NEW MEXICO INDIVIDUAL ON EXCHANGE

EVIDENCE OF COVERAGE

FHPNM-0179-082321 2022_FHP_NM_IND_HMO_ON_EOC

SECTION 1: TITLE PAGE (COVER PAGE)

INSURANCE UNDERWRITTEN BY FRIDAY HEALTH PLANS OF COLORADO, INC.

NEW MEXICO INDIVIDUAL ON-EXCHANGE

EVIDENCE OF COVERAGE

SECTION 2: CONTACT US

GENERAL INFORMATION / CONTACT INFORMATION

beWellnm, also referred to as NMHIX, is New Mexico's state based exchange. Staff at beWellnm can help You with enrollment in an individual health insurance plan, compare health insurance products that are offered in the exchange, and other services related to obtaining or renewing a health insurance plan for Your or Your family. You can contact beWellnm at 1-833-862-3935. You can also find helpful information on their website at: https://www.bewellnm.com/.

This health insurance product is provided by Friday Health Plans of Colorado, Inc. (FHP), and is an HMO product. Coverage under this plan generally provides benefits only for services received from In-Network or approved Non- Network Providers. If You obtain non-emergency or non-urgent services from a Non-Network Provider, the services will usually not be covered. Exceptions to this requirement are described in the How Your Plan Works section of this document. You can contact the Friday Care Crew (Customer Service) with questions about the Provider Network, access to care benefit questions, and all other Member related inquiries by calling 1-844-805-5000. Or contact Friday Health Plans of Colorado, Inc. at the following address:

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

PURPOSE OF THIS DOCUMENT

This Evidence of Coverage (EOC) describes the health care benefits available to You under the Plan. It also describes the rules that apply to individuals who participate in the Plan. The EOC describes benefits and services available under the plan, as well as any limitations on benefits or services. The EOC provides You with information on how services may be obtained, and how to access services. To understand the benefits and the rules that apply, You should know the meanings of terms used in this EOC. Generally, if a capitalized term is used in this EOC, it will have the meaning set forth in the DEFINITIONS section. A copy of this evidence of coverage will be provided upon request. If there is a material change in the operations of the organization that will affect the service to Member directly, the Plan will notify members within thirty (30) days.

If You have any questions about the Plan or the information set forth in this Evidence of Coverage You may contact the Plan in writing at:

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

Or contact us by telephone at:

1-844-805-5000 (toll free)

Together with the Summary of Benefits and Coverage, Schedule of Benefits, and the Member ID Card, this document is the entire contract between You and Us. No agent may change this contact, waive any of the provisions of this contract, extend the time for payment of premiums, or waive any of the Plan's rights or requirements.

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

SERVICE AREA

The Service Area is where a member will generally receive their care. Since the Plan is a statewide HMO and has a statewide Provider Network, the entire state of New Mexico, including all of its counties, is considered this Plan's Service Area.

FHP FONEMED (NURSE ADVICE LINE)

If You have a non-life-threatening illness or injury, or if You have questions about symptoms You are having, You may call FHP FoneMed toll-free at 1-800-225-6317 Experience registered nurses are available to talk to You twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. **If You are experiencing a medical emergency, please call 911**.

NOTICE OF NONDISCRIMINATION

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

Friday Health Plans of Colorado, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreter
    - Written information on 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 1-844-805-5000.

If You believe that Friday Health Plans of Colorado, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with: the Chief Compliance Officer, 700 Main Street, Alamosa, CO 81101; 1-844-805-5000 (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

You can also submit a civil rights complaint or inquiry to one or both of the following New Mexico resources:

Office of Superintendent of Insurance P.O. Box 1689 1120 Paseo de Peralta Santa Fe, NM 87504-1689	New Mexico Office of the Attorney General 201 3rd St. NW Suite 300 Albuquerque, NM 87102
Phone: (855) 427-5674 Toll Free	Phone: (844) 255-9210 Toll Free
Email: mhcb.grievances@state.nm.us	Web based complaint form:
By fax:(505) 827-4734	Fax: (505) 318-1050

LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al l 844-805-5000.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-805-5000.
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-805-5000.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-805-5000 번으로 전화해주십시오. 844-805-5000

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-805-5000.

وصد برقم اتصل .بالمجان لك تتوافر اللغوية لامساعدة خدمات فإن ،اللغة اذكر تتحدث كنت إذا :ملحوظة 844-805-5000 :**Arabic** ا ديك
لحق 844-805-5000 Friday Health Plans كا إن لن لأو ديك شخ دد تساع ص أ ده سئلة بخص

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-805-5000.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-805-5000.

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

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer: 844-805-5000

Portuguese: I cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. HHS não exclui ou trata de forma diferente devido à raça, cor, nacionalidade, idade, deficiência ou sexo.844-805-5000.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-805-5000.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-805-5000 まで、お電話にてご連絡ください。

SECTION 3:TABLE OF CONTENTS

SECTION 4: ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

- A member must be a US Citizen or national and may be required to provide proof of Valid ID, member must either live or be working in the service area to be eligible for coverage. For all questions or concerns regarding eligibility, premium payment, special enrollment period, coverage effective dates etc please contact beWellnm.

MISUSE OF IDENTIFICATION CARD

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

CONSUMER ADVISORY BOARD

You are a critical part of our organization. We value Your feedback about our services and Health Plan operations. We have started a Consumer Advisory Board that meets every quarter to discuss general operation from our Members' perspectives and how we might better serve You. As a Member of this Plan, You are eligible to participate on this Board. If You are interested, call us at 1-844-805-5000.

CHANGE OF BENEFICIARY

The right to change a beneficiary is reserved for the Policyholder, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

SECTION 5: THE HMO NETWORK

As a Member, You may receive Covered Services from the Friday New Mexico Network Providers including medical, surgical, diagnostic, therapeutic and preventive services provided in the Plan's Service Area. Covered Services must also be Medically Necessary. As a Member of an HMO, You and Your PCP should work together to manage Your healthcare needs. A Member is not required to obtain referrals to visit In-Network Providers. However, certain services require Prior Authorizations – please see the complete list of services that require Prior Authorizations at the end of this Section. When a Covered Service requires Prior Authorization, Your Network Providerwill work with the Plan to obtain Prior Authorizations.

Each Member should select, or have selected on his/her behalf, a PCP. You are encouraged to choose Your PCP by referring to the current Friday Health Plan's Provider Directory or by calling the Plan's Friday Care Crew. A Member may change his/her PCP at any time for any reason by contacting the Plan's Friday Care Crew.

It is the responsibility of each Plan Member to inform the Plan of any change in mailing address within thirty-one (31) days of such address change. Changes can be made by contacting the

Friday Care Crew.

THE HMO NETWORK OF NETWORK PROVIDERS

The Plan has contracted with health care providers to give affordable health care to its members. This is also done to manage Your healthcare needs. You should choose Your PCP from the Plan Network.

As a member of an HMO Health Care Plan, generally You must receive care from a Network provider for in to be considered a Covered Service. The Plan has contracts in place with Network providers to provide care at a decreased, contracted rate for You, the member. If You choose to receive healthcare services from Non-Network Providers without obtaining a Prior Authorization from the Plan, then it may result in a significant increase in cost to You. Using contracted providers will ensure coverage, lowest out of pocket expenses and will ensure that You receive the most protection. There are some instances where You are protected from the increased costs from Non-Network providers. They are discussed in the next section, "Accessing Non-Network Providers," to help provide clarity. When You are self-directing Your care to a Provider, then 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 Director or by calling Friday Care Crew at 1-844-805-5000.

The Provider Directory is available to all Members on our website at https://www.fridayhealthplans.com/members/resources/nm or by requesting a paper copy by calling our Friday Care Crew at 1-844-805-5000.

Network Providers are not required to comply with any specified numbers, targeted average, or maximum durations of patient visits.

ACCESSING NON-NETWORK PROVIDERS

If a Provider is not contracted with the Plan, then they are a Non-Network Provider. Generally, the Plan will not cover non-emergent, Non-Network Provider expenses, and the Member may be responsible for any expenses related to these Non-Network Provider, for example a specialist, generally Your Network Provider will need to request a Prior Authorization for those services. Prior Authorization to use a Non-Network Provider for a non-Emergent service will be granted if the service is not available through a Network Provider as required by New Mexico law. For questions regarding referrals and Prior Authorizations please contact the Friday Care Crew.

When self-directing care, please check that the Provider You intend to visit or receive care through is a Network Provider. You can check that a Provider is a Network Provider by checking the Plan's Provider Directory. The Provider Directory can be found at: https://www.fridayhealthplans.com/members/resources/nm or call Friday Care Crew at 1-844-805-5000.

In the event You are under the care of a Network Provider at the time such Provider stops network in the Network and at the time of the Network Provider's termination and You meet the below criteria of a continuing care patient the Plan will continue providing coverage for the Provider's services at the in-network benefit level.

- You are a continuing care patient if You are:
    - Undergoing a course of treatment for a serious and complex medical condition from the provider or facility;
    - Undergoing a course of institutional or inpatient care from the provider or facility
    - Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care such provider of facility with respect to such a surgery;
    - Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
    - Is or was determined to be terminally and is receiving treatment for such illness from such provider or facility.

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

A request for special circumstances is not available when a Provider has been terminated for reasons that could result in imminent harm or fraud. The continuity of coverage will extend until the completion of treatment or for ninety days, or more than nine months for a terminal illness diagnosis, beyond the date the Provider's termination from the Network takes effect. If the termination is effective past the 24th week of pregnancy, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six weeks after delivery. In rare cases, a Member may receive services from a Non-Network Provider in a Network Facility. If a Member receives care from a Non-Network Provider at a Network facility and the member had not specifically requested the Non-Network Provider, then the member will be held harmless and will have no greater share of cost than if they were treated by an In-Network Provider. The Plan will pay the Allowable Amount which is the amount established under Oklahoma state law for reimbursement for health care services to covered persons at a Network facility provided by an out-of-network Provider or for emergency services that are provided by out-of-network Providers or facilities.

IMPORTANT NOTICE ABOUT SURPRISE BILLING (KNOW YOUR RIGHTS)

Beginning January 1, 2021, New Mexico state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when You receive covered services, other than ambulance services, from an out-of-network provider in New Mexico. The law does not apply to all health plans and may not apply to out-of-network providers located outside of New Mexico. For additional information, please contact the Friday Care Crew at 1-844-805-5000.

WHAT IS SURPRISE/BALANCE BILLING AND WHEN DOES IT HAPPEN?

You are responsible for the Cost-Sharing amounts required by Your health plan, including Copayments, Deductibles and/or Coinsurance. If You are seen by a provider or use services in a hospital or other type of facility that are not in Your health plan's network, You may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network". Out-of-network hospitals, facilities

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

WHEN YOU CANNOT BE BALANCED-BILLED

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

- Non-emergency services at an In-Network or Out-of-Network Facility. The hospital or facility must tell You if You are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

    - A Non-Network Provider that is a facility-based Provider performing Services in a Network Facility, including as but not limited to diagnostic imaging, anesthesia, laboratory, pathology , may not be permitted to bill You for an amount greater than the applicable Copayment, Coinsurance or Deductible under Your Plan.

You have the right to request that In-Network providers perform all covered medical services. However, You may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most You can be billed for **covered** services is your In-Network Cost-Sharing amount (Copayments, Deductibles, and/or Coinsurance). These Providers cannot balance bill you.

ADDITIONAL PROTECTIONS

1. The Plan will pay out-of-network Providers and facilities directly. Again, You are only responsible for paying your In-Network Cost Sharing for Covered Services.

2. The Plan will count any amount You pay for emergency services or certain out-of-network services (described above) toward Your in-network deductible and out-of-pocket limit.

3. Your provider, hospital, or facility must refund any amount You overpay within thirty (30) days of You reporting the overpayment to them.

If You do receive a bill for amounts other than Your Copayments, Deductible, and/or Coinsurance, please contact the Friday Care Crew at 1-844-451-4444.

Ambulance Information –Non- emergency ambulance services used for convenience, are not subject to the state law against balance billing, so if You receive such services and they are not a service covered by the Plan, You will receive a bill.

When receiving care from Non-Network Providers, You may be required to make full payment at the time services are rendered if so, follow the reimbursement procedure below. The Plan will review to ensure that the services You received are covered under this plan and Medically Necessary You will be responsible for charges for non-Covered Services.

When You receive Covered Services from an Out-of-Network Provider and the Practitioner/Provider charged for that service, take the following steps to receive reimbursement:

1. Fill out a Member Medical Claim Reimbursement form available at https://www.fridayhealthplans.com/members/resources/nm or by calling the Friday Care Crew at 1-844-805-5000.

2. Mail it to the Plan within one (1) year (365 days) from the date of service. If You are relying on an Out-of-Network Practitioner/Provider to submit a claim on Your behalf, You are responsible for making sure that claims have been submitted within one (1) year (365 days) from the date of service. Any such charge for Covered Services shall be paid upon our receipt of a Practitioner/Provider billing or completed valid claim for the Health Care Services for which claim is made. If You receive Your first bill after 365 days from the date of service, then submit the bill immediately to the Plan for processing. If You have questions about a charge made by Your Practitioner/Provider, please call the Friday Care Crew at 1-844-805-5000.

Please submit Your completed Claim Reimbursement Form to:

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

SECTION 6: HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL 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 and works the Plan to get Prior Authorizations for specialized care You may need. You have the right to designate any Primary Care Provider who participates in the Plan's Network and who is available to accept You or Your Covered Dependents. The Plan does not guarantee that the Primary Care Provider You select will be able to add You or Your Covered Providers available for Your selection. By selecting a PCP, you will have access to a Provider which will work with You to manage Your Health Care needs.

You may contact the Plan in writing for a list of PCP's:

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

If You prefer, You may call the Friday Care Crew at 844-805-5000.

If the Plan terminates Your designated Primary Care Provider who has previously provided health care services to You, the Plan will provide You with assistance in transferring to another Network Primary Care Provider.

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

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

If You prefer, You may call Friday Care Crew at 1-844-805-5000.

PRIOR AUTHORIZATION

Friday reviews certain health services to determine whether the services are or were Medically Necessary, or Experimental/Investigational. This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed

(Prior Authorization); while the service is being performed (Concurrent); or after the service is performed (Retrospective). This review process results in a service being Prior-Authorized or denied as a Plan benefit.

SERVICE SUBJECT TO PRIOR-AUTHORIZATION

In some cases, your provider 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 do not require Prior Authorization. Please be aware that some procedures whether received from a non- specialist Provider, or a Specialist do require Prior Authorization. You are able to see the network Specialist as often as You need without Prior Authorization for routine care. However, please be aware that additional services/procedures may require Prior Authorization on Your behalf. This is done when the Network Provider makes a request for Prior Authorization to the Plan. Your Network Provider will ask the Plan that You be permitted to receive services that require Prior-Authorization. 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 and the Provider requesting the Prior Authorization, The Prior Authorization request will identify the name of the Provider. It will also identify the health care services to be performed by the 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 guarantee does not apply if You lose Plan eligibility before the date of the services.

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

The Plan will pay for Covered Services that require Prior Authorization if you or your provider 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 may deny claims for such services.

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

You should contact the Plan at 1-844-805-5000 or check the Prior Authorization at the end of this section if You are unsure if a service needs Prior Authorization before services are rendered.

When a Prior Authorization is requested by the Plan, the Prior Authorization shall be deemed granted for determinations not made within seven days for routine care and twenty-four (24) hours if the provider requests an expedited Prior Authorization.

EXCEPTION FOR OBSTETRICAL/ GYNECOLOGICAL CARE

Your OB/GYN may act as your Primary Care Provider and Your Cost-Sharing for those visits will be the same as Your Primary Care Visits. You do not need Prior Authorization for obstetrical or gynecological care from a Network Provider who is an OBGYN or reproductive health specialist. You also do not need a referral from your PCP to get such care. This includes any and all Obstetrical or Gynecological ultrasounds. 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 of Colorado, Inc.
700 Main Street
Alamosa, CO 81101
questions@fridayhealthplans.com

You may also get this information from the Friday Care Crew at 1-844-805-5000.

EXCEPTION FOR EMERGENCY SITUATIONS

You are not required to obtain Prior Authorization from the Plan when you receive health care services in a Medical Emergency. However, the health care provider may be required to comply with certain procedures. These procedures include obtaining Prior Authorization for certain services that could be considered non-emergent. If you are hospitalized without Prior Authorization due to a Medical Emergency, you must notify the Plan by telephone of the hospitalization at 844-805-5000. Alternatively, you must instruct the hospital or a family member to notify the Plan. This notice must occur on the first business day following the hospital admission, or as soon as medically possible. If you are unable to contact the Plan or to instruct another person to do so, the notice may be delayed until you are able to notify the Plan, or to instruct another person to notify the Plan. If you can communicate with others, you will be considered capable of notifying the Plan. The Plan may refuse to reimburse you for the cost of any non-emergent treatment if proper notice is not provided to the Plan. You have the right to request that In-Network providers perform all covered medical services. However, You may have to receive medical services from an out-of-network provider if an in- network provider is not available. When this happens, the most You can be billed for **covered** services is your In-Network Cost-Sharing amount (Copayments, Deductibles, and/or Coinsurance). These Providers cannot balance bill you.

PRIOR-AUTHORIZATION TIMELINE

All timelines for Prior-authorization requirements are provided in keeping with applicable state and federal regulations.
On receipt of a request from a Participating Provider for Prior-Authorization, the Plan shall review and issue a determination indicating whether the health care services are authorized. The determination will be issued and transmitted no later than 7 Calendar days after all relevant information is received.

Concurrent Prior-Authorization – For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than twenty-four (24) hours after receipt of Your claim for benefits.

Urgent/Expedited Prior Authorization Review with respect to urgent Prior-Authorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 24 hours of receipt of the request. Written notice will follow the determination within two (2) business days or three (3) calendar days of receipt of the request, whichever is earlier.

If additional information is required, we will request it from Your provider as soon as possible but not later than the timelines listed above. You or Your Provider will then have forty-eight (48) hours to submit the information. We will continue the review of the requested services as soon as possible but not later than 3 Business days.

OTHER EXCEPTIONS TO PRIOR AUTHORIZATION REQUIREMENTS

You are not required to obtain Prior Authorization from the Plan when you visit a Network 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 Network Provider.

Prior-Authorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Other Professional Provider.

FAILURE TO USE A NETWORK PROVIDER

As a general rule, Covered Health Care Services obtained from a Non-Network Provider will not be covered if You self-refer for non-Emergency health care services from a non-Network Provider, the Plan may not pay for such services. If the reason You are receiving care from a non-Network Provider is due to a Medical Emergency or as a result of an Authorization from the Plan, the Plan will pay for the Covered Services You receive. Cost Sharing and benefit limitations for a medically necessary, non-emergent health care service where no Network provider is available to render the service and the Plan's Authorization is obtained shall be the same as if the service were rendered by a Network provider. In addition, if You access a non-network Emergency or Urgent Care Center as a medical emergency, then the cost share for the Member would be the same as if You accessed a Network facility—see definition of Emergency and Urgent Care Services in the Definitions section.

- You will only be responsible for your regular Cost-Sharing (Copayments, Deductibles and Coinsurance) amounts if you are referred and see a Non-Network provider and did not receive notification from the Plan that such care has not been approved.

MEMBER PORTAL

As a Member of the Plan, You can use the online Member Portal to review claims, print Your ID card, check the status of Prior Authorizations, and perform many other functions that will help You as a Member. To enter the Member Portal, go to the https://www.fridayhealthplans.com/ website, Members link (found in the ribbon at the top of the home page), then click on the Member Hub, then click on member portal login (located at the bottom then the Member hub page). You will be prompted to set up Your account, and You will need Your member ID number.

LIST OF PRIOR AUTHORIZATION REQUIREMENTS

Service	Authorization Required	Service	Authorization Required
Acupuncture	Yes after first 20 visits	Mental Health Inpatient- unplanned	You or Your designee must notify the plan you are there
Bariatric Surgery	Yes	Substance abuse Inpatient- planned	Yes
Biopsy – Bone Marrow	Yes	Substance Abuse Inpatient - unplanned	You or Your designee must notify the plan you are there
Bone Scan – 3 phase	Yes	Inpatient hospital stay-unplanned	You or Your designee must notify the plan you are there
Breast Reconstruction	Yes	Insulin Pump	Yes
Chemotherapy	Yes	PT/OT/ST	After first 20 visits.
Cleft lip/palate	Yes	IV infusion Home or Outpatient	Yes
Cochlear implants	Yes	Mastectomy	Yes
Continuous Glucose Monitor	Yes	MRI	Yes
CPAP	Yes	Newborn Stay – Beyond Mom's	Yes
CT/CTA Scan	Yes	Nuclear Medicine	Yes
Dialysis	Yes	Nuclear Stress	Yes
DME	Yes items over $500	Orthotics/diabetic shoes	Yes
EEG- Inpatient only	Yes	Orthotics	Yes
Genetic Testing	Yes	OP Surgery- Hospital/Surgery Ctr	Yes
Mental Health Inpatient- planned	Yes	In-office procedures	Yes >$1000
Hida Scan	Yes	PET Scan	Yes
Home Health	Yes after first 30 visits	Pulmonary Perfusion Test	Yes
Hospice- Inpatient/Home Hospice	Yes after first 6 months	VQ Scan	Yes
Infertility Testing	Yes	Radiation	Yes
Injectables	Yes for meds over	PET Scans	Yes
Inpatient Admission- Preplanned	Yes	SNF (skilled Nursing- Inpatient)	Yes
Inpatient Surgery	Yes	Sleep Study- in lab	Yes
Wigs (Chemo)	Yes	Specialty Drugs-PBM	Yes
Mental health Outpatient procedures- TMS, ECT	Yes	Transplants	Yes
Chiropractic care	Yes after first 20 visits	TMJ Tx	Yes

Friday health Plans requires authorization for in-office procedures or injectables over $1000 to protect members from unexpected cost sharing expenses. To inquire whether a service requires authorization please contact the Friday Care Crew at 1-844-805-5000.

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, or the member receives Prior Authorization from the Plan);
- The covered person at an in-network facility does not have the ability or opportunity to choose a Network provider who is available to provide the covered services
- Medically necessary care is unavailable within a health benefits plan's network; provided that Medical Necessity shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan and health insurance carrier

A. Coverage for Newly Born and Adopted Children

☐ Newborn Coverage. Your newborn Child will be covered by the Plan for the first thirty-one (31) days of his/her life if the newborn is enrolled with thirty-one (31) days from the date of birth. Failure to do so will result in denial of any claims incurred within the first thirty-one (31) days after birth. Please refer to the Special Enrollment section.

- 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.

☐ 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 that forty-eight (48) hours. If the forty-eight (48) hours ends after 8 p.m., Your stay will continue until 8 a.m. the next day. The hospital stay after a caesarean section will not be less than ninety-six (96) hours. If the ninety-six (96) hours ends after 8 p.m., coverage will continue until 8 a.m. the next day. Additionally, the Plan will cover circumcision for newborn males.

- 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. In order for a newborn to receive treatment within the first thirty- one (31) days after birth, the Subscriber must notify the Plan of the birth of the newborn, enroll the child, and pay the appropriate Premium for the child. Please refer to the Special Enrollment section. The plan also includes medically necessary air transport to the nearest available tertiary care facility for newly born infants.

☐ 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, You must enroll Your child within the first thirty-one (31) days after birth or any expenses incurred for cleft lip and/or palate may be denied. Prior-Authorization is required. 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.

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

- Genetic Inborn Errors of Metabolism. The Plan will provide coverage for inherited enzymatic disorders cause by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; propionic acidemia; immunoglobulin E and nonimmunoglobulin E- mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the result of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include, to the extent Medically Necessary, medical foods for home use for which a Provider who is a Network Provider or approved Non-Network Provider has issued a written, oral, or electronic prescription. In order for Your Child's Plan coverage to continue beyond the thirty-first (31st) day of life, You must enroll Your Child in the Plan. Please refer to the Special Enrollment sections.
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  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).

- Food Supplements. The care covered by the Plan will include medical foods for home use, if Medically Necessary. “Medical foods” means metabolic formulas and their modular counterparts, obtained through a pharmacy. These foods are specifically designated and made for the treatment of inherited enzymatic disorders for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed to be deficient in one or more nutrients. These foods are to be consumed or administered enterally either via tube or oral route under the direction of a Network Provider or approved Non-Network Provider. You must have a prescription from a Provider and receive the medical

  foods through a pharmacy. You may access a non-Network pharmacy if a Network pharmacy cannot fulfill Your needs, this requires Prior Authorization. This shall not be construed to apply to cystic fibrosis, lactose- intolerant or soy-intolerant Members.

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

  Coverage of medical foods, as contained herein shall only apply to benefit plans that include an approved pharmacy benefit and shall not apply to alternative medicines.

  Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and sever protein allergic conditions, elemental enteral nutrition and parenteral nutrition are covered as medically necessary.

B. New Mexico Family, Infant and Toddler (FIT) Program

☐ Standard. Your Covered Child may receive certain early intervention services that are covered by the Plan. These benefits are available from birth until Your Covered Child reaches age three (3). The New Mexico Department of Health (DOH) must determine that Your Covered Child has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or has a developmental disability. These services are subject to Deductibles but are not subject to Copayments or Coinsurance.

- General. Coverage generally, the Plan will cover those early intervention services specified in Your Covered Child’s Individualized Family Service Plan (IFSP). However, the services must be delivered by a Network Provider or approved Non-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 primary service. The early intervention services will supplement, but not replace, services for autism spectrum disorders. The maximum reimbursement under the Plan is $3,500.00 per year.

☐ 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.

☐ 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.

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

C. Autism Spectrum Disorders

☐ The Plan provides coverage for the assessment, diagnosis, and treatment of autism spectrum disorders for Members under the age of nineteen (19) or, if enrolled in high school, until the Member reaches the age of twenty-two (22). This includes treatment for the following neurobiological disorders: Autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, at the time of the diagnosis. Covered Services must be provided by a duly licensed Provider, psychologist, Behavior Analyst, licensed assistant behavior analyst, registered behavior technician or other Provider that is supervised by the licensed Provider, psychologist, or Behavior Analyst.

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

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

- Limitations. Coverage required pursuant to the following provisions: shall be limited to treatment that is prescribed by the Member's treating physician in accordance with a treatment plan. Shall not be subject to annual or lifetime dollar limits. Shall not be denied on the basis that the services are habilitative or rehabilitative in nature. May be subject to other general exclusions and limitations of the health maintenance organization contract, including coordination of benefits, Network provider requirements, restrictions on services

provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions. May be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

☐ Coverage is also available for Childhood Disintegrative Disorder (CDD).

D. Congenital Defects and Birth Abnormalities

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.

E. Child Speech and Hearing Benefits

☐ Speech Therapy. If a Covered Child experiences speech delay, the Coverage is available for speech therapy visits.

☐ Hearing Exams The Plan will cover routine hearing exams for a Covered Child who is under the age nineteen (19). The Plan will cover hearing tests in support of a diagnosis and medically covered condition. The Plan does not include audiometry and tympanograms not in support of a diagnosis

☐ Hearing Aids:. Coverage is provided for purchase, repair, and replacement of one (1) Medically Necessary hearing aid per ear, once every three years. This will include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, provided by audiologist, a hearing aid dispenser or a physician. The Plan does not cover hearing aids that have functionality that is not Medically Necessary such as Bluetooth and GPS technology. Hearing Aids are only covered if obtained from approved Providers. No age limit for hearing aids.

F. Child Dental and Vision Benefits

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

☐ Pediatric Vision Care. The Plan will cover one vision exam each Plan Year for a Covered Child who is under the age of nineteen (19) for services rendered by an optometrists, therapeutic optometrists, and ophthalmologists. Eyeglasses for a Covered Child will be covered for 1 pair every 12 months and includes either eyeglasses frames and lenses or contact lenses. The Plan will also cover one eye refraction per calendar year is covered for

children under age six when medically necessary to aid in the diagnosis of certain eye diseases.

G. Special Preventive Services with No Cost-Sharing

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

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

a. Office Screenings

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

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

- Smoking Screening and Cessation Program- the Plan will cover diagnostic services, smoking cessation programs including, intervention services, behavioral interventions and prescription drugs. The Plan will cover two quit attempts per plan year. The Plan will cover at least four (4) sessions of individual, group or telephone cessation counseling. The smoking cessation program includes all FDA approved tobacco cessation medications
    - o Nicotine patch,
    - o Nicotine gum,
    - o Nicotine lozenge,

- Nicotine oral and nasal spray
- Nicotine inhaler
- Bupropion
- Vernnicline
- The smoking cessation services must be provided by a Network Provider or approved Non-Network Provider that is trained in managing a smoking cessation program. There is no cost sharing or Prior Authorization requirement for these programs, You can access the Quitline by calling 1-800-Quit-NOW/1-800-784-8669.

- Low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged fifty (50) to fifty-nine (59) years who have a 10% or greater ten (10)-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least ten (10) years, and are willing to take low-dose aspirin daily for at least ten (10) years.
- Low-Dose aspirin as preventative medication after 12 weeks gestation in women who are at risk for pre-eclampsia.

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

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

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

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

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

b. Imaging or Procedural Screenings

- 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. All forms of low dose mammography are covered.

- Benefits for preventative 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 Policy. If a Covered Person

receives more than one screening in a Plan Year, the other benefit provisions in the Policy apply with respect to the additional screening.

- FHP follows the recommendations of the American College of Obstetricians and Gynecologist (ACOG) guidelines for breast cancer screening which recommend screening earlier and more frequent than USPSTF. Mammogram preventive benefits include one baseline mammogram to persons aged thirty-five through thirty-nine. One mammogram and clinical breast exam once a year for female Members who is at least forty (40) years of age but up seventy-five (75) years of age. One mammogram and clinical breast exam starting at ages between thirty-five (35) and forty (40) for BRCA ½ carriers. If or Member with family members with cancer or female Member with at least one risk factor for breast cancer, they may receive one mammogram and clinical breast exam starting at age twenty-five (25).

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

- BRCA 1 and 2 testing for women with family members with breast, ovarian tubal, or peritoneal cancer.

- Interventions during pregnancy and after birth to support breastfeeding.

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

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

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

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

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

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

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

- Early screening for syphilis infection in all pregnant women.

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

- Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps starting at age 45 and continuing until age eighty-five (85). 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. This benefit includes: 1) a fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years; or (2) a colonoscopy performed every ten (10) years.

    - 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 Network Provider or approved Non-Network Provider.

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

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

- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than sixty-five (65) years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

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

- Screening for lung cancer with low-dose computed tomography (LDCT) in adults aged fifty-five (55) to eighty (80) years who have a thirty (30) pack-year smoking history and currently smoke or have quit within the past fifteen (15) years. Screening should be discontinued once a person has not smoked for fifteen (15) years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

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

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

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

- Artery calcification screening for the diagnosis of heart disease

c. Laboratory Testing

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

- Cholesterol screening for lipid disorders.

- The USPSTF recommends screening for cervical cancer in women aged twenty-one (21) to 29 years with cervical cytology (Pap smear) alone every 3 years or, for women aged thirty (30) to sixty-five (65) years to receive screening for cervical cytology alone every three (3) years, and for a combination of cervical cytology and human papillomavirus (HPV) testing every 5 years.

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

- Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged forty (40) to seventy (70) years who are overweight or obese.

- Screening for gonorrhea and / or chlamydia and / or syphilis in sexually active women aged twenty-four (24) years and younger and in older women who are at increased risk for infection.

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

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

- Screening for HIV infection in adolescents and adults aged fifteen (15) to sixty-five (65) years. Younger adolescents and older adults who are at increased risk of infection should also be screened.

d. Vaccinations

- All immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as required by Federal law.

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

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

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

- COVID vaccine

e. PrEP

- HIV testing: Persons must be tested and confirmed to be HIV uninfected before starting PrEP and tested again forHIV every three months while taking PrEP so that, if they have become infected, the medication can be stopped promptly before it could cause a harmful drug resistance to develop.
- Hepatitis B and C testing: Persons should be screened for hepatitis B virus (HBV) at baseline for the initiation of PrEPconsistent with CDC guidelines, so

that when the PrEP medications, which suppress HBV replication in the liver, are stopped, persons can be monitored to ensure safety and torapidly identify any potential injury. Additionally, persons should be screened for hepatitis C virus (HCV) infection at baseline and periodically consistent with CDCguidelines. Screening for HCV infection is indicated for all people with ongoing risk of contracting HCV.

- Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR): Forpersons taking PrEP, their estimated eCrCl or eGFR must be measured and calculated at the beginning of treatment to assess if kidney function is in the range for safe prescribingof PrEP medication. Creatinine and eCrCL or eGFR should be checked periodically consistent with CDC guidelines while on PrEP medication to assess for potential kidney injuryand to ensure that it is safe to continue PrEP medication.
- Pregnancy testing: Persons with childbearing potential taking PrEP must be tested for pregnancy at baseline andshould be tested again periodically thereafter consistent with CDC guidelines until PrEP is stopped so that pregnant patients, together with their health care providers, can make afully informed and individualized decision about taking PrEP.
- Sexually transmitted infection (STI) screening and counseling: Persons taking PrEP must be screened for STIs atbaseline and should be screened periodically thereafter consistent with CDC guidelines, which may require multiple anatomic site testing (i.e., genital, oropharyngeal, and rectal) forgonorrhea and chlamydia, and testing for syphilis, together with behavioral counseling, which are recommended to reduce the risk of STIs, the presence of which may increase the likelihood of acquiring HIV sexually.
- Adherence counseling: Persons taking PrEP must be offered regular counseling for assessment of behavior and adherence consistent with CDC guidelines to ensure that PrEP is used as prescribed and to maximize PrEP's effectiveness.

- 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.
  You can access the full list at:
  https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

For a detailed list of preventive services covered by the Plan, You may contact the Plan in writing at:

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

If You prefer, You may call Friday Care Crew at 1-844-805-5000.

H. Wellness Visits

- 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.

- 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 folate counseling for women of childbearing age); blood work; history and physical; urinary analysis; chemical profile; fasting lipid panel; and stool hemoccult. The Plan will also cover cervical cancer vaccines for all female Members. However, these Members must meet the standards identified by U.S. Department of Health & Human Services (HHS). Services covered herein may not be all inclusive and may change from time to time to comply with Federal and State Statutes and Regulations.

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

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

Services covered herein may not be all inclusive and may change from time to time to

comply with Federal and State Statutes and Regulations.

- 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.

☐ For Adult Women: When provided by a Network Provider or approved Non-Network 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 Network Provider or approved Non-Network Provider. The following schedule will apply:

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

☐ For Adult Men: When provided by a Network Provider or approved Non-Network Provider, the Plan will cover screening for the early detection of prostate cancer as follows:

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

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

I. Other Out-Patient Services

- 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 and office visit, a scheduled procedure visit, or provided by a Specialty Provider require Deductible, Copay and Coinsurance.

☐ Telehealth. The plan will cover Telehealth services. The Plan will reimburse the treating Network Provider, approved Non-Network Provider or the consulting Provider for the diagnosis, consultation, or treatment of the Member delivered through Telehealth on the samebasis that the Plan is responsible for reimbursing that provider for the provision of the same service through in-person consultations or contact by that Network 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 Network 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.

- 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.

☐ Specialty Provider Services. The Plan will cover services of a Network Providers with no 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, Copay and/or Coinsurance.

☐ Diagnostic Services. The Plan will cover diagnostic services, including radiology (X-ray); pathology; laboratory tests; diagnostic mammograms for symptomatic or high rick women and other imaging and diagnostic services. Certain diagnostic services require Prior Authorization. This is the case for magnetic resonance imaging (MRI), computerized tomography (CT) scans and Transcranial Magnetic Stimulation (TMS), among others.

☐ Outpatient or Ambulatory Surgical Procedures. Your Plan covers outpatient hospital and/or ambulatory surgical procedures, including operating, recovery and other treatment rooms, Physician and surgeon services, laboratory and pathology services, pre-surgical testing, anesthesia, and medical supplies. Services must be prescribed by your Primary Care Practitioner or attending Health Care Professional. Services may be provided at a hospital,

a Physician's office, or any other appropriately licensed facility. The Provider delivering services must be licensed to practice and must be practicing under authority of the Health Care Insurer, the medical group, an independent practice association, or other authority as applicable by state law. Prior Authorization is required.

☐ Radiation Therapy and Chemotherapy. The Plan will cover Medically Necessary radiation therapy and chemotherapy, for treatment of cancer. The Member must obtain Prior Authorization.

☐ Special Right to Reconstructive Breast Surgery. If an 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;
- Prosthesis and physical complication for all stages of the mastectomy, including lymphedemas

These benefits are subject to any Copayments, Deductibles and Coinsurance obligations applicable to any other Plan coverage.

- Urgent Care. Urgent Care Services are Medically Necessary Health Care Services provided in urgent situations for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention The Plan will cover urgent care provided in a Network Provider urgent care center within the Service Area. The Plan also covers Urgent Care Services outside the services area if Medically Necessary and are of an urgent nature. If an out-of-Network Urgent Care center is utilized, the need for services must meet the definition of Emergency and Urgent Care Services – see Definitions section for more details.

☐ Urgent Care Center. Non-Emergency care may be provided at an Urgent Care Center, but Non-Emergent Care must be provided at a Network Urgent Care Center. Use of a Non-Network Urgent Care Center within the Service Area when the services do not meet the definition of Emergency and Urgent Care Services would not be considered a covered benefit.

☐ COVID-19testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency is presumptively unreasonable and is prohibited. For purpose of this rule, a public health emergency exists when declared by the state of

New Mexico or federal government.

☐ Sickle Cell Disease and Its Variants. Your Plan includes benefits for treatment of Sickle Cell Disease and Its Variants, including Medically Necessary Prescription Drugs and necessary care management services to assist patients in identifying and facilitating additional resources and treatments, to the extent required by law.

J. Genetic Counseling/Testing

☐ Covered Services include Medically Necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Policy.

Covered Services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

☐ Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a Physician that we may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing.

☐ Medically Necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Parents of a Child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;
- Parents of a Child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome;
- Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects; or
- Parents affected with an autosomal dominant disorder who are contemplating pregnancy; or Women who are known to be, or who are likely to be, carriers of an X-

linked recessive disorder.

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

- The results will directly impact clinical decision-making and/or clinical outcome for the individual;
- The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
- One of the following conditions is met:
  - The Member demonstrates signs/symptoms of a genetically linked heritable disease; or
  - The Member or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

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

☐ In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the Member.

☐ Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

K. Hospital Inpatient Services

☐ Standard. Generally, the plan will cover Medically Necessary hospital inpatient services. However, Prior Authorization form the Plan must be obtained 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.

General Coverage. Inpatient Hospital Services shall include, but not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by the covered person's primary care practitioner or treating health care professional, pharmaceuticals and other medications, anesthesia and oxygen services, special duty

nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary. In addition, Inpatient Hospital Services include the use of operating room and related facilities; intensive care unit and services; X-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia and oxygen services; radiation therapy; chemotherapy; physical therapy; inhalation therapy; prosthetic devices approved by the Food and Drug Administration and implanted during a surgery performed pursuant to Prior Authorization (such as pacemakers and hip joints); and the administration of whole blood, blood plasma and other blood products. The Plan will cover a private room only when Medically Necessary.

- Providers and Medical Personnel. The Plan also covers the services of Treating 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.

  Bariatric Surgery. Medically Necessary surgery is covered. You must meet Plan's criteria stated below to be eligible for this service. The service must be performed by an in-Network Provider.
  Covered Services include Medically Necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese with associated Illnesses. These services may not be covered unless You receive Prior Authorization.

  Medically Necessary treatment for complications resulting from Gastric Restrictive Surgical Services will be covered the same as any other illness.

  You must meet the Plans criteria: BMI ≥ 35 kg/m2 who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions as Medically Necessary.

L. Mental Health and Chemical Dependency Treatment

☐ General Coverage. Outpatient treatment for diagnostic and therapeutic behavioral/mental health services are covered without a Prior-Authorization UNLESS you are seeking services from a Non-Network provider. Some services do require Prior Authorization by the Plan. Please refer to the Prior Authorization list for more details.

Inpatient and outpatient Medically Necessary mental health services are covered by the Plan. Services on an outpatient basis are covered for treatment, outpatient testing, and assessment. Inpatient and partial hospitalization for psychiatric care is covered when Medically Necessary for the treatment of a mental illness. Clinically appropriate facilities and programs include those offering a clearly defined course of mental health services and special programming provided by licensed clinicians in a controlled environment offering a degree of security, supervision, and structure as deemed medically appropriate. These facilities and programs must be licensed and accredited by the appropriate federal,

state, and local authorities to provide such services effectively and safely and be recognized by national accrediting bodies in accordance with the Plan credentialing policy. Care in an inpatient setting for members with mental illness or chemical dependency must include medical monitoring with twenty-four (24)-hour medical availability and twenty-four (24)-hour on-site nursing service. Such facilities and programs exclude half-way houses, supervised living arrangements, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs.

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

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

☐ Inpatient Mental Health Care. Like other inpatient care, the Plan will cover Medically Necessary inpatient mental health care services as determined by the Members health care Provider. 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.

☐ Outpatient Chemical Dependency/Substance Abuse Treatment. The Plan will cover outpatient chemical dependency/substance abuse visits in the same manner that it covers other outpatient visits with no prior authorization.

☐ Inpatient and Residential Chemical Dependency/Substance Abuse Treatment. Like other inpatient care, the Plan will cover Medically Necessary inpatient or thirty (30)-day short term residential chemical dependency/substance abuse treatment. If a short term rehabilitation stay will be longer than the prescribed 30 days, the Plan will review additional days for medical necessity. Inpatient or residential care is covered 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.

☐ Cost-Sharing Waiver for Behavioral Health Services. There will be no Cost-Sharing applied to behavioral Health services under the following conditions.

- Provider services rendered by a behavioral health Provider or Primary Care Provider
- Outpatient services at a behavioral health facility, or
  - A non-behavioral health facility but attending is a behavioral health Provider
  - Behavioral health services rendered at a non-behavioral health facility
  - This includes transcranial magnetic stimulation services or electroconvulsive

therapy

- Inpatient services rendered by a behavioral health center including substance abuse or
  - A non-behavioral health care center when attending is a behavioral health Provider
  - Behavioral health services rendered at a non-behavioral health facility.
- Clinical laboratory, radiology services or other imaging or other ancillary services when ordered by a behavioral health provider, or
  - A non-behavioral health provider orders services for a behavioral health diagnosis.
- Behavioral Health Prescriptions as see on the Plan's formulary.
- Limitations:
  - Cannot be part of an Emergency or Urgent care situation.
  - For non-behavioral health providers the behavioral health diagnosis must be listed 1st or 2nd on the claim.
  - Providers must be Network Providers or You must have received Prior Authorization of non-Network services for this waiver to apply.

M. Durable Medical Equipment

- General Coverage: With respect to durable medical equipment, the Plan will cover an 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 (i.e. glucometer). Such durable medical equipment must be provided or distributed through a Network Provider or approved Non-Network Provider hospital or other Network Provider or approved Non-Network Provider. Prior Authorization is also required. Durable Medical Equipment is authorized following applicable Medicare statutory and regulatory requirements, unless otherwise established in this document.

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

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

☐ Prosthetics: 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 Network Provider or approved Non-Network 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.

- One (1) Medically Necessary prosthetic device, approved by the Centers for Medicare & Medicaid (CMS), is covered for each missing or non-functioning body part or organ every three (3) years.

Coverage is limited to:

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

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

c. Adjustment of initial prosthetic device; and

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

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

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

☐ Breast Pumps: Breast pump rentals are covered. Purchase of Plan approved breast pumps are covered up to $250.

☐ Enteral Nutrition: The Plan covers enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a Provider; administer via tube feeding; and must be the primary source of nutrition for the Member. The Plan does not cover oral nutrition products even when prescribed or administered by a Provider.

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

N. Emergency Services

☐ Standard. An Emergency Medical Condition that qualifies for Emergency Services health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person. For the service to be covered as an Emergency Service, the Service must meet the standard set forth in the definition of Emergency and Urgent Care Services.

For a Medical Emergency, the Plan will cover the Emergency Services listed in below. These services are covered without Prior Authorization. In addition, Emergency Services linked to Mental Health or Substance Abuse issues are covered at the same level as Emergency Services for Medical conditions. Emergency Services are covered even if the provider is not a Network Provider. Please see definition of Emergency and Urgent Care Services.

Emergency and urgent care services shall include:

- Acute medical care that is available twenty-four hours per day, seven days per week, so as not to jeopardize a covered person's health status if such services were not received immediately; such medical care shall include ambulance or other emergency transportation.
- Coverage for trauma services at any designated level I, level II, or other appropriately designated trauma center according to established emergency medical services triage and transportation protocols; coverage for trauma services and all other emergency services shall continue at least until the covered person is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending physician or health care professional in consultation with the Plan;

- Reimbursement for emergency care and emergency transportation shall not be denied by the health care insurer or Plan when the covered person, seeks care that a prudent layperson would reasonably believe that emergency care is necessary regardless of eventual diagnosis or is referred for care by a Provider or the Plan,. You will only be responsible for Your Deductible, Coinsurance, Copayment regardless of the facilities Network status.

    - a reasonable person’s belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment;
    - the time of day the care was provided;

- the presenting symptoms; and
- any circumstances which precluded use of the Plan's established procedures for obtaining emergency care;

- No prior authorization shall be required for emergency care. In addition, appropriate out-of-network emergency care shall be provided to a covered person without additional cost

- Emergency Transportation. For a Medical Emergency, the Plan will pay for the Member's transportation to the hospital by ambulance if all conditions above are met

- Member Costs. If an Member receives emergency care from a non-Network Provider, the Member's Deductible, Copayment Coinsurance amounts will be the same as if the Member had been treated by a Network Provider.

- 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 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 or retrospectively deemed unnecessary based on the Patient's ability to notify.

  Transfer. If an Member is hospitalized in a non-Network Hospital, the Plan may have the Member transferred to a Network hospital as soon as medically feasible. If the Plan requests transfer to a Network Hospital, the patient must be stabilized, and the transfer effected in accordance with federal law. The Plan will not cover any services provided by a non-Network Provider to a Member who has refused a medically feasible transfer. The Plan will work with the facility to coordinate appropriate medical services after stabilization as Medically Necessary.

O. Maternity Benefits

☐ Prenatal and Postnatal Office Visits. Prenatal, intrapartum, perinatal, and postnatal care visits are covered in the same manner as routine office visits with your Primary Care Provider.

☐ 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. This includes an alpha-fetoprotein IV screening test for pregnant women, generally between sixteen (16) and twenty (20) weeks of pregnancy, to screen for certain genetic abnormalities in the fetus

Complications of Pregnancy. The Plan will cover a sickness or disease which is a complication of the Member's pregnancy or childbirth.

- Hospitalization for Delivery. The Plan will cover the Member's hospitalization for delivery. The hospital stay following a normal vaginal delivery for You and Your newborn will not be less than forty-eight (48) hours. The hospital stay following a caesarean section will not be less than ninety-six (96) hours for You and Your newborn.. These timeframes could be less at the discretion of the attending physician and the Member. If the mother and child are discharged prior to forty-eight (48) hours following delivery, then one newborn visit within the first week of life will be covered. If You and Your Child stay is longer than the timeframes stated above the plan will cover additional days as long as Medically Necessary.
  - Home Visits: postpartum care in the home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by a Provider.
    - Care will be provided by a person with the necessary experience to provide quality postpartum care.

☐ Breast Pumps: Breast pump rentals are covered. Purchase of Plan approved breast pumps are covered up to $250.

P. Family Planning and Infertility Services

- Family Planning. The Plan will cover voluntary family planning services including family planning counseling and the provision of information about birth control (see contraceptive coverage section). 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 Network Provider or approved Non-Network Provider. Oral contraceptives, including emergency contraceptives, are covered under the Member's pharmacy benefit.

☐ Infertility Services. The Plan will cover the following services, including X-ray and laboratory procedures:

- Services for diagnosis and medically indicated treatment for physical conditions causing involuntary infertility. This treatment does not cover reversals of prior voluntary sterilization surgery. If Medically Necessary, reasonable physical and behavioral health appraisal examinations and laboratory and radiological tests will be covered.

- Benefits related to infertility are limited to testing, diagnosis, and corrective procedures and treatment for physical conditions causing involuntary infertility. Please see the Limitations and Exclusions section for Infertility Services limitations and exclusions.

☐ 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. Contraception shall not be subject to Member cost-sharing, utilization review, prior-authorization, or step-therapy.

- The Plan will cover a six-month supply of contraceptives at one time.
- Vasectomies do require a member cost share – see the SBC for cost-sharing details.
- Voluntary sterilization is a covered benefit.

Q. Home Health Care Services

☐ General Coverage. The Plan will cover home health care provided to an Member who is under the direct care of a Network Provider or approved Non-Network Provider. Services will include visits to the Member by Network Providers or approved Non-Network Providers. Visits will be limited to the usual and customary time required to perform the particular services.

☐ Coverage is provided for:

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

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

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

iii. Medical social services by a licensed social worker;

b. Infusion services;

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

d. Nutritional counseling by a nutritionist or dietitian;

e. Audiology services

f. Medical supplies, lab services and medications that would be covered if the Member were an inpatient at a hospital;

g. Prosthesis and orthopedic appliances

h. Rental or purchase of DME.

☐ 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.
- Home health Care visits are limited to one hundred (100) visits per Member, per year.

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.

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

- Home Health Services require Prior Authorization after the first 30 visits per therapy.

R. Organ and Tissue Transplants

- General Coverage. The Plan will cover the following transplants: heart; lung; heart/lung; liver; kidney; pancreas islet cell infusion; multi-visceral; multi-organ; cornea; bone marrow for treatment of neuroblastoma and Hodgkin's or non-Hodgkin's lymphoma; autologous or allogeneic bone marrow transplants and stem cell rescue or hematopoietic support only for malignant tumors when necessary to support high dose chemotherapy; and autologous or allogeneic bone marrow transplant and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and high risk stage II and III breast cancer, meniscal allograft, autologous chondrocyte implantation.

☐ Related Items. The Plan will also cover services, supplies and pharmaceuticals required in connection with a covered transplant procedure. This includes valuation of an Member as a transplant candidate; tissue typing; covered transplant procedure; scheduled follow- up care and anti-rejection medication.

☐ Donors. When the recipient of a covered transplant is an 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.

☐ Conditions. All transplant services require Prior Authorization. However, the Member must

first be accepted into the transplant program ata Transplant Center. .

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. The Plan will cover donor search and acceptability testing of potential love donors as well as short-term storage of donated organs and tissues.

☐ Limited travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be Covered only if our-of state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of $150 per day for the transplant recipient, live donor and one other person combined. All Organ transplants must be performed at site that the Plan approves and require Prior Authorization.

S. Hospice

☐ 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 Treating Provider hospice facility; and/or other 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;

- Nutritional counseling by a nutritionist or dietitian.

- Respite Care (care that provides relief for the caregiver) for up to 5 continuous days every 60 days of hospice care.

☐ 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 for three (3) benefit periods (if needed). If additional benefit periods are needed, the Plan's case managements staff shall work with the member's attending physician and the hospice's medical director to determine the appropriateness of continued hospice care.

- Hospice requires Prior Authorization after the first benefit period.

- 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.

T. Other Important Services

- Diabetes. The Plan's coverage of an Member's diabetes includes new or improved treatment or monitoring equipment; supplies; and outpatient self-management training and education. All supplies, including medications and equipment for the control of diabetes must be dispensed as written, including brand name products, unless a substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment. Such items, when obtained for a Qualified Participant, shall include but not be limited to the following:

    - Diabetes Equipment

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

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

- Podiatric appliances, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for the prevention of complications associated with diabetes.

- Diabetes Supplies

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

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

  - Biohazard disposable containers;

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

  - Glucagon emergency kits.

- Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

  Qualified Participant means an individual eligible for coverage under this Contract who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

- Skilled Nursing Care. The Plan will cover a Member's Inpatient skilled nursing services must be provided in a Network Facility or approved Non-Network Facility for Inpatient skilled nursing facility. These services also require Prior Authorization. Coverage by the Plan is limited to sixty (60) days per Plan Year.

☐ Rehabilitative Services. The Plan will cover services of licensed therapists providing short

term rehabilitative services, including physical, occupational and speech therapies. The Plan will also cover massage therapy by a licensed physical therapist as part of the rehabilitation care plan. Your Cost-Sharing for Physical therapy visits will be the same as seeing Your Primary Care Provider.

- 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 timeframe.

☐ 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 autism spectrum disorder diagnosis and treatment; and other services for Members with disabilities.

- 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.

- Excludes maintenance care for habilitative services: "When the Member reaches his maximum level of improvement or does not demonstrate continued progress under a treatment Plan, a service that was previously habilitative is no longer habilitative."

☐ Cardiac Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Network Provider and provided by Network therapists at Network facilities or approved Non-Network Provider/Facility. The Plan will also cover massage therapy by a licensed physical therapist as part of the rehabilitation care plan. These services require authorization after 36 visits

☐ Pulmonary Rehabilitation. Treatment in a program is provided if prescribed or recommended by a Netowrk Provider or approved Non-Network Provider and provided by Network therapists at Network facilities or approved Non-Network Providers/Facility. Clinical criteria are used to determine appropriate candidacy for the program, The Plan will also cover massage therapy by a licensed physical therapist as part of the rehabilitation care plan. These services require authorization after 36 visits

☐ Continuing Care. If a Member is hospitalized within a non-NetworkProvider 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-Network Provider hospital is willing to accept payment from the Plan at the rates payable to Network Providers. All other limitations and conditions of the Plan would apply.

☐ 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 of his/her own health. Such instruction must be provided by a Primary Care Provider. It could also be provided by another Network Provider.. Health education services include instruction in

personal health care measure and information about services. For example, instruction may include recommendations on generally accepted medical standards and the frequency of services.

☐ Oral Surgery/Dental Anesthesia Services. The Plan will cover the following oral surgery services for an Member when the Provider obtains Prior Authorization:

- Care for the treatment of acute facial fractures;
- Treatment of neoplasms (tumors) of the face, facial bones, or mouth;
- Medically Necessary Treatment of congenital defects;
- Treatment of disorders related to craniomandibular and temporomandibular joint disorders. Coverage includes surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders.
- Limitation: Plan does not cover orthodontic treatment and appliances, crowns, bridges, and dentures used for treatment of these disorders unless the disorder is caused by trauma.
- Treatment for accidental injury to sound natural teeth, (limited to treatment of traumatized teeth and surrounding tissue.)
- Limitation: Coverage for services will not be extended beyond twelve (12) months form the accident date. Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury and will not be Covered.

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

- Adult Eye Exams. The Plan will cover eye examination provided by an Member's Primary Care Provider to determine the need for vision correction. Eye examinations for the purpose of determining the need for corrective lenses are not covered. Vision hardware and corrective appliances are not covered.

☐ Hearing Exams and Hearing Aids. The Plan will cover hearing tests is 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. Coverage is provided for purchase, repair, and replacement of one (1) Medically Necessary hearing aid per ear, once every three years. This will include fitting and dispensing services, including ear molds as necessary to maintain optimal fit, provided by audiologist, a hearing aid dispenser or a physician.

☐ Morbid Obesity and Obesity Services-

- The Plan will pay for the following services
  - Nutritional assessment and counseling services for the medical management of morbid obesity and obesity.
  - Medically necessary prescription drugs
  - For Surgical services please see section on Bariatric Surgery.

☐ Hypnotherapy

- is only covered when performed by an anesthesiologist or psychiatrics, trained in the use of hypnosis when medically necessary or when: Used within two weeks prior to surgery for chronic pain management and
- For chronic pain management when part of a coordinated treatment plan

☐ Prescription Drugs. Prescription drugs are covered under Your benefit plan asfollows:

- The Plan allows drug manufactures coupons to be used to reduce Your cost of prescriptions and the amount you would have paid will still count towards Your Deductible, Copay, or Coinsurance amounts.
- Inpatient prescription drugs approved by the United States Food and Drug Administration (FDA) are covered when You are in a hospital or skilled nursing facility
- Outpatient prescription drugs are covered subject to the Plan's Formulary, and as follows:
  - Outpatient prescription drugs are designated as Tier 1, Tier 2, Tier 3, Tier 4, Tier 5 and Tier 6 in the Plan formulary.
  - Drugs not listed in the Plan's Formulary are not covered as Covered Services.
  - New drugs are excluded from formulary for the first six months after approval by FDA, unless it is an orphan drug.
    - The Orphan Drug Act (ODA) provides for granting special status to a drug or biological product ("drug") to treat a rare disease or condition. For a drug to qualify for orphan designation both the drug and the disease or conditionmust meet certain criteria specified in the ODA and FDA's implementing regulations at 21 CFR Part 316.
  - Prescription drugs for insulin or other qualifying diabetic drugs will not cost a member more than $25.00 per thirty (30)-daysupply.
  - 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 less

the applicable Deductible Copay or Coinsurance set forth in the Schedule of Benefits within ninety (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 FDA approved Drugs will be covered even when the drug is prescribed as a treatment for a particular indication for which the drug has not been FDA approved, provided that;

  - The drug has been recognized as sage and effective for the treatment of that indication one (1) or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American Hospital Formulary Service Drug Information," and "Drug Information for the Healthcare Provider,"

  - Or the drug is provided for cancer clinical trials.

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

Additional Prescription Drug Coverage Information:

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

- Medications for which a generic equivalent is available will be filled with an approved generic equivalent. If a brand name medication is requested when an approved generic equivalent is available the Member will pay the cost difference between the generic and brand-name drug (ancillary charge), in addition to the copayment or coinsurance amount. The difference will not apply to the Deductible, Coinsurance, Copay or the out-of- pocket maximum.

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

- Coverage for refills of prescription eye drops is covered if;

  - The renewal is requested by the insured at least twenty-three days for a thirty (30)-day supply of eye drops, forty-five (45) days for a sixty (60)-day supply of eye drops, or sixty-eight (68) days for a ninety (90)-day supply of eye drops, from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; and

  - The prescriber states that additional quantities are needed, and the renewal requested by the insured does not exceed the number of additional quantities needed.

- **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 recommend that the prescription drugs subject to step therapy protocols be taken in the specific sequence required by the step therapy protocol;

- are developed and endorsed by an interdisciplinary panel of experts that manages conflicts of interest among the members of the panel of experts by:
- requiring members to: 1) disclose any potential conflicts of interest with carriers, insurers, health care plans, pharmaceutical manufacturers, pharmacy benefits managers and any other entities; and 2) recuse themselves if there is a conflict of interest; and
- using analytical and methodological experts to work to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus;
- are based on high-quality studies, research and medical practice;
- are created pursuant to an explicit and transparent process that:
- minimizes bias and conflicts of interest;
- explains the relationship between treatment options and outcomes;
- rates the quality of the evidence supporting recommendations; and
- considers relevant patient subgroups and preferences; and
- take into account the needs of atypical patient populations and diagnoses.

o 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.

o The Plan's Pharmacy Benefit Manager (PBM) will need information from Your Provider if there is a medical reason that You cannot complete all the steps in the process before moving to the more- costly drug. Medical reasons for not completing step therapy include, but are not limited to, contraindication to the medication or the likelihood that the less costly drug would cause an adverse reaction or be ineffective. The Plan's PBM will respond to requests or exceptions to the Step Therapy program within twenty-four (24) hours if exigent circumstances exist. In circumstances where a step therapy drug has already been established, the Plan's PBM will provide members impacted by the step therapy program with a temporary supply of medication, pending the outcome of the exception request.

- **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 in accordance with federal and state laws and regulations.

o You, Your designee, or Your provider may request clinically appropriate drugs not otherwise covered by the Plan through the exception process. If the Plan grants Your request, we will cover the non-formulary drug for the duration of the prescription. If the Plan denies Your request, You, Your designee, or Your provider

may request an appeal of the decision..

- When You ask for an exception, Your Network provider or approved Non-Network Provider will need to explain the medical reasons why You need the exception approved. In addition, the provider would present to the plan evidence that the formulary drug has been or is reasonably expected to be less effective for the covered person' or the formulary drug has caused or is reasonably expected to cause adverse reactions in the covered person. If these two points are shown to be true, the Plan will cover the non-formulary drug as if it were a formulary drug.
- When we give You our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard coverage decision means we will give You an answer within seventy-two (72) hours after we receive Your doctor's statement. An expedited coverage decision means we will answer within twenty-four (24) hours 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 is recommended or given by a Provider, are excluded unless otherwise required by federal or state 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 Friday Care Crew line at the

following number: 1-844-805-5000.

☐ Exclusions include but are not limited to:

- Non-Prescription Drugs (unless specifically listed on the formulary)
- Compounded medications filled by a non-credentialed pharmacy
- Bulk chemicals used in compounds
- Compounding kits
- Drugs purchased at a pharmacy that are not in the Plan pharmacy network (unless as emergency)
- Early refills based upon the directions supplied by Your Provider. Vacation fills are handled on a case-by-case basis and are generally limited to two vacation fills per rolling Calendar Year.
- Infertility drugs
- Drugs used to treat sexual dysfunction
- Drugs or drug combinations not approved by the Food and Drug Administration
- Medications excluded by regulation as described by the Centers for Medicare & Medicaid Services
- Personal care items
- Probiotics
- Drugs used for cosmetic purposes
- Over the counter appetite suppressants/weight control drugs, dietary supplements,
- Prescription vitamins (other than prenatal)
- Experimental, Investigational, or Unproven drugs

☐ 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 or be a Clinical Trial Cancer Drug.

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 Member 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 form applying an appropriate Formulary or clinical management to any medication described in this section.

In addition, some Oral Cancer Drugs may be considered as being Off-label use of the FDA approved drugs. Off-label use of FDA approved Drugs, including Oral Cancer Drugs, will be covered even when the drug is prescribed as a treatment for a particular indication for which the drug has not been FDA approved. the Plan will approve Off-label Prescriptions if the following is true:

- The drug has been recognized and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider," or

- The Off-label drug that is being prescribed is for use in a cancer clinical trials.

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

- Routine Care During Clinical Trials (Cancer Clinical Trials). The Plan provides coverage for Medically Necessary routine patient care at a New Mexico facility, incurred as a result of the Member's participation in a clinical trial if all of the following conditions are met:

  - The clinical trial is undertaken for prevention, early detection, or treatment of cancer for which no standard cancer treatment exists or more effective standard cancer treatment exists.

  - The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.

  - The clinical trial is being provided in New Mexico as part of a scientific study of a new

therapy or intervention that is being conducted at an institution in New Mexico and is for the treatment, palliation, or prevention of cancer in humans with:

- Specific goals;
- A rationale and background for the study;
- Criteria for patient selection;
- Specific direction for administering the therapy or intervention and for monitoring patients
- A definition of quantitative measures for determining treatment response;
- Methods for documenting and treating adverse reactions; and
- A reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.

- The clinical trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention that is being conducted at an institution in New Mexico and is for treatment, palliation, or prevention of cancer in humans with:
  - Specific goals;
  - A rationale and background for the study;
  - Criteria for patient selection;
  - Specific direction for administering the therapy or intervention and for monitoring patients;
  - A definition of quantitative measures for determining treatment response;
  - Methods for documenting and treating adverse reactions; and
  - A reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.
- The clinical trial is being provided as part of a clinical trial being conducted in accordance with a clinical trial approved by at least one of the following:
  - One of the federal National Institutes of Health:
  - A federal National Institute of Health Cooperative Group or center;

- The United States Food and Drug Administration in the form of an investigational new drug application;

- The United States Department of Defense;

- The United States Department of Veteran Affairs; or

- A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

- The clinical trial or study has been reviewed and approved by an Institutional Review Board that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the federal National Institutes of Health.

- The personnel providing the clinical trial or conducting the study:

  - Are providing the clinical trial or conducting the study within their scope of practice, experience, and training and can provide the clinical trial because of their experience, training, and volume of patients treated to maintain their expertise; and

  - Agree to accept reimbursement as payment in full from the Plan and that is not more than the level of reimbursement applicable to other similar services provided by the In-Network Providers within our Provider Network; and

  - Agree to provide written notification to the Health Plan when a patient enters or leaves a clinical trial.

- There is no non-Investigational treatment equivalent to the clinical trial; and the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-Investigational alternative; and there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

- Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.

- If a Member is denied coverage of a cost and contends that the denial is in violation of New Mexico law, the Member may appeal the decision to deny the coverage of a cost to the Superintendent of Insurance and that appeal shall be expedited to ensure resolution of the appeal within no more than thirty (30) days after the date of the appeal to the Superintendent of Insurance.

- For the purposes of this specific Covered Benefit and Service, the term "Routine

Patient Care Cost" means:

- A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment.

- A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether that organization has approved the drug for use in treating the patient's Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor, or Provider of the drug.

- Routine Patient Care Cost does not include:

  - The cost of an Investigational drug, device, or procedure.

  - The cost of a non-Health Care service that the patient is required to receive because of participation in the clinical trial.

  - Costs associated with managing the research that is associated with the clinical trial.

  - Costs that would not be covered by the patient's if non-Investigational treatments were provided.

  - Costs paid or not charged for by the clinical trial Providers.

  - "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 of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

- Transgender Services. The Plan will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Transgender protections rules do not restrict an issuer, in consultation with a provider, from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case. Coverage of preventive care for transgender individuals shall be based on the treating provider's determination and not the insurance company.
  - Coverage for transgendered services may include:

    - Pharmacological support: Please see the Plans pharmacy formulary or contact the

Plan for more information.

- Surgical Procedures:
  - Male to Female transition:
    i. Intersex surgery, Clitoroplasty, Introitus plastic repair, Labiaplasty, Mammoplasty with implant, Nipple areola reconstruction, Orchiectomy, Penectomy, Prostatectomy, Vagina/Perineum reconstruction, Urethoroplasty, Vaginoplasty, Vulvoplasty, Phalloplasty. Breast Augmentation.
  - Female to Male transition:
    i. Intersex surgery, Hysterectomy with or without removal of fallopian tubes and ovaries, Vaginectomy, Mastectomy, Penile prosthesis, Scrotoplasty, Testicular prosthesis, Penis/perineum reconstruction, Nipple/areola reconstruction, Urethroplasty, Vulvectomy.

- Limitations: services not covered by the are listed below but not limited to:
  - Admonioplasty, Blephroplasty, Calf implant, Cheek, Chin or Nose implants, Collagen injections, Genioplasty, Fat grafts, Hair Removal (Laser or electrolysis), Hair grafts or transplants, Lipectomy, Lip reduction or enhancement, Mandible augmentation or reconstruction, Facial osteoplasty, Liposuction, Skin resurfacing, Tracheal shave Voice therapy lessons.

U. Medical Care Provided Outside of Service Area

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

☐ Emergency Care. The Plan will cover care that is provided to an Member outside of the Service Area (by a non-Network 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 Network Provider, except as otherwise stated in this Evidence of Coverage.

V. Cancer Drugs

☐ Off Label Use. The use of Off-label drugs to treat, prevent, or manage the symptoms of Cancer will be covered by the plan as Medically Necessary. Off-label use of FDA approved

Drugs, including Cancer Drugs, will be covered even when the drug is prescribed as a treatment for a particular indication for which the drug has not been FDA approved. The Plan will approve Off-label Prescriptions if the following is true:

- The drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider," or an authoritative reference compendium as identified by the Secretary of the United States Department of Health and Human Services; or

- The Off-label drug that is being prescribed is for use in a cancer clinical trial.

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

W. Chiropractic/Acupuncture

Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- The practitioner/provider determines in advance that chiropractic treatment can be expected to result in significant improvement in the covered person's condition within a period of two months.

☐ Chiropractic treatment is specifically limited to treatment by means of manual manipulation, i.e. by use of hands and other methods of treatment approved by the plan, including, but not limited to, ultrasound therapy.

☐ Subluxation must be documented by chiropractic examination and documented in the chiropractic record. The plan may not require radiologic (X-ray) demonstration of subluxation of chiropractic treatment.

- Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

☐ Exclusions related to Chiropractic care are as follows:

a. Chiropractic services are limited to 20 visits per year unless medically necessary care prescribed as a component of habilitative or rehabilitative services.

☐ Acupuncture visits do not require a Prior Authorization for the first 20 visits per plan year. Any visits over the 20-visit limit will require a Prior Authorization.

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

All the following services, accommodations, care, equipment, medications, or supplies are expressly excluded form Plan coverage unless otherwise stated in this Evidence of Coverage:

1. Any care that is not Medically Necessary, or specified as preventative.

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

3. All services or supplies that exceed any maximum time limitation (days or visits) identified in this document.

4. Cochlear transplants.

5. Medical, surgical, or other health care procedures, treatments, devices, products, or services that are experimental or investigative excluding routine patient care costs for clinical trials

6. Services by a non-Network Provider, except in the case of an Member's Medical Emergency, the Member's need for urgent care outside the service area, the services are not reasonably available from an In-Network Practitioner/Provider and the Plan provides a Referral to the non-Network Provider or the services of an Non- Network provider is done in conjunction with services at a an In-Network facility

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

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

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

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

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11. Nursing homes and custodial care.

12. For adults: Eye refractions or examinations, except as specifically covered under this Evidence of Coverage. Eyeglasses and all other types of vision hardware or vision corrective appliances. This includes contact lenses; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratomy; and clear lensectomy.

13. Hearing screening exams except as specifically covered under this Evidence of Coverage. .

14. Deluxe durable medical equipment or prosthetic or orthotic appliances, unless Medically Necessary. The Plan will cover standard equipment to meet the members need.

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

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

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

18. Disposable, non-prescription, or over-the-counter supplies. This includes items purchased over the counter 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 and orthotics and corrective shoes covered for diabetes.

19. Surgery or other health care services or supplies to correct or restore or enhance body parts not likely to result in significant improvement in bodily function.

20. Cosmetic products; health and beauty aids; and services and medications related to the diagnosis and treatment of, or to reverse or retard the effects of, aging of the skin. Cosmetic services that are intended primarily to change or maintain Your appearance and

that will not result in major improvement in physical function and that are not medically necessary. This includes cosmetic surgery related to bariatric surgery and tracheal saving procedures.

21. 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 event; camp; employment; marriage; trials or hearings; and licensing and insurance. However, examinations may be covered when performed as a scheduled physical examination.

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

23. All military service-connected conditions.

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

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

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

27. Infertility services are not covered by the Plan, including but not limited to:

    - In-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and variations of these procedures.

    - Surrogacy services, including the medical care of the surrogate mother, and the medical care of the surrogate mother's newborn child, unless and until that child becomes an eligible Dependent of the Subscriber as provided in the Enrollment section of this document.

    - Reversal of sterilization.

    - Any costs associated with the collection, preparation, or storage of sperm for artificial insemination, including donor fees, or donor egg or sperm retrieval.

    - Infertility injectable and suppository medications are not covered by the Plan.

28. Complications caused by treatment of infertility.
29. Elective abortions

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

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

32. Transplants disapproved by the appropriate evaluation committee.

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

34. Unless specifically identified as being covered, any testing for ability; developmental status; intelligence; aptitude or interest; or sleep therapy for insomnia. This limitation does not relate to the coverage for testing of autism for children.

35. Long term rehabilitative services.

36. Surgical treatment of hospitalization for treatment of impotency.

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

38. Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when:

    - You have reached maximum rehabilitation potential

    - You have reached a point where Significant Improvement is unlikely to occur.

    Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but re not limited to, Muscular Dystrophy, Down's syndrome, Cerebral Palsy, Autism, and Developmental Delays not associated with a defined event of illness or injury.
39. Recreational or educational therapy, non-medical self-help training or therapy; and sleep therapy.

40. Bone and eye bank charges.

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

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

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

44. Work-related illnesses or injuries are not Covered, even if:

    - You fail to file a claim within the filing period allowed by the applicable law.
    - You obtain care not authorized by Workers' Compensation Insurance.
    - Your employer fails to carry the required Worker's Compensation Insurance.
    - You fail to comply with any other provisions of the law.

45. Over the counter drugs other than insulin or mandated by the ACA.

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

47. Prescription drugs that have an over-the-counter equivalent (e.g., Monistat 7, Disobrom, etc.) unless mandated by the ACA.

48. Over the counter Anorectics and diet formulations used for the purpose of weight loss.

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

50. Abortifacient drugs are not covered.

51. Compounded medications/prescriptions are not covered.

52. Medications with no approved indications

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

54. 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.

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

56. Hair analysis

57. Routine foot care, unless You are diabetic, (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.

58. Post-Partum exercises.

59. The Plan does not provide ambulance transportation due to the absence of other transportation on the part of the Member.

60. Any and all costs related to surrogate pregnancies and deliveries
61. Enteral feedings except as mandated by Statute or Regulation.

SECTION 9: MEMBER PAYMENT RESPONSIBILITY

MONTHLY PREMIUMS

In exchange for Plan coverage, You will be required to pay monthly Premiums to beWellnm. However, Your Premiums may be reduced if You are eligible for Premium Advances. Premium Advances will be sent directly to the Plan from the Federal government.

beWellnm will send You a monthly bill for amount of Premiums You owe. Your Coverage may be terminated if You fail to pay Your Premiums timely to beWellnm. beWellNM will determine when to terminate Your coverage is described in the Effective Date of Termination of Coverage section.

PAYMENTS OUTLINED IN THE SCHEDULE OF BENEFITS

You will be responsible for paying the Copayment, Coinsurance and Deductible amounts described in the Schedule of Benefits Your Out-of-Pocket Maximum includes all Copayments, Coinsurance and Deductible amounts. However, these amounts may be reduced if You are eligible for Cost-sharing Subsidies.

You will also be responsible for paying for any health care services that do not qualify as Covered Services. In most cases, You will be responsible for the cost of non-Emergency health care services that You receive from a non-Network Provider without first receiving a Prior Authorization to that Provider from the Health Plan. In most cases, member costs for services that do not qualify as Covered Services, or Non-Emergency services received from a non-Network Provider without obtaining a Prior Authorization from the Plan, 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, or services from Non-Plan Providers even if Your Out-of-Pocket Maximum has been met.

COORDINATION WITH OTHER COVERAGE

OTHER COVERAGE

The amount of any payment by the Plan for Covered Services provided to an Member may be reduced if the Member is covered under another health care plan. This may be the case even if the Member 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.

MEDICAID COB

For individuals that are also eligible for medical benefits under the Medicaid program, the Plan will pay any overlapping benefits from health or accident insurance are owed to Human Services Department.

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 Member's prior coverage, if any.

NO DOUBLE RECOVER

In no event will You be entitled to obtain double recovery form Policies for health care services provided to You.

YOUR DISCLOSURE OBLIGATIONS

Your disclosure obligations will be satisfied by your application and Enrollment process with beWellnm.

RECOVERY RIGHTS OF THE PLAN

RIGHT OF SUBROGATION/REIMBURSEMENT

Subrogation proceedings limits your rights under New Mexico state law. 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 form 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 agree to reimburse the Plan for any benefits paid by the Plan after You or Your Covered Dependents are fully compensated. This reimbursement is not limited by the state purpose of the payment from the third party or how the payment from the third party is characterized in any agreement, or judgement.

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 know;

- 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 form 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.

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

RIGHT TO OFFSET FUTURE PAYMENTS

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

ASSIGNMENT OF RIGHTS

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

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

HEALTH CARE PROVIDER MAY SUBMIT A CLAIM

In most cases, when You or Your Covered Dependents receive health care services, the health care provider will send a claim directly to the Plan for payment. The health care Provider can do this because the Plan's information is set forth on Your identification card. Network Providers and other approved Providers are required to submit claims on Your behalf to the Plan when You supply them with Your insurance card. Non-Network Providers that have not been approved by the Plan are not obligated to submit claims on Your behalf but they may still submit claims on Your behalf.

CLAIMS YOU SUBMIT TO THE PLAN

Written Notice of Claim

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 submit a Written Notice of Claim to the Plan. The Written Notice of Claim must be given to the Plan within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. The Written Notice of Claim should be submitted by or on behalf of the insured to the Plan, see address below, or to any authorized agent of the insurance company. The Written Notice of Claim should be submitted by or on behalf of the insured to the Plan, see address below, or to any authorized agent of the insurance company. The Written Notice of Claim should contain information sufficient to identify the insured and a brief statement about the Claim. Once submitted, it shall be deemed that the Insured has provided notice to the Plan.

Claim Form

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

Proof of Loss

The insured will use the Claim Form to submit the Written Proof of Loss to the Plan. The completed Claim Form/Proof of Loss should be submitted to the Plan at the address below. Proof of Loss should be submitted to the Plan within ninety (90) days of the date that the health care services were provided. For In-Network Providers/ other Providers. Failure to furnish such Proof of Loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year form the time proof

is otherwise required.

If You file Your claim in a timely manner, the Plan will reimburse You for the amount You paid for the Covered Services that were provided up to the contracted rate with the Provider. However, the Plan will not reimburse You for any Copayment, Coinsurance or Deductible amounts that You were required to pay to the health care provider.

In some cases, the Health Care Provider may agree to send You a bill for the health care services provided. If this happens, You may file a written claim with the Plan. If You file Your claim in a timely manner, the Plan will pay the health care provider for the Covered Services that were provided at the contracted rate with the provider. However, the Plan will not pay for any Copayment, Coinsurance or Deductible amounts You owe to the health care provider. You are responsible for making sure that You receive the bill form 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 unless it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year form the time proof is otherwise required . Instead, You will be required to pay for all of the health care services that were provided unless such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year form the time proof is otherwise required.

In such cases where there is loss of life to the insured, the Plan will pay indemnities in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured within 30 days.

Content of Proof of Loss

Your claim / Proof of Loss 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.

The Notice of Claim and Proof of Loss should be sent to:

Friday Health Plans of Colorado, Inc.
Attention: Claims Director
700 Main Street
Alamosa, CO 81101
questions@fridayhealthplans.com

All clean claims shall be paid, denied, or settled with 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, policy holder, 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 with 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.

REMINDER

It is important to remember that, in most cases, the Plan will only pay for health care services provided by a Network 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 Network Provider, You will be reimbursed at the Plan's contracted rate with the Network 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.

TIMING OF THE NOTICE

After the Plan reviews Your claim, the Plan will notify You of any decision to pay or deny Your claim. Notice will be provided within the state laws and regulations timeline. This notification will be in the form of an Explanation of Benefits (EOB). The EOB is not a bill, but an explanation of how the cost of your medical care is applied to your benefits.

SECTION 11: GENERAL POLICY PROVISIONS

ENTIRE CONTRACT

This Evidence of Coverage along with , any amendments attached to this Evidence of Coverage, constitutes the Entire Contract between Friday Health Plans of Colorado, Inc., and the Member, and as of the effective date of the Contract, supersede all other Agreements between the parties. The Contract Year is the period of time for which the Agreement is in effect.

TIME LIMIT ON CERTAIN DEFENSES

As of the date of issue of this Policy, no misstatements, except willful or fraudulent misstatements, made by the Subscriber in the application for this Policy shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy).

In the event a misstatement in an application is made that is not fraudulent or willful, the Plan may prospectively rate and collect from the insured the Premium that would have been charged to the insured at the time the Policy was issued had such misstatement not been made.

GRACE PERIOD FOR PAYMENT OF PREMIUMS

If You are receiving Premium Advances the Plan will allow a three (3) month grace period for the payment of Premiums. During the first month of this grace period the Plan will continue to pay for Your Covered Services but during the second (2nd) and third (3rd) month of the grace period the Plan will not pay for Your Covered Services and these services would be paid for only after the Premiums for this period have been paid. If You are not receiving Premium Advances, the Plan will allow a thirty-one (31) day grace period for the payment of Premiums, during which Your coverage (and Your Covered Dependents) will remain in effect. The Plan has the right to pursue collection of the Premiums owed for the grace period.

REINSTATEMENT

The Plan may reinstate this Contract after it has been terminated. This may be done without the execution of a new application, the issuance of a new ID card, or any notice to the Subscriber other than the unqualified acceptance of an additional payment from the Subscriber.

WRITTEN NOTICE OF CLAIM

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 You should must submit a Written Notice of Claim to the Plan. The Written Notice of Claim should be submitted by or on behalf of the insured to the Plan, see address below, or to any authorized agent of the insurance company. The Written Notice of Claim should be submitted by or on behalf of the insured to the Plan, see address below, or to any authorized agent of the insurance company. The Written Notice of Claim should contain information sufficient to identify the insured and a brief statement about the Claim. Once submitted, it Shall be deemed that Insured has provided notice to the Plan.

CLAIM FORM

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

PROOF OF LOSS

The Insured will use the Claim Form to submit the Written Proof of Loss to the Plan. The completed Claim Form / Proof of Loss should be submitted to the Plan at the address below. Proof of Loss should be submitted to the Plan within ninety (90) days of the date that the health care services were provided. For In-Network Provider/Providers and within one (1) year (365 days) from the date of service for Out-of-Network Provider/Providers. Failure to furnish such Proof of Loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

If You file Your claim in a timely manner, the Plan will reimburse You for the amount You paid for the Covered Services that were provided up to the contracted rate with the Provider. However, the Plan will not reimburse You for any Copayment, Coinsurance, or Deductible amounts that You were required to pay to the health care provider.

In some cases, the Health Care Provider may agree to send You a bill for the health care services provided. If this happens, You may file a written claim with the Plan. If You file Your claim in a timely manner, the Plan will pay the health care provider for the Covered Services that were provided at the contracted rate with the Provider. However, the Plan will not pay for any Copayment, Coinsurance or Deductible amounts You owe to the health care provider 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.

CONTENT OF PROOF OF LOSS

Your claim / Proof of Loss 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.

The Notice of Claim and Proof of Loss should be sent to:

Friday Health Plans of Colorado, Inc.
Attention: Claims Director
700 Main Street
Alamosa, CO 81101
questions@fridayhealthplans.com

All clean claims shall be paid, denied, or settled within thirty (30) calendar days after receipt by the Plan if submitted 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 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.

PHYSICAL EXAMINATION AND AUTOPSY

The insurance company at its own expense shall have the right an opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTION

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE

In the event the age of the inured has been misstated and if, according to the correct age of the insured, the coverage provided by the Policy would not have become effective or would have ceased prior to the acceptance of such Premium of Premiums, then the liability of the Policy shall be limited to the refund, upon request, of all Premiums paid for the period not covered by the Policy.

CANCELATION

Your Plan coverage will end, or be cancelled, if:

- You fail to satisfy the eligibility conditions for participation in the Plan;
- You terminate Your coverage in the Plan with appropriate notice to the Plan or beWellnm;
- You change from one beWellnm plan to another during the Open Enrollment Period or through special enrollment;
- You fail to pay Your Premiums, and any applicable grace period has expired;

- You engage in certain misconduct, as described in the Effective Date of Termination of Coverage section; or

- The Plan is terminated or is, "decertified," by beWellnm

- When it determined that the Applicant intentionally provided to the Plan in the Application form untrue, inaccurate, or incomplete, in lieu of termination of coverage. The Plan shall have the right retroactively increase past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by the Plan within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to-date.

    - For an explanation of eligibility requirements, see the Eligibility, Enrollment and Effective Date section

CONFORMITY WITH STATE STATUTES

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

ACCEPTANCE OF CERTAIN THIRD-PARTY PAYMENTS

the Plan will accept premium and cost-sharing payments for the QHP's from the following third-party entities from plan Members (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;

2. An Indian tribe, tribal organization, or urban Indian organization; and

3. A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

FREEDOM OF CHOICE OF HOSPITAL OR PRACTITIONER

Within the area and coverage limits of the Policy, an insured person has the right to exercise full freedom of choice in the selection of a hospital, Practitioner of the healing arts, optometrist, psychologist, podiatrist, Physician Assistant, Certified Nurse Midwife, Registered Lay Midwife, registered nurse in expanded practice, or Independent Social Worker as defined in the Definitions section of this document. Treatment of an illness or injury within the Provider's scope of practice shall not be restricted under any new health insurance contract or Health Care Policy. A person insured under a health insurance Policy providing coverage for payment of benefits for the treatment or cure or correction of any physical or mental Condition shall be deemed to have complied with the requirements of the Policy by submission of a proof of loss, or upon submitting written proof supported by the certificate of the Provider or Independent Social Worker.

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.

CONFORMITY WITH LAW

The intent of this Evidence of Coverage is to conform to applicable state and federal laws and regulations in effect on the date this Evidence of Coverage became effective. Any provision of the Evidence of Coverage which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such law or regulation.

ACCESS PLAN

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

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

CASE MANAGEMENT

Our Case Management Program is free and voluntary. Your participation in the Program does not replace the care and services that You receive from You 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 of Colorado, Inc. at 1-844-805-5000.
Termination of provider status;

1. If the Plan terminates or suspends any contract with a Network Provider, then the Plan will notify, in writing, affected covered persons who are current patients of or, where applicable, assigned to the Provider, within thirty (30) days. Current patients are covered persons who have a claim with the Plan related to the provider's services within the past year, or who have received a pre-authorization prior to termination to use the provider's services at a future time.

2. The Plan will assist such affected covered persons in locating and transferring to another similarly qualified provider.

3. A covered person may not be held financially liable for services received from the provider in good faith between the effective date of the suspension or termination and the receipt of notice provided to the covered person has not received comparable notice during this time form the provider.

COVERAGE IS LIMITED TO COVERED SERVICES

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

COVERED SERVICES ARE NOT AUTOMATICALLY PAID BY THE PLAN

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

In most cases, the Covered Service must be performed by Your Primary Care Provider another Network Provider or approved Non-Network provider.

SPECIAL RIGHTS OF THE MEMBER

PRIVACY

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

HEALTH STATUS

An 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

For a Member or a Dependent with End Stage Renal Disease, the Plan will not terminate their coverage when they become eligible for Medicare.

END OF YOUR COVERAGE

Your Plan coverage will end if:

- You fail to satisfy the eligibility conditions for participation in the Plan;
- You terminate Your coverage in the Plan with appropriate notice to the Plan or beWellnm;
- You change from one beWellnmplan to another during the Open Enrollment Period or through special enrollment;
- You fail to pay Your Premiums, and any applicable grace period has expired;
- You experience a Rescission of coverage;
- You engage in certain misconduct, as described in the Effective Date of Termination of Coverage section; or
- The Plan is terminated or is, “decertified,” by beWellnm.
- If the Insured fails to give written notice within thirty-one (31) days of the loss of eligibility, the Plan will terminate coverage retroactively and refund any corresponding premium.
- When information provided to the Plan in the Application form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage. The Plan shall have the right to retroactively increase past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by the Plan within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to date.
- For an explanation of eligibility requirements, see the Eligibility, Enrollment, and Effective Date section.

END OF YOUR COVERED DEPENDENTS' COVERAGE

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

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

PROOF OF YOUR PLAN COVERAGE

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

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

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

Your request must include:

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

EFFECTIVE DATE OF TERMINATION OF COVERAGE

REQUESTED TERMINATION

If you (or any Covered Dependent) decide to terminate coverage under the Plan you must contact the Exchange to do so. The effective date of termination is assigned by the Exchange and the Plan will comply with that assigned effective date of termination. If you (or any Covered Dependent) request an earlier effective date of termination other than the date assigned by the Exchange you will need to appeal said date through the process set out by the Exchange, as that

earlier date will be subject to Exchange approval. If an earlier effective date of termination is approved by the Exchange, then the Plan will update to reflect the new effective date of termination. The Plan will comply with earlier effective dates of termination wherever possible and if approved by the Exchange if you (or any Covered Dependent) are eligible for Medicaid, other government funded programs, or a basic health plan (available to low-income individuals who are not eligible for Medicaid)I in whichcasethe last day of Plan coverage is the day before such coverage begins.

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

FOR ELIGIBILITY FAILURES

If You (or any Covered Dependent) is no longer eligible to participate in the Plan, Plan coverage will generally end on the last day of the month following the month in which beWellnm notifies You of such loss of eligibility, unless You request an earlier termination date as described above.

FOR PREMIUM PAYMENT FAILURES

If You fail to make a Premium payment that is required by the Plan and You are receiving Premium Advances, the Plan will allow a three (3) month grace period as long as You have paid at least one full month of the Premiums during the Plan Year. The Plan will notify You of Your failure to pay. During the first month of the grace period, the Plan will continue to pay for Your Covered Services (and Your Covered Dependents Covered Services).
However, the Plan may pend (holding without paying) any claims it receives during the second (2nd) and third (3rd) month of the grace period relating to You or Your Covered Dependents. If You fail to pay Your outstanding Premiums within the three (3) month grace period, Your coverage (and the coverage of Your Covered Dependents) will end as of the last day of the first month of the three (3) month grace period.
If You fail to make a Premium payment that is required by the Plan and You are not receiving Premium Advances, the Plan will allow a thirty-one (31) day grace period, during which Your coverage (and Your Covered Dependents) will remain in effect. The Plan will continue to pay for Your Covered Services (and Your Covered Dependent's Services) during the grace period. The Plan will notify You of Your failure to pay. If You fail to pay Your outstanding Premiums within the thirty-one (31) day grace period, Your coverage (and the coverage of Your Covered Dependents) will end as of the final day of the last month for which You made a full Premium payment.

FOR RESCISSIONS OF COVERAGE

If You or any Covered Dependent commits a fraud against the Plan or intentionally misrepresents a material fact in connection with the Plan or the coverage, there will be a Rescission of Your coverage (and the coverage of Your Covered Dependents). In such a case, the Plan will provide

You with thirty (30) days' advance written notice of the Rescission. However, the termination of coverage will be retroactive to the date of the event that cause the Rescission. The Plan will refund any contributions You made to the Plan relating to the period subject to the Rescission. However, the Plan may subtract from the refunded contributions any amounts paid by the Plan for Covered Services (for You and Your Covered Dependents) during such period. The Plan may also charge You for any amounts paid by the Plan for Covered Services (for You and Your Covered Dependents) during such period if those amounts are greater than the amount of Your contributions for that period. Any unpaid claims for Covered Services (for You or Your Covered Dependents) that relate to such period will, to the extent permitted by law, be denied by the Plan.

ELECTION OF OTHER BEWELLNM PLAN

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

FOR MISCONDUCT

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

FOR OTHER REASONS

If Plan coverage is being terminated because the Plan will no longer be offered by the Plan or the Plan being terminated or decertified, then 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 an 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.

RENEWAL RIGHTS

RIGHT OF RENEWAL

Generally, at the option of the Member, the Plan will renew or continue the coverage provided under the Plan.

DISCONTINUING THE PLAN

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

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

- Offers each Member the option to purchase coverage under any other health benefit plan

currently being offered by the Plan in the State of New Mexico and identifies the applicable special enrollment periods for each such plan: and

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

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

LEAVING THE INDIVIDUAL PLAN MARKET

The Plan will also not be required to renew an Member's coverage if the Plan discontinues offering and renewing all of its individual plans in the State of New Mexico and:

- Provides notice of the decision to discontinue coverage at least one hundred eighty (180) days before the discontinuance to each Member;

- Continues to provide coverage through the first renewal period, not to exceed twelve (12) months, after providing the one hundred eighty (180) day notice to Members; and

- Complies with the other applicable no-renewal requirements under the law.

SECTION 13: APPEALS AND COMPLAINTS
INTERNAL APPEAL PROCEDURES

GENERAL INFORMATION OF HEALTH INSURANCE GRIEVANCE PROCEDURES

This is a summary of the process You must follow when You request a review of the Plan's decision.

You will receive detailed information and Complaint forms form the Plan at each step. You can reach the Plan's Appeals and Grievances department in the following ways:

Email: appeals@fridayhealthplans.com
Phone: 1-844-805-5000
Fax: 844-280-1794

In addition, You can review the complete New Mexico regulations that control the process onthe Office of Superintendent of Insurance (OSI) website, www.osi.state.nm.us, found under the Departments menu Life & Health Division and then under Managed Health Care Bureau. You may also request a copy of the regulations in one of the two ways:

1. From the Plan by writing to us at:
   700 Main St.
   Alamosa, CO 81101
   questions@fridayhealthplans.com

2. From the OSI by calling:
   (505) 827-4601 or
   Toll free at 1-855-427-5674

WHAT TYPES OF DECISIONS CAN BE REVIEWED?

You may request a review of two different types of decisions:

- Adverse Determination: You may request a review if the Plan has denied Pre-Authorization (Certification) for a proposed procedure, has denied full or partial payment for a procedure You have already received, or is denying or reducing further payment for an ongoing procedure that You are already receiving and that has been previously covered. (We must notify You before terminating or reducing coverage for an ongoing course of treatment and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be Experimental, investigational, or not Medically Necessary or appropriate. It may also include a denial by the Plan of a participant's or beneficiary's eligibility to participate in a Plan. These types of denials are collectively called, "Adverse Determinations."

- Administrative decision: You may also request a review if You object to how the Plan handles other matters, such as its administrative practices that affect the availability, delivery, or quality of Health Care Services; claims payment, handling, or reimbursement for Health Care Services; or if Your coverage has been terminated.

REVIEW OF AN ADVERSE DETERMINATION

How does Prior Authorization for a health care service work?

When the Plan receives a request to pre-authorize payment for a Health Care or a request to reimburse Your Provider for a service that You have already had, we follow a two-step process.

1. Coverage: First, we determine whether the requested service is covered under Terms of Your Plan.

2. Medical Necessity: Next, if the Plan finds that the requested service is covered by the Policy, the Plan determines, in consultation with a Physician, whether a requested service is Medically Necessary. The consulting Physician determines Medical Necessity either after consultation with Specialists who are experts in the area or after application of Uniform Standards used by the Plan. For example, if You have a crippling hand injury that could be corrected by plastic surgery and You are also requesting that the Plan pay for cosmetic plastic surgery to give You a more attractive nose, the Plan might certify the first request to repair Your and deny the second, because it is not Medically Necessary.

Depending on the terms of Your Policy, the Plan might also deny the request for Prior Authorization if the service You are requesting is outside the scope of Your Policy. For example, if Your Policy does not pay for Experimental procedures, and the service You are requesting is classified as Experimental, the Plan may deny Certification. The Plan might also deny Certification if a procedure that Your Provider has requested is not recognized as a standard treatment for the Condition being treated.

Important: If the Plan determines that it will not certify Your request for services, You may have to pay the Provider Yourself for the services to go forward with the treatment or procedure. However, You will be responsible for.

How long does initial Certification take?

Standard decision: the Plan Must make an initial decision with five (5) working days. However, the Plan may extend the review period for a maximum of ten (10) calendar days if it:

- Can demonstrate reasonable cause beyond its control for the day;

- Can demonstrate that the delay will not result in increased medical risk to You; and

- Provides a written progress report and explanation for the delay to You and Your Provider within the original (5) working-day review period.

What if I need services in a hurry?
Urgent Care situation: An Urgent Care situation is a situation in which a decision from the Plan is needed quickly because of one or more of the following reasons:

- Delay would jeopardize Your life or health.
- Delay would jeopardize Your ability to regain maximum function.
- Your provider reasonably requests an expedited decision.
- The Provider with knowledge of Your medical Condition believes that delay would subject You to sever pain that cannot be adequately managed without the requested care or treatment.
- The medical demands of Your case require an expedited decision.

If You are dissatisfied with the Plan initial expedited decision in an Urgent Care situation, You may then request an expedited review of the decision by both the Plan and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, the Plan must review its prior decision and respond to Your request within seventy-two (72) hours. If You request that an IRO also perform an expedited review simultaneously with the Plan's review and Your request is eligible for IRO review, the IRO must also provide its expedited decision within seventy-two (72) hours of receiving the necessary release of information and related records. If You are dissatisfied after the IRO completes its review, You may ask the Superintendent of Insurance to review Your request. This review will be completed within seventy-two (72) hours after Your request is complete. The internal review, the IRO review and the review by the Superintendent of Insurance are described in greater detail in the following sections.

Important: if You are facing an emergency, You should seek medical care immediately and then notify the Plan as soon as possible. We will guide You through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?
If the initial request is approved, the Plan must notify You and Your Provider within one (1) working day after the decision, unless an urgent matter requires a quicker notice. If we deny Certification, we must notify You and the Provider within twenty-four (24) hours after the decision.

HOW TO APPEAL A DECISION IF YOUR INITIAL REQUEST IS DENIED
If the Plan denies Your initial request for services or You are dissatisfied with the way the Plan handles an administrative matter, You will receive a detailed written description of the Grievance procedures from the Plan as well as forms and detailed written description of the Grievance procedures from the Plan as well as forms and detailed instructions for requesting a review. **You may submit the request for review either orally or in writing.** The Plan provides

representatives who have been trained to assist You with the process of requesting a review. This person can help You to complete the necessary forms and with gathering information that You need to submit Your request. For assistance, contact the Plan's Consumer Assistance Office:

- Phone: 1-844-805-5000
- Mail:
  Friday Health Plans of Colorado, Inc.
  Attention: Appeals and Grievances
  700 Main St.
  Alamosa, CO 81101
- Fax: 844-280-1794
- Email: appeals@fridayhealthplans.com

You may also contact the Managed Health Care Bureau (MHCB) at OSI for help with preparing Your request for a review:

- Phone: (505) 827-4601 or toll-free at 1-855-427-5674
- Mail:
  Office of Superintendent of Insurance – MHCB
  P.O. Box 1689, 1120 Paseo de
  Peralta, Santa Fe, NM 87504-1689
- Email: Mhcb.grievance@state.nm.us
- Fax: (505) 827-4734, Attn: MHCB

Who Can Request a Review?
You, Your Provider, or someone that You select (with Your written consent) to act on Your behalf may request a review. The patient may be the actual Member who receives coverage through the Plan. The person requesting the review is called the Grievant.

APPEALING AN ADVERSE DETERMINATION: FIRST LEVEL REVIEW
If You are dissatisfied with the Plan's initial decision, You have the right to request that the Plan's decision be reviewed by the medical director. The medical director may make a decision based on the terms of Your policy, may choose to contact a specialist or the provider who has requested the service on Your behalf, or may rely on the Plan's standards or generally recognized standards.

TIME LIMIT FOR REQUESTING A REVIEW

You must tell the Plan that You wish to request an internal review within one hundred eighty (180) days after the date You are notified that the initial request has been denied.

What You Need to Provide

If You request that the Plan review its decision, we will provide You with a list of the documents You need to provide and will provide to You all of Your records and other information the internal panel members will consider when reviewing Your case. You may also provide additional information that You would like to have the medical director consider, such as a statement or recommendation from Your doctor, a written statement from You, or published clinical studies that support Your request.

How long does a first level internal review take?

- Expedited review. If a review request involves an urgent care situation, the Plan must complete an expedited internal review as required by the medical demands of the case, but in no case later than seventy-two (72) hours form the time the internal review request was received.

- Standard review. The Plan must complete both the medical director's review and (if You then request it) the Plan's internal panel review within thirty (30) days after receipt of Your pre-service request for review or within sixty (60) days if You have already received the service request for review or within sixty (60) days if You have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request – now what?

If You remain dissatisfied after the medical director's review, You may either request a review by a panel that is selected by the Plan or You may skip this step and ask that Your request be reviewed by an IRO that is appointed by the Superintendent.

- If You ask to have Your request reviewed by the Plan's panel, You have the right to appear before the panel in person or by telephone or have someone, (including Your attorney), appear with You or on Your behalf. You may submit information that You want the panel to consider and ask questions of the panel member. Your health provider may also address the panel or send a written statement.

- If You decide to skip the panel review, You will have the opportunity to submit Your information for review by the IRO, but You will not be able to appear in person or by telephone. OSI can assist You in getting Your information to the IRO.

If You are covered under the NM State Healthcare Purchasing Act, You may NOT request an IRO review if You skip the panel review.

How long do I have to make my decision?

If You wish to have Your request reviewed by the Plan's panel, You must inform the Plan with 5

days after You receive the medical director's decision. If You wish to skip the Plan's panel review and have Your matter, go directly to the IRO, You must inform OSI of Your decision within 4 months after You receive the medical director's decision.

What Happens During and the Plan Panel Review?

If You request that the Plan provide a panel to review its decision, the Plan will schedule a hearing with a group of medical and other professionals to review the request. If Your request was denied the Plan felt the requested services were not Medically Necessary, were Experimental, or were Investigational, then the panel will include at least one Specialist with specific training or experience with the requested services.

The Plan will contact You with information about the panel's hearing date so that You may arrange to attend in person or by phone or arrange to have someone attend with You or on Your behalf.

You may review all the information that the Plan will provide to the panel and submit additional information that You want the panel to consider. If You attend the hearing in person or by telephone, You may ask questions of the panel members. Your medical Provider may also attend and address the panel or send a written statement.

How Long an Internal Panel Review Takes

- Expedited review. If a review request involves an Urgent Care situation, the Plan must complete an expedited internal panel review as required by the medial demands of the case, but in no case later than seventy-two (72) hours from the time the internal review request was received.

- Standard review. The Plan must complete both the medical director's review and the internal panel review within thirty (30) days after receipt of Your pre-service request for review or within 60 days if You have already received the service.

You will be notified within one (1) day after the panel decision. If You fail to provide records or other information that the Plan needs to complete the review, You will be given a chance to provide the missing items. **However, the review process may take much longer, and You will be forced to wait for a decision.**

Tip: If You need extra time to prepare for the panel's review, then You may ask that the panel be delayed for a maximum of thirty (30) days.

If You Choose to Have Your Request Reviewed by the Plan Panel, Can You Still Request the IRO Review?

Yes. If Your request has been reviewed by the Plan's panel and You are still dissatisfied with the decision, You will have 4 months to decide whether You want to have the request reviewed by an IRO.

What Is an IRO and What Does It Do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues particular to a request. Depending on the type of issue, the IRO may assign a single reviewer or a panel of reviewers to consider Your request. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the Plan or with You. The reviewer will consider all the information that is provided by the Plan and You. (OSI can help You get Your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to You, Your Provider, the Plan, and OSI. The Plan must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, the Plan must provide them.

The IRO's fees are billed directly to the Plan. There is no charge to You for this service.

How Long Does an IRO Review Take?
The IRO must complete the review and report back within twenty (20) days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review for an Urgent Care matter, the IRO must report back within seventy-two (72) hours after receiving all the information it needs to review the matter.)

SUPERINTENDENT OF INSURANCE REVIEW
If You remain dissatisfied after the IRO's review, You may still be able to have the matter reviewed by the Superintendent. You may submit Your request directly to OSI, and if Your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support Your request and You may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent Co-Hearing Officers to hear the matter and to provide a recommendation.

The Co-Hearing Officers will provide a recommendation to the Superintendent within thirty (30) days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to You for a review by the Superintendent of Insurance and any fees for the Hearing Officers are billed directly to the Plan. However, if You arrange to be represented by an attorney or Your witnesses require a fee You will need to pay those fees.

REVIEW OF AN ADMINISTRATIVE DECISION
How Long DO I Have to Decide if I Want to Appeal and How Do I Start the Process?
If You are dissatisfied with an initial administrative decision made by the Plan, You have a right to request an internal review within one hundred eighty (180) days after the date You are notified

of the decision. The Plan will notify You within three (3) days after receiving Your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How Long Does an Internal Review of an Administrative Decision Take?
The Plan will mail a decision to You within thirty (30) days after receiving Your request for a review of an administrative decision.

Can I Appeal the internal Reviewer's Decision?
Yes. You have **twenty (20) days** to request that the Plan form a committee to reconsider its administrative decision.

What Does the Reconsideration Committee Do? How Long Does It Take?
When the Plan receives Your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the Plan who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within fifteen (15) days after the Plan receives Your request. You will be notified at least five (5) days prior to the committee meeting so that You may provide information, and/or attend the hearing in person or by telephone.

If You are unable to prepare for the committee hearing within the time set by the Plan, You may request that the committee hearing be postponed for up to thirty (30) days.

The reconsideration committee will mail its decision to You within seven (7) days after the hearing.

HOW TO REQUEST AN EXTERNAL REVIEW
If You are dissatisfied with the reconsideration committee's decision, You may ask the Superintendent to review the matter within twenty (20) days after You receive the written decision for the Plan. You may submit the request to OSI using forms that are provided by the Plan. Forms are also available on the OSI website, www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-855-427-5674.

How Does the External Review Work?
Upon receipt of Your request, the Superintendent will request that both You and the Plan submit information for consideration. The Plan has five (5) days to provide its information to the Superintendent, with a copy to You. You may also submit additional information, including documents and reports for review by the Superintendent. The Superintendent will review all the information received from both You and the Plan and issue a final decision within forty-five days. If You need extra time to gather information, You may request an extension of up to ninety (90) days. Any extension will cause the review process and decision to take more time.

GENERAL INFORMATION

CONFIDENTIALITY

Any person who comes into contact with Your personal Health Care records during the Grievance process must protect Your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the Provider and the Plan cannot release Your records, even to OSI, until You have signed a release.

Special Needs and Cultural and Linguistic Diversity

Information about the Grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting Requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of Grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of Superintendent. This is not legal advice, and You may have other legal rights that of are not discussed in these procedures Insurance.

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

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

CHANGES IN RATES

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

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

NOTICE

The Plan will provide thirty (30) days' notice in advance of any material changes to Your Premium amount.

SECTION 15: COORDINATION OF BENEFITS

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

Under the COB provisions of this Plan, the amount of any payment by the Plan for Covered Services provided to an Member may be reduced if the Member is covered under another health care plan. This may be the Case even if the Member 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.

The order in which each plan will pay a Claim for benefits is considered the order of benefits rule. The plan that pays first is called the primary payer. The primary payer must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary payer is considered the secondary payer. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows: The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. The secondary plan coordinates its payment based on the amount paid by the primary payer.

MEDICARE COB

In the case of individual health insurance, Medicare will be primary except as required by law.

MEDICAID COB

If You have dual coverage with Medicaid any overlapping benefits received from health and accident insurance will be paid to Human Services Department.

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 Member's prior coverage, if any.

NO DOUBLE COVERAGE

In no event will You be entitled to obtain double recovery from Policies for health care services provided to You.

ORDER OF BENEFITS

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

1. The primary Plan pays or provides it benefits according to its terms of coverage and

without regard to the benefits under any other Plan. A Plan that does not contain a COB provision that is consistent with this EOC is always primary unless the provisions of both Plans state that the complying Plan is primary..

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, the plan covering the spouse of the custodial parent, the plan covering the noncustodial parent: then the plan covering the spouse of the noncustodial parent; then the plan covering the spouse of the noncustodial parent.

YOUR DISCLOSURE OBLIGATIONS

Your disclosure obligations will be satisfied by your application and Enrollment process through beWellnm.

SECTION 16: DEFINITIONS

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

1. "ACA Preventative Care Drug" A medication that under the Affordable Care Act (ACA) some medications may have limited or $0 Cost-Sharing.

2. "Adverse Benefit Determination" A Plans determination to deny, reduce or terminate, or its failure to provide or make payment (in whole or in part) for a benefit.

3. "Allowed Amount" The maximum amount a plan will pay for a covered health care service.

4. "Appeal" An Appeal is a written request from the member or Network Provider stating their disagreement with an Adverse Benefit Determination and their desire to have the Adverse Benefit Determination overturned.

5. "Application" refers to the form used by beWellnm to collect information from You and to verify that information.

6. "Benefits" The health care items or services covered under a health insurance plan. May also be called "Covered Services".

7. "beWellnm" is the New Mexico Health Exchange.

8. "Brand Drug" A Prescription Drug, including insulin, typically protected under patent be the drug's original manufacturer or developer with a proprietary trademarked name.

9. "Child" Your natural-born child, Your adopted child, a foster child, or a child placed with You or Your Spouse for adoption, if the child:

    - Has not yet attained age twenty-six (26); or

    - Is medically certified as disabled and Dependent upon You or Your Spouse (no matter how old the child is).

10. "Cognitive Communication Therapy" Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

11. "Contract" means this Policy document, the member ID card and any attachments to this policy.

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

13. "Copayment" means a cost-sharing method that requires an Member to pay a fixed dollar amount when health care services are received, with the carrier paying the balance of the allowable amount; provided that there may be different copayment requirements for different types of services under the same individual or group health maintenance organization contract. .

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

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

16. "Covered Child" means any Child, age twenty-six (26) and Younger, who is enrolled in the Plan.

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

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

19. "Deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services. .

20. "Dependent" a Child or other individual for whom a parent, relative, or other person may claim a person exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a Premium Tax Credit to help cover the cost of coverage for themselves and their dependents.

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

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

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

23. "Emergency Care" means a health care procedure, treatment or service, , which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person

24. "Experimental or Investigational" means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished;
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;
- Reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or the drug or device is used for a purpose that is not approved by the FDA;

For the purposes of this section, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature listed in Subsection A of 13.10.13.10 NMAC; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; as used in this section, "experimental" or "investigational" does not mean

cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

25. "Formulary Drug" A Brand Drug, Generic Drug or Specialty Drug included in the Drug Formulary.

26. "Friday" means Friday Health Plans of Colorado which is the Insurance Company You are insured through.

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

28. "Grievance" means an oral or written complaint submitted by or on behalf of a covered person regarding either an adverse determination or an administrative decision.

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

30. "Injectable Drug"- A prescription drug dispensed from a pharmacy (including combination therapy kits) that are injected directly in the body by the Member or the Member's Provider. These are also drugs that can be dispensed in an office or hospital setting.

31. "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..

32. "Medically Necessary" means Health Care Services determined by a Provider, in consultation with the Health Care Insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Health Care Insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

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

34. "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.

35. "Network Facility" is an entity that provides health care services that is contracted with the Plan. This included but no limited to
    - a general, special, psychiatric or rehabilitation hospital;
    - an ambulatory surgical center;
    - a cancer treatment center;
    - a birth center;
    - an inpatient, outpatient or residential drug and alcohol treatment center;
    - a laboratory, diagnostic or other outpatient medical service or testing center;
    - a health care provider's office or clinic;
    - an urgent care center;
    - a freestanding emergency room; or
    - any other therapeutic health care setting; .

36. "Network Hospital" is any hospital listed as a Network hospital in our provider directory.

37. "Network Medical Office" is any medical office listed in our provider directory, including any outpatient facility designated by Friday Health Plan.

38. "Network Provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing. Also referred to as In-Network Providers.

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

40. "Non-Formulary" A drug that is not listed in the Drug Formulary.
41. "Non-Network Provider" means a Hospital, Provider, Behavioral Health Practitioner or Other Provider who has not entered into an agreement with Friday. Benefits are generally not available for services provided by Out-of-Network Providers.

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

43. "Out-of-Area" Outside of New Mexico and outside the area in surrounding states that is within 50 miles of the New Mexico border.

44. "Out-of-Network" The receipt of services from Non-Network Providers.
45. "Out-of-Pocket Maximum" The maximum dollar amount a Member or Family will pay for Covered Services in a calendar year. Copayments, Coinsurance and Deductibles paid by Members count towards the Out-of-Pocket Maximum. The Out-of-Pocket

Maximum does not include Premiums, expenses associate with non-Covered Services or denied claims. If coverage is extended to qualified Dependents and the family Out-of-Pocket Maximum has been paid, no further payment is required to be paid on the member's be half for Covered Services.

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

47. "Plan Year" a 12-month period of Benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.

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

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

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

51. "Primary Care Provider (PCP)" means a health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also provide primary care.

52. "Prior Authorization" Approval from a health Plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by Your Plan.

53. "Prior Written Authorization" is the proof of the Prior Authorization granted by Friday.

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

55. "Provider" means any hospital, Provider, or other provider of Health Care.

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

57. "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.

58. "Service Area" means all the counties in New Mexico where the Plan offers the Plan and has arrangements with Network Providers.

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

60. "Subscriber" means an individual who enrolls themselves and their Eligible Dependents in this Plan also referred to as a Member.

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

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

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

64. "Specialty Drugs" are high-cost oral, injectable, infused or inhaled covered drugs that are self- administered or given by a Provider. These drugs are used in an outpatient or home setting. Insulin is not considered a Specialty Drug. Contact Friday at 844-451-4444.

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

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

67. "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.

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

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

70. "Welcome Kit" is a package sent to the Member that is the primary policy holder includes the Notice of Privacy, and the member ID cards.

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