FEDERAL HEALTH INSURANCE MARKETPLACE
TEXAS INDIVIDUAL MARKET MEDICAL AND HOSPITAL PLAN EPBP

INDIVIDUAL INSURANCE POLICY

SECTION 1: TITLE PAGE (COVER PAGE)

FRIDAY HEALTH INSURANCE COMPANY, INC.

700 Main Street
Alamosa, Colorado 81101

Effective Date: January 1, 2022

FEDERAL EXCHANGE MARKETPLACE
TEXAS INDIVIDUAL MARKET MEDICAL AND HOSPITAL POLICY

EXCLUSIVE PROVIDER BENEFIT PLAN
INSURANCE POLICY

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.

Friday Health Insurance Company, Inc. is a Qualified Health Plan issuer in the Federal Health Insurance Marketplace (healthcare.gov)

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You cannot work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You do not, You may lose Your right to appeal.

Friday Health Insurance Company, Inc.

To get information or file a complaint with Your insurance company, call:

Toll-free: 1-844-451-4444

Email: questions@fridayhealthplans.com

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda? Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departmento de Seguros de Texas, también debe presenter una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Friday Health Insurance Company, Inc.

Para obtener información o para presenter una queja ante so compañía de seguros:

Toll Free: 1-844-451-4444

El Departmento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo elctrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

FRIDAY HEALTH INSURANCE COMPANY, Inc.

FEDERAL HEALTH INSURANCE MARKETPLACE
TEXAS INDIVIDUAL MARKET MEDICAL AND HOSPITAL PLAN EPBP –

Individual insurance policy

*Monthly Premium
amount is subject to change
and/or increase at renewal.

This is a guaranteed renewable Policy of insurance. See the “RENEWAL RIGHTS” language at Section 9 of this document for more information.

SECTION 2: CONTACT US

FEDERAL HEALTH INSURANCE MARKETPLACE – HEALTHCARE.GOV

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

PURPOSE OF THIS DOCUMENT

This Policy (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 the Policy. Generally, if a capitalized term is used in this Policy, it will have the meaning set forth in the Definitions section. However, some capitalized terms may be defined in the sections of this Policy where they are used.

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

Friday Health Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

Or contact us by phone at:

1-844-451-4444

Together with the Enrollment Application, Summary of Benefits and Coverage, Schedule of Benefits, and the Member ID Card, this Policy 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 Plan's rights or requirements.

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

NOTICE OF NONDISCRIMINATION

Friday Health Insurance Company, Inc. (Friday) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or political affiliations. Friday Health Insurance Company, Inc. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or political affiliations.

Friday Health Insurance Company, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreter
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If You need these services, contact the Friday Care Crew at 1-844-451-4444.

If You believe that Friday Health Insurance Company, Inc. 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:

Friday's Chief Compliance Officer
700 Main Street
Alamosa, CO 81101

Confidential Phone: 1-844-451-4444 (TTY: 1-800-659-2656)
Email address: 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, or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW, Room 509F, HHH Building
Washington, D.C. 20201
By phone: 1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al l 844-451-4444.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-451-4444.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-451-4444.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-696-6775 번으로 전화해 주십시오. 844-451-4444

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-451-4444.

Arabic: ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 844-451-4444
لحق ديك ا 844-451-4444 Friday Health Plans وص سئلة بخصد ده أ ص تساء دى شخ ديك أو لـ ن لـ إن كا

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-451-4444 .

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-451-4444.

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

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer: 844-451-4444

Portuguese: l cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. HHS não exclui ou trata de forma diferente devido à raça, cor, nacionalidade, idade, deficiência ou sexo.844-451-4444.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-451-4444.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-451-4444 まで、お電話にてご連絡ください。

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SECTION 4: DEFINITIONS

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

1. "ACA Preventative Care Drug" A medication that under the Affordable Care Act (ACA) some medications may have limited or $0 Cost-Sharing.
2. "Adverse Benefit Determination" A Plans determination to deny, reduce or terminate, or its failure to provide or make payment (in whole or in part) for a benefit.
3. "Allowed Amount" The maximum amount a plan will pay for a covered health care service.
4. "Appeal" An Appeal is a written request from the member or Network Provider stating their disagreement with an Adverse Benefit Determination and their desire to have the Adverse Benefit Determination overturned.
5. "Application" refers to the form used by healthcare.gov to collect information from You and to verify that information.
6. "Benefits" The health care items or services covered under a health insurance plan. May also be called "Covered Services."
7. "Brand Drug" A Prescription Drug, including insulin, typically protected under patent be the drug's original manufacturer or developer with a proprietary trademarked name.
8. "Child" 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).
9. "Cognitive Communication Therapy" Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
    - "Contract" means this Policy document and the following:
        - Summary of Benefits and Coverage
        - Enrollment Application Form

- Member ID Card

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

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

12. "Covered Benefits" means service that must be Medically Necessary and are subject to exclusions and limitations as described herein. Prior Authorization is required for many services. Limitations may apply. All services must be provided by Providers licensed or certified to provide the service unless otherwise indicated. The fact that a Network Provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a Covered Benefit or Medically Necessary.

13. "Complaint" Refers to an oral or written expression of dissatisfaction to the Plan from a Member or Practitioner/Provider.

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

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

16. "Covered Services" means the same as "Benefits"

17. "Deductible" The amount You pay for covered health care services before Your insurance Plan starts to pay. With a $2000 Deductible, for example, You pay the first $2000 or covered services Yourself.

18. "Dependent" a Child or other individual for whom a parent, relative, or other person may claim a person 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.

19. "Drug Formulary" A comprehensive list of Brand and Generic Drugs, approved by the U.S. Food and Drug Administration (FDA), covered under this Benefit Plan. A Covered Drug is a drug found on the Plan Drug Formulary.

20. "Elective Abortion" means an abortion, as defined by Section 245.002, Health, and Safety Code, other than an abortion performed due to a medical emergency as defined by Section 171.002 of the Health and Safety Code. Which means a life-threating physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a Provider, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

21. "Eligible Dependent" refers to a Subscriber's Dependents that are eligible to enroll in this Plan under Your Policy. See the Eligibility Section for a more detailed description of Dependents and Eligible Dependents.

22. "Emergency Care" refers to bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including sever pain, such that the absence of immediate medical attention could reasonably be expected to result in:

    - Placing the patient's health in serious jeopardy;
    - Serious impairment of bodily functions; or
    - Serious dysfunction of any bodily organ or part
    - Serious disfigurement
    - Or for a pregnant woman, serious jeopardy to the health of the fetus

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

24. "Exclusive Provider Organization (EPO)" means a type of insurance plan in which, except in the case of medical Emergency, Members must obtain covered services by Network Providers to receive benefits. The Plan is an EPO, and its members must receive services and supplies from Friday's Network of Providers. Services and supplies obtained from Providers that are not Friday's Network will generally not be covered. We will provide an updated list of Network Providers upon request, or You can view it at www.fridayhealthplans.com.

25. "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, Phase III, or Phrase IV 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.

26. “Formulary Drug” A Brand Drug or Generic Drug included in the Drug Formulary.

27. “Friday” means Friday Health Insurance Company, Inc. which is the Insurance Company You are insured through.

28. “Generic Drug” A prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with a drug having an identical amount or the same active ingredient(s) in the same proportions, that have the same information printed on the label and that perform in the same manner as the trademarked, brand-name version of the drug.

29. “Grievance” A complaint that You communicate to Your health insurer plan.

30. “healthcare.gov” is used in this Plan document to refer to Federal Health Insurance Marketplace.

31. “HHS” refers to the Department of Health and Human Services.

32. “Injectable Drug”- A prescription drug dispensed from a pharmacy (including combination therapy kits) that are injected directly in the body by the Member or the Member’s Provider.

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

34. "Medical Emergency" means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including sever pain, such that the absence of immediate medical attention could reasonably be expected to result in"

    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part;
    - Serious disfigurement; or
    - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

    Examples: Heart attack, poisoning, loss of consciousness or respiration, convulsions, and excessive uncontrolled bleeding.

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

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

37. "Member Portal" is an online portal that will allow You 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.

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

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

40. "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.

41. "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.

42. "Network Provider" is a network Hospital, Provider, 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.

43. "Network Provider Directory" A tool where You can find the Network of Facilities, Providers, and ancillary Providers.

44. "Non-Formulary" A drug that is not listed in the Drug Formulary. There is no coverage for drugs that are not listed in the Drug Formulary.

45. "Non-Network Provider" means a Hospital, Provider, Behavioral Health Practitioner or Other Provider who has not entered into an agreement with Friday. Benefits are generally not available for services provided by Out-of-Network Providers.

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

47. "Out-of-Area" Outside of Texas and outside the area in surrounding states that is within fifty miles of the Texas border.

48. "Out-of-Network" The receipt of services from Non-Network Providers resulting in the Member paying for the entire cost of the services.

49. "Out-of-Pocket Maximum" The maximum dollar amount a Member or Family will pay for Covered Services in a calendar year. Copayments, Coinsurance and Deductibles paid by Members count towards the Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include Premiums, expenses associate with non-Covered Services or denied claims. If coverage is extended to qualified Dependents and the family Out-of-Pocket Maximum has been paid, no further payment is required to be paid on the member's be half for Covered Services.

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

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

52. "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.

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

54. “Premium” The amount you pay for health insurance every month. In addition to Your premium, You usually have to pay other costs for Your health care, including a Deductible, Copayments, and Coinsurance.

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

56. “Primary Care Provider (PCP)” 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 to helps a patient access a range of health care services.

57. “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.

58. “Prior Written Authorization” is the proof of the Prior Authorization granted by Friday.

59. ”Prosthetic Appliances” means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

60. “Provider” means any hospital, Provider, 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.

61. “Rescission” means a cancellation of Plan coverage that has a retroactive effect.

62. “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.

63. "Service Area" means all the counties in Texas where the Plan offers the Plan and has arrangements with Participating Providers.

64. "Specialist" or "Specialty Care Physician" is a Provider that focuses their practice on certain disease categories, types of patients, and/or methods of treatment.

65. "Subscriber" means an individual who enrolls themselves and their Eligible Dependents in this Plan.

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

67. "Special Enrollment Period" is period of time that occurs upon a Triggering Event where You and/or Your Eligible Dependents have the right to enroll Yourself and/or Your eligible Dependents in the Plan outside of the Open Enrollment Period.

68. "Specialty Pharmacy" is a Drug provider that has contracted with Friday to provide Tier IV Drugs to its Members. Getting these drugs through a Specialty Pharmacy will often decrease the cost to the member. Contact Friday at 844-451-4444.

69. "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 Friday at 844-451-4444.

70. "Spouse" refers to Your husband or wife, or Your partner in a civil union.

71. "Step Therapy" A treatment process that requires the use of lower priced drugs first (generally with a specific therapeutic class of drugs) when multiple treatment options exist for a particular medical condition before the Plan authorizes the use of higher priced Formulary Drugs.

72. "Telehealth" means a mode of delivery of health care or dentistry 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 facsimile machine, or electronic mail systems.

73. "Triggering Event" means an event that results in an individual becoming eligible for a Special Enrollment Period.

74. "Urgent Care" Medically Necessary services for a condition that requires prompt medical attention but is not an Emergency.

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

76. “You or Your” means the Enrollee or Member or Covered Dependent.

SECTION 5: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

ELIGIBILITY OF APPLICANTS

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

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

- The Policy holder must live in Friday's Service Area.
- Complete and submit to healthcare.gov such Enrollment Application or forms that the Exchange may reasonably request.
- Be a United States citizen or national.

ELIGIBILITY OF DEPENDENTS

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

The following are the Eligible Dependents:

- A Subscriber's legal Spouse or a legal Spouse for whom a court has ordered coverage (Spouse includes a partner in a valid civil union under state law), or legal domestic partner.
- A child by birth. Stepchild. Minor child for whom a court has ordered coverage. Child being placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.
    - The child must be under the age of twenty-six (26) regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Coverage lasts until the end of the year in which the Child turns twenty-six (26) years of age.
- Adopted Child – This includes a child for whom You or Your Spouse is in a suit in which the adoption of the child is sought. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption.

- Eligible Grandchildren – An Eligible Grandchild is a child or Your child that is unmarried, Younger than twenty-six (26) years of age, and dependent on You for federal income tax purposes at the time application for coverage of the grandchild is made.

- Handicapped or Disabled Children – A child with a mental or physical handicap, or developmental disability, who is incapable of earning a living, is considered an Eligible Dependent past this Policy's age limit of twenty-six (26) years.

  - The child will stay eligible past their 26th birthday as long as the child is and remaining incapable of earning a living. To be eligible, the condition must have started before the child reached age twenty-six (26); the child became covered under this or any other Policy before the child reached age twenty-six (26) and stayed continuously covered after reaching age twenty-six (26); and the child depends on You for most of his or her support and maintenance.

  - Upon the child's 26th birthday, You have thirty-one (31) days to send Friday and healthcare.gov written proof that the child is incapacitated or developmentally disable and depends on You for most of his or her support and maintenance.

At the discretion of the Plan or healthcare.gov, proof showing that a person meets the definition of an Eligible Dependent may be required.

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 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. This provision is subject to the Time Limit of Certain Defenses provision which states "(a) After the second anniversary of the date this Policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the Policy may not be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) beginning after that anniversary."

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

- An individual who is eligible and/or enrolled for coverage under Medicare Part A and/or B at the time of Application.

- A person in prison (in prison; does not apply if You are waiting for disposition of charges).

- An individual who is eligible and/or enrolled in Medicaid either at the time of Application or after they enroll.

If there is a change in a subscriber's or Dependent's eligibility, then it is the responsibility of the subscriber to notify Healthcare.gov. Changes in a Member's eligibility status include, but are not limited to the following:

- Death
- Divorce
- Moving outside the Service Area
- A Dependent ceasing to satisfy the mental and physical handicap requirements

ELIGIBILITY FOR PREMIUM ADVANCES AND COST-SHARING SUBSIDIES

PREMIUM ADVANCES

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

If an Enrollee is eligible for Premium Advances, the Federal government will send a payment each month to the Plan. This payment may pay for all or part of the Enrollee's Premium.

COST-SHARING SUBSIDIES

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

OPEN ENROLLMENT

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

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

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

EFFECTIVE DATE OF COVERAGE

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

ANNUAL OPEN ENROLLMENT

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

You must be enrolled in the Plan in order to enroll any Dependent in the Plan. In order for You and any Dependent to enroll in the Plan, You must also agree to pay any required contributions. If You do not enroll Yourself (and Your eligible Dependents) in the Plan during an Open Enrollment Period, You (and Your eligible Dependents) must generally wait until the next annual Open Enrollment Period to do so. However, in certain cases, You may be able to enroll Yourself and/or Your eligible Dependents in the Plan before the next Open Enrollment Period. Please review the Special Enrollment section for more information.

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. The Plan may also require proof periodically during the Covered Child's coverage. The Plan will not require proof more frequently than annually after the second anniversary of the date the child attains the limiting age.

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 directly from You. The Plan may recover the cost of any benefits provided to You or Your Dependent during the

Refund Period, if those costs are greater than the Premium received by the Plan for You or Your Dependent for the Refund Period. The Plan will refund Your Premium (or Your Dependent's Premium) for the Refund Period only if You (or Your Dependent) received no Benefits from the Plan. However, the Plan will follow the Time Limit of Certain Defenses provision which states "(a) After the second anniversary of the date this Policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the Policy may not be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) beginning after that anniversary." The Plan will also continue coverage for the timeframe in which the Plan has accepted premiums unless the premium was based on misstatement of age.

IDENTIFICATION CARD

You and Your Covered Dependents will receive Plan identification cards when You enroll in the Plan. You should notify the Plan 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 purposed only. Having a Plan identification card will not give You or any other person a right 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.

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 will have the right to enroll Yourself and/or Your eligible Dependents in the Plan during the Plan Year. This means that You will not have to wait until the next Open Enrollment Period to receive Plan coverage. Following a triggering event, You will have a special enrollment period of no less than sixty (60) days. In order to qualify for a special enrollment period,

You may be required to provide proof of prior credible coverage and payment of prior premiums, based on federal regulations.

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

TRIGGERING EVENTS

Triggering Event means an event that results in an individual becoming eligible for a Special Enrollment Period. Triggering Events occur when:

- The loss of Your creditable coverage (minimum essential 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, court order, placement in foster care, or by entering into a designated beneficiary agreement of coverage is offered to designated beneficiaries.

- An individual's enrollment or non-enrollment in a health benefit Plan that is unintentional, in advertent or erroneous and is the result of an error, misrepresentation, or inaction of the Plan, producer or Healthcare.gov.

- Showing to the Insurance Commissioner that the health benefit plan in which You are enrolled has violated a material provision of its contract in relation to You.

- A Healthcare.gov enrollee becomes eligible or no longer eligible for the federal advance payment tax credit or cost-sharing reductions through Healthcare.gov.

- If an income change makes a consumer eligible for Premium Tax Credits or Cost-Sharing reduction during the Plan Year and the person bought an off-exchange plan, then they will experience a Triggering Event allowing them to purchase an on-exchange Plan that can take advantage of those benefits. As in all cases of Special Enrollment, the newly purchased benefit Plan will have a Deductible and Out-of-Pocket Maximum that is reset.

- If You Gain access to other coverage due to permanent change in residence.

- A parent or legal guardian dis-enrolls a Dependent, or a Dependent is no longer eligible for the Texas Children's Health Insurance Program (CHIP).

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

- 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 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 if the insured is a party to a suit in which the insured seeks to adopt the child, or placement in foster care, coverage must be effective on the date of the event.

- In the case of all other triggering events, where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first fay of the following month

- In the case of all other Triggering Events, where individual coverage is purchased between the sixteenth and the last day of the month, coverage shall become effective no later than the first day of the second following month

SECTION 6: THE EPO (EXCLUSIVE PROVIDER ORGANIZATION) NETWORK

This insurance Policy is an Exclusive Provider Organization (EPO) Plan. An EPO plan only covers benefits that are provided In-Network. To receive In-Network benefits You must receive care exclusively from Network Providers. Except for care for an Emergency Condition or if the services You require are not available from Network Providers, You will be responsible for paying the cost of all care that is provided by Non-Network Providers.

As a Member, You may receive Covered Services from Network Providers including medical, surgical, diagnostic, therapeutic and preventive services provided in the Friday Service Area. Covered Services must also be Medically Necessary. As a Member of a Plan, You and Your Network Provider must work together to manage Your healthcare services. When a Covered Service requires Prior Authorization, You and Your Network Provider will work with Friday to get Prior Authorizations. If You have received a Prior Authorization and need to renew the Prior Authorization, You and Your Network Provider can make a renewal request not more than sixty (60) days prior to the expiration of Your current Prior Authorization.

It is the responsibility of each Friday Member to provide Friday with a change of Your mailing address within thirty-one (31) days of such address change. Changes can be made by contacting Friday Care Crew (Customer Service) at 844-451-4444.

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

TEXAS DEPARTMENT OF INSURANCE NOTICE

- An exclusive Provider benefit Plan provides no benefits for services You receive from Non-Network Providers, with specific exceptions as described in Your Policy and below.

- You have the right to an adequate Network of Preferred Providers (known as "Network Providers").

- If Your insurer approves a referral for Non-Network services because no Preferred Provider is available, or if You have received Non-Network Emergency Care, Your insurer must, in most cases, resolve the non-preferred Provider's bill so that You only have to pay any applicable Coinsurance, Copayment, and Deductible amounts.

- You may obtain a current directory of preferred providers at the following website: www.fridayhealthplans.com or by calling 1-844-451-4444 for assistance in finding available preferred providers. If You relied on materially inaccurate directory information, You may be entitled to have an out-of-network claim paid at the in-network level of benefits.

THE EPO NETWORK OF PARTICIPATING PROVIDERS

Friday has contracted with health care Providers to give affordable health care to its Member. This is also done to manage Your healthcare needs. It is highly recommended that You choose a Primary Care Provider (PCP) from the Friday Network. You must receive Your care from Network Providers. Except for rare cases where a Non-Network Provider is Prior Authorized by Friday, You MUST receive care from a Network Provider in order for it to be considered a Covered Service. If You receive health care services from Non-Network Providers, then it will result in a significant increase in cost to You. It is vital that You confirm that the Provider that You intend to see is a Network Provider. You should confirm that a Provider is a Network Provider by checking the Provider Directory or by calling the Friday Care Crew at 844-451-4444. You can request that we provide by mail a non-electronic version of the Provider Directory. You can also find the directory at www.fridayhealthplans.com.

ACCESSING NON-NETWORK PROVIDERS

If a Provider is not contracted with Friday, then they are a Non-Network Provider. Unless the Member has prior Authorization, Friday 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 Friday 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 Friday Provider Director. The Provider Directory can be found at www.fridayhealthplans.com/member-resources-tx/ or call Friday Care Crew at 1-844-451-4444.

In the event You are under the care of a Network Provider at the time such provider stops participating in the Network and at the time of the Network Provider's termination You have special circumstances such as a disability, active treatment for a chronic or acute medical condition, a life-threatening illness, or the second or third trimester of pregnancy, the Plan will continue providing coverage for the provider's services at the in-network benefit level.

Special circumstances means that the treating Provider or health care Provider reasonably believes that discontinuing care could cause harm to the patient. Special circumstances will be identified by the treating Provider, who must request that You be permitted to continue to receive services and treatment and agree not to seek payment from You for any amounts for which You would not be responsible if the Provider or provider were still a Network Provider.

A request for special circumstances is not available when a provider has been terminated for reasons that could result in imminent harm. The continuity of coverage will not extend for more than ninety days, or more than nine months for a terminal illness diagnosis, beyond the date the provider's termination from the Network takes effect. If the termination is effective past the 24th week of pregnancy, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six weeks after delivery. In rare cases, a Member may receive services from a Non-Network provider in a Network Facility. If a Member receives care from a Non-Network Provider at a Network facility and the member had not specifically requested the Non-Network Provider, then the member will be held harmless

and will have no greater share of cost than if an In-Network Provider treated them. The Plan will pay the Allowable Amount which is the amount established under Texas state law for reimbursement for health care services to covered persons at a Network facility provided by an out-of-network provider or for emergency services that are provided by out-of-network providers or facilities.

If an Enrollee receives emergency services from a Non-Network Facility, then payment from the Plan will be limited to the Allowable Amount. Notwithstanding anything in this Plan document to the contrary, for Non-Network Emergency Care services rendered by Non-Network Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts:

1. The median amount negotiated with In-Network Providers for Emergency Care services furnished;

2. The amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Non-network services but substituting the In-Network cost-sharing provisions for the Non-Network cost sharing provisions; or

3. The amount that would be paid under Medicare for the Emergency Care service.

Each of these three amounts is calculated excluding any In-Network Copayment or Coinsurance imposed with respect to the Member.

A Non-Network Provider that rendered Emergency Care, an Out-of-Network facility-based Provider that performed Services in a Network Facility, and an Out-of-Network diagnostic imaging Provider or laboratory service Provider that performed services in connection with Network care, may not be permitted to bill You for an amount greater than the applicable Copayment, Coinsurance or Deductible under Your Plan. You can only be billed based on rates that are usual and customary rates are determined at 130% of the standard Medicare rates at the time the services are received.

IMPORTANT NOTICE ABOUT SURPRISE BILLING (KNOW YOUR RIGHTS)

Beginning January 1, 2021, Texas state 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 Virginia. The law does not apply to all health plans and may not apply to out-of-network providers located outside of Texas. For additional information, please contact the Friday Care Crew at 1-844-451-4444.

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, 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.

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 thirty (30) 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 1-844-451-4444.

Ambulance Information . Non-emergency ambulance services 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. This exception does not apply for air ambulance services.

SECTION 7: HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

PRIMARY CARE PROVIDER (PCP)

A Primary Care Provider (PCP) is a Network Provider who guides, tracks, and manages Your health care services. They work to assure continuity of care for the Member. The PCP also works with Friday to get and Prior Authorizations for specialized care the Member may need. You have the right to designate any Primary Care Provider who participates in the Plan 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 who will work with You to manage Your Health Care needs.

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

Friday Health Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call Friday Care Crew at 1-844-451-4444.

PEDIATRICIAN AS PRIMARY CARE PROVIDER

For any Covered Child, You may select a pediatrician as the Child's Primary Care Provider. Under the EPO Plan, a Covered Person does not have to select a PCP but is encouraged to do so. You may contact the Plan for a list of the Primary Care Providers who are pediatricians. You may contact the Plan in writing at:

Friday Health Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

If You prefer, You may call the Friday Care Crew at 1-844-451-4444.

PRIOR-AUTHORIZATION

The Plan reviews certain health services to determine whether the services are or were Medically Necessary, or Experimental/Investigational. This process is called Utilization Review. 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 some cases, You must obtain Prior Authorization from the Plan before You receive health care services from anyone other than Your Primary Care Provider. Visits to a network Specialist does not require Prior Authorization, but procedures from any Network Provider usually do require Prior Authorization. Generally, Your Network Provider will begin the process of obtaining Prior Authorization on Your behalf. This is done by making a request for Prior Authorization to the Plan. Your Network Provider will ask that You be permitted to receive. The Plan will respond to each request with either an approval or denial according to the Texas state mandated timelines (see below). The Plan will send a copy of its response to You. The Plan will also send a copy to the Network Provider. When a request is approved, the Plan will issue Prior Authorization. The Prior Authorization request will identify the name of the Participating Provider authorized to provide the service, the health care services to be performed by the Participating Provider, and the date(s) when the services will be performed. The Prior Authorization from the Plan guarantees payment by the Plan of all Covered Services approved in the Prior Authorization. This guaranty does not apply if You lose Plan eligibility before the date of the services. If You obtain services without a Prior Authorization when one is required, and the Plan aggress to pay the claim; the Plan may exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%.

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 1-844-451-4444 if You are unsure if a service needs Prior Authorization before services are rendered.

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 Network Provider 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 Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101
questions@fridayhealthplans.com

You may also get this information from the Friday Care Crew at 1-844-451-4444.

EXCEPTION FOR URGENT SITUATIONS

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

EXCEPTION FOR EMERGENCY SITUATIONS

You are not required to obtain Prior Authorization from the Plan when You receive health care services in a Medical Emergency. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services that could be considered non-emergent. If You are hospitalized without Prior Authorization due to a Medical Emergency, You must notify the Plan by telephone of the hospitalization at 844-451-4444. 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 exercise its rights to impose a penalty of 50% of the allowed amount in which You will be responsible for the other 50%.

PRIOR-AUTHORIZATION TIMELINE

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

On receipt of a request from a Participating Provider for Prior-Authorization, the Plan shall review and issue a determination indicating whether the health care services are authorized. The

determination will be issued and transmitted no later than the 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 later than 3 Business days.

For services that involve post-stabilization treatment or a life-threatening condition. The Plan will provide a response indicating whether services are authorized within the time appropriate to the circumstances not to exceed one hour from the receipt of the request.

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 Provider, Behavioral Health Practitioner and/or Other Professional Provider.

Some Network Providers may not be required to submit Prior Authorization of outpatient services. The Plan will evaluate Network providers every 6 months to see if they qualify for a Prior Authorization exemption from the Plan. The Plan will notify the Provider if they no longer qualify for an exemption no later than 30 days prior to the end of the exemption period.

FAILURE TO USE A PARTICIPATING PROVIDER

As a general rule, if You receive health care services from 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, 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.

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, Member's 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 then the Member 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
Artificial insemination	Not covered	Amniocentesis	No
Bariatric Surgery	Not covered	Blood products	No
Biopsy – Bone Marrow	Yes	Bereavement Counseling	No
Bone Scan – 3 phase	Yes	Biopsy – Breast	No
Breast Reconstruction	Yes	Biopsy Skin	No
Chemotherapy	Yes	Bone Density – DEXA only	No
Chiropractic	Plan limit of 35 combined with PT/OT/ST -no auth required	BRCA	No
Cleft lip/palate services/surgery	Yes	Breast Pump	No member gets $250
Cochlear implants	Yes	Cardiac Rehab	Plan year limit 36 visits
Continuous Glucose Monitor	Yes	Carotid Ultrasound	No
CPAP	Yes	Cataract Surgery	No
CT/CTA Scan	Yes	Continuous Glucose Monitor Supplies	No
Diagnostic Imaging MRI/CT/PET	Yes	Colonoscopy	No
Dialysis	Yes	Cologuard	No
DME	Items over $500	CPAP Supplies	No
Elective Abortion	Not covered	Diabetes Education	No
Genetic Testing	Yes	Diabetes Testing Supplies	No
Hida Scan	Yes	Echocardiogram	No
Home Health	After first 30 visits	EGD/Endoscopy	No
Hospice-Inpatient	Yes	Epidural Steroid Injection	Yes
Hospice Outpatient	Required after 6 months	Essure	No
Infertility Testing	See Specific service	Flu Vaccination	No
Injectables	Yes, for meds over $1000	Hearing Aids	No auth, Plan limit of 1 per ear every 36 months
Inpatient Admission-Preplanned	Yes	Holter/Event Monitor	No

Inpatient Surgery	Yes	Hospital- OBS <23hrs	No
Insulin Pump	Yes	HPV Vaccination-Boys	No
Invitro fertilization	Not covered	HPV Vaccination-Girls	No
IV infusion Home or Outpatient	Yes	Implanon/Nexplanon	No
Mastectomy	Yes	Insulin pump supplies	No
Maternity-Vaginal-delivery only	Notification required at time of admission	IUD/Diaphragm	No
Maternity- C-section-delivery only	Notification required at time of admission	Mammograms	No
Maternity- Surrogate	Not covered	Maternity-Global	No
Mental Health- Inpatient	Yes	Medication port	No
MRI	Yes	Mental Health- Outpatient	No
Newborn Stay – Beyond Mom's	Notification required at time of admission	MOHS	No
Nuclear Medicine	Yes	Neuropsychic Testing	No
Orthotics/diabetic shoes	Yes when >$500	Nuclear Stress	No
Orthotics	Yes when >$500	Nutrition Counseling	No
OP Surgery-Hospital/Surgery Ctr	Yes	O_2 & O_2 concentrator	No
In-office procedures	Yes >$1000	PICC line (all procedures)	No
PET Scan	Yes	Pneumococcal Vaccine	No
Pulmonary Perfusion Test	Yes	Pulmonary Function Test-PFT	No
VQ Scan	Yes	Diagnostic x-ray	No
Radiation	Yes	Shingles <60yo	No
SNF (Skilled Nursing-Inpatient)	Yes	SPECT/Lexiscan	No
Sleep Study- in lab	Yes	Stress Test	No
Specialty Drugs-PBM	Yes	Substance Abuse Care Outpatient	No
Substance Abuse Care Inpatient	Yes	Tubal Ligation	No
TMJ Treatment	See Section T	Ultrasounds	No
Transgender services	See category of services to be rendered	Vasectomy	No
Transplants	Yes	Wound care	No
Wigs (Chemo)	Yes	PT/OT/ST - rehabilitative	Plan limit of 35 combined with Chiropractic -no auth required
Video EEG- Inpatient only	Yes	PT/OT - habilitative	Plan year limit 35 visits per therapy
		Vaccinations	No

SECTION 8: BENEFITS/COVERAGE (WHAT IS COVERED)

GENERAL RULES

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

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

Even if the Plan pays for Covered Services, You must 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 Newly Born and Adopted 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. Your adopted Child will be covered by the Plan for the first thirty (30) days.

    - Whether the newborn child 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 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 newborn 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 newborn 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 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 newborn Child born with a cleft lip or cleft palate or both. If Medically Necessary, the care and treatment will include oral and facial surgery; surgical management; and follow-up care by plastic

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 the subsection (4). Therefore, these Benefits are available to all Enrollees.

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

6. Genetic Inborn Errors of Metabolism. The Plan will provide coverage for inherited enzymatic disorders cause 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; 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 result 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 Provider 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 sections.

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 internally 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 constructed 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 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 is covered as medically necessary.

8. Screening tests for phenylketonuria, other heritable diseases, hypothyroidism, and other disorders for which screening is required are covered including the cost of the kit.

B. Early Intervention Services

1. The Plan will not prohibit or restrict payment for covered services provided to a child and determined to be necessary to and provided in accordance with an individualized family services plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.
   - Rehabilitative and habilitative therapies will be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.
   - A child is entitled to benefits if the child, as a result of the child's relationship to an insured or enrollee in the plan.

C. Autism Spectrum Disorders

1. The Plan provides coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for Members under the age of nineteen (19) or, if enrolled in high school until the Member reaches the age of twenty-two (22). This includes treatment for the following neurobiological disorders: Autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive 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.

D. Congenital Defects and Birth Abnormalities

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

2. Annual Limitation. Each Year, the Plan will pay for up to thirty-five (35) visits for all therapies (physical, occupational and speech) for the Covered Child. The therapy visits must be spread out throughout the Plan Year without regard to reason for treatment or whether the purpose of the therapy is to maintain or to improve functional capacity.

E. Child Speech and Hearing Benefits

1. Speech Therapy. If a Covered Child under the age of six (6) experiences speech delay, the Plan will 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 and Hearing Aids. The Plan will cover routine hearing exams for a Covered Child. The Plan will cover hearing tests in support of a diagnosis and medically covered condition. The Plan does not include audiometry and tympanograms not in support of a diagnosis. Coverage is provided for purchase, repair, and replacement of one (1) Medically Necessary hearing aid, once every three years. FHP 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.

3. Screening Tests for Hearing Impairment. The Plan will cover a screening test for hearing loss from birth through the date the child is thirty (30) days old and necessary diagnostic follow-up care related to the screening tests from birth through the date the child is twenty-four (24) months. Deductibles indicated on Your Schedule of Benefits will not apply to this provision.

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 disable 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.

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 healthcare.gov as a stand-alone benefit.

3. Pediatric Vision Care. The Plan will cover one vision exam each Plan Year for a Covered Child who is under the age of nineteen (19) for services rendered by an optometrists, therapeutic optometrists, and ophthalmologists. Eyeglasses for a Covered Child will be covered for one (1) pair every twenty-four (24) 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

G. Special Preventative Services with No Cost-Sharing

How No Cost-Sharing Applies. When You or Your Covered Dependents receive certain preventative services from a Participating Provider, You do not have to pay a Copayment, Deductible, or Coinsurance for the preventive services. However, if You or Your Covered Dependent receives services a Participating Provider for more than one reason, the Participating Provider may bill for each reason separately. In that case, if the primary purpose of the service is the delivery of the preventive service or item, then no service Copayment or other cost-sharing requirement will be imposed. If the primary reason of the service is not the delivery of the preventive service or item, then the service Copayment or cost-sharing requirement can be imposed on the service.

1. Preventive Services. The Plan will pay for the preventive services, based on the A or B recommendations of the United States Preventive Service Task Force (USPSTF). Friday 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. <u>Office Screenings</u>

- Alcohol misuse screening and behavioral counseling interventions for adults. Including pregnant women and providing persons engaged in risky or hazardous drinking with behavioral counseling interventions to reduce unhealthy alcohol use.

- 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 Screening and Cessation Program- the Plan will cover smoking cessation programs including, intervention services, behavioral interventions, and prescription drugs. The Plan will cover two quit attempts per plan year. The Plan will cover at least four (4) sessions of individual, group, or telephone cessation counseling. The smoking cessation program includes all FDA approved tobacco cessation medications (Nicotine patch, gum, lozenge, nasal spray, and inhaler; bupropion and varenicline). The smoking cessation services must be provided by a Network Provider or be an approved Plan program. There is no cost sharing or Prior Authorization requirement for these programs, You can access the Quitline by calling 1-800-Quit-NOW/1-800-784-8669.

- Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults 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.
- Low-Dose aspirin as preventative medication after 12 weeks gestation in women who are at risk for pre-eclampsia.

- 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.

- Screening for depression in the general adolescent and adult population,

including pregnant and postpartum women.

- Screening for major Depressive disorder (MDD) in adolescents aged twelve

b. <u>Imaging or Procedural Screenings</u>

- Cervical cancer screening; if a cervical cancer screening test turns into a diagnostic procedure, then the plan's deductible and coinsurance will apply.

- One Breast cancer screening or diagnostic imaging with mammography, ultrasound, or MRI per Plan Year, covering the actual charge of the screening with mammography. All forms of mammography are covered.

- Benefits for preventative mammography imaging are determined on a Plan Year basis. These mammography imaging preventive and diagnostic benefits do not reduce, or limit diagnostic benefits otherwise allowed under the Policy. If a Covered Person receives more than one imaging in a Plan Year, the other benefit provisions in the Policy apply with respect to the additional screening.

- FHP follows the recommendations of the American College of Obstetricians and Gynecologist (ACOG) guidelines for breast cancer screening which recommend screening earlier and more frequent than USPSTF. Mammogram preventive benefits include one baseline mammogram to persons aged thirty-five through thirty-nine. One mammogram screening or diagnostic and clinical breast exam once a year for female Enrollees who is at least thirty-five (35) years of age. 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, screening or diagnostic, and clinical breast exam starting at age twenty-five (25). This includes mammography by any means, x-ray, digital mammography, ultrasound, or MRI.

    - Diagnostic imaging includes imaging for Members with dense breast tissue.

    - 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.

- 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 exams, tests and any other preventive services on the USPSTF recommendations with a grade of "A" or "B" for the early detection of colorectal cancer and adenomatous polyps starting at age forty-five (45) This benefit includes but not limited to: fecal occult blood test, a flexible sigmoidoscopy, an initial colonoscopy screening and a follow-up colonoscopy if initial testing is abnormal per plan year.

- 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 younger than sixty-five (65) years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

    - Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women sixty-five (65) years and older

- 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.

- The Plan covers an annual medically recognized examination for the early detection of ovarian cancer and cervical cancer to each woman eighteen (18) years of age or older. Coverage of a CA 125 blood test is also covered. This will include all FDA approved testing or screening for the detection of ovarian cancer.

- The Plan provides coverage for detection and prevention of osteoporosis which includes medically accepted bone mass measurements for the detection of low bone mass and to determine one's risk for osteoporosis and fractures of qualified individuals. These services are not limited to an age and do not require a Prior Authorization.

- 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.

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 29 years with cervical cytology (Pap smear) alone every 3 years or, for women aged 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 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.

d. <u>Vaccinations</u>

- 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).

e. 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 Plan in writing at:

Friday Health Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101

questions@fridayhealthplans.com

If You prefer, You may call the Friday Care Crew at 1-844-451-4444.

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. 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 13-18	One (1) Health Maintenance Visit Per Plan Year
Age 19-39	One (1) exam every 36 months
Age 40-64	One (1) exam every 24 months
Over age 64	One (1) exam every 12 months

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. <u>Limitations on Services and Examinations.</u> 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 or sigmoidoscopies. However, these services may be covered if they are Medically Necessary. In addition, the Plan will generally not cover examinations that are more frequent than those identified on the schedule above. However, the Plan may cover more examinations if they support a diagnosis, as determined 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. <u>For Adult Women</u>. 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 and up to seventy-five (75) years of age. All types of low dose mammography are covered. There is no age limit for diagnostic mammograms.

   - One mammogram and clinical breast exam annually between thirty-five (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).

6. <u>For Adult Men</u>. 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 who is fifty (50) years of age or older; and

   - One screening per year for any male Enrollee between (40) forty and fifty (50) years of age. However, the Enrollee must have an increased risk of developing prostate cancer. A Participating Provider must make this determination.

   - 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.

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.

2. 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.

3. Home Visits. The Plan will cover Medically Necessary visits by the Member's Primary Care Provider to the Enrollee's home within the service area. The Calendar Year maximum benefit is sixty (60) visits.

4. 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.

5. Specialty Provider Services. The Plan will cover services of a Participating Provides 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.

6. 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

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 must be prescribed by Your Health Care Professional. 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. Coverage does not include high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure.

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.

10. 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.

11. Urgent Care Center. Non-Emergency care may be provided at an Urgent Care Center, but Non-Emergent Care must be provided at a Network Urgent Care Center. Use of a Non-

Network Urgent Care Center within the Service Area when the services do not meet the definition of Emergency and Urgent Care Services would not be considered a covered benefit.

12. COVID-19 Treatment and testing as required by applicable federal or state 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:
   a. Parents of a Child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;
   b. Parents of a Child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome;

   c. 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

d. 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.

5. Covered Services include genetic testing of heritable disorders as Medically Necessary when the following conditions are met:

   a. The results will directly impact clinical decision-making and/or clinical outcome for the individual;

   b. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

   c. 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.

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

7. 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.

8. 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 Medically 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.

4. Special Coverage Following Treatment of Breast Cancer. If due to treatment of breast cancer, an Enrollee has either a mastectomy of lymph node dissection, the Plan will cover inpatient care for a minimum of:

   - forty-eight (48) hours following a mastectomy; and

   - Twenty-four (24) hours following a lymph node dissection.

5. The minimum number of inpatient hours is not required of the Enrollee receiving the treatment and the attending Provider determine that a shorter period of inpatient care is appropriate.

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 Office visits. The Plan will cover outpatient mental health office visits in the same manner that it covers other outpatient office visits with no Prior Authorization.

3. Outpatient Mental Health Procedures and Intensive Outpatient treatment. Will be covered in the same manner as other outpatient medical procedures. These services may require Prior Authorization as with other outpatient procedures.

4. 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.

5. 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.

6. 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.

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, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, 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).

2. 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 (HSA 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.

    a. 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:

       i. devices that are required to substitute for the missing or non-functioning body part or organ;

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

iii. Adjustment of initial prosthetic device; and

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

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

3. Orthotics. Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective 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.

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

5. Enteral Nutrition. The Plan covers enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a 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.

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:

a. 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.

b. 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;

c. 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 above, a Medical Emergency is limited to certain situations. There must be sudden and severe medical condition (including sever 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.

3. 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 have treated the Enrollee.

4. Plan Notification Required. The Enrollee must notify the Plan of any Medical Emergency. The Enrollee must do so on the first business day after 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.

5. Transfer. If an Enrollee is hospitalized in the 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, generally 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 Provider and the Member. If the mother and child are discharged prior to forty-eight (48) hours following delivery, then one newborn visit within the first week of life will be covered.

5. 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 covers the diagnosis of infertility.

3. 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. 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 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 sixty (60) visits per year.

- 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 autologous or allogeneic bone marrow transplant 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 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.

4. Conditions. All transplant services require Prior Authorization. However, the Enrollee must first be accepted into the transplant program at one of the Plan's Specialty Care Centers. Coverage may also be subject to approval by an appropriate evaluation committee designated by the Plan. The committee will consider factors such as the treatment's effectiveness in improving the length and quality of life; the mortality and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and the Enrollee's physical and mental condition. The Plan will cover donor search and acceptability testing of potential love donors as well as short-term storage of donated organs and tissues.

S. Hospice

1. General Coverage. The Plan covers physical, psychological, spiritual and bereavement care for terminally ill Enrollee 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; Provider 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 limitation 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;
   - Provider 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 coordination all hospice care service. This is true regardless of the location or facility providing services.

   - Hospice services are allowed only for Enrollees who are terminally ill or injured requiring skilled health care services. . 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 requires Prior Authorization after the first benefit period.

   - The Enrollee's Primary Care Provider must periodically review hospice services.

   - 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 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 Inpatient skilled nursing facility. These services also require Prior Authorization. Coverage by the Plan is limited to twenty-five (25) days per Plan Year.

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 thirty-five (35) visits, combined, for physical, occupational and chiropractic therapy per Plan Year. There are no visit limitations for these services in regard to mental Health or Substance Abuse disorders. 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 period.

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 require Prior Authorization. The Plan will not cover services for chronic or recurring conditions that do not show sustained significant improvement within the allowed period.

   b. Habilitation Services limited to one hundred twenty (120) visits per year

   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 Services

   - Cardiac Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Provider and provided by participating therapists at participating facilities. Plan limit of 36 visits per Plan Year
   - Early Detection Tests for Cardiovascular Disease Benefits. Early Detection Tests for Cardiovascular Disease Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization: Computed tomography (CT) scanning measuring coronary artery calcifications; or Ultrasonography measuring carotid intima-media thickness and plaque.

     Tests are available to each Covered Person who is (1) a male older than 45 years of age and Younger than 76 years of age, or (2) a female older than fifty-five (55) years of age and Younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

6. Pulmonary Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Provider and provided by participating therapists at participating facilities. Plan limit of eighteen visits per Plan Year.

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 generally 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; Reduction of a dislocation of excision of, and injection of the temporomandibular joint, except as excluded under the Plan.

   - Treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue.

   - Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;

   - Incision and drainage of facial abscess;

   - Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and

   - Removal of complete bony impacted teeth.

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

10. Eye Exams. The Plan will cover eye examination 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.

11. Hearing Exams and Hearing Aids. The Plan will cover hearing tests. This is in addition to the benefits described in the section above relating to Child Speech and Hearing Benefits. The Plan will cover Medically Necessary hearing aids or cochlear implants and related services and supplies for Covered Individuals. Coverage includes fitting and dispensing services, treatment for habilitation for habilitation and rehabilitation, and for cochlear implant, an external speech processor and controller with necessary component and replacement every thirty-six (36) months.

12. Prescription Drugs. Prescription drugs are covered under Your benefit Plan as follows:

- Inpatient 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. The Plan's formulary is list of FDA-approved Drugs that has been reviewed and recommended for use based on their quality and cost effectiveness. Your Prescription drug coverage is limited to those Drugs listed in Our Formulary. In addition to the requirement that the drug is listed on Friday's Formulary, coverage of outpatient prescription drugs is subject to the following:

    - 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.

- The Plan will not offer Cost-Sharing reductions for prescriptions filled at any pharmacies that the Plan or the pharmacy benefit manager has a business affiliation.
- Prescription drugs for insulin will not cost a member more than $25 for a 30-day supply.
- Members can receive emergency refills of their insulin and related equipment as they would a non-emergent routine refill.

- Outpatient prescription drugs from a Plan 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 prescribed for and FDA approved use

    - Is recognized by authoritative reference compendia as identified by the US Department of Health and Human Services.

    - Will be used to treat Covered Services.

- Coverage is also available for synchronized medication packs dispensed by a pharmacy. The prescribing provider and the enrollee must agree that synchronizing of the refill dates of drug fills is in the best interest of the enrollee. The drug copay will be based on the pro-rata share of the synchronized drug costs.

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 thirty (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 thirty (30)-day supply.

Medications for which a generic equivalent is available will be filled with an approved generic equivalent. If a brand-name medication is requested when an approved generic equivalent is available the Member will pay the cost difference between the generic and brand-name drug (ancillary charge), in addition to the copayment or coinsurance amount. The difference will not apply to the deductible or the out-of-pocket maximum. This is waived if the Prescribing Provider designates the prescription to be dispensed as written

and there is a medical reason why a generic drug does not meet the medical needs of the Member.

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

i.) 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

ii.) 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 prescription eye drops is covered if:

a. A bottle is requested by the insured or the health care provider at the time the original prescription is filled
b. 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 alternative. 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 medication 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.

Step Therapy will not apply drugs prescribed for stage-four advanced, metastatic cancer and associated conditions if the use of the prescribed drug is consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition, supported by peer-reviewed, evidence-based literature, and approved by the United States Food and Drug Administration.

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. Additions to the Formulary can be made at any time, but we will remove drugs and injectables from the Formulary only at renewal of the Plan.

Benefits for Medically Necessary drugs prescribed to treat a chronic, disabling, or life-threatening illness are available under the Plan if the drug:

- Has been approved by the united States Food and Drug Administration (FDA) for at least one indication; and

- Is recognized by the following for treatment of the indication for which the drug is prescribed:

    - A prescription drug reference compendium approved by the Texas Department of Insurance, or

    - Substantially accepted peer-reviewed medical literature.

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by us through the exception process. If Friday grants Your request, we will cover the non-formulary drug for the duration of the prescription. If Friday 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 the Appeals and Complaints section, 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 period and may require 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 provider 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 requested is denied, You, Your designee, or Your Provider (based on a written request by You to allow Your Provider 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 Friday Care Crew at 1-844-451-4444.

13. <u>Oral Anti-Cancer Medication</u>. 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 the 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, Provider, 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.

14. Routine Care during Clinical Trials.
    a. Approved Clinical Trials: Covered Services may be eligible for coverage when received in connection with a Phase I, Phase II, Phase III, or Phase IV clinical trial if all of the following conditions are met:

- The services would have been covered if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the 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 determination 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 approved clinical trial is:
    - Federally funded
    - Conducted under an FDA investigational new drug application
    - A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- 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 as 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 of the control arms of a clinical trial; except the investigational item or service, itself; 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.

15. Transgender Services. The 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.

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 sections 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. FHP will approve Off-label Prescriptions if the following is true:

a. 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 compendium as identified by the Secretary of the United States Department of Health and Human Services

   Exclusion: if a drug is being prescribed for off-label use and the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed, then the drug would not be considered a covered benefit.

W. Chiropractic

1. Chiropractic services are covered when provided by contracted providers acting within the scope of its license chiropractors and are limited to evaluation, lab services and X-rays required for chiropractic services and treatment of musculoskeletal disorders. The Plan will cover services that are within the scope of a chiropractor’s license. Limited to thirty-five (35) visits combined per Plan year. This limit is combined with physical medicine and 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. Prescription 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

X. Acquired Brain Injury

1. Benefits for Eligible Expenses incurred for Medically Necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

   Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

   - Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

   - Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

   To ensure that appropriate post-acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

   1. Has incurred an Acquired Brain Injury;

   2. Has been unresponsive to treatment; and

   3. Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

SECTION 9: 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. Medical, surgical, or other health care procedures, treatments, devices, products, or services that are experimental or investigative.

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

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

7. A private room or service of private or special duty nurses when an Enrollee is an inpatient in a hospital.

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

9. Acupuncture and acupressure whether or not by a Provider.

10. Services performed in connection with treatment to teeth or gums; upper or lower jaw augmentation or reduction or cosmetic reconstruction; or orthognathic surgery. All dental services not identified in this Policy. General anesthesia for dental procedures except those services specifically covered under this Policy.

11. Nursing homes and custodial care.
12. Eye refractions or examinations, except as specifically covered under this Policy. Eyeglasses and all other types of vision hardware or vision corrective appliances. This includes contact lenses; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy; and clear lensectomy.
13. Hearing screening exams except as specifically covered under this Policy.

14. 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 members need.

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

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

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

18. 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 modification to the home or motorized vehicles. Exceptions to this exclusion would be over-the-counter items or drugs required to be covered by federal or state statutes or regulations.

19. Surgery or other health care services or supplies to correct or restore or enhance body parts not likely to result in significant improvement in bodily function. This includes, but not limited to, breast implants except covered implant after mastectomy due to breast cancer.

20. 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.

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

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

23. All military service-connected conditions.

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

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

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

27. Complications caused by treatment of infertility.

28. Elective Abortions.

29. Diagnosis, treatment, and rehabilitation services for obesity; non-Covered Services related to obesity; weight-loss educational services; diet supplements; weight loss surgery or complications caused by weight loss surgery except as specifically covered herein. This includes surgical procedures, such as Bariatric Surgery, even if the Member has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under Preventive Services.

30. All organ and tissue transplants or autologous stem cell rescue not explicitly identified as covered.

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

32. Transplants disapproved by the appropriate evaluation committee. If the transplant request has been disapproved, You have the right to Appeal (see Appeals and Grievances section for further information).

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

34. 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 services require to be covered elsewhere in the benefit plan.

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

36. Long term rehabilitative services.

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

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

39. Bone and eye bank charges.

40. Counseling or training in connection with sexual, marital, or occupational issues.

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

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

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

44. The treatment of any injury or illness that arises out of, or as the result if, any work for wage or profit. However, this exclusion will not apply when the Enrollee is not required to be covered by a workers' compensation Policy, and, in fact does not have such coverage. This would apply in the case of:

    - A sole proprietor if the Employer is a proprietorship;
    - A partner of the employer, or someone the Employer is a partnership with; or
    - An executive officer of the Employer if the Employer is a corporation.

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

46. Over the Counter drugs other than insulin.

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

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

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

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

51. Drugs or injections for treatment of involuntary infertility are not covered.

52. Abortifacient drugs are not covered

53. Compounded medications/prescriptions are not covered.

54. Medications with no approval indications.

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

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

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

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

59. Hair analysis.

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

61. Post-partum exercises.

62. Services for conditions arising from or worsening as a result of the Enrollee's refusal to accept treatment recommended by a 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 Enrollees 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. If the services are denied You may Appeal the decision (see Appeals and Grievances section for more information).

65. Any and all costs related to surrogate pregnancies and deliveries.

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

67. Friday does not cover any health care services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of 1) committing or attempting to commit a criminal act; 2) engaging in an illegal occupation; or 3) participating in a riot, rebellion, or insurrection.

68. Services, care, or treatment for medical complications resulting from or associated with non-Covered Services.

69. Any benefits in excess of any day, visit or Calendar Year limitations.

SECTION 10: MEMBER PAYMENT RESPONSIBILITY

MONTHLY PREMIUMS

In exchange of Plan coverage, You will be required to pay monthly Premiums to the Plan. The Plan does not charge a service fee for payment processing regardless of payment method. However, Your Premiums may be reduced if You are eligible for Premium Advances. Premium Advances will be sent directly to the Plan from the Federal government.

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

PAYMENTS 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.

COORDINATION WITH OTHER COVERAGE

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

DEFINITIONS

a. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a

group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimbursement for the cost of dental care; medical care components of individuals and group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

2. Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private policy that is designed to fully integrate with other policies through a variable deductible.

   Each contract for coverage under (1) (a) or (1) (b) is a separate plan. If a plan has two parts and COB rules only apply to one of the two, each of the parts is treated as a separate plan.

b. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits. The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

c. "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, which is covered at least in part by any plan covering the person. When a plan

provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or Provider by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides overage for private hospital room expenses.

2. If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

4. If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or Provider's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and Provider arrangements.

d. "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or Provider, the allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

e. “Closed panel plan” is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and Providers, except in cases of emergency or referral by a panel member.

f. “Custodial parent” is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

c. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.

d. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

e. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or Provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

f. When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan’s compliance with this subchapter.

g. If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decides the order in which secondary plans’ benefits are determined

in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has been its benefits determined before those of that secondary plan.

h. Each plan determines its order of benefits using the first of the following rules that apply.

   1. Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

   2. Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the other of benefits using the following rules that apply.

      A For a dependent child, whose parents are married or are living together, whether or not they have ever been married:

         i The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

         ii If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

      B For a dependent child, whose parents are divorced, separated, or not living together, whether or not they have ever been married:

         i If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

         ii If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

         iii If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage

of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

iv If there is not court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

I The plan covering the custodial parent;

II The plan covering the spouse of the custodial parent;

III The plan covering the noncustodial parent; then

IV The plan covering the spouse of the noncustodial parent.

C For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

D For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h) (5) applies.

E In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

3. Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h) (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h) (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECTS ON THE BENEFITS OF THE PLAN

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Friday Health Plans will comply with federal and state law concerning confidential information for the purpose of apply these rules and determining benefits payable under this plan must Friday Health Plans any facts it needs to apply those rules and determine benefits.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Friday Health Plans may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Friday Health Plans will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF SUBROGATION/REIMBURSEMENT

In certain circumstance, You or Your Covered Dependents (or the heirs, executor, or beneficiaries of You or Your Covered Dependents) may have an obligation to reimburse the plan for payments made to or on behalf of You or Your Covered Dependents. This right of reimbursement arises if You or Your Covered Dependents receive any benefits under the plan as a result of an injury or illness, and there is a third party (including an insurance company) that is legally responsible for paying for Your injuries (or Your Covered Dependents' injuries). If Friday pays benefits under this Policy for Your medical expenses incurred due to a third-party injury, then the Plan retains the right to repayment of the full cost (or the maximum amount allowed under CPRC § 140.005) of all benefits provided by the Plan on Your behalf that are associated with the third-party injuries. In these cases, the Plan will have a legal right (known as a "right of subrogation") to recover any amounts that are payable by the third party (such as an insurance company).

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

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

- The name and address of the party that caused the injury, the facts of the accident, and any other information reasonably necessary to protect Plans rights;
- All information about the other party's liability insurer(s), if known;
- Information relating to any personal injury protection, underinsured or uninsured motorist insurance or any other insurance, as well as a copy of any such insurance Policy;
- Notice of any claim or legal action filed or submitted against a third party (within sixty (60) days of submitting or filing such claim); and
- Prior written notice of any intended settlement.

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

By filing a claim for and/or accepting benefits from the Plan, You and Your Covered Dependents are considered to have consented to the Plan's subrogation and right of reimbursement. You and Your Covered Dependents are considered to have agreed to cooperate with the Plan in any way

necessary to make, perfect or prosecute any related claim, right or cause of action. You or Your Covered Dependents agree to enter into a subrogation and reimbursement agreement with the Plan if the Plan requests such an agreement. You and Your Covered Dependents may not do anything that would prejudice or harm the rights of the Plan to pursue its rights of reimbursement and subrogation.

Texas Statues will govern Subrogation and Recovery Rights. If anything in this section is not in accordance with Texas Statutes, then Texas Statutes shall supersede it.

RIGHT TO OFFSET FUTURE PAYMENTS

If the Plan sends You or Your Cover 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). A covered person may make a written assignment of benefits to a Provider or other health care provider who provides health care services to the person.

SECTION 11: CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

HEALTH CARE PROVIDER MAY SUBMIT CLAIM

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

CLAIMS YOU SUBMIT TO THE PLAN

In other cases (such as when You fail to produce Your identification card), You may be required to pay the health care Provider for all services at the time the care is provided. If this happens, You may file a written claim with the Plan. If You file Your claim in a timely manner, the Plan will reimburse You for the amount You paid for the Covered Services that were provided up to the contracted rate with the provider. However, the Plan will not reimburse You for any Copayment, Coinsurance or Deductible amounts that You were required to pay 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 claim with the Plan. If You file Your claim in a timely manner, the Plan will pay the health care provider for the Covered Services that were provided at the contracted rate with the provider. However, the Plan will not pay for any Copayment, Coinsurance or Deductible amounts You owe to the health care provider. You are responsible for making sure that You receive the bill from the health care provider on a timely basis. If You do not file Your claim in a timely manner, the Plan will not pay the health care provider. Instead, You will be required to pay for all of the health care services that were provided.

Friday, on receipt of a notice of Claim, will provide to the claimant the forms for filing proof of loss. If the forms are not provided before the 21st day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Plan as to proof of loss for 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 the claim is made. Friday must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;

2. Bills and statements reflecting services and items furnished to a Participant and amount charged for those services and items that are covered by the claim, and

3. Correct diagnosis code(s) and procedure code(s) for the services and items.

TIMING AND CONTENTS OF CLAIM

If You are submitting a claim to the Plan, You must do so within ninety-five (95) days of the date that the health care services were provided. Claims not submitted and received by Friday within

twelve (12) months after the time proof is otherwise required will not be considered for payment of benefits except in the absence of legal capacity. 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 set to:

Friday Health Plans
PO Box 194
Sidney, NE 69162

TIME OF PAYMENT OF CLAIMS

Indemnities payable under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss.

PAYMENT OF CLAIMS

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this Policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the Member's estate. Any other accrued indemnities unpaid at the Member's death may, at the option of the insurer, be paid wither in accordance with the beneficiary designation or to the Member's estate. All other indemnities will be payable to the Member. All benefits payable under this Policy on behalf of a dependent who is insured by this Policy for which benefits for financial and medical assistance are being provided by Texas Health and Human Services Commission, shall be paid to said department whenever:

1. Texas Health and Human Services Commission is paying benefits under the Human Resources Code, Chapter 31, or Chapter 32, i.e., financial, and medical assistance service programs administered pursuant to the Human Resources Code;

2. The parent who purchased the individual Policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

3. The insurer must receive at its home office, written notice affixed to the insurance claim when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to Texas Health and Human Services Commission.

PHYSICAL EXAMINATION AND AUTOPSY

Pursuant to Texas law – n insurer at its own expense has the right and opportunity to conduct a physical examination of the insured when and as often as the insurer reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

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 ate with the Participating Provider. If You fail to submit Your claim within the required timeframe, Your claim will be denied.

CLAIM NOTIFICATIONS

IF A CLAIM IS DENIED

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

- Specific reasons for the denial;
- An explanation of the medical basis for the decision, if applicable;
- Specific reference to relevant Plan provisions;
- A description of any additional material or information necessary for You to perfect Your claim, and an explanation of why such material or information is necessary; and
- Information as to the steps You can take if You wish to appeal the decision.
- If a claim for prescription drugs or intravenous infusions is denied, or if You have a life-threatening condition, You have the right to an expedited appeal.

The notice may also include any information regarding 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 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 is 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.

TO REVIEW CLAIM DETERMINATIONS

If You believe Friday incorrectly denied all or part of Your benefits, You may have Your claim reviewed. Friday will review its decision in accordance with the following procedure:

- Within 180 days after You receive notice of a denial or partial denial, write to Friday and state why You disagree with the denial or partial denial of the claim. Send You request to:

  Friday Health Plans
  PO Box 194
  Sidney, NE 69162

Once You request a claim review, You may designate a representative to act for You in the review procedure. Your designation of representative must be in writing as it is necessary to protect against disclosure of information about You expect to Your authorized representative. Friday allows telephone requests for information, but these calls will not constitute a request for review. You and Your authorized representative may ask to see relevant documents and may submit written issues, comments, and additional medical information within 180 days after You receive notice of denial or partial denial. Friday will give You a written decision within sixty (60) days after it receives Your request for review.

SECTION 12: 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) section. If a health care service or supply is not identified in the BENEFITS/COVERAGE (WHAT IS COVERED) section, it is not 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. If Your services are denied You have the right to Appeal (see Appeals and Grievances section).

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

UNPAID PREMIUM

Any unpaid Premium may be sent to collections for recovery. We may retroactively terminate and refund a maximum of one month's Premium when You provide proof of overlapping coverage. If You had Claims during that month, Friday would not provide a Premium refund. You will be responsible for any Claims filed after the retroactive termination. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

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.

TIME LIMIT ON CERTAIN DEFENSES

After the second anniversary of the date this Policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the Policy may not be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) beginning after that anniversary.

A claim for loss incurred or disability (as defined in the Policy) beginning after the second anniversary of the date this Policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this Policy.

MISSTATEMENT OF AGE

If the age of the insured has been misstated, the amounts payable under this Policy are the amounts the premium would have been if purchased under the correct age.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

REINSTATEMENT

If a premium is not paid before the expiration of the grace period granted to make the payment, a subsequent acceptance of the premium by us or any great authorized by us to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if We or an authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application form if the application is not approved, on the 45th day after the date of the conditional receipt unless the insurer before that date has notified the insured in writing of the insurer's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness that begins more than ten (10) days after the date of reinstatement. In all other respects the insured and insurer have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days before the date of reinstatement.

LEGAL ACTIONS

An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

THIRD PARTY BENEFICIARIES

This contract is not intended to, nor does it, provide any rights in favor of any third party, including but not limited to any hospital, provider or medical practitioner providing services to You, and this contract shall not be construed to create any third-party beneficiary rights.

ACCESS PLAN

The Plan 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 Insurance Company, Inc.
700 Main Street
Alamosa, Colorado 81101

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 Network Providers. Entry into the Program may happen in many ways. For example:

- Through completing Your Health Risk Assessment
- Our review of claims information
- A referral from a hospital care manager; or
- A Provider referral
- 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 at 1-844-451-4444.

SPECIAL RIGHTS OF THE MEMBER

PRIVACY

The Plan will have access to information from Your medical records, including information received from Your health care providers seeking paying from the Plan. The Plan is permitted to

use and disclose such information only as reasonably necessary in administering Your Plan benefits and complying with applicable law. The Plan will protect the confidentiality and privacy of all such information in the manner required by applicable Federal and State law. A copy of Friday's Notice of Privacy is included in the Welcome Kit sent to Subscribers upon enrollment. You can ask for a copy of Friday's Notice of Privacy at any time.

HEALTH STATUS

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

SECTION 13: TERMINATION/NONRENEWAL/CONTINUATION

TERMINATION OF PLAN COVERAGE

END OF YOUR COVERAGE
Your Plan coverage will end if:

- You fail to satisfy the eligibility conditions for participation in the Plan;
- You terminate Your coverage in the Plan with appropriate notice to the Plan or healthcare.gov;
- You change from one healthcare.gov plan to another during the Open Enrollment Period or through special enrollment;
- You fail to pay Your Premiums, and any applicable grace period has expired;
- You experience a Rescission of coverage;
- You engage in certain misconduct, as described in the Effective Date of Termination of Coverage section; or You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end as of the Effective Date)
- The Plan is terminated or is “decertified” by healthcare.gov.
- If the Insured fails to give written notice within thirty-one (31) hays of the loss of eligibility, Friday will terminate coverage retroactively and refund any corresponding premium.
- When information provided to Friday in the Application form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage. Friday 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 Friday 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 2: Eligibility, Enrollment and Effective Date

END OF YOUR COVERED DEPENDENTS’ COVERAGE
Generally, Your Covered Dependents’ coverage ends when Your coverage ends. In the event of Your death, Your spouse may continue coverage under the Policy if he or she meets eligibility requirements. 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

When You and/or Your Covered Dependents lose Plan coverage, the Plan will, within thirty (30) days of Your request, provide You and/or such Dependents with a document called a "Certificate of Creditable Coverage" consistent with applicable federal and Texas requirements. 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 Plan in writing at:

Friday Health Insurance Company, 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 you must contact the Exchange to do so. The effective date of termination is assigned by the Exchange and 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 Exchange you will need to appeal said date through the process set out by the Exchange, as that earlier date will be subject to Exchange approval. If an earlier effective date of termination is approved by the Exchange, then the Plan will update to reflect the new effective date of termination. The Plan will comply with earlier effective dates of termination wherever possible and if approved by the Exchange 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 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 healthcare.gov notifies You of such loss of eligibility, unless You request an earlier termination date as described above. If You are a Covered Dependent no longer eligible due to divorce, You can obtain coverage under a new plan without evidence of insurability.

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 on connection with the Plan or the coverage, there will be a Rescission of Your coverage (and the coverage of Your Covered Dependents). In such 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 Plan will refund any contributions You made to the Plan relating to the period subject to the Rescission. However, the Plan may subtract from the refunded contributions any amounts paid by the Plan for covered Services (for You and Your Covered Dependents) during such period. The Plan may also charge You for any amounts paid by the Plan for Covered Services (for You

and Your Covered Dependents) during such period if those amounts are greater than the amount of Your contributions for that period. Any unpaid claims for Covered Services (for You or Your Covered Dependents) that relate to such period will, to the extent permitted by law, be denied by the Plan.

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

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

EXTENSION OF BENEFITS
If Plan coverage is terminated, an extension of benefits will be available for any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous total disability of the Member limited to the duration of the Policy benefit period, payment of the maximum benefits or to a time period of not less than three months. If Plan coverage is terminated due to cancellation by the insurer or nonrenewal by the insurer, an extension of benefits would have been available had the Policy remained effective. If a person loses coverage due to a change in marital status, that person shall be issued a Policy which Friday is then issuing which most nearly approximates the coverage of the Policy which was in effect prior to the change in marital status, and which will be issued without evidence of insurability and which will have the same Effective Date as the previous Policy. In the event of the insured's death the spouse of the insured, if covered under the Policy, shall become the insured.

RENEWAL RIGHTS

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

EXCEPTIONS TO RENEWAL RIGHTS
The Plan 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 material fact with respect to the terms of coverage; or

- There are no longer any Enrollees living, working, or residing within the Service Area.

- Enrollee has not provided the necessary hardship exemption for Catastrophic coverage for individuals over the age of thirty (30).

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

DISCONTINUING THE PLAN

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

- Provides notice of the decision not to renew coverage, at least ninety (90) days before the non-renewal of the Plan to each Enrollee;

- Offers each Enrollee the options to purchase coverage under any other health benefit plan currently being offered by the Plan in the State of Texas and identifies the applicable special enrollment periods for each such plan; and

- Provides the required notice and information to the Department id Insurance; and

- Complies with any other applicable non-renewal requirements imposed by law.

LEAVING THE INDIVIDUAL PLAN MARKET

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

SECTION 14: APPEALS AND COMPLAINTS

INTERNAL APPEAL PROCEDURE

RIGHT TO APPEAL

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

- A determination of an individual's eligibility for Policy coverage;
- The application of any Prior-Authorization requirements or other utilization review requirements;
- 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 Provider, who will consult with his/her clinical peers (unless the Provider is a clinical peer). The Provider and any clinical peers will be individuals who were not involved in making the Adverse Benefit Determination. 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 covered when the Adverse Benefit Determination was made.

If Friday denies Your appeal, in whole or in part, or You do not receive a timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

NOTIFICATION OF RECEIPT OF APPEAL

No later than the fifth (5th) business day after the date of receiving the complaint, Friday will send an acknowledgement letter to the complainant stating the following:

- The date of receipt of the complaint
- A description of the Plan's complaint procedures and time frames; and

EXPEDITED CLINICAL APPEALS

An "expedited clinical appeal" is an appeal of clinically urgent nature to health care services, including but not limited to, denial of prescription drugs or intravenous infusion, the denial of step-therapy exception, procedures or treatments ordered by a health care provider, as well as continued hospitalization, denial of another service if the requesting provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. In urgent situations where time is a factor, a member may appeal and have a decision from the Plan on an expedited manner. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, Friday will provide You with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, Friday will notify the party filing the appeal, as soon as possible, but in no event later than twenty-four (24) hours after submission of the appeal, of all the information needed to review the appeal. Friday will render a decision on the appeal within twenty-four (24) hours after it receives the requested information, but no later than seventy-two (72) hours after the appeal has been received by Friday.

HOW TO APPEAL

You (or Your authorized representative) may appeal an Adverse Benefits Determination by the following the Plan's procedures. To begin the appeals process, or to request help with the appeals process, You may call the Plan's Member Services at 1-844-451-4444. Your appeal must be received, in writing, or verbally 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.

When You file an appeal, You may submit additional comments, records and documents related to Your claim. You may also identify health care providers who will receive a copy of the Plan's decision. You may also review (at no charge) copies of the documents and information relevant to Your claim. This includes information or records that were relied on in making the Adverse Benefit Determination; information that was considered by or produced to the original decision-maker(s); information relating to administrative procedure and safeguards that were applied in making the original decision; and policies or guidance relating to the service or treatment for Your diagnosis. However, You must make a request for such review.

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

In addition, in life-threatening or urgent care circumstances, or if You are denied the provision of prescription drugs or intravenous infusions, You are entitled to an immediate appeal to an IRO Appeal and are not required to comply with Friday appeal of an Adverse Determination process. Upon receipt of an expedited pre-service or concurrent clinical appeal, Friday will notify the party

filing the appeal, as soon as possible, but in no event later than twenty-four (24) hours after submission of the appeal, of all the information needed to review the appeal. Friday will render a decision on the appeal within twenty-four (24) hours after it receives the requested information, but no later than seventy-two (72) hours after the appeal has been received by Friday.

APPEAL NOTIFICATION AND TIMING

If the Plan receives Your appeal by the appropriate deadline, Friday will acknowledge the receipt of the Appeal within five (5) business days. If the Appeal concerns an urgent care claim, then Friday will respond within twenty-four (24) hours. The Plan will independently review Your appeal and any additional information that You submit. The Plan will notify You of its decision regarding Your appeal within the following timeframes:

- For Urgent Care Claims. The Plan will notify You as soon as possible, but no later than seventy-two (72) hours after its receipt of Your appeal. If the Plan provides this notice orally, it will provide You with written confirmation of its decision within three (3) days.

- For Pre-Service Claims. For non-urgent concurrent or pre-service appeals, the Plan will notify You of its decision within a reasonable period of time, but no later than thirty (30) calendar days after its receipt of Your appeal.

IF AN APPEAL IS DENIED

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

- The decision;

- The name(s), title(s) and qualifications of the individual(s) reviewing the appeal;

- A statement of such individual(s)' understanding of the request for review;

- Specific reasons for the denial;

- Specific references to relevant Plan provisions. This will include a reference to the benefit Plan provision on which the determination was made.

- A statement that You may have access to or receive, upon request and at no charge, copies of all documents, records, and information relevant to Your claim; and

- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.

- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s), and how to access the language services provided by Friday.

- An explanation of Friday's external review process (and how to initiate an external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal

- Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

RIGHT TO ATTEND APPEAL MEETING

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

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

EXHAUSTION OF INTERNAL APPEAL RIGHTS

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

EXTERNAL APPEAL PROCEDURES

DENIALS THE QUALIFY FOR EXTERNAL REVIEW

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

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

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

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

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

There is no minimum dollar amount that applies to a claim that is eligible for an external review. For more information about IRO process, call Texas Department of Insurance (TDI) in the IRO information line at (88) TDI-2IRO (834-2476), or in Austin call (512) 322-3400

HOW TO FILE AN EXTERNAL APPEAL

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

If You are seeking an expedited review, You must state this in Your request. You must also include a Provider's certification that Your medical condition meets the criteria for an expedited external review. An expedited review is available if You have a medical condition where the timeframe for completing the standard external review would seriously jeopardize Your life or health; would jeopardize Your ability to regain maximum function; or if You have a disability, would create an imminent and substantial limitation on Your ability to live independently. An expedited review is also available if Your previous denial relates to a hospital or facility admission; availability of care; a continued stay; or to health care services for which emergency services were provided and a discharge has not occurred. If You are requesting an expedited review, You may obtain the external review at the same time as Your internal review of an Urgent Care Claim (as described in the Internal Appeal Procedures section above).

- The Plan will pay the costs of an external review.

APPOINTMENT OF EXTERNAL REVIEW ENTITY

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

- A copy of any information You or Your health care provider has submitted to the Plan in support of the request for an external review;

- A copy of relevant documents and information used by the Plan during the internal appeal process to determine medical necessity; medical appropriateness; medical effectiveness; or medical efficiency of the service or treatment, including and scientific evidence and clinical review criteria;

- A copy of any previous denial letters issued by the Plan concerning the case;

- A copy of Your signed consent form allowing the Plan to disclose Your medical information to the external review entity; and

- An index of all documents submitted.

The Plan will, upon Your request, provide You with all relevant information supplied to the external review entity, except for information that is confidential or privileged under state or federal law. You may submit additional information directly to the external review entity within five (5) business days after You receive notice from the Plan relating to the external review entity. The external review entity will provide a copy of such information to the Plan within one (1) business day. In addition to the documents and information described above, the external review entity will consider all other relevant information that is available.

PROVIDING ADDITIONAL INFORMATION

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

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

APPEAL NOTIFICATION AND TIMING

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

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

The external review entity's determination shall be in writing and state the reasons the requested treatment or service should or should not be covered by the Plan. The external review entity's decision will refer to the relevant provisions in the Plan documentation, the specific medical condition at issue, and other relevant documents that support the external review entity's decision. The decision must be based on an objective review of relevant medical and scientific evidence.

The decision of the external review entity will be binding on You and the Plan. However, other remedies may be available under federal or state law if either party is not satisfied with the decision.

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

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

OTHER GRIEVANCE PROCEDURES

OTHER DISPUTES

The Plan also has a grievance (complaint) process to help resolve issues and concerns that are not subject to the various procedures described above. A Complaint is an oral or written expression of dissatisfaction with the Plan from You regarding Your Provider. It is not necessary to have received an Adverse Benefit Determination to submit a Complaint or Grievance. Complaints should be submitted to the Plan's Friday Care Crew team in writing, or by simply making a verbal Complaint. If the Complaint cannot be resolved by the Care Crew Representative, then it will be escalated as a grievance. Examples of the types of issues You may address through this process include complaints about:

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

HOW TO FILE A GRIEVANCE

To begin the grievance process, You may call the Plan's Friday Care Crew at 1-844-451-4444.

You may also contact the *Texas Department of Public Health and Environment* for help. The Plan will provide you with the address and contact information. You should note that the *Texas Department of Public Health and Environment* only handles issues relating to Texas health care providers. For health care providers who/which are outside of Texas, you should contact the *Department of Health* for the state where the health care provider is located. You may contact the

Plan for help in locating the appropriate person within the state where the health care provider is located.

TIME PERIOD FOR FILING

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

GRIEVANCE NOTIFICATION AND TIMING

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

SECTION 15: 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 Plan may change the Premium amount You owe if there are changes in the number of Your Covered Dependents, changes in Your geographic rating area, or changes in tobacco use by You or Your Covered Dependents. The Plan may also change the Premium amount You owe during the Plan Year if the Plan makes changes to the Plan at Your request, or if there are changes in the law that impact the Plan. You will be notified in advance of any Premium changes made during the Plan Year.

At the beginning of each new Plan Year, the Plan may change the Premium amount You must pay. You will be notified sixty (60) days in advance of any changes.

NOTICE

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