or daughter reaches age twenty-six (26);
- You (or your Covered Dependent) fail to make a Premium Payment required for Dependent coverage; or
- The Plan no longer offers Dependent coverage.

PROOF OF YOUR PLAN COVERAGE

When You and/or Your Covered Dependents lose Plan coverage, the Plan will provide You and/or such Dependents with a document called a "Certificate of Creditable Coverage." The Certificate of Creditable Coverage will indicate the time period that You and/or Dependents were covered by the Plan. If You need to request a Certificate of Creditable Coverage, You should contact the Carrier in writing at:

Friday Health Plans of Georgia, Inc.
700 Main Street,
Alamosa, Colorado 81101
Or questions@fridayhealthplans.com

Your request must include:

- Your name and the names of Your Dependents who were covered by the Plan;
- The time period of Your coverage and Your Dependents' coverage by the Plan; and
- The mailing address where the Certificate of Creditable Coverage should be present.

EFFECTIVE DATE OF TERMINATION OF COVERAGE

REQUESTED TERMINATION

If You (or any Covered Dependent) decides to terminate coverage under the Plan, coverage will end on the date indicated by You (or Your Covered Dependent), If the Plan receives notice at least fourteen (14) days prior to such date. If the Plan does not receive fourteen (14) days' notice, coverage will end on the first of the month following the month after You (or Your Covered Dependent) requests an earlier effective date for termination, and the Plan is able to comply with such request, the Plan may provide for termination before the end of the fourteen (14) day period. If You (or any Covered Dependent) is eligible for Medicaid, CHP, or a basic health plan. (Available to low-income individuals who are not eligible for Medicaid), the last day of the Plan coverage is the day before such new coverage begins.

If You (or any Covered Dependent) decides to terminate coverage under the Plan, You must contact Healthcare.gov to do so. The effective date or termination is assigned by Healthcare.gov and the Plan will comply with that assigned effective date of termination. If You (or any Covered Dependent) requests and earlier effective date of termination other than the date assigned by Healthcare.gov, You will need to appeal the date through the process set out by Healthcare.gov, as that earlier date will be subject to Healthcare.gov approval. If an earlier effective date of termination is approved by Healthcare.gov then the Plan will update to reflect the new effective date of termination. The Plan will comply with earlier effective dates of termination wherever possible and if approved by Healthcare.gov if You (or any Covered Dependent) is eligible for Medicaid, other government funded programs, or a basic health plan (available to low-income individuals who are not eligible for Medicaid in which case the last day of Plan coverage is the day before such coverage begins.

FOR ELIGIBILITY FAILURES

If You (or any Covered Dependent) is no longer eligible to participate in the Plan, Plan coverage will generally end on the last day of the month following the month in which Healthcare.gov notifies You of such loss of eligibility, unless You request an earlier termination date as described above.

FOR PREMIUM PAYMENT FAILURES

If You fail to make a Premium payment that is required by the Plan and You are receiving Premium Advances, the Plan will allow a three (3) month grace period as long as You have paid at least one full month of the Premiums during the Plan Year. The Plan will notify You of Your failure to pay. During the first month of the grace period, the Plan will continue to pay for Your Covered Services (and Your Covered Dependents Covered Services).

However, the Plan may pend (holding without paying) any claims it receives during the second (2nd) and third (3rd) month of the grace period relating to You or Your Covered Dependents. If You fail to pay Your outstanding Premiums within the three (3) month grace period, Your coverage (and the coverage of Your Covered Dependents) will end as of the last day of the first month of the three (3) month grace period.

If You fail to make a Premium payment that is required by the Plan and You are not receiving Premium Advances, the Plan will allow a thirty-one (31) day grace period, during which Your coverage (and Your Covered Dependents) will remain in effect. The Plan will continue to pay for Your Covered Services (and Your Covered Dependent's Services) during the grace period. The Plan will notify You of Your failure to pay. If You fail to pay Your outstanding Premiums within the thirty-one (31) day grace period, Your coverage (and the coverage of Your Covered Dependents) will end as of the final day of the last month for which You made a full Premium payment.

FOR RESCISSIONS OF COVERAGE

If You or any Covered Dependent commits a fraud against the Plan or intentionally misrepresents a material fact in connection with the Plan or the coverage, there will be a Rescission of Your coverage (and the coverage of Your Covered Dependents). In such cases, the Plan will provide You with thirty (30) days' advance written notice of the Rescission. However, the termination of coverage will be retroactive to the date of the event that caused the Rescission.

The Plan will refund any contributions You made to the Plan relating to the period subject to the Rescission. However, the Plan may subtract from the refunded contributions any amounts paid by the Plan for Covered Services (for You and Your Covered Dependents) during such period. The Plan may also charge You for any amounts paid by the Plan for Covered Services (for You and Your Covered Dependents) during such period if those amounts are greater than the amount of Your contributions for that period. Any unpaid claims for Covered Services (for You or Your Covered Dependents) that relate to such period will, to the extent permitted by law, will be denied by the Plan.

ELECTION OF OTHER HEALTHCARE.GOV PLAN

If You (or any Covered Dependent) elect another Healthcare.gov plan during the Open Enrollment Period or when a special enrollment right arises, coverage under this Plan will end on the day before the effective date of coverage under the new plan,

FOR MISCONDUCT

If You permit another person to use Your Plan identification card or otherwise misuse the Plan, Your Plan coverage (and the coverage of Your Covered Dependents) may be cancelled upon thirty (30) days' prior written notice from the Plan.

FOR OTHER REASONS
If Plan coverage is being terminated because the Plan will no longer be offered by the Plan, the Plan is being terminated or decertified; Dependent coverage is no longer being offered; or for some similar reason, You will be notified of the effective date of Your termination of coverage (and/or Your Covered Dependents' termination of coverage).

IMPACT ON HOSPITALIZED ENROLLEE
If Plan coverage is terminated while an Enrollee is hospitalized, the Plan will renew or continue the coverage provided.

RENEWAL RIGHTS

RIGHT OF RENEWAL
Generally, at the option of the Enrollee, the Carrier will renew or continue the coverage provided under the Plan.

EXCEPTIONS TO RENEWAL RIGHTS
The Carrier will not be required to renew an Enrollee's coverage if:

- The Enrollee has failed to pay any required Premium or has failed to timely pay Premiums;
- The Enrollee has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact with respect to the terms of coverage; or
- There are no longer any Enrollees living, working, or residing within the Service Area.
- Enrollee has not provided the necessary hardship exemption for Catastrophic coverage for individuals over the age of thirty (30).
- Enrollee is an aged out dependent on the previously elected plan (over twenty-six (26) years of age).

DISCONTINUING THE PLAN
The Plan will also not be required to renew an Enrollee's coverage if the Plan elects to discontinue offering the Plan and:

- Provides notice of the decision not to renew coverage, at least ninety (90) days before the non-renewal of the Plan to each Enrollee;
- Offers each Enrollee the option to purchase coverage under any other health benefit plan currently being offered by the Plan in the State of Georgia and identifies the applicable special enrollment periods for each such plan; and
- Provides the required notice and information to the Department of Insurance; and Complies with any other applicable non-renewal requirements imposed by law.

LEAVING THE INDIVIDUAL PLAN MARKET
The Plan will also not be required to renew an Enrollee's coverage if the Plan discontinues offering and renewing all of its individual plans in the State of Georgia and:

- Provides notice of the decision to discontinue coverage at least one hundred eighty (180) days before the discontinuance to each Enrollee;
- Provides notice to the Department of Insurance at least three (3) business days before the date notice is sent to each Enrollee;
- Continues to provide coverage through the first renewal period, not to exceed twelve (12) months, after providing the one hundred eighty (180) day notice to Enrollees; and
- Complies with the other the applicable non-renewal requirements under the law.

SECTION 13: APPEALS AND COMPLAINTS

INTERAL APPEAL PROCEDURES

RIGHT TO APPEAL

The right to appeal applies to all Adverse Benefit Determinations. An "Adverse Benefit Determination" means a denial, reduction, or termination of a benefit; or failure to provide or make payment (in whole or in part) for a benefit. This includes a denial, reduction, termination, or failure to provide or make payment based on:

- The determination of an individual's eligibility for Policy coverage;
- The application of any pre-authorization requirements or other utilization review requirements;
- The determination that the benefit is experimental or investigational;
- A determination that the benefit is not Medically Necessary, appropriate health care setting or level of care; or
- A Rescission of coverage.

The appeal will be reviewed by a physician, who will consult with his/ her clinical peers (unless the physician is a clinical peer). The physician and any clinical peers will be individuals who were not involved in making the Adverse Benefit Determination. However, a person who was involved in that decision may answer questions.

The individual(s) reviewing the appeal consider all comments, documents, records, and other information submitted by the Enrollee, even if the information was not considered when the Adverse Benefit Determination was made. The decision in response to an appeal; will contain the following Information:

- The name(s), title(s) and qualifications of the individual(s) reviewing the appeal;
- A statement of such individual(s)' understanding of the request for the review;
- The decision; and
- A reference to the evidence of documentation used to make the decision.

HOW TO APPEAL

You (or Your authorized representative) may appeal an Adverse Benefit Determination by following the Plan's procedures. To begin the appeals process, or to request help with the appeals process, You may call the Friday Care Crew at 1-844-712-7999. Your appeal will be accepted in writing or by telephone, by the Plan within one-hundred and eighty (180) days after Your receipt of the notice denial.

If the deadline for appealing falls on a weekend or holiday, it will be extended to the next business day. For Urgent Care Claims, Your appeal may be made orally.

When You file an appeal, You may submit additional comments, records and documents related to Your claim. You may also identify health care providers who will receive a copy of the Plan's decision. You may also review (at no charge) copies of the documents and information relevant to Your claim. This includes information or records that were relied on in

making the Adverse Benefit Determination; information that was considered by or produced to the original decision-maker(s); information relating to administrative procedures and safeguards that were applied in making the original decision; and policies or guidance relating to the service or treatment for Your diagnosis. However, You must make a request for such review.

If Your appeal relates to a benefit that is not a Covered Service (meaning the benefit is excluded from coverage), You must provide additional information. Specifically, You must provide evidence from a medical professional that there is a reasonable medical basis that the exclusion does not apply.

APPEAL NOTIFICATION AND TIMING

If the Plan receives Your appeal by the appropriate deadline, the Plan will independently review You appeal and any additional information that You submit. The Plan will notify You of its decision regarding Your appeal within the following timeframes:

- For Urgent Care Claims: The Plan will notify You as soon as possible, but no later than seventy-two hours after its receipt of Your appeal. If the Plan provides the notice orally, it will provide You with written confirmation of its decision within three (3) days.
- For Pre-Service Claims: The Plan will notify You within a reasonable time but no later than sixty (60) days after it receipt of Your appeal.
- For Post-Service Claims: The Plan will notify You within a reasonable time but no later than sixty (60) days after it receipt of Your appeal.

IF AN APPEAL IS DENIED

If You appeal is denied, the Plan will send You a notice containing the following information:

- Specific reasons for the denial;
- Specific references to relevant Plan provisions;
- A statement that You may have access to or receive, upon request and at no charge, copies of all documents, records, and information relevant to Your claim; and
- A statement of any additional rights offered by the Plan and a description of those rights.
- A statement of any additional appeal rights offered by the Plan and a description of those rights.

If applicable, the notice will also include any information regarding an internal rule, guideline or protocol used on making the appeal decision, and/or explanation of the scientific or clinical judgment used in the denial. If the notice does not contain this information, the notice will contain a statement that this information is available to You upon written request and at no charge.

RIGHT TO ATTEND APPEAL MEETING

You may attend the meeting held to review Your case. This review will conduct by a health care professional who has appropriate expertise. You may choose to have legal counsel, advocates, and health care professionals participate in the review. You may prepare in advance for the review and provide materials to the reviewer prior to and at the time of the review. You may request that the Plan provide You with a copy of the materials it will present at the review. If You make this request, the Plan will provide a copy of materials to You at least five (5) days before the review. If the Plan makes such a request from You, You must provide a copy of the materials You will present at the review. You will also be required to provide a copy of materials at least five (5) days before the review. If new information develops after the five (5) day deadline, the new material may be presented when You are able (or the Plan is able) to present the new information.

The Plan will notify You if it intends to make an audio or video recording of the review. If a recording is made, the Plan will provide a copy to You. If an external review is conducted, the recording will be included in the material provided to the reviewing entity, if either You or the Plan requests for it to be included.

EXHAUSTION OF INTERNAL APPEAL RIGHTS

You must exhaust Your rights set forth above in this Internal Appeal Procedures section before You may file an external appeal. You may be treated as having exhausted Your internal appeal rights if the Plan has failed to comply with its obligations under this Internal Appeal Procedures section.

EXTERNAL APPEAL PROCEDURES

DENIALS THAT QUIALIFY FOR EXTERNAL REVIEW

If Your internal appeal is denied, You may be entitled to pursue an external review of Your claim by an independent, third party. This right applies if Your Adverse Benefit Determination relates to one of the following:

- The application of any pre-authorization requirements or other utilization review requirements;
- The determination that the benefit is experimental or investigational;
- A determination that the benefit is not Medically Necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care;
- A non-Covered Service for which You present evidence from a medical professional that there is a reasonable medical basis that the exclusion from coverage does not apply; or
- A Rescission of coverage.

With respect to experimental or investigational claims, an Enrollee may request an external review or an expedited external review. In each case, the Enrollee's treating physician must certify in writing that the recommended or requested health care service or treatment that is the subject of the denial would be significantly less effective if not promptly initiated. The

Enrollee's treating physician must also certify in writing that at least one of the following situations applies:

- Standard health care services or treatments have not been effective in improving the condition of the Enrollee or are not medically appropriate for the Enrollee; or
- There is no available standard health care service or treatment covered by the Plan that is more beneficial than the recommended or requested health care service, and the physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the Enrollee's condition.

Finally, in such cases, the physician must certify that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Enrollee is likely to be more beneficial the Enrollee that any available standard health care services or treatments.

There is no minimum dollar amount that applies to a claim that is eligible for an external review.

HOW TO FILE AN EXTERNAL APPEAL

Your request for an external review must be made in writing to the Plan. This must be done within four (4) months after You receive notice of an Adverse Benefit Determination following the completion or exhaustion of Your first level internal appeal. If the deadline for filing an external appeal falls on a weekend or holiday, it will be extended to the next business day.

If You are seeking an expedited review, You must state this in Your request. You must also include a physician's certification that Your medical condition meets the criteria for an expedited external review.

An expedited review is available if You have a medical condition where the timeframe for completing the standard external review would seriously jeopardize Your life or health; would jeopardize Your ability to regain maximum function; or if You have a disability; would create an imminent and substantial limitation on Your ability to live independently.

An expedited review is also available if Your previous denial relates to a hospital or facility admission; availability of care; a continued stay; or to health care services for which emergency services were provided and a discharge has not occurred.

If You are requesting an expedited review, You may obtain the external review at the same time as Your internal review of an Urgent Care Claim (as described in the Internal Appeal Procedures section above).

The Plan will pay costs of an external review.

APPOINTMENT OF EXTERNAL REVIEW ENTITY

When the Plan receives Your request for an external review, the Plan will contact the Office of the Commissioner of Insurance. The Office of the Commissioner of Insurance will inform the Plan of the name if the independent, third party, external review entity that has been selected by the Office of the Commissioner of Insurance to conduct the review. The Plan will notify You in writing that Your request for external review has been sent to the Division of Insurance. The Plan will include information about the external review entity that has been selected to conduct the review. This will generally occur within five (5) business days of Your request for external review, or three (3) business days in the case of an expedited review. Within five (5) business days of receiving the name to the assigned external review entity (or immediately, in the event of an expedited review), the Plan will provide the external review entity with the following:

- A copy of any information You or Your health care provider has submitted to the Plan in support if the request for an external review;
- A copy of relevant documents and information used by the Plan during the internal appeal process to determine Medical Necessity; medical appropriateness; medical effectiveness; or medical efficiency of the service or treatment; including medical and scientific evidence and clinical review criteria;
- A copy of any previous denial letters issued by the Plan concerning the case;
- A copy of Your signed consent form allowing the Plan to disclose Your medical information to the external review entity; and
- An index of all documents submitted.

The Plan will, upon Your request, provide with all relevant information supplied to the external review entity, except for information that is confidential or privileged under state or federal law. You may submit additional information directly to the external review entity within five (5) business days after You receive notice from the Plan relating within one (1) business day.

In addition to the documents and information described above, the external review entity will consider all other relevant information that is available.

PROVIDING ADDITIONAL INFORMATION

The external review entity will notify You, Your health care provider, and the Plan of any additional medical information required for the review. If You and Your health care Provider receive such a request, You or Your health care Provider must submit the additional information, and an explanation of why the additional information is not being submitted, to the external review entity and to the Plan. The additional information must be submitted within five (5) business days of the request.

The Plan may determine that the information provided by You, or Your health care Provider justifies a reconsideration of its denial of coverage. If that happens, and the Plan decides to provide the coverage (approve Your claim), the Plan will notify You within one (1) business day of its decision. The Plan will also notify the external entity and the Office of the

Commissioner of Insurance of its decision. At that point, the external review process will end.

APPEAL NOTIFICAION AND TIMING

When the external review entity makes its decision, it will send notice of the decision to You. It will also send notice to the Plan, the Office of the Commissioner of Insurance and to Your health care provider who supported Your request review. This decision will be sent within forty-five (45) days after the external review entity receives from the Plan Your request for external review.

In the case of an expedited review, the external review entity will issue its decision within seventy-two (72) hours after the external review entity receives from the Plan Your request for external review. If this notice of decision is not provided in writing, the external review entity will provide written confirmation of the decision within forty-eight (48) hours after the date the notice of decision is given to You or Your health care Provider.

The external review entity's determination shall be in writing and state the reasons the requested treatment or service should or should not be covered by the Plan. The external review entity's decision will refer to the relevant provisions in the Plan documentation, the specific medical condition at issue and other relevant documents that support the external review entity's decision. The decision must be based on an objective review of relevant medical and scientific evidence. The decision of the external review entity will be in binding on You and the Plan. However, other remedies may be available under federal or state law if either party is not satisfied with the decision.

If the Decision is in Your favor, the Plan will approve the coverage requested. For Pre-Service Claims and for ongoing treatment, such approval will occur within one (1) business day. For Post-Service Claims, such approval will occur within five (5) business days. In such cases, the Plan will notify You in writing of its approval of coverage within one (1) business days of its approval. For claims subject to expedited review, the Plan's approval will occur immediately, and the Plan will immediately notify You in writing of its approval of coverage.

If the decision is in Your favor, the Plan will provide coverage for the treatment and services in question, subject to other terms and conditions of the Plan.

OTHER GRIEVANCE PROCEDURES

OTHER DISPUTES

The Plan also has a grievance (complaint) process to help resolve issues and concerns that are not subject to the various procedures described above. A Complaint is an oral or written expression of dissatisfaction with the Plan from You regarding Your Provider. It is not necessary to have received and Adverse Benefit Determination to submit a complaint or Grievance.

Complaints should be submitted to Friday Health Plan's Care Crew team in writing or by simply making a verbal Complaint. If the Complaint cannot be resolved by the Friday Care Crew Representative, then it will be escalated as a Grievance.

Examples of the type of issues You may address through this process include Complaints about:

- Waiting times to see Your Primary Care Provider or other Network Provider;
- The behavior of You Primary Care Provider or another Participating Provider;
- Whether there are adequate facilities or Participating Providers available to You; or
- Any items or service that You receive through the Plan but do not have to pay for. This may also include administrative practices such as claims payment, handling, or reimbursement for Health Care Services.

HOW TO FILE A GREIVANCE

To begin the grievance process, You may call the Friday Care Crew at 1-844-512-7999.

You may also contact the *Georgia Department of Public Health and Environment* for help. The Plan will provide You with the address and contact information. You should note that the *Georgia Department of Public Health and Environment* only handles issues relating to Georgia health care Providers. For health care Providers who/which are outside of Georgia, You should contact the *Department of Health* for the state where the health care Provider is located. You may contact the Plan for help in locating the appropriate person within the state where the health care Provider is located.

TIME PERIOD FOR FILING

You must file Your grievance with the Plan within one-hundred and eighty (180) of the event on which Your grievance is based, The Plan will not consider any grievance submitted after such date.

GRIEVANCE NOTIFICATION AND TIMING

If the Plan received Your grievance by the appropriate deadline, the Plan would independently review Your appeal and any additional information that You submit. The Plan will notify You of its decision regarding Your Grievance no later than thirty (30) days after its receipt.

SECTION 14: INFORMATION ON POLICY AND RATE CHANGES

POLICY CHANGES

The Covered Services available to You and Your Covered Dependents may change each Plan Year. When You receive a new Policy, any such changes will be included in that document.

NOTICE

Friday Health Plans will provide sixty (60) days' notice for all material changes to the policy.

CHANGES IN RATES

During a Plan Year, the Plan may change the Premium amount You owe if there are changes in the number of Your Covered Dependents, changes in Your geographic rating area, or changes in tobacco use by You or Your Covered Dependents. The Plan may also change the Premium amount You owe during the Plan Year if the Plan makes changes to the Plan at Your request, or if there are changes in the law that impact the Plan. You will be notified in advance of any Premium changes made during the Plan Year. At the beginning of each new Plan Year, the Plan may change the Premium amount You must pay. You will be notified in advance of any such changes.

SECTION 15: DEFINITIONS

When they are used in this Evidence of Coverage, the following capitalized terms will have the meaning explained in this DEFINITIONS section:

"ACA Preventative Care Drug" A medication that under the Affordable Care act (ACA) some medications may have limited of $0 cost-sharing.

"Allowable Amount" The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

"Application" Refers to the form used by Georgia Health Insurance to collect information from You and verify that information or the State of Georgia Uniform Individual Application.

"Balance Billing" When a provider bills You for the difference between the provider's charge and the Allowed Amount.

"Benefits" The health care items, or services covered under a health insurance plan. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules. May also be called "Covered Services."

"Child" refers to Your natural- born child, Your adopted child, a foster child, or a child placed with You or Your Spouse for adoption, if the child:

- Has not yet attained age twenty-six (26); or
- Is medically certified as disabled and Dependent upon You or Your Spouse (no matter how old the child is).

"Contract" means this Policy document and the following:

- Summary of Benefits and Coverage
- Enrollment Application Form
- Member ID Card

"Coinsurance" The percentage of costs of a covered health care service You pay (20%, for example) after You have paid You deductible.

"Copayment" A fixed amount ($20, for example) You pay for a covered health care service after You have paid You Deductible.

"Covered Child" means any Child, age twenty-five (25) and younger, who is enrolled in the Plan.

"Covered Dependent" means any Child or Spouse who is enrolled in the Plan.

"Covered Services" the same as "Benefits"

"Deductible" means the amount You pay for covered health care services before Your insurance plan start to pay. With a $2,000 Deductible, for example, You pay the first $2,000 of covered services yourself"

"Dependent" A Child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a Premium tax credit to help cover the cost of coverage for themselves and their dependents.

"Emergency Medical Condition" An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

"Enrollee" means any person who is enrolled in and covered by the Plan.

"Experimental or Investigational" means a health service, treatment, procedure, device, drug, or product used for the Enrollee's condition that at the time it is used, meets one or more of the following criteria:

- Has not been approved by a government agency, such as, but not limited to the Food and Drug Administration (FDA);
- Is the subject of an ongoing FDA Phase I, Phase II, or Phase III clinical trial;
- Is subject to the approval or review of an Institutional Review Board (IRB) or other body that serves a similar function of approving or reviewing research on safety, toxicity, or efficacy;
- Lacks recognition and endorsement from nationally accepted medical panels, national associations, or other evaluation bodies;
- Has been disapproved by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on the analysis of clinical studies and literature for safety and appropriateness;
- Lacks conclusive evidence distracting that the service improves the new health outcome for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service may be recognized as a treatment or service for another condition, screening, or illness;
- Requires written informed consent that describes the service as experimental, investigational, education, for a research study, or in other terms that indicate that the service is being looked at for its safety, toxicity, or efficacy; or
- It is of the expert opinion, as found in the literature of the day, that the use of the service is experimental or that the service requires more research to find it the service is effective.
- The Plan is the sole judge if a health service is "Experimental or Investigational."

"FHP" means Friday Health Plans of Georgia, Inc. which is the Heath Management Organization through which You are insured.

"Formulary" a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a "drug list"

"HHS" refers to the Department of Health and Human Services.

"Grievance" a complaint that You communicate to Your health insurer plan.

"Medical Director" is the person the Plan chose as a decision-maker. This person in charge of Prior Authorizations. This person also decides if Covered Services are Medically Necessary. The Medical Director is also the Plan Medical Director.

"Medical Emergency" means a sudden and severe medical condition (including severe pain) that can reasonably be expected to result in one or more of the following, if the Enrollee does not seek immediate medical attention:

- Placing the health of the Enrollee (or, with respect to a pregnant woman, the health pf the Enrollee or her unborn child) in serious danger;
- Serious impairment to bodily functions; or
- Serious Dysfunction of any bodily organ or part.

"Medically Necessary" Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

"Member" means any person who is enrolled in and covered by the Plan.

"Member Portal" is an online portal that will allow You to review claims, print Your ID card, check the status of Prior Authorization, and perform many other functions that will help You as a Member.

"Minimum Essential Coverage" any insurance Plan that meets the Affordable Care Act requirement for having health care coverage. To avoid the penalty for not having insurance for Plans 2018 and earlier, You must be enrolled in a Plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage").

"Network Facility" is a Network Medical Office or Network Hospital.

"Network Hospital" is any hospital listed as a Network Hospital in our Provider directory. Network Hospitals are subject to change at any time without notice.

"Network Medical Office" is any medical office listed in our provider directory, including any outpatient facility designated by Friday Health Plan. Network Medical Offices are subject to change at any time without notice.

"Network Provider" " means any doctor, hospital, pharmacy, clinic, or health care provider who/which has agreed to provide health care to Enrollees at contract rates. FHP has contract rates with these Providers on a fee-for-service basis. Network Providers are subject to change at any time without notice. Also referred to as In-Network Providers.

"Network Provider Directory" is a tool where You can find the Network of Physicians, Providers, and ancillary Providers.

"Open Enrollment Period" the yearly period when people can enroll in a health insurance plan.

"Plan" a benefit Your employer, union or other group sponsor provides You to pay for Your health care services.

"Plan Year" a 12-month period of Benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.

"Policy" refers to this document. This document is intended to describe the health care benefits available to You and Your Covered Dependents under the Plan. It is also intended to describe the terms and conditions of receiving those benefits.

"Premium" the amount You pay for health insurance every month. In addition to Your premium, You usually have to pay other costs for Your health care, including a Deductible, Copayments, and Coinsurance.

"Premium Advance" A tax credit You can use to lower Your monthly insurance payment (called Your "premium") when You enroll in a plan through the Health Insurance Marketplace®. Your tax credit is based on the income estimate and household information You put on Your Marketplace application.

"Primary Care Provider A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

"Prior Authorization" Approval from a health plan that may be required before You get a service or fill a prescription in order for the service or prescription to be covered by Your plan.

"Prior Written Authorization" is the proof the Prior Authorization granted by FHP.

"Provider" means any Hospital, Physician, or other provider of Health Care. In order to be eligible for the Provider to be paid to provide Covered Services, then the Provider must be a Network Provider.

"Rescission" The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel Your entire policy if You made a mistake on Your initial application when You buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

"Refund Period" means the shorter of:

- The entire period that a person is enrolled in the Plan but is eligible for coverage; or
- The sixty (60) day period prior to the Plan's discovery of the person's ineligibility.

"Service Area" A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals

You may use, it is also generally the area where You can get routine (non-emergency) services. The plan may end Your coverage if You move out of the plan's service area.

"Specialist" A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

"Specialty Care Centers" means a Network Provider that has expertise in providing certain specialized care or treatments, such as cancer treatments or transplants.

"Specialty Pharmacy" is a Drug provider that had contracted with FHP to provide Tier IV Drugs to its Members. Getting these drugs through a Specialty Pharmacy will often decrease the cost to the member. Contact FHP at 1-844-512-7999.

"Specialty Drugs" are high-cost oral, injectable, infused or inhaled covered drugs that are self-administered or given by a Provider. These drugs are used in an outpatient or home setting. Insulin is not considered Specialty Drug. Contact FHP at 1-844-712-7999

"Spouse" refers to Your husband or wife, or Your partner in a civil union. A spouse must live or work in the Service Area. (If Your Spouse is on a temporary work assignment outside of the Service Area, the assignment must not be for more than ninety (90) days).

"Telehealth" means a mode of delivery of health care through telecommunications. This includes information, electronic, and communication technologies. It is used for the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Member's health care. This is used while the Member is located at a site and the provider is located at a distant site.

"Welcome Kit" is a package sent to the Subscriber that includes the Notice of Privacy, and member ID cards.

"You or Your" means the Enrollee or Member or Covered Dependent.