SMALL GROUP MEDICAL AND HOSPITAL POLICY

EVIDENCE OF COVERAGE

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Friday SG Gold Rx Copay	In-Network	Out-of-Network
Deductible	$950 Ind. / $1,900 Fam.	Not applicable
OOP Max	$8,250 Ind. / $16,500 Fam.	Not applicable
Preventive	$0 copay	Not covered
PCP	$20 copay	Not covered
Chiropractic	$40 copay	Not covered
Preventive Pediatric Vision Exam	$0 copay	Not covered
Telehealth PCP	$20 copay	Not covered
Telehealth Mental/Behavioral	$20 copay	Not covered
Telehealth Substance Abuse	$20 copay	Not covered
Telehealth Specialist	$40 copay	Not covered
MHSA/Behavioral Health - OP	$0 copay	Not covered
Specialist	$40 copay	Not covered
PT/OT/ST	$40 copay	Not covered
Inpatient	20% coinsurance after deductible	Not covered
Emergency Room	50% coinsurance after deductible	50% coinsurance after deductible
Urgent Care	$75 copay	$75 copay
Outpatient	20% coinsurance after deductible	Not covered
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible
X-ray and Diagnostic Imaging	20% coinsurance after deductible	Not covered
All other services	20% coinsurance after deductible	Not covered
Preventive Rx	$0 copay	Not covered
Preferred Generic Rx	$0 copay	Not covered
Preferred Brand Rx	Up to $250	Not covered
Non-Preferred Generic and Brand Rx	Up to $350	Not covered
Specialty Rx	Up to $685	Not covered

TITLE PAGE (COVER PAGE)

FRIDAY HEALTH PLANS OF COLORADO, INC.

SMALL GROUP MEDICAL AND HOSPITAL PLAN

EVIDENCE OF COVERAGE

INSURED NAME: [JANE DOE]
EFFECTIVE DATE: [XXXXX, XX, 20XX]
Monthly Premium:[$XXXX.XX]

SECTION 3: CONTACT US

PURPOSE OF THIS DOCUMENT

Your employer has entered into an agreement with Friday Health Plans of Colorado, Inc. (the "Carrier"). In that agreement, the Carrier has agreed to provide a health insurance plan (the "Plan") to eligible employees and certain family members. Eligible employees who wish to participate in the Plan may enroll themselves and certain family members for Plan coverage. To do so, they must take the actions described in this Evidence of Coverage (EOC). This EOC describes the health care benefits available under the Plan. It also describes the rules that apply to individuals who participate in the Plan.

In order to understand the benefits 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 Plan 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,
Alamosa, Colorado 81101

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

NOTICE OF NONDISCRIMINATION

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

Friday Health Plans of Colorado:

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

If you need these services, contact Member Services at 1-800-475-8466.

If you believe that Friday Health Plans of Colorado has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the Chief Compliance Officer, 700 Main Street, Suite 100, Alamosa, CO 81101; 1-800-475-8466 (TTY: 1-800-659-2656); compliance@fridayhealthplans.com. You can file a grievance in person, or by mail, or email. If you need help filing a grievance, our Chief Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Friday Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-475-8466.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Friday Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-475-8466.

Chinese: 如果您，或您正在幫助的人，有關於 Friday Health Plans方面的問題，您有權利免費以您的母語得到幫助和訊息 想要跟一位翻譯員通話，請致電 1-800-475-8466.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Friday Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-475-8466 로 전화하십시오.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Friday Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-475-8466.

Amharic: እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Friday Health Plans ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800475-8466 ይደውሉ።

Arabic: كا إن لـ ن لـ أو ديك شخ دى تساء ص أ ده بخصـ سئلة وص 1-800-475-8466 Friday Health Plans فلا ا ديك لحق ا يفا ىلءا لحصول وا لمساعدة ا لمعلومات بلغة لضرورية مـ ك ا دون ن للتحـ. ةفلكتـ ية متـ عمـ دث رجم بـ اتصل

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Friday Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-475-8466 an.

French: Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Friday Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-475-8466.

Napali: यिद तपाई ंआफ्ना लािग आफैं आवेदनको काम गद, वा कसैलाई मद्दत गद हनुहन्छ Friday Health Plans बारे प्रह छन् भने आफ्नो मातृभाषामा िन:शुल्क सहायता वा जानकार पाउने अिधकार छ । दोभाषे (इन्टरप्रेटर) सँग कु रा गनर्ुपरे 1-800-475-8466 मा फोन गनर्ुहोस् ।

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Friday Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-475-8466.

Japanese: ご本人様、またはお客様の身の回りの方でも、Friday Health Plans についてご質問がございましたら、ご希望の言語でサポートを受けたり 、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-800-475-8466 までお電話ください。

Cushite: Isin yookan namni biraa isin deeggartan Friday Health Plans irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta’een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-475-8466 tiin bilbilaa.

Persian: گر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Friday Health Plans ، داشته 1-800-475-8466 باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید تماس حاصل نمایید.

Kru: I bale we, tole mut u ye hola, a gwee mbarga inyu Friday Health Plans, U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-800-475-8466.

Ibo: Ọ bụrụ gị, ma o bụ onye I na eyere-aka, nwere ajụjụ gbasara Friday Health Plans, I nwere ohere iwenta nye maka na ọmụma na asụsụ gị na akwu gị ụgwọ. I chọrọ I kwụrụ onye-ntapịa okwu, kpọ 1-800-475-8466.

Yoruba: Bí ìwọ, tàbí ẹnikẹni tí o n ranlọwọ, bá ní ibeere nipa Friday Health Plans, o ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ongbufọ kan sọrọ, pè sórí 1800-475-8466.

SECTION 4: **TABLE OF CONTENTS**

SECTION 1: SCHEDULE OF BENEFITS (WHO PAYS WHAT) 1

SECTION 2: TITLE PAGE (COVER PAGE) 2

SECTION 3:CONTACT US 3

SECTION 4: TABLE OF CONTENTS 7

SECTION 5: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE 8

SECTION 6: THE HMO NETWORK 11

SECTION 6 (CONT): HOW TO ACCESS YOUR SERVICES AND APPROVAL OF BENEFITS 13

SECTION 7: BENEFITS/COVERAGE (WHAT IS COVERED) 16

SECTION 8: LIMITATIONS/ EXCLUSIONS (WHAT IS NOT COVERED) 46

SECTION 9: MEMBER PAYMENT RESPONSIBILITY 51

SECTION 10: CLAIMS PROCEDURE (HOW TO FILE A CLAIM) 56

SECTION 11: GENERAL POLICY PROVISIONS 61

SECTION 12: TERMINATION/NONRENEWAL/CONTINUATION 63

SECTION 13: APPEALS AND COMPLAINTS 66

SECTION 14: INFORMATION ON POLICY AND RATE CHANGES 74

SECTION 15: DEFINITIONS 75

SECTION 5: ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

ELIGIBILITY OF EMPLOYEES

You are eligible to participate in the Plan if you are an employee who:

- Is regularly scheduled to work at least thirty (30) hours per week for your employer;
- Meets the eligibility requirements identified by your employer, if any;
- Has a valid employee/employer relationship with your employer; and
- Lives or works within the Service Area.

You will not fail to meet these eligibility requirements just because you are on a temporary work assignment outside of the Service Area. However, your assignment must not last longer than ninety (90) days.

ELIGIBILITY OF YOUR DEPENDENTS

Your Dependents are also eligible to participate in the Plan.

The following are the acceptable Dependents allowed:

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

INITIAL ELIGIBILITY

When you first become eligible to participate in the Plan, you will have the opportunity to elect coverage. You may elect such coverage for yourself and your Dependents. In order to participate in the Plan, you must formally enroll in the Plan. You must also agree to pay any required contributions. You may enroll in the Plan by delivering a completed enrollment form (along with payment) to your employer. You must do so within the time period identified by your employer.

If an employee does not complete the Application process and make the appropriate payment on or before the appropriate deadline, it will be assumed that they have elected not to be in in the Plan. If an employee does not enroll (or their Dependents) in the Plan at the time they first meet the eligibility requirements, they must wait until the next annual Open Enrollment Period to enroll for coverage under the Plan. In certain cases, they may be able to enroll (and/or their Dependents) in the Plan before the next Open Enrollment Period. Please review the Special Enrollment section for more information.

EFFECTIVE DATE OF COVERAGE

If you return the completed enrollment form (along with payment) to your employer on or before the enrollment deadline, your Plan coverage will be effective as of the date that the Waiting Period, if any, has expired. If you have elected to enroll your Dependents in the Plan, their coverage will also be effective on that date. You must be enrolled in the Plan in order to enroll any Dependent in the Plan.

ANNUAL OPEN ENROLLMENT

Each year that you are eligible to participate in the Plan, you will have the opportunity to decide if you want to participate. If you want to participate in the Plan, you must complete a new enrollment form and return it to your employer during the Open Enrollment Period. The Open Enrollment Period generally lasts for thirty (30) days and occurs before the beginning of the next Plan Year. If you enroll yourself and any Dependents during an Open Enrollment Period, coverage will be effective as of the first day of the upcoming Plan Year. If you previously participated in the Plan and you do not return a completed enrollment form to your employer, you will automatically be treated as though you elected to enroll in the same coverage you elected on your most recent enrollment form, if available, for the next Plan Year.

DOCUMENTATION OF DISABLED CHILD

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

IMPROPER ENROLLMENT

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

IDENTIFICATION CARD

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

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

MISUSE OF IDENTIFICATION CARD

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

SPECIAL ENROLLMENT SECTION

SPECIAL ENROLLMENT RIGHTS

In certain cases, you will have the right to enroll yourself and/or your Dependents in the Plan during the Plan Year. This means that you will not have to wait until the next Open Enrollment Period to receive Plan coverage. Following a triggering event you will have a special enrollment period of no less than 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

- The loss of your creditable coverage for any cause other than fraud, misrepresentation, or failure to pay a premium.

- Gaining a Dependent or becoming a Dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, or by entering into a designated beneficiary agreement if coverage is offered to designated beneficiaries.

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

- Showing to the Insurance Commissioner that the health benefit plan in which you are

enrolled has violated a material provision of its contract in relation to you

- If you gain access to other coverage due to a permanent change in residence.

- If an income change makes a consumer eligible for premium tax credits or cost-sharing reduction during the plan year and the person bought an off-exchange plan, then they will experience a triggering event allowing them to purchase an on-exchange plan that can take advantage of those benefits. As in all cases of special enrolment, the newly purchased benefit plan will have a deductible and max out-of-pocket that is reset.

- A parent or legal guardian dis-enrolls a Dependent. Or a Dependent is no longer eligible for the Children's Basic Health Plan.

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

- Or an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.

COVERAGE EFFECTIVE DATES

- In the case of marriage, civil union, or in the case 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.

SECTION 6: THE HMO NETWORK

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

Each Member shall select, or have selected on his/her behalf, a PCP. You must choose Your PCP by referring to the current Friday Health Plans Provider Directory or by calling FHP customer service. A Member may change his/her PCP at any time for any reason by contacting Friday Health Plans customer service.

It is the responsibility of each Friday Health Plans Member to provide FHP with a change of Your mailing address within 31 days of such address change. Changes can be made by contacting customer service or via your secure Member Portal at www.fridayhealthplan.com.

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

THE HMO NETWORK OF PARTICIPATING PROVIDERS

FHP has contracted with health care providers to give affordable health care to its member. This is also done to manage Your healthcare needs. You must choose Your PCP from the FHP Network. You must receive Your care from Network Providers. Except for rare cases where a Non-Network Provider is Prior Authorized by FHP or in Emergency situations, You MUST receive care from a Network provider in order for it to be considered a Covered Service. If You receive healthcare services from Non-Network Providers, then it will result in a significant increase in cost to You. It is vital that You confirm that the Provider that You intend to see is a Network Provider. You should confirm that a Provider is a Network Provider by checking the Provider Directory or by calling Customer Service at (719) 589-3696 or 800-475-8466. You can also find the directory at www.fridayhealthplans.com.

ACCESSING NON-NETWORK PROVIDERS

If a Provider is not contracted with FHP, then they are a Non-Network Provider. Unless the Member has Prior Authorization, FHP will not cover Non-Network Provider expenses, and the Member must pay for any expenses related to Non-Network services or supplies. Prior Authorization for a Non-Network provider will be granted when FHP concludes that it is not possible to get the necessary medical services In-Network. Please check that the Provider you intend to receive care through is a Network Provider. You can check that a Provider is a Network Provider by checking the FHP Provider Directory. The Provider Directory can be found at www.fridayhealthplans.com or call customer service at (719) 589-3696 or 800-475-8466.

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

If an Enrollee receives emergency services from a Non-Network Facility, then payment from the Plan will be limited to the Allowable Amount. The Plan will pay the Allowable Amount which is the amount established under Colorado state law for reimbursement for health care services to covered persons at an in-network facility provided by an out-of-network provider or for emergency services that are provided by out-of-network providers or facilities.

SECTION 6 (CONT): HOW TO ACCESS YOUR SERVICES AND APPROVAL OF BENEFITS

PRIMARY CARE PROVIDER (PCP)

A PCP is a Network Provider who You choose and who guides, tracks and manages Your health care services. They work to assure continuity of care for the Member. The PCP also works with FHP to get and Prior Authorizations for specialized care the Member may need. You must select a Primary Care Provider within thirty (30) days after your Plan coverage becomes effective. You have the right to designate any Primary Care Provider who participates in the Plan network and who is available to accept you or your Covered Dependents. The Plan does not guarantee that the Primary Care Provider you select will be able to add you or your Covered Dependents as patients. However, the Plan will make an adequate panel of Primary Care Providers available for your selection. If you fail to select a Primary Care Provider within the time period required by the Plan, the Plan may select one for you.

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

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

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-3488.

CHANGES TO PRIMARY CARE PROVIDER

You will be permitted to change your Primary Care Provider by contacting the Plan's Membership Services Department. Once the Plan has approved your selection of a new Primary Care Provider, 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 Provider more than three (3) times during any Plan Year.

PEDIATRICIAN AS PRIMARY CARE PROVIDER

For any Covered Child, you may select a pediatrician as the Child's Primary Care Provider. You may contact the Carrier for a list of the Primary Care Providers who are pediatricians.

You may contact the Carrier in writing at:

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

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-3488.

SIGNIFICANCE OF PRIMARY CARE PROVIDER

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

PRIOR AUTHORIZATION REQUIREMENT

In most cases, you must obtain Prior Authorization from the Plan before you receive health care services from anyone other than your Primary Care Provider. Visits to a network Specialist does not require Prior Authorization, but procedures from any Network Provider usually do require Prior Authorization. Generally, your Primary Care Provider will begin the process of obtaining Prior Authorization on your behalf. This is done by making a request for Prior Authorization to the Plan. Your Primary Care Provider will ask that you be permitted to receive services from another Network Provider. The Plan will respond to each request with either an approval or a denial. The Plan will send a copy of its response to You. The Plan will also send a copy to your Primary Care Provider, and the Network Provider who is the subject of the request. When a request is approved, the Plan will issue Prior Authorization. The Prior Authorization request will identify the name of the Participating Provider. It will also identify the health care services to be performed by the Participating Provider, and the date(s) when the services will be performed. The Prior Written Authorization from the Plan guarantees payment by the Plan of all Covered Services approved in the Prior Authorization. This guaranty does not apply if you lose Plan eligibility before the date of the services. Friday Health Plan uses Medicare Guidelines, as well as MCG, NCCN, Uptodate, or ACOG Guidelines for Prior Authorization determinations. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare guidelines. Please note that this Evidence of Coverage may contain some, but not all, of these exclusions.

The Plan will pay for Covered Services that require Prior Authorization only if you get a Prior Authorization from the Plan before you get the Services. If you receive the Services without Prior Authorization when Prior Authorization is required by the Plan, the Plan will deny your claims for such services.

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

You should contact the Plan at (719) 589-3696 or 800-475-8466 if you are unsure if a service needs Prior Authorization before services are rendered.

EXCEPTION FOR GYNECOLOGICAL CARE

You do not need Prior Authorization for obstetrical or gynecological care from a Network Provider who is an OB GYN or reproductive health specialist). You also do not need a referral from your PCP to get such care. The Network Provider giving such care may have to comply with procedures. These procedures include Prior Authorization for some services. They may also have to follow a pre-approved treatment plan. For a list of Network Providers who specialize in OB GYN or reproductive health, you may contact the Plan at this address.

Friday Health Plans
700 Main Street
Alamosa, Colorado 81101

You may also get this information from 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 Provider. If accessing your Primary Care Provider is not an option, you may obtain care without obtaining Prior Authorization from the Plan. If your Primary Care Provider is unavailable or does not provide the particular health care services you need, you may obtain care without obtaining a Prior Authorization from the Plan. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services, 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 Prior Authorization from the Plan when you receive health care services in a Medical Emergency. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining prior authorization for certain services, that could be considered non-emergent, following a pre-approved treatment plan, or making referrals. If you are hospitalized without a Prior Authorization due to a Medical Emergency, you must notify the Plan by telephone of the hospitalization. Alternatively, you must instruct the hospital or a family member to notify the Plan. This notice must occur on the first business day following the hospital admission, or as soon as medically possible. If you are unable to contact the Plan or to instruct someone else to do so, the notice may be delayed until you are able to notify the Plan or to instruct someone else to notify the Plan. If you can communicate with others, you will be considered capable of notifying the Plan. The Plan may refuse to reimburse you for the cost of non-emergent treatment if proper notice is not provided to the Plan.

OTHER EXCEPTIONS TO PRIOR AUTHORIZATION REQUIREMENTS

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

SPECIALTY CARE CENTERS

Services for certain conditions, or certain treatments or procedures, are covered by the Plan 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 Plan. 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 Plan will not pay for these costs. The Plan 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 Plan will not pay for such services. However, if the reason you are receiving care from a non-Participating Provider is due to a Medical Emergency or an urgent medical situation, the Plan will pay for the Covered Services you receive. This is true only if you follow the other terms and conditions explained in this Evidence of Coverage. If you access an out-of-network provider for emergency and non-emergency services FHP will provide disclosures concerning a covered person's financial responsibility for those services. This information is also available on our website titled "Appendix A". This document outlines your rights as a member in regards to surprise billing.

MEMBER PORTAL

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

SECTION 7: BENEFITS/COVERAGE (WHAT IS COVERED)

GENERAL RULES

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

- The services are Medically Necessary and are received when Plan coverage is in effect;

- The services are received from a Network Provider (unless there is a Medical Emergency); and

- You have obtained Prior Authorization for the services when required.

Even if the Plan pays for Covered Services, you must still meet your Copayment, Coinsurance and/or Deductible obligations. These obligations are found in the Schedule of Benefits. The Covered Services are subject to the other limitations found in this EOC.

A. Newborn Coverage

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

    a. Whether the newborn child is covered for only 31 days or is enrolled beyond the 31 days, the family deductible and out-of-pocket maximum is applicable to the newborn child as it would be for any other Dependent of the Subscriber.

2. Initial Hospital Stay. The Plan will cover the hospital stay for your newborn Child. The hospital stay after a normal vaginal delivery will not be less than forty-eight (48) hours. If the forty-eight (48) hours ends after 8 p.m., your stay will continue until 8 a.m. the next day. The hospital stay after a caesarean section will not be less than ninety-six (96) hours. If the ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the next day.

3. Illness and Injury During First Month of Life. Generally, the Plan will cover the treatment of your newborn Child for illness and injury. This includes the care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one (31) days of your Child's life. However, in order for your Child's Plan coverage to continue beyond the thirty-first (31st) day of life, you must enroll your Child in the Plan. Please refer to the SPECIAL ENROLLMENT section.

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

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

benefits are available to all Members.

5. Inherited Enzymatic Disorders. The Plan will provide coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a Provider who is a participating provider has issued a written, oral, or electronic prescription. In order for your Child's Plan coverage to continue beyond the thirty-first (31st) day of life, you must enroll your Child in the Plan. Please refer to the SPECIAL ENROLLMENT 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 covered by the Plan will include, medical foods for home use, if Medically Necessary. "Medical foods" means metabolic formulas and their modular counterparts, obtained through a pharmacy. These foods are specifically designated and made for the treatment of inherited enzymatic disorders for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed to be deficient in one or more nutrients. These foods are to be consumed or administered enterally either via tube or oral route under the direction of a Network Provider. You must have a prescription from a Network Provider and receive the medical foods through a pharmacy. This shall not be construed to apply to cystic fibrosis, lactose-intolerant or soy-intolerant Enrollees.

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 get certain early intervention services that are covered by the Plan. These benefits are from birth until your Covered Child is 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. The condition must have a high chance of significant delays in development or has a developmental disability. These services are subject to Deductible but are not subject to Co-payments or Coinsurance.

2. General Coverage. In general, the Plan will cover those early intervention services specified in your Covered Child's Individualized Family Service Plan (IFSP). The services must be given by a Network 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 main service. The early intervention services will wrap, but not replace, services for autism spectrum disorders.

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

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

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

C. Autism Spectrum Disorders

Standard. The Plan provides coverage for the assessment, diagnosis, and treatment of autism spectrum disorders. 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.

1. General Coverage. Generally, the Plan will cover the following:

- Evaluation and assessment services;
- Behavior training and behavior management and applied behavior analysis; (This includes but is not limited to consultations, direct care, supervision, or treatment, or

any combination of these. Such services must be provided by a Participating Provider who/which is an autism services provider.)

- Habilitative or rehabilitative care; (This includes but is not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of these therapies.)

- For a Covered Child who is covered under the section below relating to Congenital Defects and Birth Abnormalities, the Plan will cover more than twenty (20) visits for each therapy (occupational, physical, and speech); (Such therapy must be Medically Necessary to treat autism spectrum disorders.)

- Pharmacy care and medication, if the Covered Child Enrollee has pharmacy benefits under the Plan;

- Psychiatric care;

- Psychological care, including family counseling; and

- Therapeutic care.

D. Congenital Defects and Birth Abnormalities

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

2. Annual Limitation. Each Year, the Plan will pay for up to 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 Plan Year. They will be distributed without regard to whether the condition is acute or chronic; and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

E. Child Speech and Hearing Benefits

1. Speech Therapy. If a Covered Child under the age of six (6) experiences speech delay, the Plan will cover up to six (6) speech therapy visits. The Plan may cover additional speech therapy visits. However, the Covered Child’s Participating Provider must first submit certain documentation to the Plan. The documentation must include the Covered Child’s diagnosis, a specific treatment plan, and expected outcomes. If additional therapy visits are expected to result in significant improvement, the Plan will cover more visits.
2. Hearing Services. The Plan will cover hearing aids and hearing services for a Covered Child who is under the age of eighteen (18) and has a hearing loss. The Plan will cover the initial hearing aids. The Plan will also cover replacement hearing aids once every five

(5) years. The Plan will cover a new hearing aid when changes to an existing hearing aid will not meet the needs of the Covered Child. The Plan 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 Plan will cover general anesthesia. The Plans 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); or
   - 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 Plan's benefit design. That benefit is available to purchase separately through the Colorado Marketplace as a stand-alone benefit.

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

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. In addition, if a "no cost-sharing" screening turns into a diagnostic procedure, then the appropriate Deductible and Coinsurance will apply.

2. Special Preventive Services. The Plan will pay for the preventive services, based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF): FHP reviews the A and B recommendations throughout the plan year. If the USPSTF makes a change to its A and B recommendations, then those changes will be reflected in the benefits of the following plan year. Below is a partial list of the A and B recommendations that FHP will cover at no cost.

   - Alcohol misuse screening and behavioral counseling interventions for adults;

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

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

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

     - Regardless of the A or B recommendations of the United States Preventive Services Task Force (USPSTF), FHP follows the recommendations of the American College of Obstetricians and Gynecologist (ACOG) guidelines for breast cancer screening which recommend screening earlier and more frequent than USPSTF. One mammogram and clinical breast exam once a year for female Enrollees who are at least forty (40) years of age but up seventy five (75) years of age.-Start mammogram ages-between 35 and 40 for BRACA ½ carriers or 10 years younger for female Enrollees with family members with breast cancer or female Enrollees with at least one risk factor for breast cancer.

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

- Cholesterol screening for lipid disorders;

- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps starting at age 50 and continuing until age 75 If a colorectal cancer screening turns into a diagnostic procedure, such as the removal of Polyps, then the procedure is then considered a diagnostic procedure and the member will be responsible for any fees such as Deductible and Coinsurance.

    - In addition to Members who are eligible for colorectal cancer screening coverage based on the A or B recommendations of the United States Preventive Services Task Force (USPSTF), the Plan will cover colorectal cancer screening for Members who are at high risk for colorectal cancer, including Members who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the Participating Provider. If a Colorectal cancer screening turns into a diagnostic procedure, then the plan's deductible and coinsurance will apply.

- The USPSTF recommends screening for cervical cancer in women age 21 to 29 years with cervical cytology (Pap smear) alone every three (3) years or, for women age 30 to 65 years to receive screening for cervical cytology alone every three (3) years, and for a combination of cytology and human papillomavirus (HPV) testing every 5 years. Cervical cancer screening for immunosuppressed Enrollees may be as frequent as once a year.

- 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 Provider; 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 established by the Patient Protection and Affordable Care Act (PPACA) and/or Health Resources and Services Administration for infants, children adolescents and women as required by Federal law.

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

- 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 Plan, you may contact the Carrier in writing at:

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

If you prefer, you may call Customer Service at 719-589-3696 or 800-475-3488.

H. Additional Preventive Services

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

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

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

Age of Member	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
Ages 7-12	Four (4) Well Child Visits
Age 13-18	One (1) Health Maintenance Visit Per Plan Year
Age 19-39	One (1) exam every 36 months
Age 40-64	One (1) exam every 24 months
Over age 64	One (1) exam every 12 months

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

4. Limitations on Services and Examinations. The Plan will not cover all services performed during scheduled physical examinations. For example, the Plan will generally not cover services such as stress tests, EKGs, chest X-rays or sigmoidoscopies. However, these services may be covered if they are Medically Necessary. In addition, the Plan will generally not cover examinations that are more frequent than those identified on the schedule above. However, the Plan may cover more examinations if they support a diagnosis, as determined by the Member's Primary Care Provider.

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

5. For Adult Women: When provided by a Participating Provider, the Plan will cover a yearly

breast and pelvic exam and PAP test. The Plan will also cover a screening mammography when recommended by a Participating Provider. The following schedule will apply:

- One mammogram and clinical breast exam is covered annualy for a female Member who is at least forty (40) years of age and up to seventy-five (75) years of age
- One mammogram and clinical breast exam annually between 35 and 40 for BRACA ½ carriers or 10 years younger for a female Member with breast cancer or with at least one risk factor for breast cancer. (This includes a family history of breast cancer or a genetic predisposition to breast cancer or a calculated lifetime risk of developing breast cancer greater than 20%. This determination must be made by the Enrollee's Primary Care Provider).

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

I. Other Out-Patient Services

1. Routine Office Visits with Primary Care Provider. The Plan will cover a Member's routine office visits to a Primary Care Provider. Covered Services, not otherwise listed in Your Schedule of Benefits, that are provided during an office visit, a scheduled procedure visit, or provided by a Specialty Provider require Deductible and Coinsurance.

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

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

4. Specialty Provider Services. The Plan will cover services of a Participating Provider when the Member has obtained Authorization. Covered Services, not otherwise listed in Your Schedule of Benefits, that are provided during an office visit, a scheduled procedure visit, or provided by a Specialty Provider require Deductible and Coinsurance.

5. Diagnostic Services. The Plan will cover diagnostic services, including radiology (X-ray); pathology; laboratory tests; and other imaging and diagnostic services. Certain diagnostic services require Prior Authorization. This is the case for magnetic resonance imaging (MRI), computerized tomography (CT) scans, echocardiograms and Transcranial Magnetic Stimulation (TMS), among others.
6. Outpatient Surgery. The Plan will cover certain outpatient surgical procedures if the Member has obtained Prior Authorization.

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

8. Urgent Care. The Plan will cover urgent care provided in a Participating Provider urgent care center within the Service Area. However, the Member must be able to show the urgent nature of the care. The Member must also be able to show that the care provided was Medically Necessary. Use of a Non-Network Urgent Care Center within the Service Area is not a covered benefit.

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

   - One screening per year for any male Enrollee who is fifty (50) years of age or older; and
   - One screening per year for any male Enrollee between (40) forty and fifty (50) years of age. However, the Enrollee must have an increased risk of developing prostate cancer. This determination must be made by a Participating Provider.
   - The prostate screening may include the following tests:
     - a prostate-specific antigen ("PSA") blood test; and
     - a digital rectal examination.

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

10. 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 Participating Provider. Your copay/coinsurance/deductible shall apply in the same manner as it would for an in-person like service.
    The Plan will include a reasonable compensation to the originating site for the transmission cost incurred through telehealth delivered by a contracted participating provider, except that, the originating site does not include a private residence at which the Member is located when he or she receives health care services through telehealth.

    "Telehealth" means a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education,

care management, or self-management of a Member’s health care while the Member is located at an originating site and the Participating Provider is located at a distant site. "Telehealth" does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

11. Testing and treatment of COVID-19, as required by applicable Federal or Colorado bulletins, laws or regulations

J. Hospital Inpatient Services

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

2. General Coverage. The Plan will cover the following items and services when a Member 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 Prior Authorization (such as pacemakers and hip joints); and the administration of whole blood, blood plasma and other blood products. The Plan will cover a private room only when Medically Necessary.

3. Providers and Medical Personnel. The Plan also covers the services of Participating Provider Providers who care for the Member when he/she is hospitalized. This includes the Member’s Primary Care Provider. It also includes specialist surgeons, assistant surgeons, anesthesiologists, and other appropriate medical personnel. The Plan will cover private duty nurses, as Medically Necessary.

4. Special Right to Reconstructive Breast Surgery. If a Member has had a mastectomy and elects breast reconstruction, the Plan will cover her care and treatment as required under the Women's Health and Cancer Rights Act. Coverage will include:

    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance; 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 Plan 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 Plan will cover the diagnosis and treatment of biologically based mental illness and mental disorders. This coverage is provided to the same extent the Plan 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 Plan will include acute detoxification. The Plan 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 Plan will cover outpatient mental health visits in the same manner that it covers other outpatient visits.

3. Inpatient Mental Health Care. Like other inpatient care, the Plan will cover Medically Necessary inpatient mental health care services. Coverage is provided for inpatient treatment if the member has a mental or behavioral disorder or requires crisis intervention. Inpatient care is covered only if you have obtained Prior Authorization before your hospital stay. The Plan will also cover a hospital stay that results from a Medical Emergency.

However, you must comply with the requirements described in the section below relating to Emergency Services.

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

5. Inpatient and Residential Chemical Dependency/Substance Abuse Treatment. Like other inpatient care, the Plan will cover Medically Necessary inpatient or residential chemical dependency/substance abuse treatment. Inpatient or residential care is covered only if you have obtained Prior Authorization before your stay. The Plan will also cover a hospital stay that results from a Medical Emergency. However, you must comply with the requirements described in the section below relating to Emergency Services.

L. Emergency Services

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

2. Emergency Transportation. For a Medical Emergency, the Plan will pay for the Member'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 Member does not seek immediate medical attention:

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

3. Member Costs. If a Member receives emergency care from a non-Participating Provider, the Member's Co-payment amount and Coinsurance amount will be the same as if the Member had been treated by a Participating Provider.

4. Plan Notification Required. The Member must notify the Plan of any Medical Emergency.

The Member must do so on the first business day after treatment is received. If that is not possible, the Member must notify the Plan as soon as medically possible. This notification must include the identity of the Member and the hospital where he/she received care. If a Member is hospitalized, the Member must notify the Plan by telephone of the hospitalization. Alternatively, the Member must instruct the hospital or a family member to notify the Plan. The notification must include the identity of the Member 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 Member is unable to contact the Plan personally or ask another person to do so, the notification may be delayed. A delay is only allowed until the Member is able to notify the Plan or instruct some other person to notify the Plan. If the Member is conscious and able to communicate with others, the Member will be treated as able to notify the Plan.

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

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

3. Complications of Pregnancy. 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, hypermemsis gravidarum, preeclampsia, but shall not include false labor, occasional spotting, Provider-prescribed rest during the period of pregnancy, morning sickness, , 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 a possible outcome.

4. Hospitalization for Delivery. The Plan will cover the Member's hospitalization for delivery. The hospital stay following a normal vaginal delivery will not be less than forty-eight (48) hours. If forty-eight hours (48) ends after 8 p.m., coverage will continue until 8 a.m. the

following morning. The hospital stay following a caesarean section will not be less than ninety-six (96) hours. If ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the following morning. These timeframes could be less at the discretion of the attending Provider and the Member. If the mother and child are discharged prior to 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 Plan will cover family planning counseling and the provision of information about birth control. Coverage also includes the insertion of contraceptive devices and the fitting of diaphragms. The Plan also covers the provision of vasectomies; and tubal ligation procedures performed by a Participating Provider. Oral contraceptives, including emergency contraceptives, and Depo-Provera injections are covered under the Member's pharmacy benefit.

2. Infertility Services. The Plan 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 Plan will cover home health care provided to a Member who is under the direct care of a Participating Provider. Services will include visits to the Member by Participating Providers. Visits will be limited to the usual and customary time required to perform the particular services.

2. Coverage is provided for:
   a. Part-time or intermittent home nursing care for:
      i. Skilled nursing care under the supervision of a Registered Nurse (RN);
      ii. Certified Home health aide services under the supervision of an RN or therapist;
      iii. ;
      iv. Medical social services by a licensed social worker.

   b. Infusion services;

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

   d. Nutritional counseling by a nutritionist or dietitian;

e. Audiology services;

f. Medical supplies and lab services that would be covered if Enrollee 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 Plan is subject to the following conditions and limitations:

- The care provided must follow an Authorized Home Health Treatment Plan;
- Services will be covered only if hospitalization would be required if such home health services and benefits were not provided;
- The services provided will be limited to the professional services as listed in 2.a. above and will not cover non-skilled personal care or services or supplies for personal comfort or convenience, including homemaker services;
- Visits are limited to no more than 28 hours a week;
- Home Health Services require Prior Authorization.

P. Durable Medical Equipment

1. General Coverage. With respect to durable medical equipment, the Plan will cover a Member's rental; purchase; maintenance or repair, when necessary due to accidental damage, or due to changes in the condition or size of the Member; 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 such as a glucometer or an insulin pump. Such durable medical equipment must be provided or distributed through a Participating Provider hospital or other Participating Provider. Prior Authorization is also required. Durable Medical Equipment is authorized following applicable Medicare statutory and regulatory requirements, unless otherwise established in this document.

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

3. Orthotics. Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of a body part that is not functioning correctly or is diseased or injured. Orthotic devices are covered when Medically Necessary and require Prior Authorization. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes, are not covered.

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 Plan will cover the following transplants when provided in a Specialty Care Center: heart; lung; heart/lung; liver; kidney; pancreas for uremic insulin-dependent diabetics concurrently receiving a kidney transplant; cornea; bone marrow for treatment of neuroblastoma and Hodgkin's or non-Hodgkin's lymphoma; autologous or allogeneic bone marrow transplants and stem cell rescue or hematopoietic support only for malignant tumors when necessary to support high dose chemotherapy, (and in that event the high dose chemotherapy is covered); and autologous or allogeneic bone marrow transplants and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and high risk stage II and III breast cancer.

2. Related Items. The Plan will also cover services, supplies and pharmaceuticals required in connection with a covered transplant procedure. This includes valuation of a Member 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 Member, the Plan will pay for certain donor costs. This includes costs directly relating to the acceptability of an organ. It also includes the costs of services directly related to surgical removal of the organ for the donor. It also includes the costs of treating complications directly resulting from the

surgery. All of these costs are subject to the other limits of the Plan. Coverage applies only if the donor is not eligible for coverage under any other health care plan or government funding program.

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

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

R. Hospice

1. General Coverage. The Plan covers physical, psychological, spiritual and bereavement care for terminally ill Members and their families. The services cover a range of inpatient and twenty-four (24) hour on-call home care. The care may be provided in the home. It could also be provided in a Participating Provider hospice facility, and/or other Participating Provider facility. Services include, but are not limited to the following: nursing services; Provider services; certified nurse aide services; nursing services of other assistants; homemaker services; physical therapy services; pastoral care; counseling; trained volunteer services; and social services. Other benefits available through hospice are covered by the Plan. Such benefits are subject to the other 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;
   - Transportation;
   - Provider 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 Members who are terminally ill and have a life expectancy of six (6) months or less. A Member 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 Provider and the hospice's medical director to determine the appropriateness of continued hospice care.
   - Hospice requires a Prior Authorization.
   - Hospice services must be reviewed periodically by the Member's Primary Care Provider.
   - Bereavement support services for the family of the deceased Member will be covered for up to twelve (12) months after the Member'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 Plan's coverage of a Member's diabetes includes equipment; supplies; outpatient self-management training and education. It also includes medical nutrition therapy, if prescribed by a Participating Provider. The Plan will cover equipment, such as a glucometer or an insulin pump, as durable medical equipment. Please refer to the section above relating to Durable Medical Equipment. The Plan will cover supplies such as test strips and lancets at 80%, if the Member has a Prior Authorization. Diabetic education classes for insulin dependent diabetes and pregnancy induced diabetes are also covered.

2. Skilled Nursing Care. The Plan will cover a Member's skilled nursing services. Such services must be provided in a Participating Provider skilled nursing facility. These

services also require Prior Authorization. Coverage by the Plan is limited to one-hundred (100) days per Plan Year.

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

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

5. Cardiac Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Participating Provider 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 Provider 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 Member is hospitalized within a non-Participating Provider hospital, the Member may return to such hospital for follow-up care. However, the Plan will cover such follow-up care only if the non-Participating Provider hospital is willing to accept payment from the Plan at the rates payable to Participating Providers. All other limitations and conditions of the Plan would apply.

8. Health Education Services. The Plan will cover instruction in the appropriate use of health services. This includes information on the ways each Member can maintain his/her own health. Such instruction must be provided by a Primary Care Provider. It

could also be provided by another Participating Provider with Prior Authorization. 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 Plan will cover the following oral surgery services for a Member who obtains Prior Authorization:

    - Care for the treatment of acute facial fractures;
    - Treatment of neoplasms (tumors) of the face, facial bones, or mouth;
    - Medically Necessary treatment of congenital defects; and
    - 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.

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

10. Eye Exams. The Plan will cover eye examinations provided by a Member's Primary Care Provider 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. This benefit is only for members and Dependents 25 years of age or younger.

11. Hearing Exams and Hearing Aids. The Plan will cover hearing tests in support of a diagnosis and medically covered condition. This is in addition to the benefits described in the section above relating to Child Speech and Hearing Benefits. The Plan does not cover screening audiometry and tympanograms not in support of a diagnosis. The Plan does not cover hearing aids and other corrective appliances, except as provided in the Child Speech and Hearing Benefits section. This benefit is for members and Dependents 25 years of age or younger.

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.

Prescription drugs for insulin and other qualifying diabetic medications will not cost a member more than $100.00 per thirty-day supply.

- New drugs are excluded from formulary for the first six months after approval by FDA, unless it is an orphan drug.
    - The Orphan Drug Act (ODA) provides for granting special status to a drug or biological product ("drug") to treat a rare disease or condition. For a drug to qualify for orphan designation both the drug and the disease or condition must meet certain criteria specified in the ODA and FDA's implementing regulations at 21 CFR Part 316.

- Off-label use of Drugs approved by the FDA for use in treatment of cancer will not be excluded or restricted if the drug receives Prior Authorization from the plan.

- Only outpatient prescription drugs related to Emergency Care or Urgent Care may be received from non-network pharmacies. The plan will repay you for the cost of an outpatient prescription drug purchased through a non-network pharmacy in an amount not to exceed the Allowed Charge, less the applicable copay or coinsurance set forth in the Schedule of Benefits within the first 90 days of purchase.

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

Coverage for a renewal of prescription eye drops is covered if i) the renewal is requested by the insured at least twenty-one days for a thirty-day supply of eye drops, forty-two days for a sixty-day supply of eye drops, or sixty-three days for a ninety-day supply of eye drops, from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; 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). The Plan will not require a covered person to undergo step therapy, or to receive Prior Authorization before a pharmacist may prescribe and dispense and HIV infection prevention drug. In addition, the Plan will not require a covered person with Stage four (4) metastatic cancer to undergo step therapy for a covered medication that has been approved by the U.S. Food and Drug Administration, or other recognized

body for the treatment of Stage four (4) advanced metastatic cancer.

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

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

You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by us through the exception process. If FHP grants Your request, then 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 64 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. This may be approved for a specified time frame and may require re-review.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard coverage decision means we will give you an answer within 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 Provider, are excluded unless otherwise required by federal or state statute or regulation to be covered by the Plan.

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

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

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

For additional information about the prescription drug exceptions processes for drugs not included in the Plan's formulary, please contact the Plan's 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, Provider, or other health care provider. Nothing herein shall prohibit coverage for oral generic medications in a health benefit plan nor prohibit the Plan from applying an appropriate formulary or clinical management to any medication described in this section.

14. 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 and provided the Plan with a copy of the signed clinical trial statement.

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

Clinical Trial exclusions include the following:

- Any part of the Clinical Trial that is paid for by a government or biotechnical, pharmaceutical or medical industry entity;

- Any drug or device used in a Clinical Trial that is paid for by the manufacturer, distributer or provider of the drug or device;

- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;

- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

- Costs for the management of research relating to the clinical trial or study;

- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the participants Covered Services.

Nothing in this section shall:

- Preclude the Plan from asserting the right to seek reimbursement from the entity conducting the clinical trial or study for expenses arising from complications caused by a drug or device used in the clinical trial or study.

- Be interpreted to provide a private cause of action against the Plan for damages arising as a result of compliance with this coverage requirement.

For the purposes of this section the following definitions apply:

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

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

15. Transgender services. Transgender services are covered for behavioral health, physical health, hormones and surgery as any other condition for the treatment of Gender Dysphoria. 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. A baby born under a Surrogate Arrangement does not have coverage rights under the surrogate’s health insurance coverage. The intended parents of a child born under a Surrogate Arrangement will need to arrange for health insurance for the newborn.

    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 Plan will cover urgent care that is provided to a Member outside of the Service Area (by a non-Participating Provider). This is true only if the care is provided by a facility other than a hospital or emergency room.

2. Emergency Care. The Plan will cover care that is provided to a Member 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

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

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

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

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

3. All services or supplies that exceed any maximum 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 Member's need for urgent care outside the service area.

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 Member is an inpatient in a hospital.

9. Services of any provider other than a Provider, a provider acting under the supervision of a Provider or certified nurse midwife, or a provider whose services must be covered by health maintenance organizations under the 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, and acupressure whether or not provided by a Provider.

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 that are not identified in this 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 Plan. 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 Plan coverage. This is true even if they are delivered after the effective date of Plan coverage.

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

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

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, except covered implant after mastectomy due to breast cancer. The Plan shall have sole discretion to determine whether the services are likely to result in significant improvement in function.

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 Member 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 invitro fertilization, ovum transplants, zygote intra fallopian transfer and gamete intrafallopian transfer procedures are not covered. These exclusions apply to fertile as well as infertile individuals or couples.

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 Member.

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

47. Services that the Member would not have to pay for in the absence of Plan coverage.

48. Services provided by a person who lives in the Member's home. Services provided by an

immediate relative of the Member.

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 Member 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(drugs that require a prescription) 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. Over the counter contraceptive drugs or devices which do not require a prescription are not covered. Abortifacient drugs are not covered. Drugs or injections for treatment of involuntary infertility are not covered

56. Medications with no approved indications.

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

58. Prescriptions that a Member 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 Member's refusal to accept treatment recommended by a Participating Provider.

67. Services when not rendered in accordance with Plan 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 Member's Primary Care Provider or approved after transport as Medically Necessary by the Plan. The Plan does not provide ambulance transportation due to the absence of other transportation on the part of the Member. An ambulance ordered by a neighbor, relative, school officer, employer, etc. may be denied for coverage if the service is not Medically Necessary, as determined by the Plan.

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.

SECTION 9: MEMBER PAYMENT RESPONSIBILITY

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. Finally, in most cases, you will be required to pay for those health care services that you receive from a health care provider who/which is not a Participating Provider, and for those health care services that were provided without a Prior Authorization from the Plan. In most cases, services that do not qualify as Covered Services, services received from a non-Network Provider or services provided without Prior Authorization do not count towards Your Deductible, nor towards your Out-of-Pocket Maximum. In addition, you

will be responsible for the cost of services that do not qualify as Covered Services, the cost of services to Non-Plan Providers and/or services provided without Prior Authorization even if your Out-of-Pocket Maximum has been met.

If you access an out-of-network provider for emergency and non-emergency services FHP will provide disclosures concerning a covered person's financial responsibility for those services. This information is also available on our website titled "Appendix A". This document outlines your rights as a member in regards to surprise billing.

Possible Deductible Credit

When you change insurance carriers (meaning you switch to Friday Health Plans from a carrier providing health coverage to your employer group), you may be eligible for a prior Deductible credit upon your initial enrollment in the Plan. You must request a prior Deductible credit and provide information regarding your prior Deductible payments within one-hundred and eighty (180) days of your employer's starting date with the Plan. Your request may be made in writing to the Plan's Customer Service Department at:

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

Assignment of Rights

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

COORDINATION WITH OTHER COVERAGE

Other Coverage

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

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

MEDICARE COB

Medicare will be primary except as required by law.

AUTO INSURANCE BENEFITS COB

- Coordination with Auto Coverage. Your benefits under this Contract will be coordinated with any no fault coverage or other automobile insurance that provides medical payment coverage or medical expense coverage in any 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 amounts you received 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.

ORDER OF BENEFITS

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

1. Subscriber or Dependent - The plan that covers the person other than as a Dependent, for example a member, is the primary plan. The plan that covers the person as a Dependent is the secondary plan.
2. Order of Dependent Coverage.
   Unless there is a court order stating otherwise, plans covering a Dependent child must determine the order of benefits using the following rules that apply.
   - For a Dependent child whose parents are married or are living together, whether or not they have ever been married the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan.
     - If both parents have the same birthday, then the plan that has covered the parent the longest is the primary plan.
   - For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married, the following rules apply.
     - If a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, then that plan is primary.
     - if a court order states that both parents are responsible for the Dependent child's health care expenses, then the Plan of the parent with the earliest birthday in the Calendar Year is Primary.
     - if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, then the Plan of the parent with the earliest birthday in the Calendar Year is Primary.

- If there is no court order stating responsibility for the Dependent child's health care expenses or health care coverage then the following order of benefits will apply: the plan covering the custodial parent, he plan covering the spouse of the custodial parent, the plan covering the noncustodial parent; then the plan covering the spouse of the noncustodial parent.

YOUR DISCLOSURE OBLIGATIONS

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

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

RECOVERY RIGHTS OF THE PLAN

RIGHT OF SUBROGATION/REIMBURSEMENT

In certain 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 Plan for payments made to or on behalf of you or your Covered Dependents. This right of reimbursement arises if you or your Covered Dependents receive any benefits under the Plan as a result of an injury or illness, and there is a third party (including an insurance company) that is legally responsible for paying for your injuries (or your Covered Dependents' injuries). The Plan's rights under this section arise after you or your Covered Dependents are fully compensated.

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

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

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

with the following information, in writing:

- The name and address of the party that caused the injury, the facts of the accident, and any other information reasonably necessary to protect Plans rights;

- All information about the other party's liability insurer(s), if known;

- Information relating to any personal injury protection, underinsured or uninsured motorist insurance or any other insurance, as well as a copy of any such insurance policy;

- Notice of any claim or legal action filed or submitted against a third party (within sixty (60) days of submitting or filing such claim); and

- Prior written notice of any intended settlement.

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

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

RIGHT TO OFFSET FUTURE PAYMENTS

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

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

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

HEALTH CARE PROVIDER MAY SUBMIT CLAIM

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

CLAIMS YOU SUBMIT TO THE PLAN

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

TIMING AND CONTENTS OF CLAIM

If you are submitting a claim to the Plan, you must do so within ninety (90) days of the date that the health care services were provided. Your claim must include the diagnosis, the type of treatment rendered, the date of service, the name and address of the health care provider, the charges for the care, the name of the Member, and the Member'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
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 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 Plan will only pay for health care services provided by a Participating Provider. It is also important to remember that the Plan will only pay for services that are Covered Services. If you are being reimbursed for a payment you have made to a Participating Provider, you will be reimbursed at the Plan's negotiated rate with the Participating Provider. If you fail to submit your claim within the required ninety (90) day period, your claim will be denied.

CLAIM NOTIFICATIONS

IF A CLAIM IS DENIED

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

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

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

TIMING OF THE NOTICE

After the Plan reviews your claim, the Plan will notify you of any decision to 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 Plan's decision within seventy-two (72) hours after the Plan's receipt of your claim, unless you do not provide enough information for the Plan to determine whether or to what extent benefits are payable under the Plan. If this occurs, the Plan will notify you of the deficiency within twenty-four (24) hours after the Plan'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 Plan 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 Plan'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 Plan's decision within a reasonable time, but no longer than fifteen (15 days) after the Plan's receipt of your claim. An extension of an additional fifteen (15) days may be available due to matters beyond the control of the Plan. However, this extension is only available if the Plan notifies you before the end of the first fifteen (15) days of the circumstances requiring the extension and the date by which the Plan 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 Plan 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 Plan's receipt of your claim. This review period may be extended for fifteen (15) days due to matters beyond the Plan's control. However, this extension is only available if the Plan notifies you before the end of the first thirty (30) days of the circumstances requiring the extension and the date by which the Plan 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 Plan 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 Plan, any reduction or termination of ongoing treatments is considered a denial. The Plan 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 Plan 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.

SECTION 11: GENERAL POLICY PROVISIONS

COVERAGE IS LIMITED TO COVERED SERVICES

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

COVERED SERVICES ARE NOT AUTOMATICALLY PAID BY THE PLAN

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

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

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. During the grace period the Plan will continue to pay for your Covered Services. The Plan has the right to pursue collection of the premiums owed for the grace period.

NO LIFETIME LIMITS OR ANNUAL LIMITS

There is no lifetime dollar limit on the essential health benefits you may receive from the Plan. There is also no annual dollar limit on the essential health benefits you may receive from the Plan.

However, there are other limits on your benefits. Those limits are described in this Evidence of Coverage.

ACCESS PLAN

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

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

CASE MANAGEMENT

Our case management program is free and voluntary. Your participation in the program does not replace the care and services that you receive from your 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 paying from the Plan. The Carrier is permitted to use and disclose such information only as reasonably necessary in administering your Plan and complying with applicable law. The Carrier will protect the confidentiality and privacy of all such information in the manner required by applicable federal and state law. A copy of FHP's Notice of Privacy is included in the Welcome Kit sent to Subscribers upon enrollment. You can ask for a copy of FHP's Notice of Privacy at any time.

HEALTH STATUS

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

SECTION 12: TERMINATION/NONRENEWAL/CONTINUATION

TERMINATION OF PLAN COVERAGE

END OF YOUR COVERAGE

Your Plan coverage will end if:

- You fail to satisfy the eligibility conditions for participation in the Plan (for example: you are no longer scheduled to work thirty (30) hours per week, or you are no longer part of the particular group of employees eligible to participate in the Plan);
- Your employment with your employer ends;
- You revoke your election to participate in the Plan (during the Open Enrollment Period or as otherwise permitted);
- You or your employer fails to make a contribution required by the Plan;
- You or your employer experiences a Rescission of coverage;
- You engage in certain misconduct, as described in the Effective Date of Termination of Coverage section;
- The Plan is no longer offered by your employer; or
- The Plan is terminated.

END OF YOUR COVERED DEPENDENTS' COVERAGE

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

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

PROOF OF YOUR PLAN COVERAGE

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

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

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

Your request must include:

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

EFFECTIVE DATE OF TERMINATION OF COVERAGE

FOR ELIGIBILITY FAILURES

If you are no longer eligible to participate in the plan, plan coverage for you and your covered dependents will generally end on the last day of the month in which you met the plan's eligibility requirements. Similarly, if your covered dependent is no longer eligible to participate in the plan, his/her plan coverage will generally end on the last day of the month in which he/she met the plan's eligibility requirements.

FOR CONTRIBUTION FAILURES

If you or any Covered Dependent fails to make a contribution that is required by the Plan, or if your employer fails to pay the monthly Premium owed to the Plan, your coverage (and the coverage of your Covered Dependents) will be terminated. There is a thirty-one (31) day grace period. The Plan will continue to pay for your Covered Services (and your Covered Dependents' Covered Services) during the grace period. If you or your employer 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, or your employer, commits a fraud against the Plan or intentionally misrepresents a material fact in connection with the Plan or the coverage, there will be a Rescission of your coverage (and the coverage of your Covered Dependents). In such a case, the Plan will provide you with thirty (30) days' advance written notice of the Rescission. However, the termination of coverage will be retroactive to the date of the event that caused the Rescission.

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

FOR MISCONDUCT

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

FOR OTHER REASONS

If Plan coverage is being terminated because the Plan will no longer be offered by your employer, the Plan will be terminated, Dependent coverage will no longer be offered, or for some similar reason, you will be notified of the effective date of your termination of coverage (and/or your Covered Dependents' termination of coverage).

IMPACT ON HOSPITALIZED MEMBER

If Plan coverage is terminated while a Member is hospitalized, the Member will continue to be covered by the Plan for the period of the hospitalization, to the extent required by law.

RIGHT TO CONTINUE PLAN COVERAGE

Under certain circumstances, you (and/or your Covered Dependents) may be permitted to continue to participate in the Plan for a certain period of time after the date coverage would otherwise end.

COBRA CONTINUATION OF COVERAGE

If your employer is obligated to comply with COBRA, you and your Covered Dependents may have a right to elect COBRA continuation coverage. You should contact your employer for more information regarding your COBRA rights.

OTHER CONTINUATION OF COVERAGE

If your employer is obligated to comply with Colorado continuation of coverage laws, you and your

Covered Dependents may have a right to continue your Plan coverage under those laws as well. You should contact your employer for more information regarding your state law continuation of coverage rights.

USERRA CONTINUATION OF COVERAGE

If you are absent from employment by reason of service in the uniformed services, you may elect to continue Plan coverage for yourself and your Covered Dependents for up to twenty-four (24) months, as provided under the Uniformed Service Employment and Reemployment Rights Act ("USERRA"). You should contact your employer for more information regarding your rights under USERRA.

SECTION 13: 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 to participate in the Plan;
- 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 Member, 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 Plan'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 Plan within one-hundred and eighty (180) days after your receipt of the notice of denial. If the deadline for appealing falls on a weekend or holiday, it will be extended to the next business day. For Urgent Care Claims, your appeal may be made orally.

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

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

APPEAL NOTIFICATION AND TIMING

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

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

- For Pre-Service Claims. The Plan 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 Plan 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 Plan will send you a notice containing the following information:

- Specific reasons for the denial;

- Specific references to relevant Plan provisions;

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

- A statement of any additional appeal rights offered by the Plan and a description of those rights; and

- A statement of your right to bring an action in federal court under Section 502(a) of ERISA (if such right applies).

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 or an action in federal court. However, you are not required to file a second appeal (as described below) in order to pursue your right to file an external appeal or a court action. 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.

HOW TO FILE A VOLUNTARY SECOND APPEAL

If you are not satisfied with the Plan's decision on your appeal, you may file a second appeal. If you wish to file a second appeal, you must do so within thirty (30) days of the date you receive a denial of your first appeal. If the deadline for filing a second appeal falls on a weekend or holiday, it will be extended to the next business day. In your appeal, you may identify health care providers who will receive a copy of the Plan's decision.

A meeting to review your case will be scheduled and held within sixty (60) days of the date the Plan

receives your request for a second appeal. You may attend the meeting held to review your case, either in person or by telephone conference. This review will be conducted by a health care professional who has appropriate expertise. The health care professional will be someone who was not involved in your prior appeal, and who does not have a direct financial interest in the appeal or outcome of the review.

You will be notified in writing at least twenty (20) days in advance of the review date. The Carrier may permit you to postpone the review if you make a reasonable request. When you receive notice of the review date, you will also be notified of your rights relating to a second appeal, as described in this section.

The Carrier will notify you if it intends to have an attorney present to represent the interests of the Plan, and will notify you that you may also want to have legal representation present. You must inform the Carrier seven (7) days in advance of the review if you intend to have an attorney present at the review. If you decide make such a decision after the seven (7) days deadline, you should provide notice to the Carrier as soon as possible.

You may prepare in advance for the review. You may present written comments, documents, records and other material relating to your request. You may provide such materials to the reviewer prior to and at the time of the review. You may request that the Plan provide you with a copy of the materials it will present at the review. If you make this request, the Plan will provide a copy of the materials to you at least five (5) days before the review. You must provide a copy of the materials you will present at the review. You will also be required to provide a copy of the materials at least five (5) days before the review. If new information develops after the five (5) day deadline, the new material may be presented when you are able (or the Plan is able) to present the new information.

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

The health care professional who conducts the review will consider all comments, documents, records, and other information that you submit, even if the information was not submitted or considered in reaching the decision on the prior appeal. The health care professional who conducts the review will, after private deliberation, issue a written decision to you within seven (7) days of the review meeting.

The decision on a second appeal will include 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.

IF A SECOND APPEAL IS DENIED

If your second appeal is denied, the decision will also include the following information:

- Specific reasons for the denial;
- Specific references to relevant Plan provisions;
- A statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim; and
- A statement of any additional appeal rights offered by the Plan and a description of those rights; and
- A statement of your right to bring an action in federal court under Section 502(a) of ERISA (if such right applies).

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.

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 Member may request an external review or an expedited external review. In each case, the Member's treating Provider must certify in writing that the recommended or requested health care service or treatment that is the subject of the denial would be significantly less effective if not promptly initiated. The Member's treating Provider 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 Member or are not medically appropriate for the Member; or

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

Finally, in such cases, the Provider must certify that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Member is likely to be more beneficial to the Member 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 Plan. Generally, this must be done within four (4) months after you receive notice of an Adverse Benefit Determination following the completion or exhaustion of your internal appeal. If the deadline for filing an external appeal falls on a weekend or holiday, it will be extended to the next business day.

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

The Carrier will pay the costs of an external review.

APPOINTMENT OF EXTERNAL REVIEW ENTITY

When the Plan receives your request for an external review, the Plan will contact the Division of Insurance. The Division of Insurance will inform the Plan of the name of the independent, third-party, external review entity that has been selected by the Division of Insurance to conduct the review. The Plan will notify you in writing that your request for external review has been sent to the Division of Insurance. The Plan will include information about the external review entity that has been selected to conduct the review. This will generally occur within five (5) business days of your request for external review, or three (3) business days in the case of an expedited review.

Within five (5) business days of receiving the name of the assigned external review entity (or immediately, in the case of an expedited review), the Plan will provide the external review entity with the following:

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

The Plan will, upon your request, provide you with all relevant information supplied to the external review entity, except for information that is confidential or privileged under state or federal law.

You may submit additional information directly to the external review entity within five (5) business days after you receive notice from the Plan relating to the external review entity. The external review entity will provide a copy of such information to the Plan within one (1) business day.

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

PROVIDING ADDITIONAL INFORMATION

The external review entity will notify you, your health care provider, and the Plan of any additional medical information required for the review. If you and your health care provider receive such a request, you or your health care provider must submit the additional information, or an explanation of why the additional information is not being submitted, to the external review entity and to the

Plan. The additional information must be submitted within five (5) business days of the request.

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

APPEAL NOTIFICATION AND TIMING

When the external review entity makes its decision, it will send notice of the decision to you. It will also send notice to the Plan, to the Department of Insurance and to your health care provider who supported your request for review. This decision will be sent within forty five (45) days after the external review entity receives from the Plan your request for external review. In the case of an expedited review, the external review entity will issue its decision within seventy-two (72) hours after the external review entity receives from the Plan your request for external review. If this notice of decision is not provided in writing, the external review entity will provide written confirmation of the decision within forty-eight (48) hours after the date the notice of decision is given to you or your health care provider.

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

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

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

OTHER GRIEVANCE PROCEDURES

OTHER DISPUTES

The Plan also has a grievance 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 Provider or other Participating Provider;
- The behavior of your Primary Care Provider or other Participating Provider;
- Whether there are adequate facilities or Participating Providers available to you; or
- Any items or services that you receive through the Plan but do not have to pay for.

HOW TO FILE A GRIEVANCE

To begin the grievance process, you may call the Plan's Member Services Department at 719-589-3696.

You may also contact the *Colorado Department of Public Health and Environment* for help. The Plan 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 Plan for help in locating the appropriate person within the state where the health care provider is located.

TIME PERIOD FOR FILING

You must file your grievance with the Plan within one year of the event on which your grievance is based. The Plan will not consider any grievance submitted after such date.

SECTION 14: INFORMATION ON POLICY AND RATE CHANGES

POLICY CHANGES

The Covered Services available to you and your Covered Dependents may change each Plan Year. When you receive a new Evidence of Coverage, any such changes will be included in that document.

NOTICE

FHP will provide Sixty (60) days' notice for all material changes to the policy.

CHANGES IN RATES

During a Plan Year, the Carrier may change the Premium rate paid by your employer if there are changes in Plan enrollment, changes in the number of Members or changes in tobacco use by Members. The Carrier may also change the Premium rate during the Plan Year if your employer requests that changes be made to the Plan or if there are changes in the law that impact the Plan. Any of these changes may have an effect on the contribution amount you are required pay for

Plan coverage. You will be notified in advance of any such changes.

The Carrier may also change the Premium rate paid by your employer at the beginning of each new Plan Year. These changes may have an effect on the contribution amount you are required pay for Plan coverage. You will be notified in advance of any such changes.

SECTION 15: DEFINITIONS

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

"Allowable Amount" is the amount established under Colorado state law for reimbursement for health care services to covered persons at an in-network facility provided by an out-of-network provider or for emergency services that are provided by out-of-network providers or facilities.

"Application" means the State of Colorado Uniform 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

"COBRA" refers to a federal law, known as the Consolidated Omnibus Budget Reconciliation Act. In certain cases, this law allows a Member who participates in the Plan to extend his/her Plan coverage beyond the date when the Member would otherwise lose coverage.

"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.

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

"Covered Child" means any Child, age 25 and younger, who is enrolled in the Plan.

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

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

"Deductible" means the amount you will be obligated to pay for certain Covered Services before the Plan will begin to pay for those Covered Services. You will be required to pay the Deductible directly to the health care provider at the time you receive health care services. Your Schedule of Benefits will state the amount of your Deductible and which services are subject to that Deductible.

"Dependent" refers to your Child or your Spouse.

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

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

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

- Has not been approved by a government agency, such as, but not limited to the Food and Drug Administration (FDA);

- Is the subject of an ongoing FDA Phase I, Phase II, or Phase III clinical trial;

- Is subject to the approval or review of an Institutional Review Board (IRB) or other body that serves a similar function of approving or reviewing research on safety, toxicity or efficacy;

- Lacks recognition and endorsement from nationally accepted medical panels, national medical associations, or other evaluation bodies;

- Has been disapproved by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness;

- Lacks conclusive evidence demonstrating that the service improves the net health outcome for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service may be recognized as a treatment or service for another condition, screening, or illness;

- Requires written informed consent that describes the service as experimental, investigational, educational, for a research study, or in other terms that indicate that the service is being looked at for its safety, toxicity or efficacy; or

- It is of the expert opinion, as found in the literature of the day, that the use of the service is experimental or that the service requires more research to find if the service is effective.

The Plan is the sole judge if a health service is "Experimental or Investigational".

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

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

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

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

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

- Placing the health of the Enrollee (or, with respect to a pregnant woman, the health of the Enrollee 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" includes the care listed below.

- The care is the most appropriate, useful, and cost-effective care, according to accepted standards of good medical practice, as determined by the Plan or the Medical Director; and

- The care that can be safely provided to an Enrollee for prevention, diagnosis, or treatment of the Enrollee's medical.

- The care follows generally accepted medical practice.

- The care us not just for the ease of You, Your family, and or your provider.

- The care is the correct level of care that can be provided to you.

  - The fact that a Plan or non-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or a covered under this EOC.

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

"Member Portal" is an online portal that will allow You to review claims, print your ID card, check the status of Prior Authorizations, and perform many other functions that will help You as a Member. To enter the Member Portal, go to the www.fridayhealthplans.com website, Member Resources link (found at the bottom of the home page), then click on Member Login. You will be prompted to set up Your account, and You will need your member ID number.

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

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

"Network Medical Office" Any medical office listed in our provider directory, including any outpatient facility designated by Friday Health Plans. Network Medical Offices are subject to

change at any time without notice.

"Network Provider" is any licensed Provider who contracts with FHP to provide Services to Members. It is from this pool of network Providers, found listed in your Provider Directory, that you should choose your PCP. Go to your Member Portal found on the FHP website to establish your PCP choice with the plan. Otherwise, you must call customer service at (719) 589-3696 or 800-475-8466.

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

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

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

"Plan" means the health benefit program described in this EOC.

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

"Premium" refers to each payment you make to FHP for Plan coverage.

"Primary Care Provider" means a physician or mid-level practitioner whom you see for your primary health care needs. For example, a Physician's Assistant (PA), Advanced Practice Nurse (APN), or other Nurse Practitioners.

"Prior Authorization" means the approval You must receive from the Plan Medical Director before you get most health care services. The term means the same as "Written Referral"

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

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

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

"Refund Period" means the shorter of:

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

“Service Area” means all of the counties in Colorado where the Carrier offers the Plan and has arrangements with Participating Providers.

“Specialist” is a Provider that focuses their practice on certain disease categories, types of patients, and or methods of treatment.

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

“Specialty Pharmacy” is a Drug provider that has contracted with FHP to provide Tier IV Drugs to its Members. Getting these drugs through a Specialty Pharmacy will often decrease the cost to the member. Contact FHP at (719) 589-3696 or 800-475-8466.

“Specialty Drugs” are high-cost oral, injectable, infused or inhaled covered drugs that are self-administered or given by a Provider. These drugs are used in an outpatient or home setting. Insulin is not considered a Specialty Drug. Contact FHP at (719) 589-3696 or 800-475-8466.
“Spouse” refers to your husband or wife, or your partner in a civil union. A spouse must live or work in the Service Area. (If your Spouse is on a temporary work assignment outside of the Service Area, the assignment must not be for more than ninety (90) days).

“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.

“Telehealth” means a mode of delivery of health care through telecommunications. This includes information, electronic, and communication technologies. It is used for the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Member’s health care. This is used while the Member is located at a site and the provider is located at a distant site. "Telehealth" does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

“Waiting Period” means the period that must pass, once you become eligible to participate in the Plan, before your coverage will begin.

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

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