INDIVIDUAL MARKET MEDICAL AND HOSPITAL POLICY

EVIDENCE OF COVERAGE

TITLE PAGE (COVER PAGE)

FRIDAY HEALTH PLANS

INDIVIDUAL MARKET MEDICAL AND HOSPITAL POLICY

EVIDENCE OF COVERAGE

Insured Name: [Jane Doe]
Effective Date: [XXXXX, XX, 20XX]
Monthly Premium: [$XXXX.XX]

CONTACT US

Purpose of this Document.
You have selected a policy insured by Friday Health Plans of Colorado, Inc. (the "Carrier"). This Evidence of Coverage describes the health care benefits available to you under the Policy. It also describes the rules that apply to your coverage. In order to understand the benefits available and the rules that apply, you should know the meanings of various terms used in this Evidence of Coverage. Generally, if a capitalized term is used in this Evidence of Coverage, it will have the meaning set forth in the DEFINITIONS section. However, some capitalized terms may be defined in the particular sections of this Evidence of Coverage where they are used.

If you have any questions about the Policy or the information set forth in this Evidence of Coverage, you may contact the Carrier in writing at:

Friday Health Plans of Colorado, Inc.
700 Main Street, Suite #700
Alamosa, Colorado 81101.

Or contact us by telephone at:
719-589-3696 or 800-475-8466 (toll free)

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ELIGIBILITY

Eligibility of Applicants.
The Carrier must make coverage available to all individuals who apply for and agree to pay for coverage. However, you must live or reside within the Service Area to obtain coverage from the Carrier.

Eligibility of Dependents.
Your Dependents may be covered under your Policy if they live or reside within the Service Area.

Individuals Considered to be Ineligible.
The Carrier may consider you and your Dependents to be ineligible if you have previously:

- failed to make payments owed to the Policy, as required by the Policy;
- performed an act or practice that is considered fraud, in connection with Policy coverage; or
- made an intentional misrepresentation of material fact, in connection with Policy coverage.

Enrollment and Effective Date of Coverage

Initial Open Enrollment.
The Carrier will provide for an initial Open Enrollment Period. If you apply for coverage during this period, the Carrier will issue a Policy that covers you and any Dependents you identified on your application.

You must be covered by the Policy in order to elect coverage for any Dependent. In order for you and any Dependent to be covered by the Policy, you must also agree to pay any required contributions.

If you do not apply for coverage for yourself (and your Dependents) during the Open Enrollment Period outlined above, you (and your Dependents) must generally wait until the next annual Open Enrollment Period to apply for coverage. However, in certain cases, you may be able to obtain coverage for yourself and/or your Dependents before the next annual Open Enrollment Period. Please review the Special Enrollment section for more information.

Effective Date of Coverage.
If you apply for coverage during the initial Open Enrollment Period, your coverage (and your Dependents' coverage, if any) will become effective on the date specified by the Carrier. That date will depend on the date you submit your application.

Annual Open Enrollment.
Each year, before the end of your Policy Year, you will be given an opportunity to decide whether to elect Policy coverage for yourself and your Dependents. You will also have an opportunity to make any changes to your prior enrollment election. This Open Enrollment Period will last for at least thirty (30) days.

You must be covered by the Policy in order to elect coverage for any Dependent under the Policy. In order for you and any Dependent to be covered by the Policy, you must also agree to pay any required contributions.

If you do not apply for coverage during an Open Enrollment Period, you (and your Dependents) must generally wait until the next annual Open Enrollment Period to apply for coverage. However, in certain cases, you may be able to obtain coverage for yourself and/or your Dependents 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 Carrier within thirty-one (31) days of the date of the Covered Child's enrollment or the Covered Child's twenty-sixth (26th) birthday. The Carrier may also require proof periodically during the Covered Child's coverage.

Improper Coverage.
If you or any other person on your Policy is not entitled to coverage by the Policy (for example, if you do not live or reside within the Service Area), you or such other person will not be covered by the Policy. This is true even if you or your Dependent has been issued coverage under the Policy. In such a case, the Carrier will have the right to seek repayment directly from you. The Carrier 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 Carrier for you or your Dependent for the Refund Period. The Carrier will refund your Premium (or your Dependent's Premium) for the Refund Period only if you (or your Dependent) received no benefits under the Policy.

Identification Card.
You and your Covered Dependents will receive identification cards when you obtain coverage under the Policy. You should notify the Carrier if you do not receive your identification cards after your Policy becomes effective. 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 Carrier for identification purposes only. Having an identification card will not give you or any other person a right to receive Policy benefits. The holder of an identification card must be a Covered Person in order to receive Policy benefits. If a person who is not entitled to receive Policy benefits uses a Covered Person's identification card to receive Policy benefits, that person will be required to pay the full cost of any health care services he/she receives.

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

Special Enrollment

Special Enrollment Rights.
In certain cases, you will have the right to obtain Policy coverage for yourself and/or your Dependents outside of an Open Enrollment Period. Following a triggering event you will have a special enrollment period of no less than 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:

- Involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium;

- Gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or

placement for adoption, placement in foster care, or by entering into a designated beneficiary agreement if coverage is offered to designated beneficiaries;

- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, in advertent or erroneous and is the result of an error, misrepresentation, or inaction of the Plan, producer.
- Demonstrating to the Insurance Commissioner that the health benefit plan in which you are enrolled has substantially violated a material provision of its contract in relation to you;
- Gaining access to other creditable coverage as a result of a permanent change in residence;
- A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Children's Basic Health Plan;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status; or
- An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

Coverage effective dates:

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

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS (APPLICABLE TO MANAGED CARE POLICIES)

Primary Care Physician.
You are required to select a Primary Care Physician within thirty (30) days after your Policy coverage becomes effective. You have the right to designate any Primary Care Physician who participates in the Carrier's network and who is available to accept you or your Covered Dependents. The Carrier does not guarantee that the Primary Care Physician you select will be able to add you or your Covered Dependents as patients. However, the Carrier will make an adequate panel of Primary Care Physicians available for your selection. If you fail to select a Primary Care Physician within the time period required by the Carrier, the Carrier may select one for you.

You may contact the Carrier for information on how to select a Primary Care Physician, and for a list of the Primary Care Physicians available. You may contact the Carrier in writing at:

Friday Health Plans of Colorado, Inc.
700 Main Street, Suite #100,
Alamosa, Colorado 81101.

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-8466.

Changes to Primary Care Physician.
You will be permitted to change your Primary Care Physician by contacting the Carrier's Membership Services Department. Once the Carrier has approved your selection of a new Primary Care Physician, the selection will become effective on the first day of the month following the approval. You will not be permitted to request a change of your Primary Care Physician more than three (3) times during any Policy Year.

Pediatrician as Primary Care Physician.
For any Covered Child, you may select a pediatrician as the Child's Primary Care Physician. You may contact the Carrier for a list of the Primary Care Physicians who are pediatricians. You may contact the Carrier in writing at:

Friday Health Plans of Colorado, Inc.
700 Main Street, Suite #100
Alamosa, Colorado 81101.

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-8466.

Significance of Primary Care Physician.
As a general rule, you and your Covered Dependents are required to receive all Covered Services within the Service Area from your Primary Care Physician.

Participating Provider Networks.
Your health benefit plan will have a participating provider network associated with it through which you will receive your healthcare services. The Plan may use preferred providers and/or tiered networks. This simply means that you could experience lower cost sharing in your deductible/copay/coinsurance cost sharing if you stay within the preferred provider pathway and/or in your Tier One Network. This preferred pathway and/or tiered network is based on provider contracting and/or care delivery programs and relationships with the Plan

Written Referral Requirement.
In most cases, you must obtain a Written Referral from the Carrier before you receive health care services from anyone other than your Primary Care Physician. Generally, your Primary Care Physician will begin the process of obtaining a Written Referral on your behalf. This is done by making a request for a Written Referral to the Carrier. Your Primary Care Physician will ask that you be permitted to receive services from another Participating Provider. The Carrier will respond to each request with either an approval or a denial. The Carrier will send a copy of its response to you. The Carrier will also send a copy of its response to your Primary Care Physician, and to the Participating Provider who is the subject of the request. When a request is approved, the Carrier will issue a Written Referral. The Written Referral will identify the name of the Participating Provider. It will also identify the health care services to be performed by the Participating Provider, and the date(s) when the services will be performed. The Written Referral guarantees payment by the Policy of all Covered Services approved in the Written Referral. This guaranty does not apply if you lose Policy coverage before the date of the services.

The Policy will pay for Covered Services requiring a Written Referral only if you receive a copy of the Written Referral from the Carrier before you receive the Covered Services. If you receive Covered Services without a Written Referral when a Written Referral is required, the Carrier will deny your claims for such services.

To make sure you are receiving the maximum benefit from the Policy, you should obtain all health care services from Participating Providers. You should also comply with the Written Referral requirements. This is the case even if you are expecting another plan or policy or a third party to pay for your health care services.

You should contact the Plan at (719) 589-3696 if you are unsure if something requires a Written Referral and prior authorization before services are rendered.

Exception for Gynecological Care.
You do not need a Written Referral to receive obstetrical or gynecological care from a Participating Provider who specializes in obstetrics, gynecology or reproductive health (such as an obstetrician, gynecologist or certified nurse midwife). You also do not need a referral from your Primary Care Physician to receive such care. The Participating Provider providing such care may, however, be required to comply with certain procedures. These procedures include obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals. For a list of Participating Providers who specialize in obstetrics, gynecology or reproductive health, you may contact the Carrier in writing at:

Friday Health Plans
700 Main Street, Suite #100
Alamosa, Colorado 81101.

You may also obtain this information by calling Customer Service at 719-589-3696 or 800-475-8466.

Exception for Urgent Situations.
In unusual cases where you have an urgent need for health care services, you must attempt to access your Primary Care Physician. If accessing your Primary Care Physician is not an option, you may obtain care without obtaining a Written Referral from the Carrier. If your Primary Care Physician is unavailable or does not provide the particular health care services that you need, you may obtain care without obtaining a Written Referral from the Carrier. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals. This paragraph applies when the situation does not qualify as a Medical Emergency, as described below.

Exception for Emergency Situations.
You are not required to obtain a Written Referral or Prior Authorization from the Carrier 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 may include obtaining prior authorization for certain services, that could be considered non-emergent, following a pre-approved treatment plan, or making referrals. If you are

hospitalized without a Written Referral due to a Medical Emergency, you must notify the Carrier by telephone of the hospitalization. Alternatively, you must instruct the hospital or a family member to notify the Carrier. 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 Carrier or to instruct someone else to do so, the notice may be delayed until you are able to notify the Carrier or instruct someone else to notify the Carrier. If you are conscious and able to communicate with others, you will be considered capable of notifying the Carrier. The Carrier may refuse to reimburse you for the cost of any non-emergent treatment if proper notice is not provided to the Carrier.

Other Exceptions to Written Referral Requirement.
You are not required to obtain a Written Referral from the Carrier when you visit a Participating Provider who is covering in the absence of your Primary Care Physician. You are also not required to obtain a Written Referral from the Carrier when you have routine laboratory or X-ray tests performed by a Participating Provider.

Specialty Care Centers.
Services for certain conditions, or certain treatments or procedures, are covered by the Policy only if such services, treatments or procedures are provided at a Specialty Care Center. You may be required to use a Specialty Care Center in order for your care to be covered by the Policy. Specialty Care Centers are located throughout the United States. Thus, you may need to travel out of the Service Area to receive care. If so, you will be responsible for making all travel arrangements and paying all travel costs associated with treatment at a Specialty Care Center. The Policy will not pay for these costs. The Policy will also not pay for board, lodging or any other expenses related to travelling to a Specialty Care Center. Transplant services are available only at Specialty Care Centers.

Failure to Use a Participating Provider.
As a general rule, if you receive health care services from a non-Participating Provider, the Policy will not pay for such services. However, if the reason you are receiving care from a non-Participating Provider is due to a Medical Emergency or an urgent medical situation, the Policy will pay for the Covered Services you receive. This is the case only if you follow the other terms and conditions explained in this Evidence of Coverage.

BENEFITS/COVERAGE (WHAT IS COVERED)

General Rules.
The Policy will pay for the following Covered Services provided to you and your Covered Dependents, as long as:

- the services are Medically Necessary and are provided when Policy coverage is in effect;
- the services are delivered by a Participating Provider (unless there is a Medical Emergency or urgent situation); and
- you have obtained a Written Referral for the services (unless a Written Referral is not required).

Even if the Policy pays for Covered Services, you must still meet your Co-payment, Coinsurance and Deductible obligations. These obligations are outlined in the Schedule of Benefits. Furthermore, the Covered Services are subject to the other limitations described in this Evidence of Coverage.

A. Newborn Coverage.

1. Automatic Coverage. Your newborn Child will automatically be covered by the Policy for the first thirty-one (31) days of his/her life. His/her coverage will then end, unless you enroll your Child for coverage under the Policy. Please refer to the Special Enrollment section.

2. Initial Hospital Stay. The Policy will cover the hospital stay for your newborn Child. The hospital

stay following a normal vaginal delivery will not be less than forty-eight (48) hours. If the forty-eight (48) hours 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 the ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the following morning.

3. Illness and Injury During First Month of Life. Generally, the Policy 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, in order for your Child's Policy coverage to continue beyond the thirty-first (31st) day of life, you must enroll your Child for coverage under the Policy. Please refer to the Special Enrollment section.

4. Cleft Lip and/or Cleft Palate. The Policy 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 Policy 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 Policy coverage to continue beyond the thirty-first (31st) day of life, you must enroll your Child for coverage under the Policy. Please refer to the Special Enrollment section.

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

5. Inherited Enzymatic Disorders. The Policy will provide coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription. In order for your Child's Policy coverage to continue beyond the thirty-first (31st) day of life, you must enroll your Child for coverage under the Policy. Please refer to the Special Enrollment section.

   There are no age limits on the benefits described in this subsection (5), except for benefits relating to phenylketonuria. Women of child-bearing age may receive benefits for phenylketonuria until age thirty-five (35). Otherwise, benefits are provided only until age twenty-one (21).

   The care and treatment covered by the Policy will include, medical foods for home use, if Medically Necessary. "Medical foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. However, you must have a prescription from a Participating Provider and receive the medical foods through a Participating Provider pharmacy. This term shall not be construed to apply to cystic fibrosis patients or lactose-intolerant or soy-intolerant Members.

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

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

B. Early Intervention Services.

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

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

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

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

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

C. Autism Spectrum Disorders.

1. Standard. The Policy provides coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for a Covered Child. 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.

2. General Coverage. Generally, the Policy will cover the following:

    - evaluation and assessment services;

    - behavior training and behavior management and applied behavior analysis; (This includes but is not limited to consultations, direct care, supervision, or treatment, or any combination of these. Such services must be provided by a Participating Provider who/which is an

autism services provider.)

- habilitative or rehabilitative care; (This includes, but is not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of these therapies.)
- for a Covered Child who is covered under the section below relating to Congenital Defects and Birth Abnormalities, the Policy will cover more than twenty (20) visits for each therapy (occupational, physical, and speech); (Such therapy must be Medically Necessary to treat autism spectrum disorders.)
- pharmacy care and medication, if the Enrollee has pharmacy benefits under the Policy;
- psychiatric care;
- psychological care, including family counseling; and
- therapeutic care.

D. Congenital Defects and Birth Abnormalities.

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

2. Annual Limitation. Each Year, the Policy will pay for up to twenty (20) visits for each type of therapy (physical, occupational and speech) for the Covered Child. The therapy visits must be distributed as medically appropriate throughout the Policy Year. They will be distributed without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

E. Child Speech and Hearing Benefits.

1. Speech Therapy. If a Covered Child under the age of five (5) experiences speech delay, the Policy will cover up to six (6) speech therapy visits. The Policy may cover additional speech therapy visits. However, the Covered Child's Participating Provider must first submit certain documentation to the Carrier. The documentation must include the Covered Child's diagnosis, a specific treatment plan, and expected outcomes. If additional therapy visits can be expected to result in significant improvement, the Policy will cover more visits. The Policy will cover up to a total of twenty (20) speech therapy visits per Policy Year until the Covered Child reaches age five (5).

2. Hearing Services. The Policy will cover hearing aids and hearing services for a Covered Child who is under the age of eighteen (18) and has a hearing loss. The Policy will cover the initial hearing aids. The Policy will also cover replacement hearing aids once every five (5) years. The Policy will cover a new hearing aid when changes to an existing hearing aid will not meet the needs of the Covered Child. The Policy will also cover services and supplies. This includes, but is not limited to, the initial assessment; fitting; adjustments; and auditory training that is provided based on accepted professional standards.

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

F. Child Dental and Vision Benefits.

1. Hospitalization/Anesthesia for Dental Procedures. The Policy will cover general anesthesia. The Policy 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 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; or

   - must have experienced extensive orofacial and dental trauma.

   In addition, the Covered Child must be:

   - under the age of twenty-six (26);

   - unmarried and medically certified as disabled and dependent on you or your Spouse.

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

3. Pediatric Vision Care. The Policy will cover one vision exam each Policy Year for a Covered Child who is under the age of nineteen (19). Eyeglasses for a Covered Child will be covered for 1 pair every 24 months and includes either eyeglasses frames and lenses or contact lenses.
4.

G. Special Preventive Services With No Cost-Sharing.

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

2. Special Preventive Services. The Policy will pay for the following preventive services, based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF):

- Alcohol misuse screening and behavioral counseling interventions for adults;
- Cervical cancer screening;
- One Breast cancer screening with mammography per Policy Year, covering the actual charge of the screening with mammography.
  - Benefits for preventive mammography screenings are determined on a Policy Year basis. These preventive and diagnostic benefits do not reduce or limit diagnostic benefits otherwise allowed under the Policy. If a Covered Person receives more than one screening in a Policy Year, the other benefit provisions in the Policy apply with respect to the additional screenings.

  - Regardless of the A or B recommendations of the United States Preventive Services Task Force (USPSTF), the Policy will cover an annual breast cancer screening with mammography for all individuals possessing at least one risk factor, including a family history of breast cancer, being forty (40) years of age or older, or a genetic predisposition to breast cancer.
- Cholesterol screening for lipid disorders;
- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps.
  - In addition to Covered Persons who are eligible for colorectal cancer screening coverage based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF), the Policy will cover colorectal cancer screening for Covered Persons who are at high risk for colorectal cancer, including Covered Persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the Participating Provider;
- 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);
- Pneumococcal vaccinations pursuant to the schedule established by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
- Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Physician; and
- 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.
- 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.
- Preventive care and screenings supported by the Health Resources and Services Administration for infants, children adolescents and women as required by Federal law.
- Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.

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

Friday Health Plans of Colorado, Inc.
700 Main Street, Suite #100
Alamosa, Colorado 81101.

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-8466.

H. Additional Preventive Services.

1. Well Child Visits. The Policy will cover your Covered Child's visits to his/her Primary Care Physician 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 Policy will cover visits to the Covered Person's Primary Care Physician. 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 foliate counseling for women of child bearing age); blood work; history and physical; urinary analysis; chemical profile; fasting lipid panel; and stool hemoccult. The Policy will also cover cervical cancer vaccines for all female Covered Persons. However, Covered Persons 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.

Well Child Visits and Health Maintenance Visits are covered according to the following schedule:

Age of Covered Person	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 Policy 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.

3. Limitations on Services and Examinations. The Policy will not cover all services performed during scheduled physical examinations. For example, the Policy generally will 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 Policy will generally not cover examinations that are more frequent than those identified on the schedule above. However, the Policy may cover more examinations if they support a diagnosis, as determined by the Covered Person's Primary Care Physician.

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

- One screening per year for any male Covered Person who is fifty (50) years of age or older; and

- One screening per year for any male Covered Person between (40) forty and fifty (50) years of age. However, the Covered Person must have an increased risk of developing prostate cancer. This determination must be made by a Participating Provider.

- The prostate screening shall consist of 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.

5. For Adult Women: When provided by a Participating Provider, the Policy will cover a yearly breast and pelvic exam and PAP test. The Policy will also cover a screening mammography when recommended by a Participating Provider. The following schedule will apply:

   - A single baseline mammogram and clinical breast exam for a female Covered Person who is at least thirty-five (35) years of age but under forty (40) years of age; (This is available once during the age 35 to 39 period.)
   - One mammogram and clinical breast exam once every two (2) years; (This is available for a female Covered Person who is at least forty (40) years of age but under fifty (50) years of age.)
   - One mammogram and clinical breast exam at least once a year for a female Covered Person with risk factors for breast cancer; (This determination must be made by the Covered Person's Primary Care Physician.)
   - One mammogram and clinical breast exam annually for women over fifty (50) years of age; and
   - One mammogram and clinical breast exam annually for a female Covered Person with at least one risk factor. (This includes a family history of breast cancer or a genetic predisposition to breast cancer.)

   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 Physician. The Policy will cover a Covered Person's routine office visits to a Primary Care Physician.
2. Home Visits. The Policy will cover Medically Necessary visits by the Covered Person's Primary Care Physician to the Covered Person's home within the Service Area.
3. Smoking Cessation Program. The Policy will cover smoking cessation programs. This is true even if the Deductible has not been met. The program must be provided by a Participating Provider or be a Carrier-approved program.
4. Specialty Physician Services. The Policy will cover services of a Participating Provider when the Covered Person has obtained a prior Written Referral.
5. Diagnostic Services. The Policy will cover diagnostic services, including radiology (X-ray); pathology; laboratory tests; and other imaging and diagnostic services. However, for all diagnostic services performed in a hospital, the Covered Person must obtain a prior Written Referral. Also, certain diagnostic services require a prior Written Referral. This is the case for magnetic resonance imaging (MRI) and computerized tomography (CT) scans. Routine procedures performed at Participating Provider facility that is not a hospital require only a verbal referral from the Covered Person's Primary Care Physician.
6. Outpatient Surgery. The Policy will cover certain outpatient surgical procedures if the Covered

Person has obtained a prior Written Referral.

7. Radiation Therapy and Chemotherapy. The Policy will cover Medically Necessary radiation therapy and chemotherapy, for treatment of cancer. The Covered Person must obtain a prior Written Referral. Coverage does not include high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure.

8. Urgent Care. The Policy will cover urgent care provided in a Participating Provider urgent care center within the Service Area. However, the Covered Person must be able to show the urgent nature of the care. The Covered Person must also be able to show that the care provided was Medically Necessary.

9. 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 consultation or contact by that provider. Your copay/coinsurance/deductible shall apply in the same manner as it would for an in-person like service.

   The Plan will include a reasonable compensation to the originating site for the transmission cost incurred through telehealth delivered by a contracted participating provider, except that, the originating site does not include a private residence at which the Member is located when he or she receives health care services through telehealth.

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

J. Hospital Inpatient Services.

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

2. General Coverage. The Policy will cover the following items and services when an Covered Person is hospitalized: a semi-private room; general nursing care; meals; special diets; 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 (other than high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure); physical therapy; inhalation therapy; prosthetic devices approved by the Food and Drug Administration and implanted during a surgery performed pursuant to a Written Referral (such as pacemakers and hip joints); and the administration of whole blood, blood plasma and other blood products. The Policy will cover a private room only when Medically Necessary.

3. Physicians and Medical Personnel. The Policy also covers the services of Participating Provider physicians who care for the Covered Person when he/she is hospitalized. This includes the Covered Person's Primary Care Physician. It also includes specialist surgeons, assistant surgeons, anesthesiologists, and other appropriate medical personnel. The Policy will cover special duty nurses, as Medically Necessary.

4. Special Right to Reconstructive Breast Surgery. If a Covered Person receives benefits under the Policy in connection with a mastectomy and elects breast reconstruction, the Policy 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; and
   - prosthesis and physical complication for all stages of the mastectomy, including lymphedemas.

   These benefits are subject to any Co-payments, Deductibles and Coinsurance obligations applicable to any other Policy coverage.

5. Inpatient Chemical Dependency Treatment. Please refer to the section below relating to Mental Health and Chemical Dependency Treatment.

6. Inpatient Mental Health Treatment. Please refer to the section below relating to Mental Health and Chemical Dependency Treatment.

7. Maternity Hospitalization. Please refer to the section below relating to Maternity Benefits.

8. Bariatric Surgery. Medically necessary surgery is covered. You must meet Plans criteria to be eligible for this service and it is only covered through programs meeting Plan criteria as centers of excellence.

K. Mental Health and Chemical Dependency Treatment.

1. General Coverage. The Policy will cover the diagnosis and treatment of biologically based mental illness and mental disorders. This coverage is provided to the same extent the Policy covers a physical illness. "Biologically based mental illness" means schizophrenia; schizoaffective disorder; bipolar affective disorder; major depressive disorder; specific obsessive-compulsive disorder; and panic disorder. A "mental disorder" means post-traumatic stress disorder; drug and alcohol disorders; dysthymia; cyclothymia, social phobia; agoraphobia with panic disorder; general anxiety disorder; anorexia nervosa; and bulimia nervosa. For drug and alcohol addiction, the treatment covered by the Policy will include acute detoxification. The Carrier will determine whether such treatment is provided on an outpatient or inpatient basis.

   Mental Health and Chemical Dependency shall be covered as described herein whether the treatment is voluntary or court ordered as a result of contact with the criminal justice or legal system to the extent they are medically necessary and covered benefits.

2. Outpatient Mental Health Care. The Policy will cover outpatient mental health visits in the same manner that it covers other outpatient visits.

3. Inpatient Mental Health Care. Like other inpatient care, the Policy 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 a Written Referral before your hospital stay. The Policy will also cover a hospital stay that results from a Medical Emergency. However, you must comply with the requirements described in the Section below relating to Emergency Services.

4. Outpatient Chemical Dependency/Substance Abuse Treatment. The Policy will cover outpatient chemical dependency/substance abuse visits in the same manner that it covers other outpatient visits.

5. Inpatient and Residential Chemical Dependency/Substance Abuse Treatment. Like other inpatient care, the Policy will cover Medically Necessary inpatient or residential chemical dependency/substance abuse treatment. Inpatient or residential care is covered only if you have obtained a Written Referral before your stay. The Policy 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.

L. Emergency Services.

1. Standard. For a Medical Emergency, the Policy will cover the medical examination conducted to evaluate the Covered Person's condition. The Policy will also cover the related services routinely performed by the emergency department. The Policy will also cover further examination and treatment required to stabilize the Covered Person. These services are covered without prior authorization. This means the Covered Person does not need to obtain a prior Written Referral. These services are covered even if the provider is not a Participating Provider. However, there must be proof that the Covered Person experienced a Medical Emergency. There must also be proof that emergency care was Medically Necessary.

2. Emergency Transportation. For a Medical Emergency, the Policy will pay for the Covered Person's transportation to the hospital by ambulance. As noted in the DEFINITIONS section above, a Medical Emergency is limited to certain situations. There must be a sudden and severe medical condition (including severe pain). The condition must reasonably be expected to result in one or more of the following, if the Covered Person does not seek immediate medical attention:

   - placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the Covered Person or her unborn child) in serious danger;
   - serious impairment to bodily functions; or
   - serious dysfunction of any bodily organ or part.

3. Covered Person Costs. If a Covered Person receives emergency care from a non-Participating Provider, the Covered Person's Co-payment amount and Coinsurance amount will be the same as if the Covered Person had been treated by a Participating Provider.
4. Carrier Notification Required. The Covered Person must notify the Carrier of any Medical Emergency. The Covered Person must do so on the first business day after treatment is received. If that is not possible, the Covered Person must notify the Carrier as soon as medically possible. This notification must include the identity of the Covered Person and the hospital where he/she received care. If a Covered Person is hospitalized, the Covered Person must notify the Carrier by telephone of the hospitalization. Alternatively, the Covered Person must instruct the hospital or a family member to notify the Carrier. The notification must include the identity of the Covered Person 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 Covered Person is unable to contact the Carrier personally or to ask another person to do so, the notification may be delayed. A delay is only allowed until the Covered Person is able to notify the Carrier or instruct some other person to notify the Carrier. If the Covered Person is conscious and able to communicate with others, the Covered Person will be treated as able to the Carrier

5. Transfer. If a Covered Person is hospitalized in a non-Participating Provider hospital, the Carrier will have the Covered Person transferred to a Participating Provider hospital as soon as medically feasible. The Policy will not cover any services provided by a non-Participating Provider to a Covered Person who has refused a medically feasible transfer. The Carrier must approve in advance any expenses for care provided after the Covered Person is stabilized, and transfer to a Participating Provider is medically feasible.

M. Maternity Benefits.

1. Prenatal and Postnatal Office Visits. Prenatal and postnatal care visits are covered in the same manner as routine office visits with your Primary Care Physician.

2. Prenatal Diagnosis. The Policy will cover the prenatal diagnosis of congenital disorders of the fetus. This coverage applies to screening and diagnostic procedures during the pregnancy of the Covered Person when Medically Necessary.

3. Complications of Pregnancy. The Policy will cover a sickness or disease which is a complication of the Covered Person's pregnancy or child birth. Complications of pregnancy shall mean (1) conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

4. Hospitalization for Delivery. The Policy will cover the Covered Person'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 time-frames could be less at the discretion of the attending physician and the Member. If the mother and child are discharged prior to 48 hours following delivery, then one newborn visit within the first week of life will be covered.

N. Family Planning and Infertility Services.

1. Family Planning. The Policy 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 Policy also covers the provision of vasectomies, and tubal ligation procedures performed by a Participating Provider. Oral contraceptives, including emergency contraceptives, and Depo-Provera injections are covered under the Covered Person's pharmacy benefit.

2. Infertility Services. The Policy will cover the following services, including X-ray and laboratory procedures: (a) services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and services related to their procurement and storage. See additional information under Limitations and Exclusions.

3. Contraceptive Coverage. Currently the food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception have options available that are covered under this policy without cost sharing as required by federal and state law.

O. Home Health Care Services.

1. General Coverage. The Policy will cover home health care provided to a Covered Person who is under the direct care of a Participating Provider. Services will include visits to the Covered Person 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. Home health aide services under the supervision of an RN or therapist,
    iii. Certified nurse aide services,
    iv. Medical social services by a licenses 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 was 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 Policy is subject to the following conditions and limitations:

- The care provided must follow an Authorized Home Health Treatment Plan.

- Services will be covered only if hospitalization would be required if such home health services and benefits were not provided.

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

- Visits are limited. No more than 28 hours a week.

- Home Health Services require a Written Referral.

P. Durable Medical Equipment.

1. General Coverage. With respect to durable medical equipment, the Policy will cover an Covered Person's rental; purchase; maintenance or repair, when necessary due to accidental damage, or due to changes in the condition or size of the Covered Person; 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. A Written Referral is also required.

2. Prosthetic Arms and/or Legs. The Policy will cover a Covered Person'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 Covered Person. Prosthetic arms and/or legs and related service must be provided by a Participating Provider vendor. The Policy will cover repairs and replacements of prosthetic arms and/or legs. However, the Policy will not cover repairs and replacements that are necessary because of misuse or loss.

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 a Written Referral. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes, are not covered.

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

5. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by the Plan.

Q. Organ and Tissue Transplants.

1. General Coverage. The Policy 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 or non-Hodgkin's lymphoma; autologous or allogeneic bone marrow transplants and stem cell rescue or hematopoietic support only for malignant tumors when necessary to support high dose chemotherapy, (and in that event the high dose chemotherapy is covered); and autologous or allogeneic bone marrow transplants and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and high risk stage II and III breast cancer.

2. Related Items. The Policy will also cover services, supplies and pharmaceuticals required in connection with a covered transplant procedure. This includes valuation of a Covered Person 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 a Covered Person, the Policy 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 Policy. Coverage applies only if the donor is not eligible for coverage under any other health care plan or government funding program.

4. Conditions. All transplant services require a Written Referral. However, the Covered Person must first be accepted into the transplant program at one of the Specialty Care Centers. Coverage may also be subject to approval by an appropriate evaluation committee designated by the Carrier. The committee will have complete decision-making power in determining whether or not a transplant will be covered. 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 Covered Person's physical and mental condition.

5. Exclusions. The Policy does not cover organ or bone marrow search, selection, transportation or storage costs.

R. Hospice.

1. General Coverage. The Policy covers physical, psychological, spiritual and bereavement care for terminally ill Covered Persons and their families. The services cover a range of inpatient and twenty-four (24) hour on-call home care. The care may be provided in the home. It could also be provided in a Participating Provider hospice facility, and/or other Participating Provider facility. Services include, but are not limited to, the following: nursing services; physician services; certified nurse aide services; nursing services of other assistants; homemaker services; physical therapy

services; pastoral care; counseling; trained volunteer services; and social services. Other benefits available through hospice are covered by the Policy. Such benefits are subject to the other limitations in this Evidence of Coverage, and include:

- medical supplies;
- drugs and biologicals;
- prosthesis and orthopedic appliances;
- oxygen and respiratory supplies;
- diagnostic testing;
- renting or purchase of durable medical equipment; and
- transportation.
- physician services;
- therapies including physical, occupational and speech; and
- nutritional counseling by a nutritionist or dietitian.

2. Limitations. Hospice care is subject to the following conditions and limitations:

   - All hospice services must be provided under active management through a hospice. The hospice is responsible for coordinating all hospice care services. This is true regardless of the location or facility providing services.

   - Hospice services are allowed only for Covered Persons who are terminally ill and have a life expectancy of six (6) months or less. A Covered Person may live beyond the prognosis for life expectancy. In this case, benefits will continue at the same rate for an additional benefit period. After the exhaustion of three (3) benefit periods 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 a Written Referral.

   - Hospice services must be reviewed periodically by the Covered Person's Primary Care Physician.

   - Bereavement support services for the family of the deceased Covered Person will be covered for up to twelve (12) months after the Covered Person'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.

S. Other Important Services.

1. Diabetes. The Policy's coverage of a Covered Person's diabetes includes equipment; supplies; and outpatient self-management training and education. It also includes medical nutrition therapy if prescribed by a Participating Provider. The Policy will cover equipment, such as a glucometer, as durable medical equipment. Please refer to the section relating to Durable Medical Equipment above. The Policy will cover supplies such as test strips and lancets at 80% if the Covered Person has a Written Referral. Diabetic education classes for insulin dependent diabetes and pregnancy induced diabetes are also covered.

2. Skilled Nursing Care. The Policy will cover a Covered Person's skilled nursing services. Such services must be provided in a Participating Provider skilled nursing facility. These services also

require a Written Referral. Coverage by the Policy is limited to one-hundred (100) days per Policy Year.

3. Rehabilitative Services. The Policy will cover services of licensed therapists providing short term rehabilitative services. This includes physical, occupational and speech therapies. Coverage by the Policy is limited to two (2) months of inpatient services and twenty (20) outpatient visits per therapy (physical, occupational, speech) per Policy Year. Rehabilitative services require a Written Referral. The Policy and will not cover services for chronic or recurring conditions that do not show sustained significant improvement within the allowed time frame.

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 Covered Persons with disabilities. Coverage by the Policy is limited to two (2) months of inpatient services and twenty (20) outpatient visits per therapy (physical, occupational, speech) per Policy Year. Habilitative services require a Written Referral. The Policy will not cover services for chronic or recurring conditions that do not show sustained significant improvement within the allowed time frame.

5. Cardiac Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Physician and provided by participating therapists at participating facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of an initial evaluation, no more than eighteen (18) cardiac rehabilitation exercise and counseling sessions and a final evaluation to be completed within a six-month period.

6. Pulmonary Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Physician and provided by participating therapists at participating facilities. Clinical criteria are used to determine appropriate candidacy for the program, which consists of an initial evaluation, six (6) educational sessions and up to twelve (12) exercise sessions and a final evaluation to be completed within a two to three-month period.

7. Continuing Care. If a Covered Person is hospitalized within a non-Participating Provider hospital, the Covered Person may return to such hospital for follow-up care. However, the Policy will cover such follow-up care only if the non-Participating Provider hospital is willing to accept payment from the Policy at the rates payable to Participating Providers. All other limitations and conditions of the Policy would apply.

8. Health Education Services. The Policy will cover instruction in the appropriate use of health services. This includes information on the ways each Covered Person can maintain his/her own health. Such instruction must be provided by a Primary Care Physician. It could also be provided by another Participating Provider with a Written Referral. 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 such services.

9. Oral Surgery/Dental Anesthesia Services. The Policy will cover the following oral surgery services for an Covered Person who obtains a Written Referral:

   - 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;

- Treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue. provided within twenty-four (24) hours after injury).

No other oral surgery services are covered by the Policy unless they are required by Colorado law.

10. Eye Exams. The Policy will cover eye examinations provided by a Covered Person's Primary Care Physician to determine the need for vision correction. This is in addition to the pediatric vision services described in the section above relating to Child Dental and Vision Benefits. 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 Policy will cover hearing tests in support of a diagnosis and medically-covered condition. This is in addition to the benefits described in the section above relating to Child Speech and Hearing Benefits. The Policy does not cover screening audiometry and tympanograms not in support of a diagnosis. The Policy does not cover hearing aids and other corrective appliances, except as provided in the Child Speech and Hearing Benefits section.

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

- Inpatient prescription drugs approved by the United States Food & Drug Administration (FDA) are covered when you are in a hospital or skilled nursing facility.
- Outpatient prescription drugs are covered subject to the Plan's Formulary, and as follows:
  - Outpatient prescription drugs are designated as Tier 1, Tier 2, Tier 3 and Tier 4 in the FHP Formulary.
  - Drugs not listed in the Plan's Formulary are not covered as Covered Services.
  - 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 to exceed the Allowed Charge, less the applicable copay or coinsurance set forth in the Schedule of Benefits
  - 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; and
    - Will be used to treat Covered Services.

The Plan reserves the right to limit the maximum amount of an outpatient prescription drug covered per copay or coinsurance. The applicable copayment or coinsurance covers the lesser of a 30-day supply or 100-unit supply or standard trade package, per prescription. Exceptions may apply to prescriptions filled through mail-order of generic maintenance medications. Specialty tier medications are always subject to one copay/coinsurance payment per 30-day supply.

Medications for which a generic equivalent is available will be filled with an approved generic equivalent. If a brand-name medication is requested when an approved generic equivalent is available the Member will pay the cost difference between the generic and brand-name drug (ancillary charge), in addition to the copayment or coinsurance amount. This is waived if the prescribing physician 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; and 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 prescriptions eye drops is covered if i) A bottle is requested by the insured or the health care provider at the time the original prescription is filled; and ii) 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 drop benefits covered under this section are subject to the same annual deductibles, copayment, or coinsurance established for all other prescription drug benefits under the health benefit plan.

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

Step therapy protocols/algorithms are developed based on current medical findings, FDA approved drug labeling, and medication costs. In general, Step Therapy is applied to therapeutic categories that have multiple agents, comparable therapeutic efficacy and utilization and those that have generic alternatives. Generic drugs are commonly prescribed as the “first-line” agent due to their established safety and efficacy for treating a given condition, and are typically less expensive than branded medications. Select branded medications may not be covered unless a plan participant tries and fails an alternate “first line” agent(s).

When a Member presents a prescription for a medication that is under a Step Therapy Algorithm, the dispensing pharmacy receives an electronic message informing the pharmacist that the medication is under a Step Therapy algorithm. The member will then need to contact their physician so the physician can either re-write the prescription or send the required step therapy information to the Members Pharmacy Benefit Management Company. That contact information is on the members Pharmacy ID card.

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

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by us through the exception process. If we grant Your request, We will cover the non-formulary drug for the duration of the prescription. If We deny Your request, You, Your designee, or Your provider may request an appeal of the decision. For more information about the appeal process, please see Page 46 of this EOC, or call Customer Service.

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, including any refills.

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 72 hours after we receive your doctor’s statement. An expedited coverage decision means we will answer within 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 Physician, are excluded unless otherwise required by federal or state statute or regulation to be covered by the Plan.

Over-the-counter contraceptive drugs or devices which do not require a prescription, except those included in the Plan's Formulary or those covered elsewhere in your Covered Services.

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

Outpatient retail prescription drugs are covered under the Plan's prescription drug program. You, your designee, or your physician may request access to clinically appropriate drugs not otherwise covered by the Plan through a special exceptions process. If the exceptions request is granted, we will provide coverage of the non-formulary drug for the duration of the prescription. If the exceptions request is denied, you, your designee, or your physician (based on a written request by you to allow your physician to do this on your behalf) may request an external review of the decision by an independent review organization.

Health Plan will provide coverage, without prior authorization, for a five-day supply of at least one of the Federal Food and Drug Administration-approved drugs for the treatment of opioid dependence; except that this requirement is limited to a first request within a twelve-month period.

For additional information about the prescription drug exceptions processes for drugs not included in the Plan's formulary, please contact the Plan's Customer Service (719) 589-3696 or (800) 475-8466

13. Oral anticancer medication. These drugs must be FDA approved for the cancer being treated. They must also be part of the approved protocol of care. They must also meet all formulary qualifications.

    Orally administered anticancer medication that has been approved by the FDA and is used to kill or slow the growth of cancerous cells is covered. The orally administered medication shall be provided at a cost to the Enrollee not to exceed the copay or coinsurance as it is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided pursuant to this section shall be prescribed only upon a finding that it is Medically Necessary for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. Nothing herein shall prohibit coverage for oral generic medications in a health benefit plan nor prohibit the Plan from applying an appropriate formulary or clinical management to any medication described in this section.

14. Routine Care During Clinical Trials. Covered Services may be eligible for coverage when received in connection with a clinical trial if all of the following conditions are met:

    - The services would have been covered if they were not related to a clinical trial.

    - You are eligible to participate in the clinical trial according to the 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 is in agreement.
    - 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 clinical trial is approved under the September 19, 2000 Medicare National Coverage Decision regarding clinical trials; as amended,
- The patient has signed a statement of consent.

For Covered Services related to a clinical trial, you will pay the applicable cost share as shown on your Schedule of Benefits that you would pay if the Covered Services were not related to a clinical trial.

Clinical Trial exclusions include the following:

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

Nothing in this section shall:

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

For the purposes of this section the following definitions apply:

- "Clinical Trial" means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

- "Routine patient care cost" means all items and services that are a benefit under a health coverage plan that would be covered if the covered person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary

care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

15. Transgender services.

- Transgender services are covered for behavioral health, physical health, hormones and surgery as any other condition. Services are subject to medical necessity and referrals and authorizations may apply as for other services herein.

16. Surrogacy. In situations where an Enrollee receives monetary compensation to act as a surrogate, the Plan will seek reimbursement for Covered Services you receive that are associated with conception, pregnancy and /or delivery of the child, except that we will recover no more than half of the monetary compensation you receive to act as a surrogate.

Within 30 days after entering a Surrogate Arrangement, Enrollee must send written notice of arrangement, including names, addresses, and telephone numbers of all parties to the arrangement., and a signed copy of any contracts and other documents explaining the arrangement. Failure to notify Plan may result in denial of all Covered Services associated with conception, pregnancy and/or delivery.

For Covered Services related to this Surrogacy Section, Enrollee will pay the applicable cost share obligations.

For the purpose of this section the following definitions apply:

- "Surrogate Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

T. Medical Care Provided Outside of Service Area.

1. Urgent Care. The Policy will cover urgent care that is provided to a Covered Person 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 Policy will cover care that is provided to a Covered Person outside of the Service Area (by a non-Participating Provider) in a Medical Emergency. This coverage will be subject to the terms described in the section above relating to Emergency Services. All follow-up care must be provided within the Service Area by a Participating Provider, except as otherwise stated in this Evidence of Coverage.

U. Cancer Drugs.

1. Off Label Use. Cancer drugs that have not been approved by the United States Food and Drug Administration for treatment of a specific type of cancer for which a drug has been prescribed, by a Participating Provider shall be covered if the drug is recognized for treatment of that cancer in the authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Services and the treatment is for a covered condition.

V. Chiropractic.

1. Chiropractic services are covered when provided by contracted chiropractors and are limited to evaluation, lab services and X-rays required for chiropractic services and treatment of musculoskeletal disorders. Visits are limited to 20 per plan year.

2. Exclusions related to Chiropractic care are as follows:
   a. Hypnotherapy

b. Behavior training
c. Sleep therapy
d. Weight loss programs
e. Services not related to the treatment of musculoskeletal system
f. Vocational rehabilitation services
g. Thermography
h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances
i. Transportation costs which include local ambulance charges
j. Prescriptions drugs, vitamins, minerals, food supplements or other similar products
k. Educational programs
l. Non-medical self-care or self-help training
m. All diagnostic testing related to these excluded services
n. MRI and/or other types of diagnostic radiology
o. Physical or massage therapy that is not a part of the chiropractic treatment
p. Durable medical equipment (DME) and/or supplies for use in the home
q. Nutritional counseling or related testing

LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

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

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

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

3. All services or supplies that exceed any maximum cost or time limitation (days or visits) identified in this Evidence of Coverage.

4. Cochlear transplants.

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

6. Services by a non-Participating Provider, except in the case of a Medical Emergency or the Covered Person’s need for urgent care.

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

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

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

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

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

12. Nursing homes and custodial care.

13. Eye refractions or examinations, except as specifically covered under this Evidence of Coverage. Eye glasses 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.

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

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

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

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

18. Batteries. Physician equipment such as sphygmomanometers, stethoscopes, etc.

19. 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; support garments. It also includes devices not exclusively medical in nature, such as, but not limited to, sauna baths; spas; elevators; air conditioners or filters; humidifiers and dehumidifiers; equipment that can be used after the medical need is over such as orthopedic chairs and motorized scooters; and modifications to the home or motorized vehicles. Exceptions to this exclusion would be over-the-counter items or drugs required to be covered by federal or state statutes or regulations.

20. 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 is not limited to, breast implants. The Carrier shall have sole discretion to determine whether the services are likely to result in significant improvement in function.

21. 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.

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

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

24. All military service connected conditions.

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

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

27. All services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such services, and donor semen and donor eggs used for such services, such as, but not limited to: in vitro 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.

28. Complications caused by treatment of infertility.

29. Elective abortions.

30. 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.

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

32. Services for an organ donor or prospective organ donor when the transplant recipient is not a Covered Person.

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

34. High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue.

35. Transplants disapproved by the appropriate evaluation committee.

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

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

38. Diagnosis and treatment for mental retardation; learning or behavioral disorders; psychosocial problems; speech delay; conceptual handicap or developmental disability or delay; or dyslexia. Exceptions to this exclusion would be services required to be covered elsewhere in the benefit plan.

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

40. Long term rehabilitative services.

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

42. Genetic testing, counseling or engineering, except prenatal diagnosis of congenital disorders as specifically identified in this Evidence of Coverage.

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

44. Bone and eye bank charges.

45. Counseling or training in connection with family, sexual, marital, or occupational issues, and diabetes classes for situations other than newly diagnosed diabetes and pregnancy induced diabetes.

46. Orthoptic; pleoptics; visual analysis; visual therapy and/or training.

47. Services that the Covered Person would not have to pay for in the absence of Policy coverage.

48. Services provided by a person who lives in the Covered Person's home. Services provided by an immediate relative of the Covered Person.

49. The treatment of any injury or illness that arises out of, or as the result of, any work for wage or profit. However, this exclusion will not apply when the Covered Person 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, if the employer is a partnership; or
    - an executive officer of the employer, if the employer is a corporation.

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

51. Non-legend drugs other than insulin.

52. Injectables obtained through a pharmacy (other than insulin).

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

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

55. Nystatin oral powder; progesterone suppositories and oral suspension; and growth hormones. All forms of Benzoyl Peroxide.

56. Medications with no approved indications.

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

58. Prescriptions that a Covered Person is entitled to receive without charge from any workers' compensation law or automobile accident liability insurance.

59. 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.

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

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

62. Treatment at pain clinics and chronic pain centers.

63. Hair analysis.

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

65. Post-partum exercises.

66. Services for conditions arising from or worsening as a result of the Covered Person's refusal to accept treatment recommended by a Participating Provider.

67. Services not rendered in accordance with Carrier policies and procedures. Services rendered by non-participating Providers (except for Medical Emergencies and urgent care situations).

68. Any ambulance services that are not Medically Necessary. Medically Necessary ambulance service is provided if authorized prior to transport by the Covered Person's Primary Care Physician or approved after transport as Medically Necessary by the Policy. The Policy does not provide ambulance transportation due to the absence of other transportation on the part of the Covered Person. 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 Carrier.

69. Any and all costs related to surrogate pregnancies and deliveries of non-members are excluded.

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

MEMBER PAYMENT RESPONSIBILITY

Monthly Premiums.
In exchange for Policy coverage, you will be required to pay monthly Premiums to the Carrier. The Carrier will send you a monthly bill for the amount of Premiums you owe. Your coverage may be terminated if you fail to pay your Premiums timely. The Carrier'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 Co-payment, Coinsurance and Deductible amounts described in the Schedule of Benefits. Your Out-of-Pocket Maximum includes all Co-payments, Coinsurance and Deductible amounts. You will also be responsible for paying for any health care services that do not qualify as Covered Services. 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. You will also be required to pay for those health care services that were provided without a Written Referral from the Carrier.

Coordination with Other Coverage

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

- the full amount payable for the Covered Services under the Policy, or
- an amount that, when added to the amount payable under the other plan, will be no more than the amount payable by the Policy for the Covered Services.

Medicare COB.
Medicare will be primary except as required by law.

Auto Insurance Benefits COB.

- Coordination with Auto Coverage. Your benefits under this Contract will be coordinated with any no fault coverage or other automobile insurance that provides medical payment coverage or medical expense coverage in any form as allowed by law.

- Payment. If you are eligible for benefits under Auto Coverage, such coverage will be primary and responsible for all benefits payable under Auto Coverage. If you are eligible for coverage under more than one automobile insurance policy, each policy will pay its maximum Auto Coverage before we will make any payments. We apply payments made by Auto Coverage to any Cost Sharing payable under this Contract as required by law. We may request proof that Auto Coverage has paid all benefits required. If we request information you must give it to us before we are obliged to make any payments.

- Settlement of Auto Coverage Claims. You may not release or settle any Auto Coverage claims without our written consent if we paid or may have to pay benefits for services that would be covered by the Auto Coverage. If you release or settle an Auto Coverage claim without our consent we may refuse to provide benefits for services that would be provided to you by the Auto Coverage. If you release or settle an Auto Coverage claim without our consent we may refuse to provide benefits for services that would be provided to you by the Auto Coverage. We may also recover amo0unts you got under the Auto Coverage for any benefits we provided that should have been provided to you by the Auto Coverage. Amounts you get or may get for future health care services that would be provided by the Auto Coverage will be placed in a trust account as directed by us for payment of these services.

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

No Double Recovery
In no event will you be entitled to obtain double recovery from Policies for health care services provided to you.

Insurance With Other Insurers
This applies if you have double coverage and no other coordination of benefits provisions apply. This generally occurs where one of the policies that provides double coverage is not a group policy.

For this Section, "Other Valid Coverage" means coverage provided by:

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

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

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

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

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

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

Recovery Rights of the Carrier

Right of Subrogation/Reimbursement.
In certain circumstances, you or your Covered Dependents (or the heirs, executor, or beneficiaries of you or your Covered Dependents) may have an obligation to reimburse the Carrier 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 Policy 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). The Plan’s rights under this section arise after you or your Covered Dependents are fully compensated.
In these cases, the Policy 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 Carrier for any benefits paid by the Policy after you or your Covered Dependents are fully compensated. This reimbursement obligation is not limited by the stated purpose of the payment from the third party or how the payment from the third party is characterized in any agreement, or judgment.

You agree to notify the Carrier, in writing, of any benefits paid by the Policy that arise out of any illness or injury that was caused by a third party. You also agree to provide the Carrier 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 Carrier’s 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;
- notification 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 Carrier's prior written approval.

By filing a claim for and/or accepting benefits from the Policy, you and your Covered Dependents are considered to have consented to the Carrier's subrogation and right of reimbursement. You and your Covered Dependents are considered to have agreed to cooperate with the Carrier 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 Carrier, if the Carrier requests such an agreement. You and your Covered Dependents may not do anything that would prejudice or harm the rights of the Carrier to pursue its rights of reimbursement and subrogation.
Colorado Statutes will govern Subrogation and Recovery Rights. If anything in this section is not in accordance with Colorado Statute, then it shall be superseded by Colorado Statute.

Right to Offset Future Payments.
If the Carrier sends you or your Covered Dependent a payment by mistake, or the Policy overpays an amount owed to you or your Covered Dependent, the Carrier 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 Carrier'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 Policy to another person. You may not assign (transfer) any claim, right of recovery or right to payment you may have against the Policy or the Carrier. However, you are permitted to assign (transfer), in writing, any amount payable to you by the Policy.

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 Carrier for payment. The health care provider is able to do this because the Carrier's information is set forth on your identification card.

Claims You Submit to the Carrier.
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 Carrier. If you file your claim in a timely manner, the Policy 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 Policy will not reimburse you for any Co-payment, 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 Carrier. If you file your claim in a timely manner, the Policy will pay the health care provider for the Covered Services that were provided up to the contracted rate with the provider. However, the Policy will not pay for any Co-payment, 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 Policy will not pay the health care provider. Instead, you will be required to pay for all of the health care services that were provided.

Timing and Contents of Claim.
If you are submitting a claim to the Carrier, you must do so within ninety (90) days of the date that the health care services were provided. Your claim must include the diagnosis, the type of treatment rendered, the date of service, the name and address of the health care provider, the charges for the care, the name of the Covered Person, and the Covered Person's identification number. If you have already paid the health care provider,

you must also include receipts showing your payment.

All claims should be sent to: Friday Health Plans of Colorado, Inc.
700 Main Street, Suite #100
Alamosa, CO 81101
Attention: Claims Director.

All clean claims shall be paid, denied or settled within thirty (30) calendar days after receipt by the Plan if submitted electronically and within forty-five (45) calendar days after receipt by the Plan if submitted by any other means.

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

Absent fraud, all claims (except clean claims) shall be paid, denied or settled within ninety (90) calendar days after they are received by the Plan.

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

Claim Notifications

If a Claim is Denied.
If your claim, or any part of your claim, is denied, the Carrier 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 Policy provisions;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why such material or information is necessary; and
- information as to the steps you can take if you wish to appeal the decision.

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

Timing of the Notice.
After the Carrier reviews your claim, the Carrier will notify you of any decision to deny your claim. Notice will be provided within the following timeframes, depending on the type of claim involved:

- For Urgent Care Claims. You will receive notice of the Carrier's decision within seventy-two (72) hours after the Carrier's receipt of your claim, unless you do not provide enough information for the Carrier to determine whether or to what extent benefits are payable under the Policy. If this occurs, the Carrier will notify you of the deficiency within twenty-four (24) hours after the Carrier's receipt of your claim. You will have a reasonable amount of time, not less than forty-eight (48) hours, to provide the additional necessary information. The Carrier will then notify you of its decision as soon as possible, but no later than forty-eight (48 hours) after the earlier of (i) the Carrier's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

  An "Urgent Care Claim" is a claim for medical care or treatment where a delay in making a decision could (a) jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or, (b) in the opinion of your health care provider or your Covered Dependent's health care provider, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

- For Pre-Service Claims. You will receive notice of the Carrier's decision within a reasonable time, but no longer than fifteen (15 days) after the Carrier's receipt of your claim. An extension of an additional fifteen (15) days may be available due to matters beyond the control of the Carrier. However, this extension is only available if the Carrier notifies you before the end of the first fifteen (15) days of the circumstances requiring the extension and the date by which the Carrier expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional information needed. You will have at least forty-five (45) days to provide the additional information. The Carrier will suspend the time period for responding to your claim until (i) you respond to the notice, or (ii) at least forty-five (45) days have passed since your receipt of the notice, whichever is earlier.

  A "Pre-Service Claim" is a request for approval of a medical benefit where receipt of the medical benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include pre-authorization for hospital stays, second surgical opinions, etc.

- For Post-Service Claims. You will receive notice within a reasonable time, but no later than thirty (30) days after the Carrier's receipt of your claim. This review period may be extended for fifteen (15) days due to matters beyond the Carrier's control. However, this extension is only available if the Carrier notifies you before the end of the first thirty (30) days of the circumstances requiring the extension and the date by which the Carrier expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional information needed. The Carrier will suspend the time period for responding to your claim until (i) you respond to the notice, or (ii) at least forty-five (45) days have passed since your receipt of the notice, whichever is earlier.

  A "Post-Service Claim" is any claim for medical benefits that is not a Pre-Service Claim or an Urgent Claim.

- For Ongoing Treatment. If you are receiving ongoing treatments (i.e., treatment over a period of time or a specified number of treatments) that have been previously approved by the Carrier, any reduction or termination of ongoing treatments is considered a denial. The Carrier must notify you within a reasonable time prior to the reduction or termination of services.

  If you request to extend urgent care beyond the approved period of time or number of treatments, the Carrier will notify you of its decision as soon as possible, but no later than twenty-four (24) hours after receiving your claim. However, this will be the case only if your request was made at least twenty-four (24 hours) in advance of the end of the approved ongoing treatment. If you do not make your claim at least twenty-four (24) hours before the expiration of the ongoing treatment, then the time frames for Urgent Care Claims (outlined above) will apply.

If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a Pre-Service Claim or Post-Service Claim, as applicable.

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 the service or supply is a Covered Service. The health care services and supplies that are paid for by the Policy 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 a Covered Service and will not be paid for by the Policy. 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 Policy.
It is important to note that the Policy will pay for Covered Services only if other terms and conditions of the Policy are met. For example, in order for a Covered Service to be paid for by the Policy, the Covered Service must be Medically Necessary. The Medical Director must decide whether a Covered Service is Medically Necessary.

In addition, in most cases, the Covered Service must be performed by your Primary Care Physician or by another Participating Provider. Generally, if you receive Covered Services from a Participating Provider who/which is not your Primary Care Physician, you must first receive a Written Referral.

Grace Period for Payment of Premiums.
The Plan allows a thirty-one (31) day grace period for payment of your premium. The Plan will continue to pay for your Covered Services during this grace period. 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 Policy. There is also no annual dollar limit on the essential health benefits you may receive from the Policy. However, there are other limits on your benefits. Those limits are described in this Evidence of Coverage.

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

Friday Health Plans
700 Main Street, Suite #100
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 PCP and other Providers.

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

- through completing your Health Risk Assessment
- our review of claims information
- a referral from a hospital care manager or one of your Providers
- self- referral

Experienced nurses can help you understand and get the care you need if you are overwhelmed with a new diagnosis or if you or your loved one has any special needs such as limited mobility or intellectual struggles.

If you feel you would benefit from our Care Management program you may call Friday Health Plans at:
(719) 589-3696 or (800) 475-8466

Special Rights of the Member

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

Health Status.
A Covered Person may not be cancelled or non-renewed on the basis of the status of his/her health or health care needs.

TERMINATION/NONRENEWAL/CONTINUATION
Termination of Policy Coverage

End of Your Coverage.
Your Policy coverage will end at the end of the Policy Year, unless you have elected to renew your coverage. Your coverage will also end if:

- you move outside of the Service Area;
- you fail to abide by the terms of the Policy;
- you terminate your coverage under the Policy with appropriate notice to the Carrier;
- 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
- the Carrier no longer offers individual coverage.

End of Your Covered Dependents' Coverage.
Generally, your Covered Dependents' coverage ends when your coverage ends. In addition, your Covered Dependents' coverage also ends if:

- he/she no longer meets the definition of a Child or a Spouse (for example: if your non-disabled son or daughter reaches age twenty-six (26)); or
- you (or your Covered Dependent) fails to make a Premium payment required for Dependent coverage.

Proof of Your Policy Coverage.
When you and/or your Covered Dependents lose Policy coverage, the Carrier will provide you and/or such Dependents with a document called a "Certificate of Creditable Coverage." The Certificate of Creditable Coverage will indicate the time period that you and/or your Dependents were covered by the Policy.

If you need to request a Certificate of Creditable Coverage, you should contact the Carrier in writing at:

Friday Health Plans
700 Main Street, Suite #100
Alamosa, Colorado 81101.

Your request must include:

- your name and the names of your Dependents who were covered by the Policy;
- the time period of your coverage and your Dependents' coverage by the Policy;
- the mailing address where the Certificate of Creditable Coverage should be sent.

Effective Date of Termination of Coverage

Out of Service Area.
If you (or any Covered Dependent) no longer lives/resides within the Service Area, Policy coverage will generally end on the last day of the month during which you (or such Covered Dependent) met this requirement.

For Premium Payment Failures.
If you fail to make a Premium payment that is required by the Policy, the Carrier will allow a thirty-one (31) day grace period, during which your coverage (and your Covered Dependents' coverage) will remain in effect. The Plan will continue to pay for your Covered Services (and your Covered Dependents' Covered Services during the grace period. The Carrier will notify you of your failure to pay. If you fail to pay your outstanding Premiums within the thirty-one (31) day grace period, termination of your coverage (and the coverage of your Covered Dependents) will be effective as of the first day immediately following the 31-day grace period.

For Rescissions of Coverage.
If you or any Covered Dependent commits a fraud against the Carrier or intentionally misrepresents a material fact in connection with the Policy or the coverage, there will be a Rescission of your coverage (and the coverage of your Covered Dependents). In such a case, the Carrier will provide you with thirty (30) days' advance written notice of the Rescission. However, the termination of coverage will be retroactive to the date of the event that caused the Rescission.

The Carrier will refund any contributions you made to the Policy relating to the period subject to the Rescission. However, the Carrier may subtract from the refunded contributions any amounts paid by the Carrier for Covered Services (for you and your Covered Dependents) during such period. The Carrier may also charge you for any amounts paid by the Policy for Covered Services (for you and your Covered Dependents) during such period, if those amounts are greater than the amount of your Premiums 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 Carrier.

For Misconduct.
If you permit another person to use your identification card or otherwise misuse your coverage, your Policy coverage (and the coverage of your Covered Dependents) may be cancelled upon thirty (30) days' prior written notice from the Carrier.

For Other Reasons.
If Policy coverage is being terminated because the Carrier will no longer offer coverage in the individual market or for some similar reason, you will be notified of the effective date of your termination of coverage (and/or your Covered Dependents' termination of coverage).

Impact on Hospitalized Covered Person.
If Policy coverage is terminated while a Covered Person is hospitalized, the Covered Person will continue to be covered by the Policy for the period of the hospitalization, to the extent required by law.

Renewal Rights

Right of Renewal.
The Carrier is required to renew your coverage under the Policy as long as you continue to live or reside within the Service Area. The Carrier will also renew coverage of any Covered Dependent, as long as your Covered Dependent continues to live or reside within the Service Area.

Exceptions to Renewal Rights.
The Carrier will not be required to renew a Covered Person's coverage if:

- the Covered Person has failed to pay any required Premium or has failed to timely pay Premiums;
- the Covered Person has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact with respect to the terms of coverage; or
- there are no longer any Covered Persons living or residing within the Service Area.

Discontinuing the Policy.
The Carrier will also not be required to renew a Covered Person's coverage if the Carrier elects to discontinue offering the Policy and:

- provides notice of the decision not to renew coverage, at least ninety (90) days before the non-renewal of the Policy to each Covered Person;
- offers each Covered Person the option to purchase coverage under any other health benefit policy currently being offered by the Carrier in the State of Colorado and identifies the applicable special enrollment periods for each such policy; and
- provides the required notice and information to the Department of Insurance; and
- complies with any other applicable non-renewal requirements imposed by law.

Leaving the Individual Policy Market.
The Carrier will also not be required to renew a Covered Person's coverage if the Carrier discontinues offering and renewing all of its individual policies in the State of Colorado and:

- provides notice of the decision to discontinue coverage at least one hundred eighty (180) days before the discontinuance to each Covered Person;
- provides notice to the Department of Insurance at least three (3) business days before the date the notice is sent to each Covered Person;
- 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 Covered Persons; and
- complies with the other applicable non-renewal requirements under the law.

APPEALS AND COMPLAINTS
Internal Appeal Procedures

Right to Appeal.
The right to appeal applies to all Adverse Benefit Determinations. An "Adverse Benefit Determination" means a denial, reduction or termination of a benefit; or 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 pre-authorization requirements or other utilization review requirements;
- the determination that the benefit is experimental or investigational;
- a determination that the benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; or
- a Rescission of coverage.

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

The individual(s) reviewing the appeal will consider all comments, documents, records and other information submitted by the Covered Person, even if the information was not considered when the Adverse Benefit Determination was made.

The decision in response to an appeal will contain the following information:

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

How to Appeal.
You (or your authorized representative) may appeal an Adverse Benefit Determination by following the Carrier's procedures. To begin the appeals process, or to request help with the appeals process, you may call Plan's Member Services at 719-589-3696. Your appeal must be received, in writing, by the Carrier within one-hundred and eighty (180) days after your receipt of the notice of denial. If the deadline for appealing falls on a weekend or holiday, it will be extended to the next business day. For Urgent Care Claims, your appeal may be made orally.

When you file 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 Carrier's decision. You may also review (at no charge) copies of the documents and information relevant to your claim. This includes information or records that were relied on in making the Adverse Benefit Determination; information that was considered by or produced to the original decision-maker(s); information relating to administrative procedures and safeguards that were applied in making the original decision; and policies or guidance relating to the service or treatment for your diagnosis. However, you must make a request for such review.

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

Appeal Notification and Timing.
If the Carrier receives your appeal by the appropriate deadline, the Carrier will independently review your appeal and any additional information that you submit. The Carrier will notify you of its decision regarding your appeal within the following timeframes:

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

- For Pre-Service Claims. The Carrier will notify you within a reasonable period of time, but no later than thirty (30) days after its receipt of your appeal.

- For Post-Service Claims. The Carrier will notify you within a reasonable period of time, but no later than thirty (30) days after its receipt of your appeal.

If an Appeal is Denied.
If your appeal is denied, the Carrier will send you a notice containing the following information:

- specific reasons for the denial;

- specific references to relevant Policy provisions;

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

- a statement of any additional appeal rights offered by the Policy and a description of those rights.

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.

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 Carrier has failed to comply with its obligations under this Internal Appeal Procedures section.

External Appeal Procedures

Denials that 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 right applies if your Adverse Benefit Determination relates to one of the following:

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

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

- standard health care services or treatments have not been effective in improving the condition of the Covered Person or are not medically appropriate for the Covered Person; or

- there is no available standard health care service or treatment covered by the Policy that is more beneficial than the recommended or requested health care service, and the physician is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the Covered Person's condition.

Finally, in such cases, the physician must certify that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Covered Person is likely to be more beneficial to the Covered Person 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.

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

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

The Carrier will pay the costs of an external review.

Appointment of External Review Entity.
When the Carrier receives your request for an external review, the Carrier will contact the Division of Insurance. The Division of Insurance will inform the Carrier of the name of the independent, third-party, external review entity that has been selected by the Division of Insurance to conduct the review. The Carrier will notify you in writing that your request for external review has been sent to the Division of Insurance. The Carrier 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 case of an expedited review), the Carrier will provide the external review entity with the following:

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

The Carrier 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 Carrier relating to the external review entity. The external review entity will provide a copy of such information to the Carrier 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 Carrier 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 Carrier. The additional information must be submitted within five (5) business days of the request.

The Carrier 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 Carrier decides to provide the coverage (approve your claim), the Carrier will notify you within one (1) business day of its decision. The Carrier 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 Carrier, 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 Carrier 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 Carrier 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 Policy. The external review entity's decision will refer to the relevant provisions in the Policy 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 Carrier. 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 Carrier 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 Carrier 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 Carrier's approval will occur immediately, and the Carrier will immediately notify you in writing of its approval of coverage.

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

Other Grievance Procedures

<u>Other Disputes</u>.
The Carrier also has a grievance process to help resolve issues and concerns that are not subject to the various procedures described above. Examples of the types of issues you may address through this process include complaints about:

- waiting times to see your Primary Care Physician or other Participating Provider;
- the behavior of your Primary Care Physician 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 Policy but do not have to pay for.

<u>How to File a Grievance</u>.
To begin the grievance process, you may call the Carrier's Member Services Department at 719-589-3696.

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

<u>Time Period for Filing</u>.
You must file your grievance with the Carrier within one year of the event on which your grievance is based. The Carrier will not consider any grievance submitted after such date.

INFORMATION ON POLICY AND RATE CHANGES

<u>Policy Changes</u>.
The Covered Services available to you and your Covered Dependents may change each Policy Year. The Carrier will inform you of any changes in your coverage. Any changes will also be set forth in the new Evidence of Coverage you receive.

<u>Changes in Rates</u>.
During a Policy Year, the Carrier may change the Premium amount you owe if there are changes in 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 Carrier may also change the Premium amount you owe during the Policy Year if the Carrier makes changes to the Policy at your request, or if there are changes in the law that impact the Policy. You will be notified in advance of any Premium changes made during the Policy Year.

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

Notice.
Sixty (60) day notice will be given for all material changes to the policy.

DEFINITIONS

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

"Application" refers to the form used by the Plan to collect information from you and to verify that information when you enroll for coverage or the State of Colorado Uniform Individual Application.
“Benefits” means the same as “Covered Services”

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

- has not yet attained age twenty-six (26); or
- is medically certified as disabled and dependent upon you or your Spouse (no matter how old the child is).

“Contract” means this Evidence of Coverage document and the following:

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

"Coinsurance" refers to your share of the costs of a Covered Service. Your share is calculated as a percentage of the rate charged by a Participating Provider for the Covered Service. You are required to make Coinsurance payments directly to the health care provider at the time you receive health care services.

"Co-payment" refers to the fixed dollar amount that you pay for Covered Services. You are required to pay the Co-payment amount directly to the health care provider at the time you receive health care services.

"Covered Child" means any Child who is covered by the Policy.

"Covered Dependent" means any Child or Spouse who is covered by the Policy.

"Covered Person" refers to you or any Covered Dependent.

"Covered Services" means those health care services and supplies that the Policy is required to pay for, if the other terms and conditions of the Policy have been satisfied.

"Deductible" means the amount you owe for Covered Services before the Policy will begin to pay for health care services. You will be required to pay the Deductible directly to the health care provider at the time you receive health care services.

"Dependent" refers to your Child or your Spouse.

"Evidence of Coverage" refers to this document. This document is intended to describe the health care benefits available to you and your Covered Dependents under the Policy. It is also intended to describe the terms and conditions of receiving those benefits.

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

- has not been approved by an appropriate governmental agency, such as, but not limited to the Food and Drug Administration (FDA);
- is the subject of an ongoing FDA Phase I, Phase II, or Phase III clinical trial;
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that serves a similar function of approving or reviewing research on safety, toxicity or efficacy;
- lacks recognition and endorsement from nationally accepted medical panels, national medical associations, or other evaluation bodies;
- has been disapproved by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness;
- lacks conclusive evidence demonstrating that the service improves the net health outcome for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service may be recognized as a treatment or service for another condition, screening, or illness;
- requires written informed consent that describes the service as experimental, investigational, educational, for a research study, or in other terms that indicate that the service is being looked at for its safety, toxicity or efficacy; or
- is part of a prevailing opinion among experts as expressed in published authoritative medical or scientific literature that the use of the service is experimental or further researched is necessary to determine safety, toxicity, or efficacy of the service.

Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a health service, treatment, procedure, device, drug, or product is Experimental or Investigational.

"Medical Director" refers to the person the Policy has selected as a decision-maker. This is the person responsible for issuing Written Referrals. This person also determines whether Covered Services are Medically Necessary.

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

- placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the Covered Person or her unborn child) in serious danger;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

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

"Medically Necessary" refers to the following types of care, if they are not otherwise excluded from Policy coverage:

- the most appropriate, useful, and cost-effective care, according to accepted standards of good medical practice, as determined by the Carrier or the Medical Director; and
- care that can be safely provided to a Covered Person for prevention, diagnosis, or treatment of the Covered Person's medical condition

"Minimum Essential Coverage" refers to coverage under Medicare Part A; Medicaid; CHIP; Tricare; the Tricare for Life program; the veteran's health care program; the Peace Corps program; a governmental plan including FEHBP and any plan established by an Indian tribal government; any plan offered in the

individual, small group or large group market; coverage under an employer-sponsored plan; a grandfathered health plan; and any other health benefits coverage, such as a State health benefits risk pool.

"Open Enrollment Period" means the period of time each Policy Year when you will be given an opportunity to enroll for Policy coverage or make changes to your prior enrollment election.

"Participating Provider" means any doctor, hospital, pharmacy, clinic, or other health care provider who/which has agreed to provide health care services to Covered Persons at contracted rates. Friday Health Plans has contracted rates with Participating Providers on a fee for service basis.

"Policy" means the health benefit coverage described in this Evidence of Coverage.

"Policy Year" means each twelve (12) month period that the Policy is in effect.

"Premium" refers to each payment you make to the Carrier for Policy coverage.

"Primary Care Physician" means the particular doctor you have selected to be your primary health care provider. You will be required to select this doctor from a list of Participating Providers supplied by the Carrier.

"Prior Authorization" refers to written approval you must receive from the Plan Medical Director before you receive health care services from anyone other than your Primary Care Physician. Means the same as "Written Referral"

"Rescission" means a cancellation of Policy coverage that has a retroactive effect.

"Refund Period" means the shorter of:

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

"Service Area" means all of the counties in Colorado where the Carrier offers the Policy and has arrangements with Participating Providers.

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

"Spouse" refers to your legally-recognized husband or wife, or your partner in a civil union, who lives within the Service Area.

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

"Written Referral" refers to written approval you must receive from the Plan Medical Director before you receive health care services from anyone other than your Primary Care Physician. Means the same as "Prior Authorization".