NORTH CAROLINA HEALTH BENEFIT OFF-EXCHANGE
INDIVIDUAL MARKET
MEDICAL AND HOSPITAL POLICY HMO

Important Cancellation Information - Please Read The Provision Entitled, "TERMINATION / NONRENEWAL /CONTINUATION", Found On Page "80"

SECTION 1: TITLE PAGE (COVER PAGE)

FRIDAY HEALTH PLANS OF North Carolina, INC.

NORTH CAROLINA HEALTH BENEFIT OFF-EXCHANGE
INDIVIDUAL MARKET
MEDICAL AND HOSPITAL POLICY HMO

THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND FRIDAY HEALTH PLANS OF NORTH CAROLINA, INC. PLEASE READ YOUR POLICY CAREFULLY.

Notice of Insured's Right to Examine Policy for Ten Days If You are not satisfied You have the right to return this Policy within ten (10) days of delivery to You, for a full refund of any Premium paid.

SECTION 2: CONTACT US

FRIDAY HEALTH PLANS OF NORTH CAROLINA, INC.

Friday Health Plans of North Carolina, Inc. (The Plan) is certified under the laws of North Carolina as a Health Maintenance Organization (HMO). As an HMO, coverage for services requires that you go to a Participating Providers within the Plan's Network. There are a few specific situations when you may receive care from Providers who are not in our network. Please see Section 5 of this document for more information. In addition, the Plan is a Qualified Health Plan able to sell our plans on the Federal Health Insurance Marketplace (healthcare.gov).

This Policy, along with the Schedule of Benefits and the enrollment application, make up the Entire Legal Contract between You, the Member, and Friday Health Plans of North Carolina, Inc. In consideration of your application and Your timely payment of premiums, we will provide benefits to you, the member, for covered services as outlined in this policy. Benefits are subject to policy definitions, provisions, limitations, and exclusions. Please read this policy carefully.

This Plan is guaranteed renewable, but there are instances where the policy may be cancelled, terminated, or not renewed. Please read this important Cancellation Information in Section 12 - Termination/Nonrenewal/ Continuation of this document.

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 Section 16: DEFINITIONS. However, some capitalized terms may be defined in the sections of this Policy where they are used.

If you have any questions about the Plan or the information in this Policy, you may contact the Carrier in writing at:

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

Or contact us by telephone at:
1- 844-465-5500 (toll free)

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. No agent may change this contact, waive any of the provisions of this contract, extend the time for payment of premiums, or waive any of the Plans' rights or requirements.

All riders or endorsements added after date of issue, except those by which the insurer effectuates a request made in writing by the Policyholder or exercises a specifically reserved right under this

document or those which increase benefits, shall require signed acceptance by the Policyholder.

FHP FONEMED (NURSE ADVICE LINE)

If You have a non-life-threatening illness or injury, or if You have questions about symptoms You are having, You may call FHP FoneMed toll-free at 1-800-247-9312 Experience registered nurses are available to talk to You twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. If You are experiencing a medical emergency, please call 911.

NOTICE OF NONDISCRIMINATION

Friday Health Plans of North Carolina 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 North Carolina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Friday Health Plans of North Carolina:

- 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 Friday Care Crew at 844-465-5500.

If you believe that Friday Health Plans of North Carolina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the Chief Compliance Officer, 700 Main Street, Alamosa, CO 81101; 844-465-5500 (TTY:1-800-659-2656); compliance@fridayhealthplans.com. You can file a grievance in person, or by mail, or email. If you need help filing 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 through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/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: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Friday Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 844-465-5500.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Friday Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 844-465-5500.

Chinese: 如果您，或您正在幫助的人，有關於 Friday Health Plans方面的問題，您有權利免費以您的母語得到幫助和訊息 想要跟一位翻譯員通話，請致電 844-465-5500.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Friday Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 844-465-5500 로 전화하십시오.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Friday Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 844-465-5500.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያበቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 844-465-5500 ይደውሉ።

Arabic: إذا كان لديك أو لدى شخص تساعده سؤال بخصوص Friday Health Plans 844-465-5500 فلديك الحق في الحصول على المساعدة والمعلومات بلغتك مجانًا. اتصل برقم الهاتف النصي 844-465-5500 للتحدث إلى مترجم فوري.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Friday Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 844-465-5500 an.

French: Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Friday Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 844-465-5500.

Napali: यि द तप ई आफ्न ल ि ग आफ आवेदनक क म गद, व कस ल ई मद्दत गद हन हन्छ Friday Health Plans ब र े प्रह छन ् भन े आफ्न म तभ ष म ि न:श लक् प उन े ि धक र छ । सह ि त व ज नक र द भ षे (इन्टरप्रेटर) सग क र गनर परे 844-465-5500 म फ न गनर ह स ् ।

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Friday Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 844-465-5500.

Japanese: ご本人様、またはお客様の身の回りの方でも、Friday Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり　、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、844-465-5500　　までお電話ください。

Cushite: Isin yookan namni biraa isin deeggartan Friday Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 844-465-5500 tiin bilbilaa.

Persian: ، Friday Health Plans داشته 844-465-5500- سوال در مورد ، میکنید کمک او به شما به که کسی یا شما، گر
.باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید تماس حاصل نمایید

Kru: I bale we, tole mut u ye hola, a gwee mbarga inyu Friday Health Plans, U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 844-465-5500.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 844-465-5500.

Yoruba: Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nipa Friday Health Plans, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 844-465-5500.

SECTION 3: TABLE OF CONTENTS

SECTION 4: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

ELIGIBILITY OF APPLICANTS

The Plan will determine whether you are eligible for coverage under the Plan based on your Application. If you are eligible, and you decide to enroll in the Plan, the Plan will help You with Your enrollment. If the Plan determines that You are not eligible, the Plan will notify You. The Plan will give you a chance to appeal the determination.

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

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

ELIGIBILITY OF DEPENDENTS

the Plan will also determine whether Your Dependents are eligible for coverage under the Plan. If one or more of your Dependents are eligible, and you choose to enroll them in the Plan, the Plan will assist with the enrollment. If the Plan determines that one or more of Your Dependents are not eligible, the Plan will notify You. the Plan will give you a chance to appeal the determination.

The following are Dependents eligible for enrollment in this Plan:

- A Subscriber's legal spouse or a legal spouse that the court has ordered coverage (Spouse includes a partner in a valid civil union under state law, Domestic Partners, or designated beneficiary).
- A child by birth. Adopted child. Stepchild. Foster Child. Minor child that a court has ordered coverage. Child being placed for Adoption with the Subscriber. A child that a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.
    a. The child must be under the age of twenty-six (26).
    b. A Child will continue to be eligible until the end of the calendar year that they reach age twenty-six (26) if he or she continues to meet all other eligibility requirements.
    c. Your own, Your spouse's or domestic partner's Newborn children are automatically covered for the first thirty-one (31) days of life. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within sixty (60) days of the date of birth and pay any additional premium. Coverage for a newborn dependent child enrolled within sixty (60) days of birth will be effective as of the date of the child's birth. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's birth, or the first date of coverage under this

POLICY, whichever is later.

d. An adopted child, including a child who is placed with You for adoption, is automatically covered for thirty-one (31) days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within sixty (60) days of the date of adoption and pay any additional premium. Coverage for an adopted dependent child enrolled within sixty (60) days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's placement for adoption or initiation of a suit of adoption, or the first date of coverage under this POLICY, whichever is later.

e. A foster child is automatically covered for thirty-one (31) days from the date of placement in Your residence. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within sixty (60) days of the date of placement in the home and pay any additional premium. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's placement for foster care, or the first date of coverage under this Policy, whichever is later. Coverage for a foster child dependent enrolled within sixty (60) days of the placement in the home will be retroactive to the date of the child's placement for foster care.

   A Dependent child who is either mentally disabled or physically handicapped and incapable of self-support may continue to be covered under the health benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the age of twenty-six (26). The child's health care Provider must medically certify the handicap

INDIVIDUALS THAT ARE NOT ELIGIBLE

The Plan may consider You and Your 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 enrolled for coverage under Medicare Part A and/or B at the time of Application.

- A Spouse becomes ineligible if they are no longer married to the subscriber.
- A child placed in the applicant or Subscriber's home other than 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).

CHANGE IN ELIGIBILITY STATUS

It is the responsibility of the Subscriber to notifying the Plan or the Plan of any changes that affect eligibility for services under this Policy. Changes in eligibility may be for the Subscriber or for an enrolled Dependent. The Subscriber must notify the Plan within sixty (60) days of the event. This includes changes of address, addition or deletion of dependents resulting from death, reaching age twenty-six (26), and changes in Dependent Disability or Dependent status. Coverage for ineligible members will terminate in accordance with the termination provisions described in this Policy.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

ANNUAL OPEN ENROLLMENT

The Plan will have an annual open enrollment period. The open enrollment period is usually from November 1st through December 15th. It is possible that these dates may change, and the Plan should be checked each year to confirm that the dates for the Annual Open Enrollment have not changed. During the Annual Open Enrollment Period, You can chose to enroll of make changes to Your existing coverage. If you are eligible to enroll, then you apply, and you select a plan during this time period. Once you are approved by the Plan you will enrolled for coverage. Also, if any Dependent is eligible, you should include the Dependent on your Application, and you select plan coverage for the Dependent. You will do this during the initial open enrollment period. If done, then the 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. For certain Qualifying Events, 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, and have paid your first month's Premium, your coverage will begin on the date listed as the Effective Date on Your ID Card. No health services received prior to the Effective Date on Your card are covered.

DOCUMENTATION 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 of the date of the Covered Child's enrollment.

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 even 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 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 844-465-5500

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 changes in this Policy.

SPECIAL ENROLLMENT SECTION

SPECIAL ENROLLMENT RIGHTS

In certain cases, you may be eligible for a Special Enrollment Period during which you will be eligible to enroll yourself and/or your eligible Dependents in the Plan outside the dates of the Annual Open Enrollment period. This means that you will not have to wait until the next Open Enrollment Period to receive Plan coverage. Following a Qualifying 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 qualifying event that will occur in the future, you may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. You must be able to provide written documentation to support the effective date of the qualifying event at the time of Application. The effective date of this enrollment must comply with the coverage effective dates found in this section.

QUALIFYING 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 is 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 the Plan.

- 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.

- 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 that 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-enrolling a Dependent, or a Dependent becoming ineligible for Medicaid or an S-CHIP plan;

- An individual becoming ineligible under the North Carolina Medicaid Program;

- An individual or enrollee:

    - is a victim of domestic abuse or spousal abandonment, including a Dependent or

unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or

- is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.

- An individual, who was not a citizen, a national, or a lawfully present individual, gains such status.

- Or an Indian, as defined by Section 4 of 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 the 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, or placement in foster care, coverage must be effective on the date of the event.

- In the case of all other qualifying 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 the case of all other qualifying 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 are entitled to receive Covered Services from Network Providers including medical, surgical, diagnostic, therapeutic and preventive services provided in the Plan Service Area. Covered services may be subject to Your payment of Copayments, Coinsurance and any applicable Deductible as specified in the Benefit Schedule, and subject to the conditions, limitations and exclusions of this POLICY. Covered Services must also be Medically Necessary. As a Member of an HMO, You and Your 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 shall select, or have selected on his/her behalf, a Primary Care Practitioner (PCP). You must choose Your PCP by referring to the current Friday Health Plan Provider Directory or by calling the Friday Care Crew.

It is the responsibility of each Friday Health Plan's Member to provide the Plan with a change of Your mailing address within thirty-one (31) days of such address change. Changes can be made by

contacting the Friday Care Crew at 844-465-5500.

Except for Emergency Services only services which are coordinated by a Network Provider, and/or Prior Authorized 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

This plan uses a network of Participating Providers to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:

- You have a medical emergency;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or
- We authorize services out-of-network because the Medically Necessary services that you need are not available from a Network Provider.

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 Plan Network. You must receive Your 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. The Plan may authorize services to an out- of-network Provider because the Medically Necessary services that you need are not available from a Network Provider or not available from a Network Provider without an unreasonable delay. If You receive healthcare services from Non-Network Providers without authorization from the Plan, 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 the Friday Care Crew at 844-465-5500. You can also find the directory at www.fridayhealthplans.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 the Plan 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 Plan Provider Directory. The Provider Directory can be found at www.fridayhealthplans.com or call the Friday Care Crew at 844-465-5500.

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 they were treated by an In-Network Provider. The Plan will pay

the Allowable Amount.

Emergency or Urgent Care Services received from an Out-of-Network Provider will be covered at the In-Network benefit level. Payment to the Out-of-Network Provider will be based on the Plan's Allowable Amount. The Allowable Amount refers to the maximum amount of a billed charge that the Plan deems payable for covered services or supplies. For In-Network Providers, the Allowable Amount is determined by In-Network Provider contracts. For Out-of-Network Providers, such as Out-of-Network emergency room services, the Allowable Amount is the fee the Plan negotiates with the Out-of-Network Provider or the average amount the Plan would have paid for services if they were performed Network.

IMPORTANT NOTICE ABOUT SURPRISE BILLING (KNOW YOUR RIGHTS)

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 an out-of-network provider in North Carolina. For additional information, please contact the Friday Care Crew at 1-844-465-5500.

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". Out-of-network hospitals, facilities or providers often bill you the difference between what the Plan decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called 'surprise' or balance' billing.

WHEN YOU CANNOT BE BALANCED-BILLED

- Emergency Services. When You receive services for emergency medical care, for an Emergency Medical Condition usually the most You can be billed for emergency services is Your plan's in-network Cost-Sharing amounts, which are Copayments, Deductibles, and/or Coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers You may see for emergency care.

- Non-emergency services at an In-Network or Out-of-Network Facility. The hospital or facility must tell You if You are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-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.
    - A Non-Network Provider that is a facility-based Provider performing Services in a Network Facility, including as but not limited to diagnostic imaging, anesthesia, laboratory, pathology , may not be permitted to bill You for an amount greater than the applicable Copayment, Coinsurance or Deductible under Your Plan.

You have the right to request that In-Network providers perform all covered medical services. However, You may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most You can be billed for **covered**

services is your In-Network Cost-Sharing amount (Copayments, Deductibles, and/or Coinsurance). These Providers cannot balance bill you.

ADDITIONAL PROTECTIONS

1. The Plan will pay out-of-network Providers and facilities directly. Again, You are only responsible for paying your In-Network Cost Sharing for Covered Services.
2. The Plan will count any amount You pay for emergency services or certain out-of-network services (described above) toward Your in-network deductible and out-of-pocket limit.
3. Your provider, hospital, or facility must refund any amount You overpay within forty-five (45) days of You reporting the overpayment to them.

If you receive services from an out-of-network provider, 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 an out-of-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 the Friday Care Crew at 1-844-465-5500.

Ambulance Information – Non-emergency ground 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 a service covered by the Plan, 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 Prior Authorizations for specialized care the Member may need. You must select a Primary Care Provider within thirty (30) days after your Plan coverage becomes effective. 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.

The Primary Care Provider You select for Yourself may be different from the Primary Care Provider You select for each of Your Dependent(s).

Members diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may designate a specialist, with expertise in treating the disease or condition, as their Primary Care Physician. If We determine that care would not be appropriately coordinated by the designated specialist, We may deny access to that specialist as a primary care provider.

You may contact the Carrier for information for a list of the Primary Care Providers. You may contact the Carrier in writing at:

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

If you prefer, you may call the Friday Care Crew at 844-465-5500. You may also contact the Plan to see if a physician is accepting new patients.

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 Carrier for a list of the Primary Care Providers who are pediatricians. You may contact the Carrier in writing at:

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

If you prefer, you may call the Friday Care Crew at 844-465-5500.

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 part of this process, the Plan looks at whether health 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 the Certification was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage (including your voluntary termination of coverage) or nonpayment of premiums.

RIGHTS AND RESPONSIBILITIES UNDER THE UM PROGRAM

You have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for an Adverse Determination of a requested treatment or health care 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 or Your Provider to information that is needed to review the service in question.

- Request all 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 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

Friday reviews certain health services to determine whether the services are or were Medically Necessary, or Experimental/Investigational. This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Prior Authorization); while the service is 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 cases, you must obtain Prior Authorization from the Plan before you receive certain health care services, supplies or medications. Visits to a network Specialist do not require Prior Authorization, but medical and surgical procedures from any Network Provider usually do require Prior Authorization. Generally, a Participating 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. The Plan will respond to each request with either an approval or a denial. 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 Prior Authorization. The Prior Authorization request will identify the name of the Participating Provider. It will also identify the health care services to be performed by the Participating Provider, and the date(s) when the services will be performed. The Prior Written 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.

If You are actively undergoing a medically necessary course of treatment from a Provider of health care whose contract with the insurer is terminated, for reasons other than medical incompetence or professional misconduct, during the course of the medical treatment, You may continue to obtain medical treatment for the medical condition from the Provider if the Provider agrees to accept the payment terms of the terminated agreement and You receive Prior Authorization.

THE PLAN WILL PAY FOR COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION ONLY IF YOU GET A PRIOR AUTHORIZATION FROM THE PLAN BEFORE YOU GET THE SERVICES. IF YOU RECEIVE 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 Participating Providers. You should also comply with the Prior Authorization requirements. This is the case even if you are expecting another plan or a third party to pay for your health care services.

You should contact the Plan at 844-465-5500 if you are unsure if a service needs Prior Authorization before services are rendered.

PRIOR AUTHORIZATION TIMELINE

Prior Authorization requests must be received by the Plan according to the following timeframes:

- At least five (5) days prior to an elective admission as an inpatient in a hospital, skilled nursing or rehabilitation facility, or hospice facility.
- At least thirty (30) days prior to the initial evaluation for organ transplant services.
- At least thirty (30) days prior to receiving clinical trial services.
- Within twenty-four (24) hours of any inpatient admission, including emergent inpatient admissions.
- At least five (5) days prior to the start of home health care, except those members needing home health care after hospital discharge.

After prior authorization has been requested and all required or applicable documentation has been submitted, the Plan will make the determination to authorize in the following timeframe:

- 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 3 Business days after all relevant information is received.

- 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 24 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 more than 3 Business days

  - For post-service requests, within thirty (30) calendar days of receipt of the request.

EXCEPTION FOR GYNECOLOGICAL CARE

You do not need Prior Authorization for obstetrical or gynecological care from a Participating 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 Participating Providers who specialize in OB GYN or reproductive health, you may contact the Plan at this address:

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

You may also get this information from the Friday Care Crew at 844-465-5500.

EXCEPTION FOR URGENT 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. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or making referrals. 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 844-465-5500. 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 AUTHORIZATION REQUIREMENTS

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 Participating Provider.

Prior-Authorization is not required for therapy visits to a Physician, 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-Participating Provider, the Plan will not pay for such services. However, if the reason you are receiving care from a non-Participating 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 an out-of-network provider for emergency and non- emergency services, the Plan will provide disclosures concerning a covered person's financial responsibility for those services. . This also does not apply when a Non-Network Provider that is a facility-based Provider performing Services in a Network Facility, including but not limited to diagnostic imaging, anesthesia, laboratory, pathology. This is true only if You follow the other terms and conditions explained in this Evidence of Coverage.

MEMBER PORTAL

As a Member of the Plan, 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 the www.fridayhealthplans.com website, Members link (found in the ribbon at the top of the home page), then click on Member Hub, then click on member portal login (located at the bottom of the Member Hub page). You will be prompted to set up Your account, and You will need your member ID number.

LIST OF PRIOR AUTHORIZATIONS REQUIREMENTS

Service	Authorization Required	Service	Authorization Required
Acupuncture	Not covered	Allergy Testing	No

Service	Authorization Required	Service	Authorization Required
Artificial insemination	Lifetime limit of 3 cycles No auth required	Amniocentesis	No
Bariatric Surgery	Yes	Blood products	No
Biopsy – Bone Marrow	Yes	Biopsy – Breast	No
Bone Scan – 3 phase	Yes	Bone Density – DEXA only	No
BRCA	Yes	Cardiac Rehab	No auth see Limitations
Breast Pump	Member gets $250 toward purchase	Carotid Ultrasound	No
Breast Reconstruction	Yes	Cataract Surgery	No
Chemotherapy	Yes	Chiropractic	No auth see Limitations
Cleft lip/palate services/surgery	Yes	Continuous Glucose Monitor Supplies	No
Cochlear implants	Not Covered	Colonoscopy	No
Continuous Glucose Monitor	Yes	CPAP Supplies	No
CPAP	Yes	Depo Provera Injection	No
CT/CTA Scan	Yes	Diabetes Education	No
Dialysis	Yes	Diabetes Testing Supplies	No
Durable Medical Equipment (DME)	Yes, items over $500	Echocardiogram	No
EEG- Inpatient only	Yes	EGD/Endoscopy	No
Therapeutic Abortion	Yes	Epidural Injection	No
Genetic Testing	Yes	Essure	No
Hearing Aid	No auth see limitations	Holter/Event Monitor	No
Hida Scan	Yes	Hospital Admission- Observation <48hrs	No
Home Health	Yes, after first 30 visits	HPV Vaccination	No
Hospice-Home Hospice	Yes, after first 6 months	Implanon/Nexplanon	No
Hospice- Inpatient	Yes	Insulin pump supplies	No
Infertility Testing	Yes	IUD/Diaphragm	No
Injectables	Yes, for meds over $1000	Mammograms	No
Inpatient Admission-Preplanned	Yes	Maternity-Global	No
Inpatient Surgery-pre-planned	Yes	Medication port	No
Insulin Pump	Yes	Mental Health- Outpatient	No
Invitro fertilization	Not covered	Neuropsychic Testing	No
IV infusion	Yes	Nutrition Counseling	No

Service	Authorization Required	Service	Authorization Required
Mastectomy	Yes	O_2 & O_2 concentrator	No
Maternity-Dependents	Baby not covered	PICC line (all procedures)	No
Maternity-Vaginal	Notification required at admission for delivery	Pulmonary Function Test-PFT	No
Maternity- C-section	Notification required at admission for delivery	X-ray	No
Maternity- Surrogate	Not Covered	SPECT/Lexiscan	No
Mental Health- Inpatient	Yes	Stress Test	No
MRI	Yes	Tubal Ligation	No
Newborn Stay – Beyond Mom's	Notification required	Ultrasounds	No
Nuclear Medicine	Yes	Vasectomy	No
Nuclear Stress	Yes	Wound care- In office	No
Diabetic shoes	Yes	Vaccinations	No
Orthotics	Yes	PT/OT- habilitative	No auth see Limitations
Outpatient/Ambulatory Surgery	Yes	PT/OT- rehabilitative	No auth see Limitations
In-office procedures	Yes >$1000	Speech Therapy	Auth required after first 30 visits
PET Scan	Yes	Wigs for medically induced alopecia	Yes
VQ Scan	Yes		

SECTION 7: BENEFITS/COVERAGE (WHAT IS COVERED)

NORTH CAROLINA STATE MANDATED BENEFITS

The following North Carolina state mandated benefits are covered in the policy: Diagnosis and treatment of lymphedema, emergency care, minimum inpatient stay following delivery of a baby, minimum benefit offerings for alcoholism/drug abuse treatment, access to nonformulary drugs, hearing aids, bone mass measurements, prescription drug contraceptives and devices, colorectal cancer screenings, newborn hearing screening, ovarian cancer surveillance tests, mammograms and cervical cancer screening, prostate cancer screenings, reconstructive breast surgery following a mastectomy, congenital defects and abnormalities, certain clinical trials, anesthesia and hospital charges for certain dental procedures, diabetes, minimum coverage for mental illness, certain off-label use for cancer treatment and TMJ joint dysfunction.

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 still meet your Copayment, Coinsurance and/or Deductible obligations. These obligations are found in the Schedule of Benefits. The Covered Services are subject to the other limitations found in this POLICY.

A. COVERAGE FOR 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. Any adopted/fostered Children will also be covered by the Plan for the first thirty (31) days.

    - Whether the newborn fostered or adopted Child is covered for only thirty-one (31) days or is enrolled beyond the thirty-one (31) days, the family Deductible and out-of-pocket maximum is applicable to the newborn, fostered or adopted 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 Child. The hospital stay after a normal vaginal delivery will not be less than 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 than 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. Additionally, the Plan will cover circumcision for newborn males.

3. Illness and Injury During First Month of Life. Generally, the Plan will cover the treatment of your Child for illness and injury. This includes the care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one (31) days of your 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 includes medically necessary air transport to the nearest available tertiary care facility for newly born infants.

4. Cleft Lip and/or Cleft Palate. The Plan will cover the care and treatment of a 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 surgeons 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 condition 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 In born Errors of Metabolism. The Plan will provide coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well 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 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility 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 physician who is a participating provider has issued a written, oral, or electronic prescription. 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 (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 foods 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 the 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.

   You must have a prescription from a licensed health care professional with specific training in managing patients diagnosed with genetic inborn errors of metabolism.

   Coverage of medical foods, as contained herein 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 covered as medically necessary.

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 from birth until your Covered Child reaches age three (3). The North Carolina 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 has 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 service 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. The Plan provides coverage for the assessment, diagnosis, and treatment of autism spectrum. This includes treatment for the following neurobiological disorders: Autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental 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. Covered Services must be provided by a duly licensed Provider, psychologist, Behavior Analyst, licensed assistant behavior analyst, registered behavior technician or other Provider that is supervised by the licensed Provider, psychologist, or Behavior Analyst.

2. Treatment of autism spectrum disorders must be identified in a treatment Plan and may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care. The treatment Plan must meet the following criteria:

    - Prescribed for a person diagnosed with an autism spectrum disorder by a licensed Provider or licensed psychologist; and provided for a person diagnosed with an autism spectrum disorder by a licensed Provider, licensed psychologist, licensed behavior analyst or other Provider that is supervised by the licensed Provider, psychologist, or behavior analyst.

3. Limitations: 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.

2. Annual Limitation. Each Year, the Plan will pay for up to thirty (30) visits for combined therapies (physical, occupational and speech) for the Covered Child. The therapy visits must be distributed as medically appropriate throughout the Plan Year. They will be distributed without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

3. Congenital Conditions Involving any Bone or Joint of the Face of Head
   For medically necessary procedures involving any bone or joint of the face or head used to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, illness, or bodily injury.

    - Therapeutic procedures include splinting, intraoral prosthetic appliances used to reposition the bones or any other Coverage for medically necessary procedures involving any bone or joint of the jaw, face, or nonsurgical treatment of temporomandibular joint dysfunction.

    - Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

E. CHILD SPEECH AND HEARING BENEFITS

1. Speech Therapy. If a Covered Child experiences a speech delay, the Plan will cover up to thirty (30) 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 Exams: The Plan will cover routine hearing exams for a Covered Child who is under the age of the end of the month that the Child turns twenty-two (22). The Plan will cover hearing tests in support of a diagnosis and medically covered condition. The Plan does not include audiometry and tympanogram not in support of a diagnosis.

3. Hearing Aids: Coverage is provided for purchase, repair, and replacement of one (1) Medically Necessary hearing aid, once every three years regardless of age. 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.

4. Exclusions: Bone anchored hearing aids are excluded except when either of the following applies: a) Member's with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) Member's with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

5. Limitations: The Plan will cover the hearing aids 1 per ear every 36 months.

F. CHILD DENTAL AND VISION BENEFITS

1. Hospitalization/Anesthesia for Dental Procedures. The Plan will 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 Dependent on 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.

- Be under the age of nine (9) and need dental care.

2. Pediatric Dental Care. A pediatric dental benefit is not included in the Plan's benefit design. That benefit is available to purchase separately through the Plan as a stand-alone benefit.

    - Initial treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue) is a covered benefit. To be eligible, the Initial dental work to repair accidental injuries to sound teeth must be requested within sixty (60) days from the onset of injury and are performed within six (6) months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

3. Pediatric Vision Care. The Plan will cover one vision exam each Plan Year for a Covered Child until the end of the month that the Child turns twenty-one (21)for services rendered by an optometrists, therapeutic optometrists, and ophthalmologists. Eyeglasses for a Covered Child will be covered for 1 pair every 12 months and includes either eyeglasses frames and lenses or contact lenses. Ultraviolet Protective Coating, Polycarbonate, Lenses (if not child, monocular or prescription >+/-6.00 diopters), Blended Segment Lenses, Intermediate Vision, Lenses, Standard Progressives, Premium Progressives, Photochromic Glass Lenses, Plastic Photosensitive Lenses, Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating , Hi-Index Lenses, Contact Lenses: covered once every calendar year –in lieu of eyeglasses and Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism. And for low vision: one comprehensive low vision evaluation every 5 years. The Plan will also cover low vision aids.

G. SPECIAL PREVENTIVE SERVICES WITH NO COST-SHARING

1. How No Cost-Sharing Applies. When you or your Covered Dependents receive certain preventive 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 with a Participating Provider for more than one reason, the Participating Provider may bill for each reason separately. In that case, if the primary reason of the service is the delivery of the preventive service or item, then no office visit Copayment or other cost-sharing requirement will be imposed. If the primary billed reason of the service is not the delivery of the preventive service or item, then the office visit 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. Preventive Services. The Plan will pay for the preventive services, based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF). The Plan reviews the A and B recommendations throughout the plan year. If the USPSTF makes a change to its A and B recommendations, then those changes will be reflected in the benefits of the following plan year. Below is a partial list of the A and B recommendations that the Plan will cover at no cost.

    a. Office Screenings

    - Alcohol misuse screening and behavioral counseling interventions for adults.
    - Cervical cancer screening; if a cervical cancer screening test turns into a diagnostic procedure, then the plan's deductible and coinsurance will apply.
    - Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Physician.
    - Preventive care and screenings established by the Patient Protection and Affordable Care Act (PPACA) and/or Health Resources and Services Administration (HRSA) for infants, children adolescents and women as required by Federal law.
    - Smoking Cessation Program - the Plan will cover smoking cessation programs including screening, intervention services, behavioral interventions and prescription drugs. The Plan will cover two quit attempts per year. The Plan will cover at least four sessions of individual, group or telephone cessation counseling. The smoking cessation program includes all FDA- approved tobacco cessation medications (nicotine patch, gum, lozenge, nasal spray and inhaler; bupropion and varenicline). The smoking cessation services must be provided by a Participating Provider or be an approved Plan program. There is no cost-sharing or prior authorization requirements for these smoking cessation programs. You can access Quitline by calling 1-800-QUIT-NOW/1-800-784-8669.
        - Nicotine gum
        - Nicotine patch
        - Nicotine lozenge
        - Nicotine oral or nasal spray - Nicotine inhaler - Bupropion
            - Coverage for Primary Care Providers to provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.
    - Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged fifty (50) to fifty-nine (59) years who

have a 10% or greater ten (10) year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least ten (10) years, and are willing to take low-dose aspirin daily for at least ten (10) years.

- Screening for high blood pressure in adults aged eighteen (18) years or older.

- Screening for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.

- Screening for latent tuberculosis infection (LTBI) in populations at increased risk.

b. Imaging or Procedural Screenings

- One Breast cancer screening with mammography per Plan Year, covering the actual charge of the screening with mammography.

    - Benefits for preventive mammography screenings are determined on a Policy Year basis. These preventive 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.

    - The Plan follows the recommendations of the American College of Obstetricians and Gynecologist (ACOG) guidelines for breast cancer screening which recommend screening earlier and more frequent than USPSTF. Mammogram preventive benefits include one baseline mammogram to persons age thirty-five through thirty-nine. One mammogram and clinical breast exam once a year for female Enrollees who is at least forty (40) years of age One mammogram and clinical breast exam starting at ages between thirty-five (35) and forty (40) for BRACA ½ carriers. If or Enrollee with family members with cancer or female Enrollee with at least one risk factor for breast cancer, they may receive one mammogram and clinical breast exam starting at age twenty-five (25).

        - Coverage for clinicians to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

    - Screening for depression in the general adult population, including pregnant and postpartum women.

        - Screening for major depressive disorder (MDD) in adolescents aged twelve (12) to eighteen (18) years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

- Interventions during pregnancy and after birth to support breastfeeding.

- Coverage for a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for women who are planning or capable of pregnancy.

- Screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after twenty-four (24) weeks of gestation.

- Screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.

- Screening for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.

- Screening for unhealthy alcohol use in primary care settings in adults eighteen (18) years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

- Low-dose aspirin (81 mg/d) as preventive medication after twelve (12) weeks of gestation in women who are at high risk for preeclampsia.

- Rh(D) antibody testing for all unsensitized Rh(D)-negative women at twenty-four (24) to twenty-eight (28) weeks' gestation, unless the biological father is known to be Rh(D)-negative.

- Early screening for syphilis infection in all pregnant women.

  - Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps starting at age forty-five (45) If a colorectal cancer screening turns into a diagnostic procedure, such as the removal of Polyps, then 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 based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF), the Plan will cover 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 turns into a diagnostic procedure, then the Plan's deductible and coinsurance will apply.

- If a Colorectal cancer screening turns into a diagnostic procedure, then the plan's deductible and coinsurance will apply.

- One (1)-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged sixty-five (65) to seventy-five (75) years who have ever smoked.

- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

- 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 past fifteen (15) years. Screening should be discontinued once a person has not smoked for fifteen (15) years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

- "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

- Ovarian Cancer Screening for female Members ages twenty-five (25) and older at risk for ovarian cancer. Coverage includes an annual screening, a transvaginal ultrasound and a rectovaginal pelvic examination. A female Member is considered "at risk" if 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.

- Currently the Food and Drug Administration (FDA) has approved eighteen (18) different methods of contraception. Please contact the Plan for the methods that are approved for not cost sharing.

- Scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis. Bone density testing does

not require a Prior Authorization.

c. Laboratory Testing

- The USPSTF recommends screening women and men aged twenty (20) or older for lipid disorders if they are at increased risk for coronary heart disease.

- Cholesterol screening for lipid disorders.

- The USPSTF recommends screening for cervical cancer in women aged twenty-one (21) to twenty-nine (29) years with cervical cytology (Pap smear) alone every three (3) years or, for women age thirty (30) to sixty-five (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 five (5) years.

- Cervical cancer screening for immunosuppressed Enrollees may be as frequent as once a year.

- Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged forty (40) to seventy (70) years who are overweight or obese.
- Screening for gonorrhea and/or chlamydia and/or syphilis in sexually active women aged twenty-four (24) years and younger and in older women who are at increased risk for infection.

- Screening for hepatitis B virus (HBV) infection in persons at high risk for infection.

- Screening for hepatitis C virus (HCV) infection in adults aged eighteen (18) to seventy-nine (79) years.

- Screening for HIV infection 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.

3. 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.

- Pneumococcal vaccinations pursuant to the schedule established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).

- Child health supervision services (for any Covered Child under age thirteen (13)), and childhood immunizations based on the schedule established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and

Prevention (ACIP).

- Influenza vaccinations pursuant to the schedule established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).

4. Any other preventive services that are included in the A or B recommendations of the United States Preventive 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 of North Carolina, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If you prefer, you may call the Friday Care Crew at 844-465-5500.

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 coverage 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 behaviors, 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 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) home 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 Women: When provided by a Participating Provider, the Plan will cover a yearly breast and pelvic exam and PAP test. The Plan will also cover a 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

   - One mammogram and clinical breast exam annually between thirty (35) and forty (40) for BRACA ½ carriers or ten (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 20%. This determination must be made by the Enrollee's Primary Care Provider).

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

5. For Adult Men: When provided by a Participating Provider, the Plan will cover screening for the early detection of prostate cancer as follows:

   - One screening per year for any male Enrollee as determined by a Participating Provider.
   - The prostate screening may include the following tests:
     - a prostate-specific antigen ("PSA") blood test; and
     - a digital rectal examination.

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

Limitations on Services and Examinations. Some services completed within your office visit such as The Plan will not cover all services performed during scheduled physical examinations. For example, the Plan will generally not cover services such as stress tests, 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.

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. OTHER 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.

    - Other Professional Providers - A person or entity other than a Doctor who is accredited and licensed or certified in the state where they are located to provide covered services, and which is acceptable to the Plan. Examples may include physician assistants (PAs), nurse practitioners (NPs), Podiatrist, or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement

1. Telehealth. The plan will cover Telehealth services. The Plan will reimburse the treating Participating Provider or the consulting participating provider for the diagnosis, consultation, or treatment of the Member delivered through Telehealth on the same basis that the Plan is responsible for reimbursing that provider for the provision of the same service through in-person consultations or contact by that Participating Provider. Your copay/coinsurance/deductible shall apply in the same manner as it would for an in-person like service.

    The Plan will include a reasonable compensation to the originating site for the transmission cost incurred through telehealth delivered by a contracted Participating Provider, except that, 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.

    Telehealth means a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Member’s health care while the Member is located at an originating site and the Participating Provider is located at a distant site. "Telehealth" does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

2. Home Visits. The Plan will cover Medically Necessary visits by the Member's Primary Care Provider to the Member's home within the Service Area.

3. Smoking Cessation Program. The Plan will cover smoking cessation programs including screening, intervention services, behavioral interventions, and prescription drugs. This is true even if the Deductible has not been met. The program must be provided by a Participating Provider or be an approved Plan program.

4. Specialty Physician Services. The Plan will cover services of a Participating Provider with no authorization. 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, including radiology (X-ray); pathology; laboratory tests; and other imaging and 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.

6. Blood. The plan will cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a member's own blood only when it is stored and used for a previously scheduled procedure.

7. 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, a Physician'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, an independent practice association, or other authority as applicable by state law. Prior Authorization is required.

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. Special Right to Reconstructive Breast Surgery. If an 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 Cancer Rights Act. Coverage will include:

    - Reconstruction of the breast on which the mastectomy was performed;

    - Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prosthesis and physical complication for all stages of the mastectomy, including lymphedemas

These benefits are subject to any Copayments, Deductibles and Coinsurance obligations applicable to any other Plan coverage. These benefits are available without regard to any time lapse from the Member's mastectomy.

10. Sterilization Services- The Plan will cover female and male sterilizations procedures such as vasectomies and tubal ligations and occlusions.
11. 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 Participating Provider urgent care center within the Service Area. The Plan also covers Urgent Care Services outside the services area if Medically Necessary and are of an urgent nature. If an out-of-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.

12. Testing and treatment of COVID-19, as required by applicable Federal or North Carolina bulletins, laws or regulations.

13. Sickle Cell Disease and Its Variants

- Your Plan includes benefits for treatment of 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/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 determine 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 solely for research, or for the benefit of individuals not covered under the Policy.

2. Covered Services also include the explanation by a genetic counselor of 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 an appropriately certified genetic counselor and/or, in our discretion, as approved by a Physician 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 ultrasound tests 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 Parents 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 heritable disorders as Medically Necessary when the following conditions 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 heritable disease; and

    - One of the following conditions is met:

        i. The Member demonstrates signs/symptoms of a genetically linked heritable disease; or

        ii. The Member or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

    Additional genetic testing will be covered as required by Federal or state mandates.

    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.

7. Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, 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 or state law.

K. HOSPITAL INPATIENT SERVICES

1. Standard. Generally, the Plan will cover Medically Necessary hospital inpatient services. However, the Enrollee must obtain Prior Authorization from the Plan before his/her hospital stay. The Plan will also cover a hospital stay that results from a Medical Emergency. However, the Enrollee must comply with the requirements described in the section below relating to Emergency Services.

2. General Coverage. Inpatient Hospital Services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral 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 covered person's primary care practitioner or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary. In addition, Inpatient Hospital Services include the use of operating room and related facilities; intensive care unit and services; X-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia and oxygen services; 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 also 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.

4. Bariatric Surgery. Medically Necessary surgery is covered. You must meet Plans criteria to be eligible for this service and it is only covered through programs meeting Plan criteria as 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.

   Limitations: Bariatric Restrictive Services are covered when all of the following have been determined and are limited to one procedure every three years:

i. The Member must have either:

- BMI ≥ 40 kg/m2 without co-morbidities;
- BMI ≥ 35 kg/m2 and a high-risk obesity-related condition or a combination of three 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 gynecologic abnormalities.
    - Must be at least eighteen (18) years of age.
    - 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.

ii. 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 included 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 6-month period.
- Failure of less invasive methods is determined by the Plan Medical Director and his/her designee.

iii. Member has been obese for at least five (5) years;

iv. If Member is diabetic, disease is controlled;

v. Member must have the capacity to be compliant with post-surgical treatment or follow-up requirements, which may include a psychiatric or behavioral evaluation;

vi. Procedures must be performed at an In-Network Facility unless pre-approved by Friday Health Plans to be performed at an Out-of-Network Facility Facility/Provider; and

vii. Tobacco free for eight (8) weeks prior to the surgery

L. MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT

1. General Coverage. Outpatient treatment for diagnostic and therapeutic behavioral/mental health services are covered without a Prior-Authorization UNLESS You are seeking services from a Non-Network Provider. Some services do require Prior Authorization by the Plan. Please refer to Your Summary of Benefits and Coverage for level of Covered Services.

   Inpatient and outpatient Medically Necessary mental health services are covered by the Plan. 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 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 twenty-four (24)-hour medical availability and twenty-four (24)-hour on-site nursing service. Such facilities and programs exclude half-way houses, supervised living arrangements, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs.

2. Outpatient Mental Health Care. The Plan will cover outpatient mental health visits in the same manner that it covers other outpatient visits. This included coverage for biofeedback.

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 that results 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 with no prior authorization.

5. Inpatient and Residential Chemical Dependency/Substance Abuse Treatment. Like other inpatient care, the Plan will cover Medically Necessary inpatient or thirty (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 that results from a Medical Emergency. However, you must comply with the requirements described in the Section below relating to Emergency Services.

M. DURABLE MEDICAL EQUIPMENT

1. General Coverage: With respect to durable medical equipment, the Plan will cover an Enrollee's rental; purchase; maintenance or repair, when necessary due 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 or distributed through a Participating Provider hospital or other Participating Provider. Prior Authorization is also required. Durable Medical Equipment is authorized following applicable Medicare statutory and regulatory requirements, unless otherwise established in this document.

2. Limitations: Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.

   Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, hearing aids, and any other primarily non-medical equipment, except as otherwise covered and described within this document.

   Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by a Professional to treat a medical condition).

3. Prosthetic Arms and/or Legs: The Plan will cover an 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 allowed rates minus an amount equivalent to the Medicare Part B Deductible as of January 1 of each Plan Year. Qualified High Deductible Health Plans (HAS qualified Plans) and Catastrophic Plans will have the medical Deductible applied, as required under federal law. If a non-Contracted Provider is used the Benefit 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 Participating 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.

   i. 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 every three (3) years.

   Coverage is limited to:

   ii. Devices that are required to substitute for the missing or non-functioning body part

or organ;

iii. Devices provided in connection to an Illness or Injury that occurred subsequent to Your effective date of coverage;

iv. Adjustment of initial prosthetic device; and

v. The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.

vi. Orthotic devices to treat positional plagiocephaly

Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

4. Orthotics: Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form 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 use and arch supports, except for diabetic shoes, are not covered. Orthotics are limited to one item every three years.

5. Breast Pumps: Breast pump rentals are covered. Purchase of Plan approved breast pumps are covered.

6. 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 Physician; 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 Physician.

Foods obtained from a grocery store or internet Provider will not be covered as Special Medical Foods.

7. Compression devices- The plan will cover custom compression devices (non-disposal) for lymphedema.

N. EMERGENCY SERVICES

1. Standard. An Emergency Medical Condition that qualifies for 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, the loss of a 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 in 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 not a Participating Provider Please see definition of Emergency and Urgent Care Services.

Emergency and urgent care services shall include:

(1) acute medical care that is available twenty-four hours per day, seven 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 area or out-of-network coverage in cases where the covered person cannot reasonably access in-network services or facilities.

(2) 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 judgment of the attending physician or health care professional in consultation with the Plan;

(3) Reimbursement for emergency care and emergency transportation shall not be denied by 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 in above, a Medical Emergency is limited to certain situations. There must be sudden and severe medical condition (including severe pain). The condition must 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 of the Enrollee or her unborn child) in serious danger;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Enrollee Costs. If an Enrollee receives emergency care from a non-Participating Provider,

the Enrollee's Copayment amount and Coinsurance amount will be the same as if a Participating Provider had treated the Enrollee.

3. Plan Notification Required. The Enrollee must notify the Plan of any Medical Emergency. The Enrollee must do so on the first business day after 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 received 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 on the first business day following the hospital admission, or as soon as medically possible. If 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 able to notify the Plan or instruct some other person to notify the Plan. If the Enrollee is conscious and able to communicate with others, the Enrollee will be treated as able to notify the Plan.

4. 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, intrapartum, perinatal, 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 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, between sixteen and twenty 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 the Enrollee's pregnancy or childbirth.

4. Hospitalization for Delivery. The Plan will cover the Enrollee's hospitalization for delivery. The hospital stay following a normal vaginal delivery will not be less than forty-eight (48) hours. If forty-eight hours (48) ends after 8 p.m., coverage will continue until 8 a.m. the following morning. The hospital stay following a caesarean section will not be less than ninety- six (96) hours. If ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the following morning. These timeframes could be less at the discretion of the attending physician and the Member. If the mother and child are discharged prior to 48

hours following delivery, then one newborn visit within the first week of life will be covered. Breast Pumps: Breast pump rentals are covered. Purchase of 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 Participating 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 and treatment of involuntary infertility and artificial insemination, up to three (3) cycles per Member per Lifetime. Artificial insemination services do not include donor semen, donor eggs and services related to their procurement and storage. See additional information under Limitations and Exclusions.

3. Prescription drugs: The Plan covers certain prescriptions related to infertility treatment. Please see the Plan's formulary for a list and conditions of coverage of these medications.

4. Contraceptive Coverage. Currently the food and Drug Administration (FDA) has approved eighteen (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.

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 Participating Provider. Services will include visits to the Enrollee by Participating Providers. Visits will be limited to the usual and customary time required to perform the particular services.

2. Coverage is provided for:

    a. Part-time or intermittent home nursing care for:

        i. Skilled nursing care under the supervision of a Registered Nurse (RN);

        ii. Certified Home health aide services under the supervision of an RN or therapist;

        iii. Private Duty Nursing

        iv. Medical social services by a licensed social worker;

b. Infusion services;

c. Physical, occupational, pulmonary, respiratory and speech therapies;

d. Nutritional counseling by a nutritionist or dietitian;

e. Audiology services;

f. Medical supplies and lab services that would be covered if Enrollee were an inpatient at a hospital;

g. Prosthesis and orthopedic appliances

h. 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 as 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 twenty-eight (28) hours a week.

- Home Health Care does not include personal care, custodial care, domiciliary care, or homemaker services, In-home services provided by certified nurse aides or home health aides, or over-the counter medical equipment, over-the-counter supplies, or any Prescription Drugs, except to the extent that they are covered elsewhere in this document.

- Home Health Services require Prior Authorization after the first thirty (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; liver; kidney; pancreas for uremic insulin - dependent diabetics concurrently receiving a kidney transplant; 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 in that event

the high dose chemotherapy is covered); 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 costs directly relating to the search, and 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

5. Travel and Lodging Expenses: The Plan will cover costs for travel and lodging expenses. These expenses will only be reimbursed with an approved authorization for the transplant as outlined above. Members must submit for reimbursement with receipts to the Friday Care Crew via email questions@fridayhealthplans.com or mail at:
   Friday Health Plans
   Attn: Accounts Payable
   700 Main St
   Alamosa, CO 81101

6. Exclusions. The purchase price of the organ or tissue is sold rather than donated to the recipient Member. The procurement of organs, tissue, bone marrow, or peripheral blood stem cells or any other donor services if the recipient is not a Member.

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 this Policy 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 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 for three (3) benefit periods (if needed). 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 services do not include homemaker services, such as cooking, housekeeping, and food or meal preparation.
- 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 or 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 is approved by the physician or practitioner 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:

    a) Diabetes Equipment

        i. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);

        ii. Insulin pumps (both external and implantable) and associated appurtenances, which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, and durable and disposable devices to assist in the injection of insulin; and

        iii. Podiatric appliances, including up to two (2) pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

    b) Diabetes Supplies

        i. Test strips specified for use with a corresponding blood glucose monitor, lancets and lancet devices, visual reading strips and urine testing strips and tablets;

        ii. Insulin and insulin analog preparations; Injection aids, including devices used to assist with insulin injection and needleless systems, insulin syringes;

        iii. Biohazard disposable containers;

        iv. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and

        v. Glucagon emergency kits.

    c) 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 Contract 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. Skilled Nursing Care. The Plan will cover an Enrollee's Inpatient skilled nursing services. Such services must be provided in a Participating Provider for inpatient skilled nursing facility. These services also require Prior Authorization. Coverage by the Plan is limited to sixty (60) days per Plan Year. This sixty (60) day limit is a combined limit that includes all days in skilled nursing facilities, inpatient rehabilitation facilities, and sub-acute facilities.

3. 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 sixty (60) days of inpatient services per plan year, and thirty (30) outpatient visits for physical, occupational, and chiropractic therapy combined. Speech therapy has a separate limit of thirty (30) therapy visits 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.

    - Rehabilitative services include cardiac rehabilitation and pulmonary rehabilitation – see below for benefit details.

4. 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-language pathology; and other services for Enrollees with disabilities. Inpatient

    a. Habilitative services do not 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.

    b. Habilitation Services limited to thirty (30) visits per year for combined therapies (phycial, occupational and chiropractic).

    c. 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.".

5. Cardiac Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Physician and provided by participating therapists at participating facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists

of an initial evaluation, no more than eighteen (18) cardiac rehabilitation exercise and counseling sessions and a final evaluation to be completed within a six-month period.

6. Pulmonary Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Physician and provided by participating therapists at participating 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.

7. Continuing Care. If an Enrollee is hospitalized within a non-Participating Provider 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-Participating Provider hospital is willing to accept payment from the Plan at the rates payable to Participating Providers. All other limitations and conditions of the Plan would apply.

8. 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 Participating 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 accepted medical standards and the frequency of services.

9. 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 causing significant respiratory or ingestive dysfunction. and other disorders of the bones and joints of the jaw, face, or head;

        - Medical services for TMJ and other disorders of the bones and joints of the jaw, face, and head are covered on the same basis as any other medical condition. Dental services (i.e., dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e., braces and other orthodontic appliances) are not covered by this POLICY for any diagnosis.

    - Initial treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue. To be eligible, the Initial dental work to repair accidental injuries to sound teeth must be requested within sixty (60) days from

the onset of injury and are performed within 6 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair.

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

The Plan will 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. However, in order for coverage to apply, the Member 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.

10. 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 twenty-six (26) years of age.

11. 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 tympanogram, not in support of a diagnosis.
    a. Hearing Aids: Coverage is provided for the purchase, repair, and replacement of one (1) Medically Necessary hearing aid, once every three years regardless of age. 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.
    b. Exclusions: Bone anchored hearing aids are excluded except when either of the following applies: a) Members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) Members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
    c. Limitations: The Plan will cover the hearing aids 1 per ear every 36 months.

12. Routine foot care (including treatment for corns, calluses, and cutting of nails). All routine Foot care including but not limited to treatment for flat feet; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.

13. Prescription Drugs. Prescription drugs are covered under your benefit plan as follows:

- Inpatient prescription drugs approved by the United States Food & Drug Administration (FDA) are 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 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 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 criteria specified in the ODA and FDA's implementing regulations at 21 CFR Part 316.

    - Only outpatient prescription drugs related to Emergency Care or 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 90 days of purchase.

    - Outpatient prescription drugs from an in-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 for use in treatment of cancer will not be excluded or restricted if the drug:

        - Is approved by the federal Food and Drug Administration,

        - Has been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

            (1) The National Comprehensive Cancer Network Drugs & Biologics Compendium;

            (2) The Thomson Micromedex Drug Dex;

(3) The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

- Will be used to treat Covered Services.

- Exclusion – The Plan does not cover off-label experimental or investigational off-label cancer drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

- 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.

- You cannot refill a prescription until three-fourths of the time period has passed or twenty-one (21) days of a 30-day –prescription that the prescription was intended to cover, or when the full time period has passed that the prescription was intended to cover if quantity limits apply.

    - The above refill requirement is true except during a government-declared state of emergency or disaster in the county in which you reside. A refill of a prescription with quantity limitations may consider the proportionate dosage use prior to the disaster.

- 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. This is waived if the Prescribing Provider designates the prescription to be dispensed as written and there is a medical reason a generic drug does not meet the medical needs of the Member.

  The difference will not apply to the deductible or the out-of-pocket maximum.

- Coverage for a renewal of prescription eye drops is covered if
    - The renewal is requested by the insured at least twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-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 of 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 months. The prescription eye drops benefits covered under this section are subject to the same annual deductibles, copayment, or coinsurance established for all other prescription drug benefits under the health 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 Plan participants use clinically appropriate drugs in a cost-effective manner.

  Step therapy protocols/algorithms are developed based on current medical findings, FDA approved drug 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).

  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.

- Formulary Exceptions - 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, Your designee, or Your provider may request an appeal of the decision. For more information about the appeal process, please see appeals and grievances section of this document, or call the 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 specified 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 drug you already bought.

- 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. You, your designee, or your physician may request access to clinically appropriate drugs not otherwise covered by the Plan through a special exceptions process. If the exceptions request is granted, we will provide coverage of the non- formulary drug for the duration of the prescription. If the exceptions request is 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.

- Health 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 opioid dependence; except that this requirement is limited to a first request within a twelve-month period.

- For additional information about the prescription drug exceptions processes

for drugs not included in the Plan's formulary, please contact the Plan's the Friday Care Crew 844-465-5500.

14. 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 is 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 only upon a finding that it 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 medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not 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 from applying an appropriate Formulary or clinical management to any medication described in this section.

15. Routine Care During Clinical Trials. Covered Services may be eligible for coverage when received in connection with a clinical trial (Phases I-IV) 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 trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probably unless the course of the condition is interrupted), as determined in one of the following ways:

        - A Participating Provider makes this determination and the Plan's Medical Director agrees.

        - You provide us with medical and scientific information establishing this criterion and it is approved by the Plan's Medical Director.

    - If any Participating 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 Participating 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 with a copy of the signed clinical trial statement.

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 the 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 directly 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 used in the clinical trial or 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 purposes 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 of the patient; items and services customarily provided by the 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.

16. Transgender Services Friday Health Plans assures member and Provider that any request for treatment of gender dysphoria is reviewed in a consistent manner and in accordance with accreditation agency standards, state and federal regulations and statutes.

    a) Coverage for transgender services may include:

        i. Pharmacological support: Please see the Plans pharmacy formulary or contact the Plan for more information.

        ii. Surgical Procedures:

            - Male to Female transition:

                - Intersex surgery, Clitoroplasty, Introitus plastic repair, Labiaplasty, Mammoplasty with implant, Nipple areola reconstruction, Orchiectomy, Penectomy, Prostatectomy, Vagina/Perineum reconstruction, Urethroplasty, Vaginoplasty, Vulvoplasty, Phalloplasty.

            - Female to Male transition:

                - 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.

    b) Limitations: services not covered by the are listed below but not limited to:

        i. Abdominoplasty, Blepharoplasty, Calf implant, Cheek, Chin or 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.

17. Sexual Dysfunction Services This Policy provides benefits for certain services related to the diagnosis, treatment, and correction of any underlying causes of Sexual Dysfunction for all Members.
18. Lymphedema-Related Services - Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice.

    - Benefits include Medically Necessary equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only with a PRESCRIPTION and when custom-fit for the patient.

    - Lymphedema benefits excludes over-the-counter compression or elastic knee-high or other stocking products.

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-Participating 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 of the Service Area (by a non-Participating 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 Participating 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 when 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 healthcare provider,” or an authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Services

2. 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. Chiropractic services are limited to 30 visits per year. The thirty (30) visit limit includes all Chiropractic visit, physical rehabilitation visits and visits for occupational therapy.

2. Exclusions related to Chiropractic care are as follows:

    a) Hypnotherapy

    b) Behavior training

    c) Sleep therapy

    d) Weight loss programs

    e) Services not related to the treatment of musculoskeletal system

    f) Vocational rehabilitation services

    g) Thermography

    h) Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances

    i) Transportation costs which include local ambulance charges

    j) Prescriptions drugs, vitamins, minerals, food supplements or other similar products

    k) Educational programs

    l) Non-medical self-care or self-help training

    m) All diagnostic testing related to these excluded services

    n) MRI and/or other types of diagnostic radiology

    o) Physical or massage therapy that is not a part of the chiropractic treatment

    p) Durable medical equipment (DME) and/or supplies for use in the home

q) 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 (days or visits) identified in this Policy.

4. Cochlear implants.

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

6. Services by a non-Network Provider, except in the case of a Member's Medical Emergency, the Member's need for urgent care outside the service area, the services are not reasonably available from an In-Network Practitioner/Provider and the Plan provides a Referral to the non-Network Provider or the services of an Non- Network provider is done in conjunction with services at a an In-Network facility
7. Services or supplies for any illness, condition or injury received while incarcerated in a county, State or Federal penal facility.

8. A private room or services, other than as Medically Necessary, when an Enrollee is an inpatient in a hospital.

9. Services of any provider other than 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 laws of the State of North Carolina. Examples of providers whose services are not covered include but are not limited to physiologists, homeopaths, naturopaths, rolfers, religious practitioners, and hypnotherapists.

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

11. Services performed in connection with treatment to teeth or gums; upper or lower augmentation or reduction or cosmetic reconstruction; or orthognathic surgery. These services include treatment for disorders of the temporomandibular joint, regardless of the cause, except those services specifically covered under this Policy. All dental services not identified in this Policy. Treatment of disease or pain related to temporomandibular joint dysfunction, except those services specifically covered under this Policy. General anesthesia for dental procedures except those services specifically covered under this Policy.

12. Any non-surgical (dental restorations, orthodontics, or physical therapy) or nondiagnostic

services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.

13. Nursing homes and custodial care.

14. Eye refractions or examinations, except as specifically covered under this Policy. Eyeglasses and all other types of vision hardware or vision corrective appliances, except those covered for children under the age of nineteen (19). This includes contact lenses; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy; and clear lensectomy.

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

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

17. 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.

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

19. Batteries not for use in implantable medical devices. Physician equipment such as sphygmomanometers, stethoscopes, etc.

20. All disposable, non-prescription, or over-the-counter supplies. This includes items such as ace bandages and splints; exercise and hygiene equipment; corrective shoes and arch supports; 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.

21. 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. This includes, but not limited to, breast implants except covered implant after mastectomy due to breast cancer. The Plan shall have sole discretion to determine whether the services are likely to result in significant improvement in function.

22. Cosmetic products; health and beauty aids; and services and medications related to the

diagnosis and treatment of, or to reverse 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.

23. 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.

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

25. All military service-connected conditions.

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

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

28. All services and supplies (other than artificial insemination) 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 invitro fertilization, ovum transplants, zygote intra fallopian transfer and gamete intrafallopian transfer procedures are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

29. Infertility/Reproduction The following Infertility and Reproductive services are not covered by the Plan:

    - Donor semen, donor eggs and services related to their procurement and storage;
    - GIFT procedures;
    - Foams and condoms;
    - Services and supplies related to conception by artificial means. This means prescription drugs related to such services, such as but not limited to in vitro fertilization, embryo or ovum transplants, gamete intra fallopian transfers and zygote intra fallopian transfers.

    These exclusions apply to fertile as well as infertile individuals or couples.

    - Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

- Surrogate parenting, donor eggs, donor sperm, and host uterus.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue, and ovarian tissue;
- Fetal reduction surgery; and
- Genetic testing of embryos pre or post implantation.

30. Complications caused by treatment of infertility.

31. Elective abortions except when the pregnancy is a result of rape, incest or the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from pregnancy itself.

32. Treatment and rehabilitation services for obesity; weight-loss educational services; diet supplements except as specifically covered herein.

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

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

35. Transplants disapproved by the appropriate evaluation committee.

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

37. Diagnosis and treatment for mental retardation; learning or behavioral disorders, psychosocial 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.

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

39. Long term rehabilitative services.

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

41. Genetic testing, counseling, or engineering, unless otherwise stated in this document.

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

43. Bone and eye bank charges.

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

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

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

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

48. Over the Counter drugs other than insulin.

49. Certain injectables obtained through a pharmacy (other than insulin) except as covered on the formulary or as otherwise stated in this Policy.

50. Prescription drugs that have an over-the-counter equivalent (e.g., Monistat 7, Disobrom, etc.) except as covered on the formulary.

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

52. Drugs or injections for treatment of involuntary infertility are not covered except as covered on the formulary or as otherwise stated in this Policy.

53. Abortifacient drugs are not covered unless medically necessary or as otherwise covered in the Policy or on the formulary.

54. Compounded medications/prescriptions are not covered.

55. Medications with no approved indications.

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

57. 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.

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

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

60. Hair analysis.

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 Participating Provider.

63. Services not rendered in accordance with Plan policies and procedures. Services rendered by non-participating 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 if 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. Any and all costs related to surrogate pregnancies and deliveries of non-members are excluded.

66. 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 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.

PREMIUM PAYMENTS FROM THIRD-PARTY PAYORS

The Plan requires each policy holder to pay his or her applicable Premiums, and does not, in general, accept payment from third-party payers. Consistent with Federal guidance, the following are the only acceptable third-party payers who may pay premiums on your behalf:

- Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations, or urban Indian organizations;
- State and Federal government programs; or
- Family members.

The Plan will not accept payment from third-party payers other than those listed above.

PAYMENTS OUTLINED IN THE SCHEDULE OF BENEFITS

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 for any health care services that do not qualify as Covered Services. Finally, in most cases, you will be required to pay for those health care services that you receive from a health care provider who/which is not a Participating Provider, and for those health care services that were provided without Prior Authorization from the Plan. In most cases, services that do not qualify as Covered Services, services received from a non-Network Provider or services 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-Plan Providers and/or services provided without Prior Authorization even if your Out-of-Pocket Maximum has been met.

RECOVERY RIGHTS OF THE PLAN

RIGHT TO OFFSET FUTURE PAYMENTS

If the Plan sends you or your Covered Dependent a payment by mistake, or the Plan overpays an amount owed to you or your Covered Dependent, 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 in any other manner.

ASSIGNMENT OF RIGHTS

You may not assign (transfer) any of your rights 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 to Your healthcare Provider.).

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. You will be responsible for Your Annual Deductible, Copayments and Coinsurance. The health care Provider can do this because the Plan's information is set forth on your identification card. Although You are usually required to pay Copayments at the time the service is delivered, any fees for the Deductible or Coinsurance will be billed to the member at a later date. The bill from the Provider for Deductible or Coinsurance should be checked against the Explanation of Benefits that You will receive from the Plan once the Plan completes its adjudication of the Claim. If there is a discrepancy between the Provider Bill

charges and Your Explanation of Benefits, then please contact the Friday Care Crew to discuss.

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 should submit a Written Notice of Claim to the Plan. The Written Notice of Claim should contain information sufficient to identify the insured and a brief statement about the Claim. The Written Notice of Claim must be given to the Plan within twenty (20) days after any loss that would be covered by the policy, or as soon possible for extenuating circumstances. 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 to 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 Notice of Claim with the Plan and attach the bill You receive from the Provider. 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 pay for any Copayment, Coinsurance or Deductible amounts you owe to the health care provider.

CLAIM FORM

The Plan, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the Insured submits the Written Notice of Claim the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

TIMING AND CONTENTS OF CLAIM

If you are submitting a claim to the Plan, you must do so within one hundred and eighty (180) 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 North Carolina, Inc.
Attention: Claims Director
700 Main Street,
Alamosa, CO 81101
questions@fridayhealthplans.com

All clean claims shall be paid, denied, or settled within thirty (30) calendar days after receipt by the Plan if submitted any 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 ninety (90) 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 Participating 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 Participating 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 one-hundred and eighty (180) day period, your claim will be denied. If it is not reasonably possible submit with the 180 days, you must submit claims no later than 1 year unless there is an absence of legal capacity of the insured.

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 judgment used in making the 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 pay or 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 an approved Provider or meet urgent and emergent criteria. Generally, if you receive Covered Services from a Participating Provider who/which is 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 dollar 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.

ACCESS PLAN

The Carrier has developed an "Access Plan." The Access Plan ensures that you and other Enrollees have access to an appropriate number and type of Participating Providers. The Access Plan is available upon request by mail and at the Plan's business office. The business office is located at:

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

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
- 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 any 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 844-465-5500.

SPECIAL RIGHTS OF THE MEMBER

PRIVACY

The Carrier will have access to information from your medical records, including information received from your health care providers seeking paying from the Plan. The Carrier is permitted to use and disclose such information only as reasonably necessary in administering your Plan benefits and complying with applicable law. The Carrier will protect the confidentiality and privacy of all such information in the manner required by applicable Federal and State law. A copy of the Plan'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.

ELIGIBILITY FOR MEDICARE

If You or a Dependent are entitled to and enrolled in Medicare or if a Member of this Policy becomes eligible for and enrolled in Medicare by reason of age, disability, End Stage Renal Disease, or any other eligibility category, We will consider what Medicare will pay to the extent permitted by law. This means that We will determine coverage and payment available to the Member after subtracting the amounts that Medicare will pay.

MEDICAID REIMBURSEMENT

The amount provided or payable under this Policy will not be changed or limited for reason of a Covered Person being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this Policy to the state if:

- A member is eligible for coverage under his or her state's Medicaid program; and
- The Plan receives proper proof of loss and notice that payment has been made for covered service expenses under that program.

Our payment to the state will be limited to the amount payable under this Policy for the Covered Service expenses for which reimbursement is due. Payment under this provision will be made in good faith and will satisfy Our responsibility to the extent of that payment.

CONTINUITY OF CARE

Continuity of Care may be available for members with an ongoing special condition which includes:

- In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- In the case of pregnancy, pregnancy from the start of the second trimester; or
- In the case of terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

If you are undergoing treatment for one of these ongoing special conditions at the time the contract between the Plan and Your treating Provider is terminated and You have filed a claim for services provided by the terminated Provider or we know you are a patient of the terminated provider, we will notify you on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the Provider. You will continue to receive treatment up to ninety (90) days after we notify you of the Provider's termination.

If You are undergoing treatment from a Provider for an ongoing special condition and are newly covered under this policy, we will notify you on your enrollment date of your right to elect to continue treatment with the Provider currently treating your ongoing special condition. You will continue to receive treatment up to ninety (90) days after you enroll in this policy.

If you had surgery, organ transplant, or other inpatient care scheduled prior to the Provider being terminated or your recent enrollment in this policy, or if you were listed on an established waiting list as of the date of notice of the Provider termination or enrollment, you will be able to continue to see the Provider through the date of discharge after completion of the surgery, transplant, or other inpatient care and through post-discharge follow-up care related to the surgery, transplant, or other inpatient care occurring within 90 days after the date of discharge.

If You are in your second trimester of pregnancy when your Provider was terminated or if you are a newly enrolled member, you will be able to continue to see the treating Provider through sixty (60) days of postpartum care.

If you were determined to be terminally ill at the time of a Provider's termination or when you enrolled in this policy and the Provider was treating the terminal illness before the date of the termination or enrollment, you will be able to continue to see the treating Provider for the remainder of your life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

SECTION 12: TERMINATION / NONRENEWAL /CONTINUATION

TERMINATION OF PLAN COVERAGE

GUARANTEE RENEWABLE

Except as provided in End of Your Coverage section below, the Plan shall renew or continue in force the coverage at the option of the individual.

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 the Plan or the Plan; Coverage will end on the first of the month following the Plan's receipt of Your written notice to cancel.
- You change from one the Plan 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;
- You experience a Rescission of coverage;
- You engage in certain fraud or misconduct, as described in the Effective Date of Termination of Coverage section; or
- The Plan is terminated or is "decertified" by the Plan.
- When the Plan discontinues offering this type of Plan to all individuals
- When the Plan leaves the individual market.
- 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 rate 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 a 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

Certificate of Creditable Coverage

Upon request, when you and/or your Covered Dependents lose Plan coverage, the Carrier 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 your 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 North Carolina, Inc.
700 Main Street
Alamosa, Colorado 81101
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 sent.

EFFECTIVE DATE OF TERMINATION OF COVERAGE

REQUESTED TERMINATION

If you (or any Covered Dependent) decide 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 termination. However, if you (or any Covered Dependent) request an earlier effective date for termination, and the Carrier is able to comply with such request, the Carrier may provide for termination before the end of the fourteen (14) day period. If you (or any Covered Dependent) is

eligible for Medicaid, CHIP or a basic health plan (available to low-income individuals who are not eligible for Medicaid), the last day of Plan coverage is the day before such new coverage begins.

If you (or any Covered Dependent) decide to terminate coverage under the Plan you must contact the Plan to do so. The effective date of termination is assigned by the Plan will comply with that assigned effective date of termination. If you (or any Covered Dependent) request an earlier effective date of termination other than the date assigned by the Plan you will need to appeal said date through the process set out by the Plan, as that earlier date will be subject to the Plan's approval. If an earlier effective date of termination is approved by 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 the Plan if you (or any Covered Dependent) are eligible for Medicaid, other government funded programs, or a basic health plan (available to low-income individuals who are not eligible for Medicaid) I in which case the last day of Plan coverage is the day before such coverage begins.

Covered Dependent) is eligible for Medicaid, CHIP, or a basic health plan (available to low-income individuals who are not eligible for Medicaid), the last day of Plan coverage is the day before such new coverage begins.

FOR ELIGIBILITY FAILURES

If you (or any Covered Dependent) are 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 the Plan 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 a case, 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 Carrier will refund any contributions you made to the Plan relating to the period subject to the Rescission. However, the Carrier 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, be denied by the Plan.

ELECTION OF OTHER THE PLAN PLAN

If you (or any Covered Dependent) elect another the Plan 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 Carrier.

FOR OTHER REASONS

If Plan coverage terminated because the Plan will no longer be offered by the Carrier; 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 Enrollee will continue to be covered by the Plan for the period of the hospitalization, to the extent required by law.

CONTINUTION

If a Member's eligibility under this POLICY would terminate due to the Subscriber's death, divorce or if other Member(s) would become ineligible due to age or no longer qualify as Dependents for coverage under this POLICY; except for Your failure to pay premium, the Member's insurance will be continued if the Member exercising the continuation right notifies the Plan and pays the appropriate monthly premium within sixty (60) days following the date this POLICY would otherwise terminate. Coverage will continue without evidence of insurability.

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 30.

- Enrollee is an aged out dependent on the previously elected plan (over twenty-six (26) years of age).

DISCONTINUING THE PLAN

The Carrier will also not be required to renew an Enrollee's coverage if the Carrier 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 Carrier in the State of North Carolina 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 Carrier will also not be required to renew an Enrollee's coverage if the Carrier discontinues offering and renewing all of its individual plans in the State of North Carolina 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 the 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 applicable non-renewal requirements under the law.

CONTINUATION

In addition, You and/or Your Dependents, who are determined by the Social Security Administration to be disabled, may be eligible to extend their eighteen (18)-month period of continuation coverage,

for a total maximum of twenty-nine (29) months. The disability has to have started at some time before the sixtieth (60th) day of continuation coverage and must last at least until the end of the eighteen (18)-month period of continuation coverage. Notice must be provided to the Plan within sixty (60) days of the determination of disability by the Social Security Administration and prior to the end of the original eighteen (18)-month period of continuation coverage. In addition, notice must be provided to the Plan within thirty (30) days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

SECTION 13: APPEALS AND GRIEVENCE

INTERNAL APPEALS AND GRIEVENCE PROCEDURES

As a Member of this Plan, You have the right to file an appeal/grievance with any issue You may have with a denied service, or any decision, policy, or action of the Plan that affects your coverage. A **'Grievance"** means a written complaint submitted by a covered person for any of the following:

- The Plan's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the Policy.
- Claims payment or handling; or reimbursement for services
- The contractual relationship between a covered person and an insurer.

HOW TO FILE A GRIEVANCE

You (or your authorized representative) may voluntarily submit a grievance by following the Plan's procedures. To begin the grievance process, or to request help with the process, you may call Plan's Customer Service at 1-844-465-5500. The customer service staff will attempt to resolve the Grievance to Your satisfaction. If you do not receive a satisfactory resolution, then you have the option to submit a Grievance in writing for formal review. The Customer Service staff can assist you with the process of submitting a written Grievance. You may also mail your Grievance at the following address:

Friday Health Plans of North Carolina, Inc.
Attention Grievance and Appeals Staff
700 Main Street
Alamosa, CO 81101
Fax: 844-280-1794
Email: Appeals@fridayhealthpans.com

Your grievance must be received, in writing, by the Plan within one-hundred and eighty (180) days after your receipt of the notice of 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 a grievance, 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), is not subject to the grievance procedures.

GRIEVANCE PROCEDURE

1ST LEVEL GRIEVANCE

Within three (3) business days of the Plan receiving a written Grievance, You will be provided with the name and contact information of the Plan staff member that will be coordinating the review. You will also receive instructions on submitting written material. If the Grievance concerns a clinical issue, then at least one reviewer must be a physician with appropriate expertise to evaluate the matter.

FHP will provide You with a written decision within fifteen (15) days after receiving the grievance. The written decision will contain the following information:

- The professional qualifications and licensure of the person or persons that reviewed the Grievance;
- A statement of the reviewers' understanding of the Grievance;
- The reviewers' decision and the basis for that decision; including the relevant sections of the POLICY or other Plan documents.
- A clear statement that the decision is the Plan's final determination.
- If the Grievance is about the authorization of a service or supply, then the written decision will include a statement that You have the right to request an external review.
- Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:

The North Carolina Department of Insurance
P.O. Box 26387, Raleigh, NC 27611
Phone number: 1-800-546-5664; and

For a Grievance concerning the quality of clinical care, the Plan will acknowledge the receipt of the Grievance within ten (10) business days of receipt of the Grievance. Grievances about quality of care are not eligible for a second level review. Therefore, quality of care issues are considered final once

the first level review is completed.

2ND LEVEL GRIEVANCE

FHP has established a second-level grievance review process for members who are dissatisfied with the first-level grievance review decision. A member or the member's provider acting on the member's behalf may submit a second-level grievance.

- FHP will within 3 business days after receiving a request for a second-level grievance review, make known to the member:
    - The name, address, and telephone number of a person designated to coordinate the grievance review for the Plan.
    - A statement of a member's rights, which include the right to request and receive from the Plan all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without limitation to: a provider, family member, employer representative, or attorney. If the member chooses to be represented by an attorney, an attorney may also represent the Plan.
    - The availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

- The Plan will convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not employees of the Plan and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a non-certification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however on a first-level grievance review panel may use one of the Plan’s employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

Second-Level Grievance Review Procedures

The Plan’s procedures for conducting a second-level grievance review include:

- The review panel shall schedule and hold a review meeting within 15 days after receiving a request for a second-level review.
- The member shall be notified in writing at least 15 days before the review meeting date.
- The member's right to a full review shall not be conditioned on the member's appearance at the review meeting.

Second-Level Grievance Review Decisions

The Plan will issue a written decision to the member and, if applicable, to the member's provider, within seven (7) business days after completing the review meeting. The decision will include:

- The professional qualifications and licensure of the members of the review panel.

- A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
- The review panel's recommendation to the Plan and the rationale behind that recommendation.
- A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
- The rationale for the Plan's decision if it differs from the review panel's recommendation.
- Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.
- Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

Expedited Second-Level Procedures

An expedited second-level review will be made available where medically justified whether or not the initial review was expedited. When a member is eligible for an expedited second-level review, the Plan will conduct the review proceeding and communicate its decision within four (4) days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

The Plan will not discriminate against any provider based on any action taken by the provider on behalf of a member.

RIGHT TO APPEAL

The right to appeal applies to all non-certifications. An "Non-Certification" determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency service, and the requested service is therefore denied, reduced, or terminated based on:

- A 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, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; or
- A Rescission of coverage.

The appeal will be reviewed by a physician licensed in North Carolina, who will consult with his/her clinical peers (unless the physician is a clinical peer) that are also licensed in the State of North Carolina. The physician and any clinical peers, along with the Appeals committee, will be individuals who were not involved in making the Non-certification. However, a person who participated in that decision may answer questions.

The individual(s) reviewing the appeal will consider all comments, documents, records, and other

information submitted by the Enrollee, even if the information was not considered when the noncertification was made.

Within three (3) business days of the Plan receiving a written appeal, You will be provided with the name and contact information of the Plan staff member that will be coordinating the review. You will also receive instructions on submitting written material.

The Plan will provide You with a written decision within thirty (30) days after receiving the appeal. The written decision will contain the following information:

- The professional qualifications and licensure of the person or persons that reviewed the appeal;
- A statement of the reviewers' understanding of the Appeal;
- The reviewers' decision and the basis for that decision; including the relevant sections of the POLICY or other Plan documents.
- A clear statement that the decision is the Plan's final determination.
- If the Appeal is about the authorization of a service or supply, then the written decision will include a statement that You have the right to request an external review.
- Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:

The North Carolina Department of Insurance
P.O. Box 26387, Raleigh, NC 27611
Phone number: 1-800-546-5664; and

EXPEDITED APPEALS

In certain cases, You may request in writing or verbally that the appeal process be expedited. An expedited appeal may be requested if,

a. The time frame for the regular appeal process would seriously jeopardize Your life, health, or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or

b. Your appeal involves non-authorization of an admission inpatient Hospital stay.

If You meet the qualifications for an expedited review, then You may request an expedited external review from NCDOI. In order for You to request and expedited external review from the NCDOI, then you must have requested an expedited appeal from the Plan.

One of the Plan's Physicians licensed in the state of North Carolina, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, We will

consult with a Physician who is licensed to practice medicine in North Carolina and will respond orally with a decision within seventy-two (72) hours, followed up in writing within the lesser of two working days or four calendar days. If the expedited review is a concurrent review determination, Cigna will remain liable for health care services until the Member has been notified of the determination.

Retrospective noncertifications are not eligible for an expedited timeframe.

You may contact the North Carolina Department of Insurance for assistance at:

North Carolina Department of Insurance
Health Insurance Smart NC
325 N. Salisbury St.
Raleigh, NC 27699-1201
Telephone: 1-919-807-6800
Telephone: 1-855-408-1212 (Toll-free)
https://www.ncdoi.gov/consumers/health-insurance

EXTERNAL APPEAL PROCEDURES

North Carolina law provides for review of noncertification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. The Plan will notify you in writing of your right to request an external review each time you:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision[, or
- receive a second-level grievance review decision upholding the original noncertification].

In order for your request to be eligible for external review, the NCDOI must determine the following:

- that your request is about a medical necessity determination that resulted in a noncertification decision;
- that you had coverage with the Plan in effect when the noncertification decision was issued;
- that the service for which the noncertification was issued appears to be a covered service under your policy; and
- that you have exhausted the Plan’s internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, you will be considered to have exhausted the internal review process if you have:

- completed the Plan's appeal process and received a written determination on the appeal from the Plan, or
- filed an appeal and except to the extent that you have requested or agreed to a delay, have not received the Plan's written decision on appeal within 60 days of the date you can demonstrate that you submitted the request, or

- received notification that the Plan has agreed to waive the requirement to exhaust the internal appeal process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed internal review the Plan's process and received a written final determination from the Plan.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving the Plan's notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of the Plan's written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- the name and contact information for the Independent Review Organization (IRO) assigned to your case;
- a copy of the information about your case that the Plan has provided to the NCDOI;
- notice that the Plan will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to the Plan at the same time using the same means of communication (e.g., you must fax the information to the Plan if you faxed it to the IRO). When faxing information to the Plan, send it to 1-844-280-1794. If you choose to mail your information, send it to:

Friday Health Plans of North Carolina
700 Main St
Alamosa, CO 81101

Please note that you may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and the Plan. The NCDOI will forward this information to the IRO and the Plan within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the noncertification, the Plan , reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by the Plan at the time the Plan receives notice of the IRO's decision to reverse the noncertification, the Plan will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize

your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written request to the NCDOI for an expedited review after you:

- receive a noncertification decision from the Plan and file a request with the Plan for an expedited appeal, or
- receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if you receive an first level appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if the Plan's internal review process was already completed, or (2) require the completion of Plan's internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to you within 3 days days of the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, the Plan will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by the Plan at the time the Plan receives notice of the IRO's decision to reverse the noncertification, the Plan will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on the Plan and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax)919-807-6865

In Person:
NC Department of Insurance
Albemarle Building
325 N. Salisbury St.
Raleigh, NC 27603
855-408-1212 (toll-free)

Smart NC for External Review information and Request Form

The Health Insurance Smart NC Program is also available to aid consumers who wish to file an appeal or grievance with their health plan.

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

The Plan will provide sixty (60) days' notice for all material changes to the policy.

CHANGES IN RATES

During a Plan Year, the Carrier may change the Premium amount you owe if there are changes in the number of your Covered Dependents, a change in age of any Member which results in a higher Premium, changes in your geographic rating area, or changes in tobacco use by you or your Covered Dependents. The Carrier may also change the Premium amount you owe during the Plan Year if the Carrier 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. Changes in the Premium rate will go into effect the first of the month following the change, unless as otherwise stated on Your Premium notice.

At the beginning of each new Plan Year, the Carrier may change the Premium amount you must pay. You will be notified in advance of any such changes.

NOTICE

The Plan will provide sixty (60) days' notice for all material changes to the policy.

SECTION 15: DEFINITIONS

When they are used in this Policy, the following capitalized terms will have the meanings explained in this DEFINITIONS section:

"ACA Preventative Care Drug" a medication that under the Affordable Care Act (ACA) some medications may have limited or $0 cost-sharing; examples of categories of medications that may be subject to limited or $0 cost share

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

If your provider charges more than the plan's allowed amount, you may have to pay the difference. (See Balance Billing)

"Application" refers to the form used by Georgia Health Insurance to collect information from You and to 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. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

"Benefits" The health care items, or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules

"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).

"Complication of Pregnancy" means a non-elective cesarean section (c-section), or any other medical condition arising due from or in conjunction with a Member being pregnant or immediately following the pregnancy.

"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 your deductible.

"Copayment" A fixed amount ($20, for example) you pay for a covered health care service after you have paid your 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" means those health care services and supplies that the Plan is required to pay for if the other terms and conditions of the Plan have been satisfied.

"Deductible" The amount you pay for covered health care services before your insurance plan starts 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.

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

"Policy" (EOC) 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.

"Experimental or Investigational" means a health service, treatment, procedure, device, drug, or product used for an 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 medical 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 analysis of clinical studies and literature for safety and appropriateness;
- Lacks conclusive evidence demonstrating that the service improves the net 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, educational, 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 if the service is effective.
- The Plan is the sole judge if a health service is "Experimental or Investigational".

"The Plan" means Friday Health Plans of North Carolina, Inc. which is the Health Management Organization that You are insured through.

"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 THE PLAN
"HHS" refers to the Department of Health and Human Services.
Grievance A complaint that you communicate to your health insurer or 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 Directory.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

"Emergency Services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

"Infertility" means the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm

"Medically Necessary" Health care services or

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under GS 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the insured, the insured's family, or the provider.

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

"Member Portal" As a Member of the Plan, 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 the www.fridayhealthplans.com website, Members link (found in the ribbon at the top of the home page), then click on Member Hub, 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.

"Minimum Essential Coverage" Any insurance plan that meets the Affordable Care Act requirement for having health 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"). Examples of plans that qualify include Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

"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" is a Network Hospital, Physician, or other health care Provider that we claim as a Network Provider. 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.

"Participating Provider" means any doctor, hospital, pharmacy, clinic, or health care Provider who/which has agreed to provide health care to Enrollees at contract rates. The Plan has contract rates with these Providers on a fee-for-service basis. Participating Provider means the same as Network Provider.

"Plan" A benefit your employer, union or other group sponsor provides to 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. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

"Premium" The amount you pay for your 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.

"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 of the Prior Authorization granted by the Plan.

"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 ineligible 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's 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.

"Sexual Dysfunction" Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder, and hypoactive sexual desire disorder.

"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 Participating Provider that has expertise in providing certain specialized care or treatments, such as cancer treatments or transplants.

"Specialty Pharmacy" is a Drug Provider that has contracted with THE PLAN to provide Tier IV Drugs to its Members. Getting these drugs through a Specialty Pharmacy will often decrease the cost to the member. Contact the Plan at 844-521-7999.

"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 a Specialty Drug. Contact the Plan at 844-521-7999.

"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. "Telehealth" does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

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

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