Nevada Transparency in Coverage

Out-of-network liability and balance billing

Except for emergency services, you should always try to see providers that are in our network. But if you need to see an out-of-network provider, you will need to arrange care with your PCP and get approval from us. We have to approve an appointment with any out of network provider before you get non-emergency or non-urgent treatment.

If we approve your appointment with an out-of-network provider, your copayment and deductible will not change. We will let you know when the authorization is approved. If you don't receive our prior authorization, we cannot provide any benefit, coverage or reimbursement. You will be financially responsible for any and all payments.

When receiving care at one of our in-network hospitals, it is possible that some hospital-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with us as in-network providers. These providers may bill you for the difference between our allowed amount and the provider's billed charge — this is known as "balance billing." We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with us.

Enrollee Claim Submission

Providers will typically submit claims on your behalf, but sometimes you may be financially responsible for covered services. This usually happens if:

- Your provider is not contracted with us
- You have an out-of-area emergency

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your deductible, copayment or cost sharing to reimburse you.

To request reimbursement for a covered service, you need a copy of the detailed claim from the provider. You also need to submit an explanation of why you paid for the covered services. Send this to us at the following address:

Friday Health Plans
Attn: Claims Department

700 Main St.
Alamosa, CO 81101
After getting your claim, we will let you know we have received it, begin an investigation and request all items necessary to resolve the claim. We will do this in 10 days or less.

We will notify you, in writing, that we have either accepted or rejected your claim for processing within 10 days as well. If we are unable to come to a decision about your claim within 10 days, we will let you know and explain why we need additional time.

We will accept or reject your claim no later than 30 days after we receive it. If we reject your claim, the notice will state the reason why. If we agree to pay all or part of your claim, we will pay it no later than the fifth business day after the notice has been made.

Grace Periods and Claims Pending

If you don’t pay your premium by its due date, you’ll enter a grace period. This is the extra time we give you to pay (we understand that stuff happens sometimes).

During your grace period, you will still have coverage. However, if you don’t pay before a grace period ends, you run the risk of losing your coverage. During a grace period, we may hold — or pend —payment of your claims.

If your coverage is terminated for not paying your premium, you won’t be eligible to enroll with us again until Open Enrollment or a Special Enrollment period. So make sure you pay your bills on time!

If you receive a subsidy payment
After you pay your first bill, you have a three-month grace period. During the first month of your grace period, we will keep paying claims for covered services you receive. If you continue to receive services during the second and third months of your grace period, we may hold these claims. If your coverage is in the second or third month of a grace period, we will notify you and your healthcare providers about the possibility of denied claims. We will also notify the U.S. Department of Health and Human Services (HHS) that you haven’t paid your premium.

If you don’t receive a subsidy payment
After you pay your first bill, you have a grace period of one month. During this time, we will continue to cover your care, but we may hold your claims. We will notify you, your providers and the HHS about this non-payment and the possibility of denied claims.

Retroactive Denials

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or off setting against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

There are instances where claims may be denied retroactively if you received services from a provider or facility that is not in our network, terminate coverage with Friday Health Plans, late notification of other coverage due to new coverage, a change in circumstance, such as divorce or marriage. This causes Friday Health Plans to request recoupment of payment from the Provider.

If you believe the termination is in error, you are encouraged to contact the entity in which you enrolled for this policy.

Recoupment of Overpayments

Members may call in to request a refund of overpaid premium. Refunds are processed by two methods, electronically or by a manual check. The type of refund that is issued is dependent on the method of payment.

Medical Necessity and Prior Authorization

Services are only covered if medically necessary. Medically necessary services are those that:

- Are the most appropriate level of service for the member considering potential benefits and harm.
- Are known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes.

Some *covered service expenses* require prior authorization. There are some *network eligible service expenses* for which *you* must obtain the prior authorization.
For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

Prior Authorization requests must be received by phone/fax/ Provider portal as follows:

1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility.

2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of an admission for inpatient mental health or substance abuse treatment.
5. At least 5 days prior to the start of home health care.

After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your provider if the request has been approved as follows:

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or emergency admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent pre-service, within 72 hours from date of receipt of request.
4. For non-urgent pre-service requests within 5 days, but no longer than 14 days, of receipt of the request.
5. For post-service requests, within 30 calendar days of receipt of the request.

Failure to Obtain Prior Authorization

Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.
Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.
Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Drug Exceptions Timeframes and Enrollee Responsibilities

Standard exception request
A *member*, a *member's* designee or a *member's* prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's* designee or
the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request
A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee or

the *member's* prescribing *physician* with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make our determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If *we* grant an external exception review of a standard exception request, *we* will provide coverage of the non-formulary drug for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

Information on Explanations of Benefits

An explanation of benefits (EOB) is a statement that we send to members to explain what medical treatments and/ or services we paid for on behalf of a member. This shows the amount billed by the provider, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy. We will send an EOB to a member after we receive and adjudicate a claim on your behalf from a provider. If you need assistance interpreting your Explanation of Benefits, please contact Customer Service at 1-844-535-2000.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

The order of benefit determination rules govern the order 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 according to 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 do not exceed 100 percent of the total Allowable Expense.

Out-of-network liability and balance-billing

Definition: Balance-billing occurs when an out-of-network provider bills an enrollee/member for charges other than copayments, coinsurance, or any amounts that may remain on a deductible.
When you see a provider who is part of your network, he or she has agreed to accept a set amount as full payment for covered services and will only bill you for any copays, coinsurance or deductibles under your health benefit plan.

When you see an out-of-network provider, if he or she charges more than this amount, the provider may try to bill you the difference. This is known as balance or "surprise" billing.

If you receive medical care on or after Jan. 1, 2020, you are protected from surprise bills in many situations where you don't have a choice in where to get care. Instead, the responsibility for agreeing on the price for services is on the health care provider and the insurance company. The provider and insurer use an independent reviewer, called an arbitrator or mediator, to help them decide how much can be charged for the services provided.

The law outlaws surprise medical bills from various Nevada health care providers, including:

- Out-of-network providers at in-network hospitals, birthing centers, ambulatory surgical centers and free-standing emergency medical care facilities
- Out-of-network providers and facilities, including hospitals and free-standing emergency medical care facilities, that provide emergency services and supplies
- Certain out-of-network diagnostic imaging services and laboratories

If you visit a health care provider outside of your plan's network, they may ask you to sign a form that would allow them to balance bill you before they provide any care. **It is very important that you read any paperwork that a doctor asks you to sign.** They cannot ask you to sign this form if you received emergency services.
If you have any additional questions regarding surprise medical bills, please contact us at the number on the back of your ID Card.

To avoid balance billing charges, use the Provider Directory to make sure that the provider is in network.

Learn more about surprise medical bills and your protections against them.
All covered services are subject to contract benefits, limitations and exclusions. For more information regarding your benefits, please refer to your policy.

Will I have financial liability for out-of-network services?

If you are a member of a Friday Health Plans **HMO** plan and receive care, services, and/or supplies from an out-of-network (non-participating) provider, those services/supplies will not be covered unless prior approval is obtained from Friday Health Plans before the services occur. If you do not receive prior approval, you may be responsible for the charges.

When will I be balance-billed?

When receiving care from an out-of-network provider, payment from the plan will be limited to the usual, customary, and reasonable (UCR) charges of the covered service. You will be responsible for your deductible and coinsurance amounts, and for charges that exceed UCR rate. The out-of-network provider may choose to balance-bill you for the charges that exceed the UCR rate.

Are there any exceptions to out-of-network liability, such as emergency services?

Definition of medical emergency: Healthcare procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain. The absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in: danger to the person's health, serious harm to bodily functions and any bodily organ or part, or disfigurement to the person.

If you reasonably believe that you have an emergency medical condition, the initial treatment of that condition is paid at the in-network benefit level, even if care is provided by an out-of-network provider.

For follow-up care (which is no longer considered an emergency), you will need to visit an in-network provider in order to receive in-network benefits.

For more information, please refer to the Evidence of Coverage book for your plan.